MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
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9:21 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[9:21 a.m.]

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

implementation of the policy.

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

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

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

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

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

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

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

beneficiaries who do not meet the criteria.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Lastly we consider national rates of risk-

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

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

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

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

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

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

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

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

We'll take clarifying questions. Kathy.

MS. BUTO: Thanks a lot for this presentation.

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

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

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

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

LTCHs are located relative to the beneficiaries.

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

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

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

So does that answer your first question, Kathy?

MS. BUTO: Yeah. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

One of the assumptions of the work on PAC PPS

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

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

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

question.

DR. CROSSON: Okay. Sue.

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

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

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

country use LTCHs very differently.

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

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

DR. CROSSON: Jaewon.

DR. RYU: Thanks for the presentation.

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

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

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

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

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

So I think it comes from both kind of an

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

DR. CROSSON: I've got David first, then Brian.

I'm sorry. Did I miss somebody?

DR. SAFRAN: I was in there somewhere.

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

Go ahead, Dana.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

population they serve.

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

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

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

DR. CROSSON: Yeah. Very interesting. Thanks.

Brian.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In terms of the increase in payments to other

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

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

MS. CAMERON: Oh, sorry. Excuse me.

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

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

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

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

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

DR. CROSSON: Okay. A couple of observations. We have used up almost all of our time and we're still on

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

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

David.

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

around ICU days. Thanks.

DR. CROSSON: Marge.

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

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

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

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

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

DR. CROSSON: Okay. Jonathan.

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

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

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

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

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

Paul and Warner.

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

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

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

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

DR. CROSSON: Warner.

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you.

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

DR. CROSSON: Yes, on that.

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

DR. CROSSON: Okay. Sue.

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

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

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

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

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

DR. CROSSON: Marge on this point.

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

DR. CROSSON: Brian. Last comment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you, and we look forward to the discussion.

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

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

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

[Laughter.]

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

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

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

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

DR. CARTER: That's right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

this option.

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

DR. SAFRAN: Yeah.

DR. CARTER: Yeah. Okay.

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

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

work.

DR. CROSSON: Questions. Sue and then Marge.

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

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

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

DR. CARTER: Yes. Yes.

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

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

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

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

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

DR. CROSSON: Marge.

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

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

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

DR. CROSSON: Pat.

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

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

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

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

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

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

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

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

DR. SAFRAN: Just a quick comment on that exact

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

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

DR. CROSSON: Okay. Very good.

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

Dana is going to start the discussion.

DR. SAFRAN: Yes. Thanks.

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

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

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

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

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

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

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

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

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

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

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

Thanks.

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

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

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

DR. SAFRAN: Correct.

DR. CROSSON: Or additional set of issues.

Jon.

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

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

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

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

Kathy.

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

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

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

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

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

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

DR. CROSSON: Okay. Bruce.

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

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

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

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

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

But I really want to thank you. It was

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

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

DR. PYENSON: But before Jon cut me off.

[Laughter.]

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

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

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

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

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

MR. PYENSON: Correct.

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

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

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

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

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

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

DR. CROSSON: Jon, on this point?

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

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

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

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

MR. PYENSON: Oh.

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

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

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

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

DR. CARTER: Well, my personal thought is I

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Jon.

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

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

I would take some issue with the statement that

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

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

independently.

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

DR. CROSSON: Thank you. Brian.

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

[Laughter.]

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

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

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

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

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

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

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

So I hope that as we move forward with this work

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

DR. CROSSON: Thank you. David.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I see one individual coming to the microphone.

MR. BRIERLY: Great. Good morning --

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

remarks to approximately two minutes.

MR. BRIERLY: Sounds good.

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

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

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

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

DR. CROSSON: Thank you.

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

populations.

Thank you.

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

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

AFTERNOON SESSION

[1:00 p.m.]

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

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

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

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

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

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

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

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

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

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

medical homes.

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

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

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

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

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

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

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

Overall, we have a number of concerns.

First is the administrative complexity that I just alluded to.

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

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

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

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

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

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

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

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

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

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

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

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

In 2019 and 2020, there will be a small increase

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

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

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

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

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

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

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

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

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

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

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

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

MS. WANG: Okay.

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

MS. WANG: Thank you.

DR. CROSSON: Jonathan and Sue and Amy.

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

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

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

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

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

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

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

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

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

DR. JAFFERY: Okay.

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

DR. JAFFERY: Okay. Thanks.

DR. CROSSON: Sue.

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

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

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

the attribution of that beneficiary.

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

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

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

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

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

that.

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

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

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

yeah, we would love to know that as well.

MS. THOMPSON: Thank you.

DR. CROSSON: Amy.

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: No? All right, then.

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

DR. CROSSON: Okay. Help me here.

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

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

DR. CROSSON: Yes.

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

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

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

DR. CROSSON: It's not MA?

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

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

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

MR. GLASS: Yes.

DR. CROSSON: All right. Thank you.

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

DR. JAFFERY: Not exactly, but --

[Laughter.]

DR. CROSSON: I got that.

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

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

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

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

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

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

MR. GLASS: They're taking some risk.

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

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

MR. GLASS: Right.

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

MR. GLASS: Oh, yeah.

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

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

zero to 25?

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

MR. THOMAS: Okay. Thanks.

DR. CROSSON: Paul.

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

MS. BLONIARZ: I think that's kind of a question of design.

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

that.

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

DR. CROSSON: Dana.

DR. SAFRAN: Thanks.

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

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

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

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

DR. CROSSON: Brian, on this?

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

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

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

MR. GLASS: Off of them?

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

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

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

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

DR. CROSSON: More to come.

Marge.

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

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

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

[Laughter.]

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

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

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

MS. BLONIARZ: Yes, 2016.

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

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

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

[Laughter.]

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

Okay. Kathy?

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

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

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

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

[Laughter.]

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

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

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

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

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

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

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

The thesis here is that at the end of this

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

Paul is going to start the discussion.

DR. PAUL GINSBURG: Sure.

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

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

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

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

I don't want to throw this opportunity away to

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

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

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

MS. THOMPSON: Well, in part.

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

the payments upon which the 5 percent is applied.

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

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

DR. CROSSON: Yeah, that's fine.

MS. THOMPSON: Is that okay?

DR. CROSSON: GO for it.

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

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

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

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

We'll go down this way. Jonathan.

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

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

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

minimis of 25 percent or whatever it would be.

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

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

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

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

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

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

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

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

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

Those are my thoughts.

DR. CROSSON: Okay. Further comments?

Bruce.

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

DR. CROSSON: Jaewon.

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

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

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

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

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

And just a number of things that are not

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

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

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

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

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

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

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

DR. CROSSON: Paul.

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

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

DR. CROSSON: Brian.

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

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

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

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

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

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

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

DR. CROSSON: Okay. Dana.

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

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

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

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

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

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

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

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

DR. SAFRAN: Oh, yeah.

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

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

DR. SAFRAN: I would.

MR. GLASS: -- want to --

DR. SAFRAN: I would.

MR. GLASS: -- reward that anyway?

DR. SAFRAN: I would, yeah.

MR. GLASS: Really?

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

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

MS. BLONIARZ: It's a bonus.

DR. SAFRAN: It's a bonus.

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

DR. SAFRAN: Right.

MS. BLONIARZ: I think that varies by model.

DR. SAFRAN: Yeah. Okay. Thank you.

DR. CROSSON: Warner.

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

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

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

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

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

MR. THOMAS: Yeah.

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

Pat.

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

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

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

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

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

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

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

MS. WANG: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

you'll hit me.

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

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

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

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

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

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

DR. CROSSON: Yep.

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

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

Now, okay, Kate, let me have it.

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

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

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

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

MS. WANG: I was saying the former.

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

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

DR. CROSSON: Okay. All right.

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

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

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

MR. GLASS: Just fee-for-service.

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

MS. BLONIARZ: Okay.

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

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

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

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

[Pause.]

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

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

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

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

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

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

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

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

So why should Medicare modernize the MDH program?

First, it fails to accurately measure what

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

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

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

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

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

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

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

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

Now Stephanie will walk you through some of the data.

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

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

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

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

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

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

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

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

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

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

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

requirement.

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

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

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

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

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

percent.

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

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

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

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

using a sliding scale is preferable over a flat increase.

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

And with that, I turn it back to Jay.

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

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

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

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

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

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

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

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

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

MS. WANG: That's fine.

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

MS. WANG: Thank you.

DR. CROSSON: Jon.

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

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

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

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

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

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

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

DR. CROSSON: Dana.

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. SAFRAN: Thanks.

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

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

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

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

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

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

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

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

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

DR. SAFRAN: Thank you.

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

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

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

[Laughter.]

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

[Laughter.]

DR. CROSSON: All right. Further questions?

David.

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

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

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

MS. CAMERON: That's right.

DR. GRABOWSKI: Thanks.

DR. CROSSON: Sue.

MS. THOMPSON: Thank you both for this chapter.

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

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

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

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

the program.

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

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

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

be concerned there too.

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

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

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

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

DR. CROSSON: Okay. Kathy.

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

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

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

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

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

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

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

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

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

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

be looking at Medicare profitability at all.

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

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

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

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

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

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

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

Is that fair enough, Jim?

DR. MATHEWS: Mm-hmm.

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

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

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

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

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

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

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

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

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

DR. CROSSON: Okay. Further discussion?

We'll start over here with Pat again, I guess.

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

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

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

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

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

DR. CROSSON: Dana.

DR. SAFRAN: Thanks.

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

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

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

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

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

DR. CROSSON: Further comments?

Bruce, then Marge.

MR. PYENSON: Thank you very much. Considering

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

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

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

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

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

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

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

[Comment off microphone.]

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

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

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

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

MR. PYENSON: That they had turned negative.

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

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

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

DR. CROSSON: Okay. Go ahead.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thanks.

DR. CROSSON: Amy.

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

MS. CAMERON: That's right.

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

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

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

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

MS. CAMERON: Right.

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

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

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

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

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

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

What I'm somewhat concerned about is that, you

know, since most of the money went to rural except for some urban hospitals that snuck in because their member of Congress dictated that they're in a rural area, except for that, in a sense, I think we're thinking a program for rural and we're, you know, greatly expanding it to do more for urban hospitals. And I wonder if we'd be better off just fixing this program for the rural hospitals and very separately, perhaps in conjunction with doing the update, or maybe later, you know, think about what we should be doing for urban hospitals where Medicare -- they have a mix of Medicare and Medicaid, very little commercial, Medicare's declining rates or declining margins becoming increasingly a problem for them. But it seems like this may be a tail wagging the dog thing, and this prompted, I think appropriately, Sue's comments about their taking the rural money and putting it in urban hospitals.

DR. CROSSON: Yeah, Warner.

MR. THOMAS: So I would agree with Sue and I would agree with Paul as well. I think that, you know, it's a program that's morphed and really had a specific purpose. We ought to go back to that. But I'd also agree with Amy that I think we ought to just aggregate these

different programs if there's others like it so we look at them together along with the update, and to me we shouldn't be allocating more dollars to special programs. We ought to look at the update factor and figure out what we want to do from that perspective across the whole spectrum of hospitals. And if there's targeted areas like rural and we've got to make sure we take care of that, then let's make sure we do that, but not broaden a program that had a specific focus.

But I do think it would be nice if there's other special programs like this. You know, a lot of people don't know about Medicare-dependent hospitals. I'm sure there's other programs -- I don't know. It would be nice to look at them all and just kind of understand what they are and what their target has been.

DR. CROSSON: Kathy.

MS. BUTO: This reminds me of something I've thought of for a long time, which is I don't think we're smart enough to do this for every region of the country, with all the different rural options that are out there. And at some point -- not now -- I think we ought to consider something more like a payment that gets decided by

a region to make decisions about what rural entities -- they could be EDs; they could be, you know, urgent care centers; they could be primary care practices, not just hospitals. But it just feels like we think maybe if we keep tinkering around all these individual entities, that maybe we'll get it right. But I just don't believe that, having watched the program struggle to do this for quite a long time.

DR. CROSSON: Okay. So here we come to the time when we try to say where we are.

[Comment off microphone.]

DR. CROSSON: Yeah, go for it. I think my sense of this is that we probably need to divide the issue here, and I think there's a -- I heard a number of people in different ways saying let's take the rural issue and look at that from a policy perspective as a whole. And I think we can do that. We can't do that next month, but I think we can do that.

What remains for me then is still the issue -- and it goes back to last year, and we'll see when we get to the update discussion on hospitals next month what the margins look like. And I understand your concern, Bruce.

We'll see, you know, whether the trend that we've identified is continuing. If it is, it still raises for me the question that we tried to address last year, and I think we need to address again this year, which is: Do we have a concern about the viability or just the stress that this is placing on hospitals who are dedicated to serving more than the average percentage of Medicare beneficiaries? Because I think there's reason to be concerned. And so I think if -- and melding this -- we had some suggestions. Isn't this part of the update? It certainly could be. And I think it needs to be, and so I think when we come back in December we'll segment out the issue of rural hospitals. We'll take that on when we can. But I do recommend that, as we get into the update in December and then in January, that we look at this issue of Medicare-dependent hospitals.

And with that, Stephanie and Jeff -- do you want to make a comment?

DR. MATHEWS: Let me just say one last thing. So in response to Sue, I do understand that, you know, the original intent of the MDH program was indeed to support rural providers and ensure access. However -- and so what we are explicitly considering here is a redefinition of the

program, that if we are talking about Medicare dependency, it is a broader definition. It is not necessarily restricted to rural but would include any hospital that met the criteria that -- you know, assuming we can collectively come to some agreement.

So you are correct, this would be a reorientation of the program, and I am, you know, sensitive to the point you raise about this, whether -- depending on how this would be funded, does it shift dollars from rural to urban? That's a fair point to raise, and we can think about that when we get back to the office. But one of the motivations that led us down this path was comments that have been made by the Commissioners in the context of our payment adequacy work over the last several years to the effect that, as the Medicare population becomes a greater and greater share of providers' patient census, it becomes more and more difficult for any provider to walk away from that patient because Medicare is not paying adequately. And, therefore, if a provider does have some, you know, determined share of Medicare patients in its census, that the program does have an obligation to pay adequately for those kind of providers.

So I just want to say that as, you know, why we are putting this information in front of you in general, and in particular, why we are putting it in front of you in advance of our payment adequacy discussion next month.

DR. CROSSON: Good. Jeff, Stephanie, thank you very much.

Okay. We are now going to take on the issue which we've discussed a number of times over the years and particularly recently, which is the particular problem of integrating care services and other aspects of the management of Medicare and Medicaid for the dual-eligible patients, and particularly the duals who are in D-SNPs.

And Eric, I just want to compliment you for the chapter which you wrote, which was so thorough and so articulate that it was quite enjoyable, actually. So let's take us through the discussion.

* MR. ROLLINS: Thank you. Today I'm going to talk about promoting greater Medicare-Medicaid integration in dual-eligible special needs plans, or D-SNPs. This session is a continuation of the work on managed care plans for dual eligibles that we started during the last meeting cycle. We plan to follow today's presentation with another

session in the spring that looks at other aspects of integration, and the material from these two presentations will appear as a chapter in the Commission's June 2019 report.

Before I begin, I'd like to note that CMS released a proposed rule last Friday that has several provisions related to D-SNPs. We are still reviewing the proposed rule and have not accounted for it in the material that I am going to walk you through today.

I'd like to start by giving you an overview of the presentation. I will start by briefly recapping the work we did last year on managed care plans for dual eligibles and by providing some background on D-SNPs. After that, I will talk a bit about the extra benefits that D-SNPs provide and how they differ from the extra benefits provided by regular MA plans. Then I will describe some factors that limit the level of Medicaid integration in D-SNPs and outline some potential policies that would promote greater integration.

Last year, the Commission began looking at managed care plans that serve individuals who qualify for both Medicare and Medicaid, known as dual eligibles. These

beneficiaries often have complex health needs but may receive fragmented care because of the challenges in dealing with two distinct programs.

Many observers have argued that creating plans that provide both Medicare and Medicaid services would improve quality and reduce spending for this population because these plans would have stronger incentives to coordinate care than either program does on its own. Integrated plans have shown some ability to reduce the use of inpatient and nursing home care, but they have been difficult to develop and enrollment in highly integrated plans is low.

In our work last year, we reviewed the progress of the financial alignment demonstration, which is testing the use of highly integrated plans known as Medicare-Medicaid Plans, and described how Medicare has four types of integrated plans that serve dual eligibles but differ in many respects. We noted that policy changes to better define the respective roles of each type of plan or consolidate them in some fashion may be needed.

Today's presentation focuses on the most widely used type of integrated plan, the Medicare Advantage D-SNP.

During our work last year, Commissioners expressed interest in learning more about why dual eligibles enroll in these plans and why the level of Medicaid integration for D-SNPs is generally low. We are here today to provide you with more information on both issues.

D-SNPs are identical to regular MA plans in most respects but they have three additional features. First, D-SNPs only enroll dual eligibles while regular plans are open to all beneficiaries in their service area. This restriction is meant to make it easier for sponsors to tailor plans to meet the care needs of dual eligibles. Second, D-SNPs must follow an evidence-based model of care that has been approved by the National Committee for Quality Assurance. Third, D-SNPs must take steps to integrate Medicaid coverage by having contracts with states that meet certain minimum standards. However, the level of integration required by these contracts is fairly minimal. For example, states are not required to make capitated payments for any Medicaid services.

At the same time, D-SNPs that meet higher standards for integration can become what are known as fully integrated D-SNPs, or FIDE SNPs, which may enable

them to receive higher Medicare payments. For example, FIDE SNPs must have a capitated Medicaid contract that includes acute and primary care services as well as services like nursing home care.

This slide gives you a high-level overview of the current D-SNP market. D-SNPs are available in 43 states and have about 2 million enrollees. However, the level of integration for D-SNPs is generally low because most plans either do not provide any Medicaid services or provide only a limited subset, such as Medicare cost sharing. As you can see, relatively few plans -- 46 out of 381 -- are FIDE SNPs. These plans are available in 10 states and have about 172,000 enrollees, but most of their enrollment is in just three states: Massachusetts, Minnesota, and New Jersey.

Since D-SNPs typically provide few or no Medicaid services, they have little advantage over other MA plans in terms of greater integration, and must have other features that are attractive to dual eligibles. One feature is likely the ability of plans to offer extra benefits that are not covered by traditional Medicare. In MA, plans submit bids that represent the cost of providing the Part A

and B benefit package. These bids are compared to benchmarks that are based on local fee-for-service spending, and plans that bid below the benchmark receive part of the difference as a rebate that must be used for extra benefits.

These benefits can take many forms, such as coverage of Part A and B cost sharing, supplemental medical or drug benefits that Medicare does not cover, or a reduction in the Part B or Part D premiums. However, dual eligibles already receive many of these benefits from other programs. For example, Medicaid covers Part A and B cost sharing for most dual eligibles and the Part D low-income subsidy covers most or all of the premiums and cost sharing for drug coverage.

Since D-SNPs only serve dual eligibles, plan sponsors can account for this existing coverage in their extra benefits. Compared to regular MA plans, we found that D-SNPs use more of their rebates to cover supplemental benefits like dental, hearing, and vision services. States may not cover these services under Medicaid, or cover them in a very limited fashion, so the extra benefits offered by D-SNPs can be appealing for many dual eligibles.

The next slide compares how regular MA plans and D-SNPs use their rebates based on information submitted during the bid process. As you can see, the rebate amounts for the two types of plans in 2018 are comparable, at $94 and $89, respectively. However, regular MA plans used most of their rebates to reduce Part A and B cost sharing, while D-SNPs used most of their rebates on supplemental medical benefits. Regular MA plans also used more of their rebates to provide supplemental drug benefits or lower their Part D premiums.

We will now shift gears to look at why the level of integration for many D-SNPs is relatively low. The lack of integration is a concern because D-SNPs will not have the proper incentives to coordinate care unless they are responsible for both Medicare and Medicaid services. States' use of Medicaid managed care is thus a key ingredient for greater integration. This is particularly true for long-term services and supports, or LTSS, which account for about 80 percent of Medicaid’s spending on dual eligibles. The ability to make capitated payments for these services makes greater integration more feasible.

States have been slower to use managed care to

provide LTSS than acute care services, but the number of states with managed LTSS or MLTSS programs has grown from 8 in 2004 to 24 today, and further growth is likely. It is also worth noting that most large states have these programs and that these 24 states account for about 75 percent of all dual eligibles. Many programs do not cover the entire state or exclude certain types of beneficiaries, but the number of dual eligibles enrolled in Medicaid managed care could grow substantially over time as states develop their programs.

To better understand the overlap between D-SNPs and Medicaid managed care, we compared the plans operating in each market in mid-2018. The areas where the markets overlap, meaning that a company offers both products in a state, are in the best position to achieve greater integration.

We found that only 17 percent of D-SNP enrollees, about 350,000 people out of 2 million, were in plans with a meaningful level of integration, which we defined as instances where the parent company of the D-SNP also provides all or most of the beneficiary's Medicaid benefits. About half of these beneficiaries were in FIDE

SNPs and about half were in regular D-SNPs that had a companion or "aligned" MLTSS plan.

We found that the low level of integration for the remaining D-SNP enrollees had three underlying causes, and I am going to take a little time here to walk you through each one.

The first factor limiting integration is that a significant number of D-SNP enrollees, about 27 percent, are partial-benefit dual eligibles. For these beneficiaries, Medicaid only covers the Part B premium and, in some cases, Part A and B cost sharing. There is no coverage of LTSS or other important services such as behavioral health. This coverage is so limited that there simply isn't much to integrate and D-SNPs provide little obvious benefit in this regard over other MA plans. It is worth noting that FIDE SNPs, the D-SNPs with the highest levels of integration, are all limited to full duals.

The second factor is that about 40 percent of enrollees -- and these are all full duals -- are in D-SNPs that don't have MLTSS contracts. This can happen for several reasons, but the most obvious is when D-SNPs operate in a state without an MLTSS program. However,

these plans accounted for only about 14 percent of enrollment. The other 26 percent were in states that have MLTSS programs but the plan sponsor either doesn't have a Medicaid plan or has a Medicaid plan but doesn't offer it in every county served by the D-SNP. In all of these situations, some plan sponsors might be willing to develop more highly integrated plans, but are simply not in a position to do so.

The third factor is misaligned enrollment, which accounts for about 16 percent of enrollees, and again, these are all full duals. These are cases where the D-SNP has a companion Medicaid plan but the beneficiary is only enrolled in the D-SNP. Some mismatches may occur because the Medicaid plan has more restrictive eligibility requirements, but we don't have enough data to determine how many beneficiaries are in this situation. However, many beneficiaries have to enroll in MLTSS plans, and enrolling in another company's D-SNP is not a recipe for integrated care.

Now that we have examined why the level of integration for many D-SNPs is relatively low, I am going to outline some potential policies that would promote

greater integration. States can already implement many of these policies using their contracts with D-SNPs, but only a small number have done so. Given the lack of integration, the question is whether federal policymakers turn some of these policies into standard requirements, especially in states with MLTSS programs.

The first policy would limit the ability of partial duals to enroll in D-SNPs. Medicaid's coverage for partial duals is so limited that there isn't much to do in terms of integration, and, as we discussed in the mailing materials, our analysis of HEDIS quality data for partial duals suggests that D-SNPs perform about the same as regular MA plans. Policymakers could do one of two things. They could limit D-SNP enrollment to full duals, which would require the partial duals in D-SNPs to switch plans, or they could require plan sponsors to cover partial duals and full duals in separate plans. Both options would make it easier to pursue greater integration for full duals, but the second option would give partial duals access to the specialized extra benefits that D-SNPs typically offer.

Turning now to Slide 12, the level of integration for D-SNPs will remain low if they do not have Medicaid

contracts where states make capitated payments for key services such as LTSS. One potential policy to increase integration would thus be to require D-SNPs to have Medicaid MLTSS contracts.

States vary greatly in their ability, and willingness, to contract more extensively with D-SNPs, so policymakers would need to decide if this requirement would apply to all D-SNPs, or just those in states with MLTSS programs. If the requirement applied to all D-SNPs, some states that do not have MLTSS programs might be prompted to develop them, particularly those that have previously explored the idea. However, states usually need several years to develop a program and would need time before the requirement took effect.

Having said that, most of these states would probably not be persuaded to develop MLTSS programs and would respond by closing their D-SNPs, but the impact on areas such as care coordination would be limited because the level of integration for these plans is low.

The next potential policy would require D-SNPs to follow a practice known as aligned enrollment. Under this approach, beneficiaries could not enroll in a D-SNP unless

they were enrolled in an MLTSS plan offered by the same parent company. This policy would address each of the barriers to greater integration that I discussed earlier in the presentation, and effectively incorporates the other policies that I described as well, because partial duals cannot enroll in MLTSS plans and a company would not be able to offer a D-SNP unless it had an MLTSS contract. Four states -- Idaho, Massachusetts, Minnesota, and New Jersey -- currently use aligned enrollment, and almost all of the D-SNPs in these states are FIDE SNPs. Here again, policymakers would need to decide if this policy would apply to all D-SNPs or just those in states with MLTSS programs.

This policy would ensure that all D-SNP enrollees receive their Medicare and Medicaid benefits from the same company and would lay the groundwork for integration in other areas, such as developing a single care coordination process that oversees all Medicare and Medicaid service needs, a single set of member materials instead of separate versions for each program, and a unified process for handling grievances and appeals.

Requiring D-SNPs to use aligned enrollment would

likely reduce the number of D-SNPs because the ability to offer them would be linked to participation in the MLTSS market, which often has fewer plans. Judging from the robust D-SNP market, plan sponsors find dual eligibles profitable, and some sponsors might respond by looking for ways to circumvent the limit on D-SNPs.

One way that plan sponsors might do this is by offering what are known as look-alike plans. These are regular MA plans that "look like" D-SNPs because they offer the same kinds of extra benefits as D-SNPs, such as richer coverage of dental, hearing, and vision services as I described earlier. However, because look-alike plans operate as regular MA plans, they are not subject to the requirements that apply to D-SNPs, such as the need to have a Medicaid contract. Efforts to promote greater integration in D-SNPs thus may need to account for potentially offsetting effects in the market for regular MA plans.

Policymakers could do this by taking steps to restrict or prohibit look-alike plans. For example, CMS could be given authority to reject applications to offer look-alike plans, freeze enrollment in plans where dual

eligibles account for a sizable majority of enrollees, or designate look-alike plans as de facto D-SNPs and require them to meet the same requirements as actual D-SNPs.

That brings us to the discussion portion of our session. We would like to get your feedback on whether D-SNPs should be required to meet higher standards for integration, focusing on the three policies that we outlined. First, should Medicare prohibit partial duals from enrolling in D-SNPs or, as an alternative, require plan sponsors to cover partial duals and full duals in separate plans? Second, should D-SNPs be required to have Medicaid MLTSS contracts? Third, should D-SNPs be required to use aligned enrollment? We would also like to know if you think these policies should apply to all D-SNPs, or just those in states that have Medicaid managed care programs.

Finally, we would also like to know if you think CMS should have authority to prevent the use of look-alike plans. That concludes my presentation. I will now be happy to take your questions.

DR. CROSSON: Thank you, Eric. So we'll go to clarifying questions. We'll start over here with David.

DR. GRABOWSKI: Great. Let me echo Jay in saying what an impressive chapter this was to read, so great work.

The first question, one approach is obviously to put these higher standards on D-SNPs. You also discussed the FIDE SNPs. Why not just require D-SNPs be FIDE SNPs? Take us through the distinction there of why this approach rather than that approach.

MR. ROLLINS: So I think at this point, again, circling back to the material that we discussed in the spring, it was sort of starting from the ground up on understanding why is the level of integration in D-SNPs low, and I think we're trying to sort of flesh that out here. And I think sort of based on that you would say, well, to have greater integration you need to figure out what you want to do with partial duals, and you may want to consider something like aligned enrollment. Once you had those policies in place I would say you are already a lot of the way towards being a FIDE SNP.

The reason why we didn't get into it in detail here was more sort of just interest of time. I didn't want to talk for longer than Jim was going to make me talk. And also to leave open, I think, the potential for discussion

later about sort of, okay, in some states maybe we think a more integrated plan is conceivable, but to sort of leave open the discussion of what exactly should that look like. Does it necessarily have to be the FIDE SNP model we have now or would we maybe want to start incorporating elements that we're seeing from the financial alignment demonstrations.

DR. GRABOWSKI: And just to follow on that, you mentioned aligned enrollment. In the chapter, it almost sounds like aligned enrollment solves everything, but like you have all these other steps. If I'm thinking about aligned enrollment correctly, that's going to already push out the partial duals that's going to deal with -- it's going to require an MLTSS plan. So you're ultimately going to get there with an aligned enrollment.

Am I thinking about that correct?

MR. ROLLINS: It gets you a lot of the way there. I think you can still have a discussion about other issues.

So I think having the same company responsible for both your Medicare benefits and your Medicaid benefits is sort of a necessary first step. I think one question that you can discuss is how much integration do we sort of

want to require. Is it simply enough for us to know that the same company is handling both sides?

The concern that we have heard in some of our site visits for the financial alignment demonstrations has been that these are, in some cases, very large insurance companies, and they can be somewhat siloed internally. And so the fact that Betty Jones is in this company's Medicare benefits over here and then their Medicaid plan over here, you may not want to go but so far in assuming that the two sides talk to each other really well. And so you could sort of say, "Okay. We're going to go further and sort of take other steps to ensure that this really does look like a single product.

DR. GRABOWSKI: Yeah. One final question, when you put up that figure of 17 percent were integrated, was that financial integration or actual care integration? Because I imagine financial integration was necessary but not sufficient for care integration, and you could think about exactly the point you just made. I could be in the same kind of product but not actually be truly integrated.

MR. ROLLINS: So the 17 percent had a mix of situations. It had about -- half of them were in FIDE

SNPs, where you're going to have some clinical care integration as well because they're supposed to use a single process. But the other half were in sort of these companion D-SNP and Medicaid plans, and I think in that area, it's less clear how much care coordination we have going on.

DR. CROSSON: Great. Thank you.

Clarifying questions?

Kathy.

MS. BUTO: So thank you, Eric, for a great chapter on an important topic.

I wondered whether we can differentiate the experience of the under-65 dual eligibles from the over-65 dual eligibles in terms of their enrollment in FIDE SNPs or the MLTSS companion plans, whatever that arrangement is. Do we know how that breaks out? Are they both represented in these plans?

MR. ROLLINS: In most cases, yes. The share of people in the FIDE SNPs who are 65-plus, it's going to be a little higher. Two of the largest programs in Massachusetts and Minnesota that have been around for a long time and have substantial enrollment are just 65 only.

So they're going to be a little more heavily weighted, but in most states, these are plans that are serving both the under-65 and the over-65 populations.

MS. BUTO: Okay. And I guess one question I had as I was reading the material was, What exactly is wrong with the lookalike plans from your perspective? What don't we like about it?

From my perspective, if MA plans are interested in serving the dual eligibles, that's a good thing. So I'm wondering what we think is wrong with that, other than it may actually not help with the integration part as much as we'd like.

MR. ROLLINS: I think it's largely grounded on our view that we think integration is a worthwhile endeavor to pursue, both in terms that it can provide a better care experience for the beneficiary in terms of more coordinated care and hopefully better care, and we have some evidence of this, for example, from the evaluation of the integrated program that's in Minnesota.

So to the extent that you have lookalike plans out there that are similar in the sense of the extra benefits they offer, but they don't bring that care

integration and sort of bringing your Medicaid together and giving you sort of a single experience, I think that's the concern about lookalikes. They're diverting dual eligibles away from a more integrated product.

MS. BUTO: Okay. And the last question is, Do the MLTSS plans include personal care services, or are they just long-term care?

MR. ROLLINS: As with all things Medicaid, there will be some variation.

By and large, most of your MLTSS programs that the states are developing these days are fairly comprehensive. They will include personal care, home and community-based waiver services, and nursing home care.

As I did note in the paper, there are certain dual populations that aren't sort of as heavily into MLTSS programs yet, like those who had intellectual and developmental disabilities, but once they are in these programs, at least on the LTSS front, they are usually fairly comprehensive.

MS. BUTO: Thanks.

DR. CROSSON: I'm sorry. I'm not familiar with that term of art. Personal care services is what?

MS. BUTO: This would be personal care attendance, people who help with activities of daily living, particularly for the disabled.

DR. CROSSON: All right. Thanks.

Okay. Jon.

DR. PERLIN: Thanks.

Let me pile on the accolades. A terrific chapter.

I want to get a little more granular and find out if you can expand a little bit on what the components of integration, the care coordination were that made a difference. I would imagine that in that 17 percent that there were plans that yielded better outcomes for beneficiaries. Do you have any data, or how might you access the data as to what the distinguishing feature of better performance was?

And I ask that question having had the privilege of leading the VA Health System, which by virtue of its enrollment, our requirements really almost as a representation of dual eligibles, below the level of plan integration, is really a set of specific features of care coordination that lead to better outcomes in all

dimensions.

Thanks.

MR. ROLLINS: We have not looked at it sort of in that granular detail.

As I noted in the paper, the Bipartisan Budget Act does include a provision that is going to require us to sort of undertake this kind of analysis going forward once CMS sort of delineates sort of these levels of integration that D-SNPs are now going to be required to meet.

So I think once we have a better sense of which -- as part of that, we will have better information about what each D-SNP is going or not doing on the integration front. So I think as that evolves, we'll be in a better position to sort of get at that issue, which I think a lot of folks are interested in.

DR. CROSSON: Seeing no further clarifying questions, we'll move to the discussion.

So we have on Slide No. 15 some areas that I think Eric would like input into.

I would also like to get a sense -- you don't have to be explicit, but I'd also like to get a sense from the discussion, the level of support and certitude behind

some of these ideas. And the reason for that is, in the end, I think we need to decide whether we construct a chapter, which is informative, or we comprehensively or selectively come up with bald-faced recommendations, and that will depend a lot on, I think, what I hear.

So Paul and Dana are going to start. Let's start with Paul. No? I messed it up? Did I get my list wrong?

DR. MATHEWS: Pat and David.

DR. CROSSON: David and Pat. I'm sorry. I must have read something wrong.

MS. WANG: Thanks very much.

Eric, this was such a good chapter. I think it's a very confusing topic, and I think there were probably a lot of Commissioners who, like me, were drawing a lot of Venn diagrams to figure out what the overlapping issues were here.

And just by way of illustration, just to kind of -- I think it's relevant to the comments that I'm going to make. This is the world I live in. I have a mainstream Medicaid plan. So I got confused in the chapter when you said Medicaid plan. You meant an MLTSS plan.

Mainstream Medicaid plan, whose members age into

Medicare on a fairly regular basis into dual status; a D-SNP whose enrollment is full duals, at least in my case; and MLTSS plan which is responsible for -- it's a contract with the state Medicaid program that provides long-term post-acute care benefits, including what Kathy said, personal care hours, which is home attendant. It's not skilled. It's not skilled home health care, but it's to assist with the activities of daily living for aged and disabled. And the benefit will differ in different states. A FIDE SNP, a fully integrated dual eligible plan, which is essentially a combination of a D-SNP and the MLTSS in one integrated Medicare product. And I participate in the state's -- the demonstration for duals.

My MLTSS plan, mandatory enrollment, and I assume that that's true in many states. So somebody, a dual in my state, who wants to receive long-term care services must enroll in a plan. That's mandatory.

My MLTSS members are also enrolled in my D-SNP. About half are enrolled in Medicare fee-for-service, and the balance are enrolled in somebody else's D-SNP.

So part of my purpose here is to lay a foundation, but it's also -- if my fellow Commissioners

didn't get it, I'm looking for some sympathy here from you.

[Laughter.]

DR. CROSSON: I have to say I'm just exhausted listening.

MS. WANG: I am in one region. My products are pretty much with like a county exception or two. It's very overlapping.

But I think that this description points out the complexity of the task that Eric undertook because the Medicare program is a federal program. It's one program. It may have different flavors -- D-SNP, FIDE SNP, the MMPs, all of those. But it's 51 different Medicaid programs. There's different benefits. The states have their different ways of doing things, and so I say that just to kind of -- I think there's a need to be realistic about kind of one model fitting everywhere because it's probably going to take some shoehorning and backing up.

Another thing to observe is Medicare Advantage enrollment, D-SNP, FIDE SNP is voluntary. Voluntary. At least in my state, MLTSS enrollment is mandatory. So somebody who enrolls in MLTSS is going to make a choice that has to be respected based, I think, on beneficiary

choice and their caretaker's choice about where they want to go. So there's a very large chunk there.

Some states for MLTSS do procurements. They do an RFP, and they select the plans. And others sort of like let a thousand flowers bloom. so there's different ways of configuring that.

The other observation I had when reading the chapter was it's through the lens of describing integration as long-term care services.

Less than half of duals use MLTSS services, or they don't need them quite, they might at some point. But at any given time, fewer than half do. I think it's important, in my perspective, to recognize that D-SNPs have value in and of themselves, even when they are not providing long-term care services.

I think it is -- in the context of long-term care, I understand the statement that if they don't have a FIDE SNP or an MLTSS that they're not integrating care, but for duals who don't need long-term care, there's a lot of care coordination going on. So I think they're very valuable, and for that reason, I wouldn't sort of pull the trigger on them just because they don't have an MLTSS plan

associated with them.

I also think that the -- and I can speak firsthand. I do have MLTSS members who are also enrolled in my D-SNP who we try to persuade to move into the FIDE SNP, but they find their way in. They find their way into these two separate products.

It's not just silos. They're separate companies. They're separate products. They're set up separately. It's very hard to do real care coordination. Their enrollment is misaligned as well. They can change MLTSS plans and stay in the D-SNP and vice versa. So it's kind of doing that kind of attempt at virtual integration is very difficult.

So I'm with David about FIDE SNP being the solution here, and I'll come back to that in a second.

I think that a big issue that is not -- that you addressed, Eric, but that is difficult to solve is where behavioral health fits in because Medicaid programs have extensive behavioral health programs, and they are in varying degrees available in some of these integrated products.

It's a very complex program. It's typically

governed by different agencies in a state that have extremely specific criterion, at least from my observation. There's a different navigation and route through there.

I personally don't think that D-SNPs are even MLTSS's -- I would worry about their capability to manage the full Medicaid behavioral health benefit, but I think it's really important for duals. And so my preference would be to leave the behavioral health benefit in the mainstream Medicaid plan, which is administering it on a very large basis. And I'll explain how I think that this works.

So rather than looking at D-SNP and MLTSS as the right combination, I would say it's D-SNP plus FIDE SNP availability for people who want to choose Medicare Advantage route. Leaving the behavioral health benefit in the mainstream Medicaid plan that was associated with that member, because as you can tell, I do believe in having a family of products that are relevant to the member and having the Medicaid plan if there were a way, continue to manage the behavioral health benefit there.

To me, having MLTSS and mainstream Medicaid plan alignment then leads to two possibilities, and if there's a

D-SNP in the mix, it's enrollment in D-SNP when there is a need for long-term care services, go straight to FIDE SNP. The MLTSS plus mainstream Medicaid plan is then available for folks who choose not to go to a Medicare plan but want to stay in Medicare fee-for-service, and the behavioral health benefit is managed by the Medicaid plan for both populations.

I know you guys think I'm nuts, but this is what I think about.

I think that there are some clean-up issues that are important in there. I think that to the extent that there is D-SNP and a side-by-side MLTSS enrollment, it would be helpful if there were a seamless process to get them into the affiliated organizations or the parent organizations, FIDE SNP, because that's really where they should be.

And so some of the takeaways form this would be to focus on improving the FIDE SNP program. Eric, you mentioned it in here. There is a tremendous need to fix and align the enrollment process for a FIDE SNP because what happens today is that a plan is subject to the enrollment rules of each program. Somebody enrolls on

January 1st, their enrollment is effective on January 1st for one program and on February 1st for the second program. I mean, it's painful, and I think that one of the reasons that FIDE SNPs have not grown more in enrollment is that there's a very small window where you can enroll in both programs at the same time.

The demonstrations align to that, and I think that that is something that should be brought straight into the FIDE SNP program.

The other thing that would really improve the FIDE SNP program is aligning appeals and grievances. There's five levels of appeal for Medicare, four levels of appeal for Medicaid. The rules in a FIDE SNP essentially are if it's a Medicare-only benefit, you follow Medicare. If it's a Medicaid-only benefit, you follow Medicaid. If it's a benefit that's available from both programs, you pick.

It is so confusing for the beneficiary, and it is incredibly difficult to administer for a plan. The MMPs solve this problem as well by coming up with an aligned A&G process, and I think it's critically important to advance FIDE SNPs that these two critical issues be addressed.

I think that the example of the MMPs, the MMPs that were very successful, kudos to them. There were states that were less successful, as we know, but I think that you pointed something out in the paper, which is important to remember for any of these recommendations and suggestions that you've posited here, which is every market is different, and the degree of existing D-SNP penetration in a market does seem to have an impact on how you can develop one aligned model, for example, because if there's already many, many D-SNPs in the market, I think it's hard to put the genie back in the bottle and sort of say, "We're going to a New Jersey-aligned model kind of pattern."

I think that there are other things that can be done with seamless. I think Medicare did not make the seamless regulation as flexible as it could have been, and we can talk about that later. But I think that allowing more flexibility and seamless enrollment from mainstream plans into dual SNPs that are not what they call integrated, because there is on long-term care piece, but that have an affiliated long-term care plan or FIDE SNP would really further the cause of keeping people inside of one organization that has integrated products available to

them.

As far as the specific questions, partial benefit duals, I don't have any issue with that, and I think that you're right about separating them out.

Requiring D-SNPs to have MLTSS contracts, I think it should be FIDE if people are going to go down that route.

Using aligned enrollment, like I said, I think that there are difficulties. I think more flexibility is needed there, just based on kind of what's in the market already.

And should the higher standards apply only to plans and states that use Medicaid managed care? Again, Medicaid managed care, I think you mean MLTSS, right? Medicaid MLTSS. I don't think so. It's kind of, I think, in this effort of, hopefully, there will be many different options that have flexibility.

And should CMS have the authority to prevent these lookalike plans? I would say no because I do think that D-SNPs that don't provide long-term care are still very, very valuable, and MLTSS is a very specific thing. You have to know the Medicaid program. You have to know

long-term care. It's not an insurance company, really. It's like a provider insurance company mix, and so I wouldn't go that far.

That's it. Thank you.

DR. CROSSON: Pat, thank you.

David.

DR. GRABOWSKI: Great, thanks. So, Jay, to start, I'm highly supportive of crafting recommendations here, not just making this an informational chapter, so just to answer that question.

I think this chapter very much gets at the question of what's so special about special needs plans for duals, and I think many of us had hoped that what would be special about the D-SNPs is they would offer greater care integration. That hasn't been the case except for in a minority of plans because really what they've offered is these supplemental benefits like vision, hearing, and dental. Those are important, but I don't think that's quite what we had in mind when these plans were developed.

Similar to Pat, I'm much more optimistic about the FIDE-SNPs. I think we have a vehicle right now that's offering an integrated product. I would like to see us

kind of push towards that model. I think if we have to go through the D-SNP route, I like a lot of the ideas that are here. I don't have a problem with prohibiting kind of eligibility for partial duals, although I think covering them in separate D-SNP plans sounds fine to me. I think keeping them in the kind of products, this sort of menu of products, is positive. I don't want to see them -- I don't want to lose those partial duals. But I don't think they have any place in these integrated products.

I think Pat made a nice distinction there between those who need long-term services and supports and those who don't, and I think at least for those who need those services, requiring that D-SNP or hopefully that FIDE-SNP to have that contract I think is fundamental.

And in terms of aligned enrollment, I think that's a really important step here to make certain that you're placing individuals into, both on the Medicaid side and the Medicare side, a product that's working together.

I think these higher standards should apply everywhere. I don't think just applying them to states with Medicaid managed care makes a lot of sense.

And then, finally, I guess I'm not in favor of

CMS having the authority to prevent the use of look-alike plans. Once again, similar to Pat, if we want to get duals into kind of products that offer them additional benefits, that's a positive. I'd hate to siphon off folks who could be -- beneficiaries who could be in truly aligned products, but I like the idea that if they want to be in this kind of plan that largely offers supplemental benefits, they have that option.

So, once again, thank you for a great chapter, and I look forward to our further work on this issue. Thanks.

DR. CROSSON: Okay. Continuing discussion, Kathy?

MS. BUTO: I wanted to ask Pat in particular if -- because it does sound like the FIDE-SNP for the dual who needs both long-term care and regular services is something we'd like to promote. Is there anything we ought to consider from an incentive perspective to promote those from the Medicare side? I don't think Medicaid is going to come up with more incentives, but I'm just wondering if we could think about that, because saying we think this is a more desirable option I don't think is going to make it

happen unless there's some additional incentive payment associated with the integration.

MS. WANG: So FIDE=SNPs now -- you mean incentives for plans or for beneficiaries?

MS. BUTO: For plans [off microphone].

MS. WANG: For plans.

MS. BUTO: They get paid the same, don't they, as --

MS. WANG: Yeah, you're part of the Medicare bid. I think that it's -- I think removing barriers with the ones that I described, I mean, it is very hard to be a FIDE-SNP with those restrictions.

MS. BUTO: Right.

MS. WANG: If those were removed, it would be appealing to many plans who are committed to the dual population.

MS. BUTO: And I know you haven't -- you and I have talked about this before. You haven't mentioned the difficulty of beneficiaries transitioning from one of these categories to another. They may just need a D-SNP today, but next week it turns out they do need the long-term care services, how to make that more seamless and less

bureaucratic. So I just hope, Eric, that we could maybe at least touch on the fact that there may be factors that would make the FIDE-SNP more attractive as an option for plans -- and for beneficiaries, for that matter -- and that states would actually support.

DR. CROSSON: Marge.

MS. MARJORIE GINSBURG: I think this is a question for Pat. Is there an interest group, a professional association of programs like yours that meet periodically and strategize growth and money and stuff like that? That's question number one.

The other one is we had a very brief discussion before about the role of MACPAC, and since is the first time I'm aware of that we've talked about a program that involved both Medicare and Medicaid, has MACPAC been involved in any way with these discussions?

MS. WANG: I don't know about MACPAC, and there are associations that -- the comnenter who said that she was from the SNP Alliance, who was -- that's an organization that is out there. But, you know, I think that because the Medicaid piece is so significant, at least from my perspective, you know, it's a very local product.

So you're probably going to be dealing with -- the Medicare side is not as complicated. Medicare is Medicare. If you have a D-SNP, you know what the integrated product is going to be. It's really the Medicaid side and working with a state. That's been my experience on some of the fine-tuning around that. So we don't tend to -- maybe it's just because we're not joiners. No, but, you know, we're not, but I think that there are organizations out there that work on this.

DR. CROSSON: Further comments?

[No response.]

DR. CROSSON: I'm not seeing any, and I think part of it is the fact that it's late in the afternoon, but part of it is the fact that this is really intricate and complicated. And it also involves a portion of health care that is not Medicare, and so it's not something we talk about all the time, and I think people have identified that.

Now, fortunately, with Eric and other members of the staff, we've kind of got our own expert to help us sort that through. So I think -- one second, Warner. I think we don't have as broad an input on this particular issue as

we often do, so I think we're going to be more dependent here on the judgment of the staff -- we always are, but particularly in this case -- as well as, I think, a couple of our Commissioners who live and think about this stuff. So my thought here, Jim, is I haven't seen -- I mean, David and Pat don't agree on anything, but I think -- don't agree on everything.

[Laughter.]

DR. CROSSON: But I have great hopes that in further dialogue and perhaps direct work with Eric and others, we can come to the point where we at the very least have a valuable informational chapter, and at least on some of these elements we can come up with a recommendation that, first of all, we all understand and, secondly, we can get behind. So I think that would be the goal.

Yeah, Warner.

MR. THOMAS: Just a brief comment, because I would concur with you, I think this is very complicated. So one of the things may be are there any ways to make this more simplistic? Because if we're sitting here having trouble kind of comprehending all of it, imagine if you're a beneficiary. And I do think the more integration we can

create between -- you know, for dual-eligible beneficiaries, I mean, we can do a much better job taking care of them. And it sounds like because of the fragmentation in some of these programs, it's very difficult to create an integrated experience or an integrated set of benefits. So I don't know if that can be a key part of the goals as well.

DR. CROSSON: You know, I think that's an excellent point because, you know, I think the beneficiary piece of this, to the extent that, you know, we can get this done in the work, would be a valuable addition. That's my own --

MS. BUTO: And, Jay --

DR. CROSSON: Yeah.

MS. BUTO: I'm sure it's -- I'll have to go back and look, Eric, but, you know, the share of costs to the Medicare program that this population represents is huge, and to Medicaid.

DR. CROSSON: It's huge, right.

MS. BUTO: And so, I mean, it's difficult, but it is kind of one of the things that has to be really looked at. I will say I was really surprised, like David, that,

you know, the D-SNPs had so little to do with Medicaid and that really the benefits were in supplemental benefits that are not really what you would consider, I think, or hope for better integration of care between the two funding streams. So, you know, I just think this is something we have to get our arms around one way or the other.

DR. CROSSON: Yep. Agreed. Yes, Paul.

DR. PAUL GINSBURG: There's one small comment I wanted to make, only because it didn't come up in discussion, but I think in reading the paper Eric wrote, he pointed out that the spending per beneficiary is dramatically different between full duals, partial duals, and beneficiaries that aren't duals. And this I think was behind his interest in separating the partial duals from the full duals and really both groups from the non-duals. And we need to always maintain that because we don't want to get a dramatic selection process.

DR. CROSSON: Okay. Eric, I hope this has been helpful, and we again thank you for taking us through an extremely complicated area in a way that I think has advanced our knowledge, perhaps not all the way we hoped it would be, but significantly forward. So thank you for

that.

And with that, I think the presentations and the discussion are over with, and we have now the opportunity for a public comment period. If there are any members, I'd like to see people line up, and I'll make a comment in a minute.

[Pause.]

DR. CROSSON: So thank you for being willing to talk to us, and I would ask you, please, if you could identify yourself and any organization or institution you belong to. We would ask you to keep your comments to about two minutes, and when my red light goes on here, two minutes will have expired. Thanks.

* DR. PHILLIPS: Absolutely. Thank you. Cheryl Phillips, Special Needs Plan Alliance, and a fantastic conversation, having spent the last many days reading the new proposed rule. This has actually been a refreshing conversation.

But I want to touch on I think many of us -- I'm a clinician and believe passionately in the value of integration. It has been a journey that we have set out for decades. There are a lot of barriers, and, Pat, you've

articulated them so well. If it were easy, we would have done it. Lots of barriers to integration, barriers at the state side, barriers at the plan side, barriers with dueling regulation. And I want to add another one, and I think it's an important test to why we haven't moved integration.

D-SNPs just became permanent this February. Up until now they were reauthorized at two- and three-year segments. Nobody wanted to put the money and the effort into escalating this. So I think we now have a platform.

But I think until we address the barriers, we have to look at the flexibility and create incentives; otherwise -- and I will disagree respectfully, David. I think that the look-alike plans will destroy integration. They will because they will become the least resistance pathway. If a plan can do that and not have a model of care, not have a MIPPA contract, not do care coordination, why on Earth would they do that? If the states can just close their eyes and not worry about a MIPPA contract, they'll go to the look-alikes. It's not inherently that they are bad, but they will stop integration.

So if our commitment is integration, I think we

have to look at not just what are the barriers, but what are some of the incentives, if you will, the flexibilities, and looking at the Medicare-Medicaid demonstration plans is a great place to start with enrollment and grievance and appeals.

And then, lastly, I think there is a value to the partial duals. I think what happens in a well-run D-SNP enhances their vulnerabilities as a population, but I would agree that we want to separate them if we're going to move towards fully integrated duals, so the SNP Alliance would support let's continue to allow partial duals and D-SNPs but separate.

Thank you.

DR. CROSSON: Thank you for your comments.

Seeing no one else at the microphone, we are adjourned until -- what time tomorrow morning?

DR. MATHEWS: 8:30.

DR. CROSSON: 8:30 tomorrow morning.

[Whereupon, at 4:13 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, November 2, 2018.]

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
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AGENDA PAGE

P R O C E E D I N G S

[8:30 a.m.]

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

with a discussion of a different financing mechanism for the QBP program that would be budget neutral.

The MA quality bonus program was introduced by legislation and has been in place since 2012. The program provides bonuses to MA plans based on their overall average star rating. There are 46 measures tracked, each with different weights that are used to arrive at a weighted overall average. Bonuses are available for contracts at or above an overall average of 4 stars. The bonus takes the form of a 5 percent increase in plan benchmarks, or 10 percent in some counties. As you know, the benchmark is the bidding target for MA plans. When plans bid below the benchmark to provide the Medicare benefit, a portion of the difference has to be used to finance rebates, which are extra benefits for plan enrollees. The portion or share of the difference between the bid and the benchmark used for rebates is specified in the statute as varying by a plan's star rating, ranging from 50 percent for the lowest-rated plans to 70 percent for plans at 4.5 or 5 stars.

Beneficiaries can see overall star ratings and the results and stars for the 46 individual measures by using the Health Plan Finder tool at the medicare.gov

website. Star ratings are updated each year at the beginning of October for the October-December annual election period. The posted star ratings reflect the most recent results, but in choosing among plans, the benefit packages that beneficiaries will see, which are a major factor in beneficiary decisionmaking, are benefit packages based on the star rating from a year earlier because those were the ratings available to plans when they submitted their bids in June for the following year.

For a number of years, the Commission has been concerned with the use of the MA contract as the reporting unit for quality measures and the determination of star ratings. Contracts can cover wide, disparate geographic areas. Currently, about 40 percent of HMO and local PPO enrollment is in contracts that cover states that do not border each other.

In the last five years, contracts have gotten larger and larger because of a CMS policy that allows contracts to merge or consolidate to get a bonus-level star rating. What happens is that if, for example, a sponsor has a contract with a 4-star rating and one with a 3-star rating, the sponsor can decide to merge the two contracts

and choose the 4-star contract as the so-called surviving contract. The contract that was at 3 stars disappears and is subsumed under the 4-star contract with a 4-star rating applying to all enrollees. This is the case even if the 4-star contract has very low enrollment and the 3-star contract is a much larger contract.

The result is unwarranted additional program payments under the bonus program and inaccurate information for beneficiaries. The consumed contract which is being absorbed by the 4-star contract will immediately acquire a 4-star rating for both bonus purposes and in terms of what is displayed on Health Plan Finder. What was actually a 3-star contract is immediately classified as a 4-star contract on Health Plan Finder.

The Commission addressed the issue of unwarranted bonus payments with two recommendations in the March 2018 report. The first recommendation essentially would freeze contract configurations for the purposes of reporting quality and determining stars. So in the example I just used, one contract area would maintain its 4 stars and the other contract area would stay at 3 stars. We also repeated a recommendation made in 2010, which was to have

quality data reported at the local market area level, with stars also determined at that level.

Recent legislation has partly addressed the consolidation issue by revising current policy so that, beginning in 2020, in the case of a consolidation, the consolidated or surviving contract will get a new star rating that is the weighted average of the quality results for the two contracts. So in my example of a 3-star contract merging with a 4-star contract, if the two contracts had equal enrollment, the likely result would be a contract at 3.5 stars. In such a case, the sponsor would be giving up bonuses under the 4-star contract through this merger. This is the kind of consolidation we are unlikely to see going forward, but sponsors still have the opportunity to consolidate contracts when it can be expected that the averaging boosts a contract that was previously below 4 stars when merged with another contract at 4 or more stars.

We will now turn to specific issues with the current system that is the basis for determining star ratings.

The Commission has established a set of

principles to apply to quality measurement systems. The principles call for using a small set of meaningful outcomes-based measures and reducing the reporting burden on providers and plans. Consistent with those principles, in MA, where up to 46 measures are used for star ratings, the reporting burden could be reduced by eliminating process measures and administrative measures. Plans could continue to track process measures, and CMS would treat administrative performance as a compliance function.

The Commission has also advocated using claims-based measures, the MA equivalent of which would be encounter data. The burden of reporting could be diminished, and the uniformity of measurement as well as the comparability with fee-for-service could be enhanced by having measures based on MA encounter data that could be compared with fee-for-service claims-based quality results.

Another issue is that the current system has both a "cliff" and a "plateau." If a contract has an overall rating below 3.75 stars, which is rounded to 4, it does not receive any bonus payments. The plateau issue is that contracts above 4 stars receive the same benchmark increase as 4-star contracts. The limited incentives to reach a

level above 4 stars are that the 4.5- or 5-star ratings have a slight increase in the rebate share, and for 5-star plans, they can enroll beneficiaries outside of the annual election period; 5-star plans are also highlighted in Health Plan Finder, giving them an advertising advantage.

Looking to the recent work the Commission has done on quality incentive programs for hospitals, one approach that could address the cliff and plateau issue is to have a continuous scale for determining financial rewards.

For most of the MA star measures, CMS uses what we refer to as a tournament model to evaluate plan performance and to group that performance into the 5 different star levels. Each year CMS determines new "cut points" for assigning measure results into the 5 star groups -- meaning that every year there is a clean slate and the tournament, or competition, among plans determines which contracts fall into which star category, regardless of where the cut points might have been in the preceding year, for example. This means that in a tournament model, overall quality can decline and there will still be 5-star plans.

In the context of the number of contract consolidations we have seen and the number of new contracts participating in MA, another issue with the tournament model is that the composition of the 5 star groups can shift with either an upward or downward direction in the cut points for different star levels, with sometimes unexpected results from one year to the next.

A possible solution again is to use a continuous scale to determine bonus payments and to establish pre-set targets that promote improvement; however, determining an appropriate pre-set target is also a difficult task as illustrated in the mailing material with the example of the kidney disease monitoring measure that had a very low pre-set threshold in the early years of the quality bonus program.

The CMS proposed rule would change the method of cut point determinations while still using a tournament model that addresses some of the issues with the current model. CMS also proposes putting limits on year-to-year changes in cut points.

One of the concerns with the quality bonus program is whether it can ensure a level playing field that

allows an apples-to-apples comparison for bonus purposes. Currently, CMS makes an adjustment to a contract's overall star rating based on the contract's share of low-income enrollees and beneficiaries entitled to Medicare on the basis of disability. For these populations, there are systematic differences in the results for certain measures that lead to the adjustment.

For most of the measures subject to adjustment, contracts with high shares of the two populations have a modest increase in their star rating. But there are also measures for which these plans show better performance, so the adjustment would be in the opposite direction. Our analysis suggests that another category of MA enrollee for which an adjustment should be considered is for enrollees of employer-group waiver plans, who have systematically better results than beneficiaries who are in MA but do not have their MA coverage through an employer- or union-sponsored retirement plan for Medicare beneficiaries.

Possible solutions here are to make an adjustment in the overall ratings for the employer-group population, along the lines of the low-income/disabled adjustment, or remove the employer-group enrollees from the star

calculations.

We looked at specific measures in the quality bonus program and found issues with some of the measures. In the case of the patient experience measures collected through a member survey, the Consumer Assessment of Health Plans and Providers survey for MA, we found that the cut points for the star levels fall within a very narrow range. The table on the slide shows that there is a difference of only one or two points in the cut points for the 5 star levels. This contrasts with the measure tracking whether diabetics receive necessary eye exams, which is a measure with a much wider difference across the cut points.

While the CAHPS cut points are very close to each other, and most contracts have results that are within a very narrow range, there are differences among contracts in their CAHPS performance at the tails of performance, with a few contracts having very low results and others, also a small number, having relatively high results.

A possible solution is to have the overall star rating affected only when a contract has a very high level of performance or a very low level of performance. Other contracts would be in a "hold harmless" situation of

receiving 4 stars, for example, or otherwise not having the CAHPS results affect their relative bonus status. Alternatively, a general approach of using a continuous scale that we have talked about as applying to all measures could address this issue.

We have also found issues with the risk adjustment system used for the MA hospital readmission measure.

One issue is that the readmission measure is risk-adjusted to establish whether or not a readmission is to be expected for a given patient when considering factors such as the person's age and health status. If in a given MA plan every patient who was readmitted could have been expected to be readmitted, the observed, or actual, rate of readmissions matches the expected rate of readmissions -- that is, the ratio is 1.0. But if a plan's observed or actual rate of readmissions is higher than expected, the ratio would exceed 1.0. If a plan had twice as many readmissions as were to be expected, the observed-to-expected ratio would be 2.0 -- readmissions occur twice as often as in a plan where every readmission is an expected readmission.

What we have observed about the readmission measure is that, although you might expect a range of readmission rates across contracts, you would not expect too much variation within a single contract, given that the measure is a risk-adjusted measure. However, we found that, consistently across all contracts, if you look at admissions included in the readmission measure, but separate beneficiaries who died during the year from those who did not, every contract has a higher observed-to-expected ratio for the members who died during the year. The average across all contracts with at least 1,500 admissions in the year was a two-fold difference in the observed-to-expected ratio when separating admissions among those who died versus those not dying in the year.

Another issue with the readmission measure is that the current minimum number of readmissions for a contract to get a star rating in this measure is 10. So in the 2018 star ratings, the single 1-star contract had 4 readmissions out of 16 admissions. At the other end, many of the 5-star plans also had a small number of admissions. These results are probably not statistically valid.

As for solutions, CMS and NCQA are aware of and

working on the risk adjustment issue. The CMS proposed rule includes a provision to raise the minimum denominator to 150 admissions from the current 10.

A larger issue that can be viewed as a leveling-the-playing field issue has to do with the financing of the MA quality bonus program. The MA quality incentive program is not like other such programs in Medicare. The MA quality bonus program consists of increases in county benchmarks, including in counties where the benchmarks without any bonus add-ons are at or above 100 percent of fee-for-service. The program expends additional funds, and there are no penalties that might result in program savings. This is different from fee-for-service quality programs that are either budget neutral or produce program savings.

When the Commission has described what it would envision for a quality bonus program in Medicare Advantage, it has always been on a budget-neutral basis, with both bonuses and rewards.

This slide repeats what the Commission said in 1999 and in 2004 regarding how to structure a bonus program for Medicare's private plans. Again, it was to be budget

neutral and would have bonuses and penalties in the sense that a small share of plan capitation payments would be withheld (such as 1 percent or 2 percent) to be redistributed to the highest performing plans.

I'll conclude with this slide for your discussion, which is the list of the issues that we have discussed and for which we have proposed possible solutions, and then for further discussion the matter of whether the bonus system should be a budget-neutral system based on withholds and redistributions, consistent with the Commission's principles regarding reasonable equity between MA and fee-for-service.

I look forward to your discussion.

DR. CROSSON: Thank you, Carlos. Very clear, as usual.

Let's take clarifying questions. Brian.

DR. DeBUSK: Let me find the -- bear with me. You were walking us through the proposed changes to the quality system, and let me see where that starts. Bear with me. Starting on Chart 6, and it looked like you were walking us through sort of a cadence that we've seen in other things, like your proposed changes in the hospital

value-based purchasing program as well.

Just to clarify, could you sort of compare and contrast, just walk me through the hospital value-based program as proposed in June 2018 and what you're proposing, sort of what's similar and what's different?

MR. ZARABOZO: I think if you're saying what might be -- it could be the same, that is to say, use what we would be using for the hospital value-based program and applying it to the MA program, right?

DR. DeBUSK: So you're saying even the same domains?

MR. ZARABOZO: No, no. It would be whatever measures we would be using in MA.

DR. DeBUSK: That's what I was getting at. Walk me through. So it would be different or subtly different domains.

MR. ZARABOZO: Well, see, one point that is made in the paper is that it would be nice if the measures were the same measures. For example, the readmission measure, as I talked about at length in the paper, we typically say this is a good measure to look at. So you would look at readmissions in hospitals. But as I pointed out in the

paper, there are some differences in MA with regard to readmissions that need to be taken into account. So you would want to have a comparable readmission measure for purposes of comparing MA to fee-for-service. But within MA, the readmission measure would be treated just like the readmission measure in fee-for-service in terms of a continuous scale of rewards.

DR. DeBUSK: And then it would be to a domain -- one of the domains, and then it would be risk-adjusted and peer-grouped and --

MR. ZARABOZO: Right, right.

DR. DeBUSK: -- prospective target. So that's -- I was trying to gather that from the reading materials and this, but you're taking us down that path, just to be clear, correct?

MR. ZARABOZO: Well, the issue would be: Does the Commission want to go down that path in Medicare Advantage?

DR. DeBUSK: Okay. I just wanted to make sure that we were going -- okay. Thank you.

MR. ZARABOZO: I'm not taking you anywhere, really.

[Laughter.]

MR. ZARABOZO: If I'm taking you anywhere, you're driving because I don't drive.

DR. MATHEWS: Brian, if I could try and add a little clarification here, we are indeed trying to conform to the same set of principles that we articulated in our June report this year with respect to how we're handling what we're doing in MA here.

DR. DeBUSK: Okay. And then one other question, you were talking about the readmission measure, and I'm just barely beginning to learn about this, but I know CMS on the non-MA side uses that random effects model that you guys introduced me to. Is this the same -- do they use the same model --

MR. ZARABOZO: No, no. The current MA model is different.

DR. DeBUSK: Is there any reason that we couldn't have used the same random effects model in --

MR. ZARABOZO: Well, in speaking with Ledia, I think the issue was it was thought that MA should have an MA-specific model?

DR. DeBUSK: Because?

MR. ZARABOZO: You'll have to speak to Ledia about that. Here she comes, and fortunately her name is already set up.

MS. TABOR: So, like Carlos says, the risk-adjusted models are different. It's two different measure developers, two different kind of sets of expert panels that are advising the measures. So what I would say is that according to the Commission's principles, we would like consistent risk-adjusted models, but they are different right now.

DR. DeBUSK: So would you consider the CMS random effects model that's used on the non-MA patients for readmissions calculations to be adequate? I mean, is it a competent model?

MS. TABOR: I am not a statistician. There's pros and cons to using different risk-adjustment models, whether it's just fixed effects or not. That could be a separate Commission discussion.

MR. ZARABOZO: But in the paper, we said some person over at CMS should look to see whether or not that model works for MA and test that model within fee-for-service to see whether we have the same issue in fee-for-

service that we have in MA, which is if you look at the people who died during the year and those who did not, do you get the same results?

DR. DeBUSK: Thank you.

MR. ZARABOZO: Yeah. That's the Test 1 and Test 2 in the paper.

DR. CHRISTIANSON: Let's start here with Jonathan and move up.

DR. JAFFERY: Thanks.

Just a quick question. You referred in Slide 5 to a few previous reports about reporting quality at the local market level, which seems to be maybe a significant issue with the continue -- how do we define local market?

MR. ZARABOZO: At the time, we defined the local market as the metropolitan statistical area for metropolitan areas, and then the remainder of a state was grouped into what's referred to as health service areas, not the Dartmouth health service areas, but the National Center for Health Statistics had developed health service areas for the non-metropolitan areas, so that's the way we were defining it.

But we're open to other definitions of what is a

local market.

We also separated -- if, for example, in the case of an MSA that crossed two states, we separated the two MSAs from the two states.

DR. CHRISTIANSON: Bruce?

DR. PYENSON: Thank you very much.

Just a background question or a foundation question here. We have a complicated structure for bonuses and quality metrics that's evolved over years, and I think -- am I correct in saying that some of the suggestions here would, in effect, scrap it and we'd have the opportunity to start all over again? Because I'm thinking there's a number of the HEDIS-type measures that don't fit in well with our principles.

There's methods of measuring that we don't think are quite -- are good, and we think perhaps the scoring mechanism, the Star point system and the way that's applied doesn't fit well with our principles.

So it almost sounds like -- is there anything left that fits with our principles? And I think that's okay, but it almost seems as though we really have an opportunity to decide if this is the future for Medicare

Advantage.

Let me ask the question.

[Laughter.]

DR. PYENSON: What about the current structure fits within the MedPAC principles?

MR. ZARABOZO: Well, this is similar to Brian's question of what direction are we going in. If you move towards what we're proposing for the hospitals, it would be very different from the current structure. The question would be what measures do you retain, if any, and our comment that you could remove the process measure, the administrative measure should be dealt with as not being quality measures. And you're limited to a small number of measures, and you would use this continuous -- so it would be very different from the current system, but some of the measures may survive into --

DR. CROSSON: Kathy and then Jaewon.

MS. BUTO: So I was struck by the Commission's recommendation back in 1999, which may seem to make a lot of sense and I guess was followed up by more specifics of how to reward exceptional performance and penalize -- I guess, operationally, how do you withhold a certain amount

of capitation and so on and so forth.

I'm just wondering. Given the fact that such -- I think it's 75 percent of plans are bonus-eligible or get bonuses. How much distinction is there? I mean, when you think about exceptional performance, it feels like a lot of the plans are kind of in the same place from a quality bonus standpoint. Do we feel that if the measures were different, we could make distinctions, or are there distinctions there that are not being amply rewarded from your perspective?

MR. ZARABOZO: Well, it's 75 percent of the enrollees are in bonus-level status.

MS. BUTO: Right.

MR. ZARABOZO: You could just raise the threshold for five-star -- four-star performance really is the bonus level of performance, do something other than tournament model and say we recognize some of the measures that appear to be topped out to being this. So you wouldn't want to use those measures.

But where there are differences, you would say here is the new five-star level, which will result in only 10 percent or 20 percent of the enrollment reaching this

level.

MS. BUTO: The other thing is I was struck in the paper by the fact that beneficiaries generally do not appear to use the Star system to select plans. Then I wondered quality systems still make sense from the standpoint of the program making distinctions or potentially providing some bonuses, but should there be some aspect from your perspective that captures what beneficiaries really care about in plans as part of a refined system?

MR. ZARABOZO: Well, the intention of the Star system is to capture what is important to beneficiaries. That's why you have these number of measures, including the patient experience measures, and it is hoped that beneficiaries will use the Star ratings to choose among plans.

MS. BUTO: But they don't.

MR. ZARABOZO: Well, yes. Mostly, they do not, based on our site visits and so on and focus groups.

MS. BUTO: Yeah.

MR. ZARABOZO: They usually do not.

DR. CROSSON: Jaewon.

Marge, I got you next after Jaewon.

DR. RYU: So I had a question about the employer group waiver plans. You allude to the fact that they -- pound for pound, quality is higher there. I think you mentioned that their cost shares are on average lower. Is that predominantly what drives the fact that quality tends to be higher there? Do we know anything about the socioeconomic status of that group?

MR. ZARABOZO: Well, they would tend to be higher income people, right.

DR. RYU: Okay.

MR. ZARABOZO: But we don't know about the cost sharing, actually. On the specific measure that was in the paper, that doesn't have cost sharing for anybody.

DR. RYU: I see.

MR. ZARABOZO: So the benefit packages are more generous for the employer group.

DR. RYU: Then the other question I had was around the consolidations. The health plans that are driving that, do you have a sense of what the characteristics of those plans are? I'm guessing they're mostly for profit and national, but is that valid?

MR. ZARABOZO: That is valid, particularly the national point, because many of the plans that are sitting here, for example, cannot consolidate. There's nothing to consolidate with.

DR. CROSSON: Marge.

MS. MARJORIE GINSBURG: Just a quick sort of 3,000-foot-level question. I kept thinking in reading this, where's the evaluation for fee-for-service, and then thinking, gee, that would be a little hard to do. You can go to any doctor you want in the community. How do you begin to consolidate? But, of course, there are ways of comparing hospital admission rates and a number of things.

I think there has been discussion previously about introducing an evaluation for fee-for-service, and I wonder if you could just briefly sum up where you are on that.

MR. ZARABOZO: Well, currently, the CAHPS measures are compared between fee-for-service and Medicare Advantage on sort of a wide geographic level, and we have always said -- in 2010 -- that we want to be able to compare fee-for-service to Medicare Advantage, which is why we bring up the point, if we had claims-based measures, we

could use fee-for-service claims and Medicare encounter data, which are the equivalent of claims to make this kind of comparison.

So this is one of our goals, if you want to put it that way or the program goals, really, because even CMS would like to be able to do this kind of comparison, I think.

MS. MARJORIE GINSBERG: So it's on the radar.

MR. ZARABOZO: Right. This is definitely on the radar screen, and that's the hope of using claims-based data.

DR. CROSSON: Karen.

DR. DeSALVO: One of the questions I was going to ask, Kathy already raised about consumers using the Stars ratings and what about them has made it not so friendly. We know that this is often a difficult issue to get people to assess quality.

I wondered if in your site visits, you thought about talking with brokers or others who might be using that data.

MR. ZARABOZO: We have talked to brokers. The SHIPs use the data. The health counseling people use the

Medicare, the health plan finder.

The brokers, we've got sort of a mixed reaction from brokers. Some of them say we don't use the Star ratings. We know the plans in our area. We know which one is better than another, which is best for this kind of person, whether this kind of person is better to be in a Medigap plan and so on.

MS. MARJORIE GINSBURG: Interesting.

MR. ZARABOZO: So even the brokers have sort of, as I say, a mixed reaction to these, the stars.

MS. MARJORIE GINSBURG: And I wanted to understand a little bit, Carlos, about the small area quality issue that you guys bring up in the paper. I just didn't follow all the logic of how important it is to be able to track on the local market versus the consolidated plan across the country.

MR. ZARABOZO: Right. So the example that I gave of the Florida plan that has like 80 percent of its enrollment in Florida, so all the quality measures are based on what's happening in Florida, really.

And so the people in Oregon that are a member of the same contract see the Star rating that reflects what is

happening in Florida probably doesn't have very much to do with what is happening in Portland. Right, right. And there are several other states involved there too, so yeah.

DR. CROSSON: Dana.

DR. SAFRAN: Thanks.

It's a really important paper and really nicely done. I have four questions.

One is when you're talking about the possibility of having fewer measures and simplification as we talk about on the hospital. You point to administrative performance and say that could be treated as a compliance issue. Would that actually relieve a reporting burden?

MR. ZARABOZO: Not really, actually, because a lot of those measures are tracked by CMS. They have the complaint tracking module and the audit function and so on. So it's already kind of removed, in a sense, so yeah.

DR. SAFRAN: So it would simplify the program --

MR. ZARABOZO: Right. It would --

DR. SAFRAN: -- but it wouldn't change the reporting --

MR. ZARABOZO: Right. And if you say that much of the Stars represent, that they represent clinical

quality. No, they represent more than clinical quality. So this would say, well, let's go back to clinical quality.

DR. SAFRAN: Yeah. Okay, thanks.

My second question is on the employee plans -- and this is a little where Jaewon was going, but I just wonder whether we know -- it seemed in the paper that it's the characteristics of the people in the plans plus the benefit structure that may be causing the difference, like lower out-of-pocket cost sharing and so forth. And so I was just curious whether, as you think about a possible adjustment that would include the employer plans, would the data be available to adjust for the characteristics we think are driving it as opposed to adjusting for whether some of these in an employer plan? Because that seems like kind of a blunt instrument.

MR. ZARABOZO: Well, if you think employer group status is a proxy for income, that would be the kind of information -- I mean, based on Jay's question -- because already we're adjusting for income with the low income.

So this just says there is another group of people who have low income. You have what you might call middle income and relatively higher income among

beneficiaries, which is the employer group waiver people. They're typically in that category.

And I think the differences are such that it's a good proxy for saying employer group waiver as a characteristics represents a characteristic that should be adjusted for.

DR. DeBUSK: On this --

DR. SAFRAN: Go for it.

DR. DeBUSK: I see where you guys were going with that.

Just one quick question. Is the EGWP a characteristic that you put into the adjustment calculation, or if we're moving more towards Ledia's unified model, wouldn't peer grouping --

MR. ZARABOZO: Yes. Peer grouping would handle that because, as I pointed out, there are a lot of contracts that are heavily employer group waiver, so they would be peer grouped.

DR. DeBUSK: But if you just threw it all into the same peer grouping mechanism and stratified it by SSI percentage, would the EGWP plans just fall into the --

MR. ZARABOZO: No. What I'm saying, in response

to Dana essentially, that you would have three categories of income, if you want to look at it that way. That you would have the SSI percentage. You would have the non-SSI, and among the non-SSI, you have the EGWP and the non-EGWP. So it's three kind of groups.

DR. DeBUSK: But we stratify our current peer grouping mechanism as 10 deciles. Are we going to a different --

MR. ZARABOZO: Well, for example, for the disabled and currently in MA, there are only five that are quintiles because the percentage in plans, it doesn't reach like 50 percent or so. The low income is a different matter.

DR. SAFRAN: Okay. So my other two questions, one is I'm liking your suggestion about getting more geographically proximate unit of analysis. Have you looked at for how many other measures that are currently in the program would plans have adequate sample sizes to be measured on those things?

MR. ZARABOZO: Yeah. The reason I use the risk cancer screening measure so often for analysis is that it's a measure that is population-based measure, and it's not

medical record sampling measure.

So the medical record sampling measure, as I discussed in the paper, which are many in the HEDIS system, those would need to have a bigger sample.

Similarly for the patient experience measure, the CAHPS, what the CAHPS people say is you need 100 to have reasonable CAHPS results for a given area, if you want to put it that way.

Now, CAHPS used to be done on an area level, as you seem to know. Yes.

DR. SAFRAN: Yeah. Okay. We'll come back to that in the second round.

MR. ZARABOZO: Okay.

DR. SAFRAN: So then my final question -- and I should know this, but I don't -- the 5 percent bonus, I know that you say that gets added to the benchmark. I'm trying to figure out what that actually means.

So does that mean that an MA plan that has done well and is a 4 or above has 5 percent added to its budget, or how much funding --

MR. ZARABOZO: In an area that is 115 percent fee-for-service, the benchmark becomes 120 percent of fee-

for-service.

DR. SAFRAN: So they have a larger budget for taking care of people because they're providing better quality?

MR. ZARABOZO: Right.

DR. CROSSON: Well, so they have a larger benchmark to bid against.

DR. SAFRAN: Yeah.

MR. ZARABOZO: Right.

So this matters in the case of extra benefits. They have a better ability to offer extra benefits.

DR. SAFRAN: Yes.

MR. ZARABOZO: They can increase. They can if they want to increase their extra benefits.

DR. SAFRAN: Right.

MR. ZARABOZO: They're not required to do so. When they get more money, it's a matter of --

DR. SAFRAN: Is there a reason that the bonus wouldn't be paid out as an actual bonus as opposed to adjusting the benchmark, or is that part of what you're trying to propose in your --

MR. ZARABOZO: Well, I think, yes, the 1999 and

2004, I would view as it's just a bonus. It's an actual bonus paid out. After the year of performance, you get a bonus.

DR. CROSSON: Jon.

DR. CHRISTIANSON: So if they don't have to pay it back, they can treat it as an actual bonus, right?

MR. ZARABOZO: Right. Yes.

DR. CHRISTIANSON: So, in effect, if you want to treat it as a bonus, you can.

DR. CROSSON: Well, but there's a time element.

Okay. Let's see where we are. Brian, we already got you. Pat and then Jonathan.

MS. WANG: Thanks, Carlos. As usual, just an incredible amount of detail and really, really insightful analysis.

I am a little confused about how the phenomenon of contract consolidation and the size of some of these contracts and sort of the non-contiguous nature of one contract would affect -- I mean, you have already pointed out how it would affect some of the sample sizes and try to get to a geographic area, but on the specific notion of peer grouping, how do you do that? Does the size of some

of the contracts at this point and the kind of geographic dispersion affect in any way the ability to peer group? In the past, folks have talked about peer grouping by low-income status, for example. Can you find the relevant plan in a geographic area or otherwise to do peer grouping when the contracts are so big now?

MR. ZARABOZO: Well, now the peer grouping -- I mean, the way they do the categorical adjustment index is what percentage of low-income people you have, what percentage of disabled do you have, but it is strictly on a contract basis. So if you have a contract covering 11 states, none of which is bordering each other, they just go into the mix as whatever percent they have of low income and so on.

If it was at the geographic level, then the peer grouping would be many, many more units to be peer-grouped, and possibly a better peer grouping in the sense that a company might have a D-SNP, for example, in one area and not in another. In the area where they have a D-SNP, they would be peer-grouped with D-SNP kind of entities.

MS. WANG: So getting down to a smaller geographic unit of measurement seems important?

MR. ZARABOZO: Right. And that would, I think, improve the peer grouping, which is why we made the comment about the underpinnings of the current system. When you have these large contracts, it doesn't make sense, in a way.

MS. WANG: Right, right.

The second question is, Can you share more of your thoughts about how you would achieve or how one could achieve budget neutrality if you wanted to with the current starts taking the approach of carving out but in a budget-neutral way? How would that work?

MR. ZARABOZO: Well, I think it's a -- so let's say everybody is being paid at 100 percent of fee-for-service. You would instead pay, if you're doing a 1 percent you would be paying 99 percent of fee-for-service and we're withholding 1 percent, as it works through the payment system, risk adjusted and so on. And then that money is used to give bonuses to the highest-performing plans, so that the low end, the people that are not essentially bonus eligible, would have been paid 99 percent in that year. They're not going to get any additional money. Other plans, there could be plans where they were

paid 99 percent but they will get 9 percent back, or, you know, the maximum bonus amount.

MS. WANG: So that presupposes, then, a complete reform of the benchmarks as well, in your example.

MR. ZARABOZO: That particular example, and what was proposed in 1999 and then 2004 would have been in that way.

MS. WANG: Yeah. Okay. Thank you.

DR. CROSSON: Jonathan.

DR. JAFFERY: Thanks. So we've talked a bunch about trying to get some better comparisons with fee-for-service performance and thinking about the ACO models that have a set of 33 metrics and 4 domains, the mix of CAHPS surveys and claims data and medical record clinical data. Have you thought about trying to get some synergy with those metrics and what it would take, and then sort of as a related thought, thinking about, you know, following on Pat's last question, at least in the next-gen program for next year, moving toward a quality withhold, which it's not totally clear to me all the details of it yet but I don't think it's going to be budget neutral. I think it's going to be a net savings. And just thinking about how do we, as

a Commission, recommend things that really have some equity across the different programs, both for participants as well as comparisons?

MR. ZARABOZO: Yeah. I think for purposes of comparison we would like essentially uniform measures across all the sectors, in a sense, so that the ACO measure can be directly compared to an MA measure, and, you know, if you do a separate non-ACO fee-for-service, if you want to approach it that way -- see, these are all comparable measures across these three sectors. And we've said that already in a report, that we want the ability to compare in a given market ACO's MA plans, and, well, of course, ACOs are part of fee-for-service but you can separately say non-ACO results are this.

DR. JAFFERY: Because I was hearing a lot about comparisons to, for example, the hospital based.

MR. ZARABOZO: Right. So the readmission measure, we want something to be able to compare to. And, you know, you look to it as, well, this seems like a no-brainer, readmissions. It's claims-based and you can do this easily.

DR. CROSSON: Bruce.

MR. PYENSON: Carlos, could you talk a little bit about how changing the current rebate system, based on stars, changing that to a bonus system, a withhold bonus, paid at the end of the year, how that would change the bid process and the process of offering supplemental benefits.

MR. ZARABOZO: Well, should I take this, Jim, or should I --

DR. MATHEWS: You can start talking and I'll --

MR. ZARABOZO: So I would imagine -- let's say it's a 1 percent withhold, so everybody gets 99 percent, so that's what you're dealing with is a benchmark. So you do whatever benefit package you're going to do, 99 percent. And I would think that instead of saying, you know, 50 percent, 65 percent, whatever, 70 percent, it would be the entire difference between bid and benchmark is what is available for rebates, right, so no discounting off of the rebate because you're already, actually, you know -- in the end you'll be at 100 percent, so there doesn't seem to be a reason to have that percentage difference in the rebate levels.

But, yeah, it's a bid. You know what the target is, which is 99 percent, and then after that you get a

bonus, and what you do with the bonus is up to you, you know, as a plan.

DR. CROSSON: Okay. Seeing -- Pat.

MS. WANG: In that scenario could a plan, in your thinking, put the bonus into benefits for the members, because that is a very structured process now through the bid, in your thinking about this.

MR. ZARABOZO: Well, again, this is just me talking. I don't know that we would say you're obligated when you get a bonus to put it into extra benefits. It's your bonus. I don't know that we tell other providers that, you know, here's what you have to do with this money.

MR. PYENSON: But presumably --

MR. ZARABOZO: You are back to bidding against the 99 percent. Every year you are bidding against the 99 percent, essentially, right? So it is a true bonus in the sense that it's, yeah.

MR. PYENSON: And you can bid whatever you want, the difference between the bid and the benchmark --

MR. ZARABOZO: Right.

MR. PYENSON: -- all of it's used to fund supplemental benefits.

MR. ZARABOZO: Right. Now, of course, we haven't gone to this level of detail in talking about that. I mean, and I think we might in the future, do that.

DR. CROSSON: Jaewon, another question?

DR. RYU: Just on this point, and maybe this is what you were asking, Pat. Mechanically, though, if you get it as a bonus, would you even be able to put it into benefits? Was that where you were going, because I'm kind of confused on that too.

MR. ZARABOZO: Well, if it you did it as a bonus that means you have extra money. I mean, you, as a plan, can say, well, we will bring down our bid, essentially, because we have this extra money.

DR. CROSSON: In the next year.

MR. ZARABOZO: Yeah. In the year in which you receive the bonus dollars, or, yeah, in which you have the bonus dollars available to you. Right.

DR. RYU: I got it. Thank you.

DR. CROSSON: Okay. Seeing no more questions we'll go to the discussion period. We've got -- can we put up the last slide, 14? So we've kind of got -- I mean, these are connected to the bonus program but we've kind of

got two bodies of proposal here. One has to do with, you know, kind of fixing the current program, the first set of small bullet points, and the second one is a question of whether we should recommend converting the current program to a budget-neutral program.

So I think in the discussion period I would like to, to the extent that you have interest, comment on both of those two things. And we have Dana and Paul who have offered to start. Yeah, so, Dana, why don't we start with you.

DR. SAFRAN: Thanks. So this paper is really extremely well done and lays out so many important issues. There's a lot there in the MA quality program. And, in particular, I think your overarching framing about the concerns around the inaccurate information that the current Stars program structure yields for beneficiary choice and the unwarranted bonuses being paid because of some of the features are really important things for us to keep in mind as we talk through some of your specific questions. The issues you raised, that we've raised before about consolidation are really important ones and I'm glad to see us tackling them again. Your suggestions around aligning

the methods here to the ones that we are recommending over on the hospital side I think are important, and the issues that you flagged, which I don't believe we've talked about in the slides but are in the paper, around new and small plans and the way they're treated are I think important too.

So I guess starting with the issues around consolidation, you know, I think that absolutely we should do what we can do to move toward -- move further toward disallowing that but also toward shifting the unit of measurement, as you are proposing in the paper, closer to where the member beneficiary is actually getting care, to your point about provide as accurate as possible information. It's probably not the reason that beneficiaries aren't using the information but it certainly doesn't help us encourage them to use it when we know that the information they might get if they did use it doesn't actually represent the truth of what their care might look like in their market. So I think that's extremely important. I do think we have to do a pretty robust look at what does that mean for available sample sizes, what would it mean for expanding CAHPS data collection, you

know, or revering back to market level CAHPS data collection and so forth.

Which kind of takes me to your question about reducing the number of measures, and you might be surprised by my point of view on this, but I don't think we're ready for that yet in this program. I see this as very different from the hospital program, for example, where I think we really are ready to go towards our principles of outcomes-oriented measures and have a very robust and multifaceted view to inform beneficiaries and to inform those who are running the program about the most important differences in hospital performance that need attention.

I don't think the same is true for Medicare Advantage plans, like of like ACOs, right? They are responsible for end-to-end, every aspect of care, and I think if we -- unfortunately we're not at the state where if we remove the HEDIS measures and if we remove the administrative measures that we actually have enough left that gives us confidence that we are giving good information to beneficiaries upon which to choose and a good basis for differentiating and rewarding plans differently. So I would say no, not yet, on that.

You didn't say anything in the paper, or at least I didn't catch it if you did, about the health outcomes survey, which we talked about a little bit yesterday. But I would say we want to actually see what we can do to elevate the patient-reported measures, and to something to help plans see where they can differentiate on the HOS measures, because I know, you know, there has been no differentiation, and we talked a little bit yesterday about some of the reasons why that might be. I don't think it's because there can't be differentiation. I think, you know, and I've seen that there are things that provider systems can certainly do to improve those functional outcomes in this subset of the population, which is probably a large share of Medicare beneficiaries who have conditions that lead to impaired functioning.

So I think we should do something in our recommendation that really elevates the importance of those and CAHPS. And on CAHPS, as we already said, you know, collecting enough data that we've got market-level information, but I might also suggest two other things. One is, you know, the industry is kind of getting warmed up to net promoter scores, which are used in so many other

industries and haven't been used in health care. And, you know, for those here who aren't familiar with them it's, you know, a one question that has to be the first question in a survey so that it doesn't get context-biased about whether somebody would recommend, in this case the health plan, to family and friends. And the health care industry, overall, does really poorly on their promoter scores compared to lots of other industries, you know, down there around the same as cable companies.

So I think it would be really potentially very important to recommend adding this into the CAHPS survey and trying to shift reporting -- I know we're focused here on the quality Stars program, but since we do talk in the chapter about the lack of use of the measures, you know, we know that the general public and older people, in particular, most value, in quality measures, the measures that have to do with what did other people say. And in this day and age we really ought to be able to have a Medicaid compare site that enables us to show them even what do people like me say, you know.

So, you know, pulling those measures out and potentially supplementing CAHPS with net promotor scores

and not just having the stars there, which are filled with lots of things that beneficiaries don't care about or assume they have no control over, or assume are fine.

A couple of last points. One is I absolutely support your recommendation to shift to absolute versus relative, you know, getting rid of the tournament, also getting rid of cliffs. And the last thing was -- I forget who over on that side of the table saying it. Maybe it was you, Karen. Maybe it was you, Marge. But I really do think we should be saying something here about alignment of measurement across Medicare plans so that beneficiaries actually have information to inform a choice, not just of which MA plan but to what you were sharing, Carlos, about the brokers, and, you know, their sort of informal way of, well, we kind of know which plans are better. We ought to actually have comparable data for how Medigap plans function compared to Medicare Advantage plans and just help people inform like what is their best option.

So thanks. Thanks for the great content that you put forward for us to discuss.

DR. CROSSON: Thank you, Dana. Paul.

DR. PAUL GINSBURG: Yeah. I also want to

compliment Carlos on the terrific job he did on this presentation. He's shown us that the problems with star ratings are numerous and serious. And, you know, we know that beneficiaries do not use them. That may be a positive in many cases, where beneficiaries certainly have a geographic should not use them, and all the problems that have been brought up, you know, underline it. The problem is even if the beneficiaries aren't using it the plans are using it, and the plans are using that to devote their resources to pulling themselves up on different dimensions to get star ratings. So they're still dangerous when they don't work well, even if consumers don't use them.

So I really question whether we, as taxpayers and beneficiaries, get much value for the $2 billion a year that we spend on star bonuses.

So I support a comprehensive review, as Carlos has done, and a really comprehensive restructuring. I do believe that there is promise, potential for star ratings to have value and do good but we need a lot of changes.

On the six specific issues that Carlos mentioned, I'm comfortable with all of them except the tournament model, and I've been waiting here, since I've been on

MedPAC, and knowing that tournament models are dirty words, to say that I see some virtues in tournament models in some situations. Basically they work when it's not clear what the target should be, either because we don't know what the gold standard is or, more commonly, we don't know what's practical as far as the speed of moving towards the gold standard. There's always a risk that, you know, particularly with net bonus model, you know, the standard is set easy, everyone gets it, and then there's a political resistance to making it tougher because they're all enjoying the ride. So I think we need to be selective as to where tournament models are useful and where they're not.

Now I strongly support making this budget neutral, and I think it was foolish decision that the policymakers made to make this upside only, because of the political dimension, you know, that now there's a large political force that wants to maintain this system with upside only because they're benefitting to the tune of $2 billion a year. So, in a sense, the sooner this can be moved towards budget neutrality the better because it gets more difficult over time as this becomes more and more

entrenched, and I think policymakers clearly do understand that. So thank you.

DR. CROSSON: Thank you, Paul. Further discussion. Let's start down there with -- did I see your hand, Jon?

DR. PERLIN: Yeah. Thank you. Let me add to the accolades. Really terrific chapter and thoughtfully presented. I appreciate that a great deal.

You know, if you start with this sort of primary question, what is the utility of these star measures, I mean, it's really to help the beneficiary make an informed choice. I think the data that we have before us suggests that it's not serving that purpose.

And, Jay, as you so nicely weighed out, the two fundamental questions, budget neutrality and fixing the program, and I think in that regard there is some degree of interrelationship. So let me just say, at the outset, that I agree with others to suggest that this should be budget neutral.

You know, I think one of the challenges in the health care ecosystem is a diffusion of effort based on permutations of measurement rather than a consolidated

approach that really aligns focus on the same measures. And so I think we can gain more traction in some of the areas of quality, safety, you know, consumer or patient experience, et cetera, with more parsimony around focus on measures. And that's great. I think there's a principle that's just that we should, to the extent possible, aim to align measures across the different programs, be they ACOs, be it fee-for-service, and, frankly, be at the measures that are at the hospital level as well.

I think there has to be a consolidated or consistent philosophy of measurement. You know, the notion of the budget neutrality really responds mentally to the concerns that you've raised in your very thoughtful presentation but also, again, the parsimony with inconsistency of philosophy with all the other elements, be it at the provider level, hospital-acquired conditions are all downside, readmissions are all downside. Only value-based payment is neutral. So I think there is an argument also there for consistency.

In terms of a couple of the areas, and I'm just generally agreeing, I just want to highlight a couple of things. I think Paul raised some really good points on

tournament model. You know, there are times where we have to have absolute in times tournament works, and I'm going to invoke the Warner Thomas curve here, where they may be a place where you actually have a tournament model but only after achieving some acceptable threshold. And, you know, the challenge is what measures that are ambitious yet realistic so they actually invite traction toward improved performance, and we have to concede that there are areas where we don't know what the threshold is. We don't know, at some point, while the goal of avoidable harm should be zero, there may be some finite number of infections in the area, and I realize that different population of preventing early elective delivery, it's not 100 percent at 39 weeks. There's some judgment between fetal and maternal distress and we can't absolutely specify 100. Even though that's a laudable aspiration, it's impossible to distinguish.

So I think there is utility in terms of a measurement structure that gates some improvement in performance, probably higher over time, probably informed by the literature about what's possible, and then ultimately parsed by relative performance in some way that helps to differentiate for consumers what the difference in

performance is at different levels. So I suggest this notion of a gate or a threshold and then some stratification.

I agree with Dana in terms of not, you know, constraining the set, just outcomes measures, but ironically, for a slightly different reason. I think there is utility in process measures, and if you don't believe me I'll do a little experiment with you. How many of you wear a seat belt when driving. Come on, Commissioners, a show of hands.

[Show of hands.]

DR. PERLIN: Yeah, that's a process measure, not an outcome measure, and I assume you didn't want to experience the outcome measure. But I think we just proved that there is an intense link between the process and the outcome. And so if there are areas where the evidence is really compelling, it's not a bad reason. And, by the way, I didn't risk-adjust for who's a good driver or bad driver among us, so he gets a bye on this one. And that proves the point. Not all measures apply to all folks.

A final issue is that I do think there's a role for developing sort of information or experimental or

learning measures, and I really like Dana's notion of expanding our concept of differentiation through novel approaches such as net promoter score. In fact, you know, I think when we think about the generations that will be aging into the Medicare program and increasing familiarity, I just think of my nonagenarian father who was scanning Open Table for reviews. I think we need to think about the ways in which consumers communicate with each other in other domains and hope that there is some room not for accountability measures but for a dialogue that creates an opportunity for learning measures that may, in fact, achieve a level of evidentiary support that allows them ultimately to become accountability, but perhaps equally, if not more importantly, help consumers to become informed about meaningful differences amongst their choices.

Thanks.

DR. CROSSON: Let me just make one comment, because I thought, Dana, that you were going there, and Jon almost as well. But in thinking about, you know, the measures that we use, there is a difference between measuring an MA plan's performance and measuring a hospital's performance in the sense that the hospital,

we're really measuring clinical -- you know, we're heading towards clinical outcomes.

In the case of MA, we've got that, but we also have the insurance functions, whatever you want to call them, that the MA plan itself is responsible for and should be accountable for to the consumers or the beneficiaries.

DR. PERLIN: Can I come back on that point?

DR. CROSSON: Yeah.

DR. PERLIN: Yeah, I think your point is well taken, and there are some measures that relate more to the administration. And I neglected to say I think there's one other aspect, which is that we've had a penchant for measuring points or specific services as outcomes. I think the other area of experimentation, particularly for an insurance function, where I thought you might be going, is integrating a variety of services potentially from different providers over time may require a bucket of measures that look more like episode measures than perhaps the types of measures we've been using, again, parsing those perhaps into the learning set.

Thanks.

DR. CROSSON: Okay. Further -- do you want to

comment on that again?

DR. SAFRAN: Commenting on that, you know, there's an exact parallel on the commercial side with NCQA, and, you know, the NCQA annual ratings of health plans include a percentage that is based on hundreds of NCQA standards that are burdensome to report, you know, take a lot of effort and resources to improve, but they're core health plan functions that probably the general public couldn't give a hoot about. But, you know, they do get rolled into what NCQA does when it gives its ratings of health plans, and they're very important things. So I think that, you know, your point, Jay, about the insurance function and needing that to be included here is part of what maybe both Jon and I were getting at, but saying, you know, not so fast with getting rid of measures.

DR. CROSSON: Further commentary? Brian.

DR. DeBUSK: First of all, thank you for a great chapter. It was certainly well done and gave us a lot to think about. I really applaud the technical fixes that you identified. I have to admit, in a blanket statement I agree with all of them. I really think that getting the geographic unit right, though, going to a MedPAC unit, is

probably going to be the linchpin of a lot of the things that you're proposing here, because I think that's -- you know, as we go forward and start doing some of this peer grouping and risk adjustment, we have to have the units -- sort of I digress for a second, but it makes no point in trying to measure SSI percentages for the purposes of peer grouping if you're going to spend three-state non-contiguous states. So I do think that getting that geographic unit right may be a real linchpin.

But I doubly applaud the larger effort that you're looking to harmonize this, you know, in terms of the selection of population health-based -- you know, a small number of population health-based measures, the peer grouping mechanism, the use of prospective targets. It was really nice to see some familiarity as you were proposing these changes, trying to see the bigger picture and address the technical fixes at the same time. I really, really like that.

The one I wanted to talk about, though, the EGWPs, it felt like you were going to try to segment the EGWPs and the plans with like the D-SNPs and things into different compartments, like entirely different data sets.

I'm just curious to see if we could put them -- if we could treat them as one, but then in the peer grouping mechanism stratify them, say, on SSI percentage and just see if they'll sort themselves out from there, because, you know, there could be some subtle differences.

What if I have a look-alike plan that emerges that, you know, really should be a D-SNP but it's a SNP because all the changes to the recommendations we made -- well, the things we discussed yesterday came through. I mean, you can imagine that it might be hard just to simply say, well, this is an EGWP and -- I mean, would an EGWP that served, say, your lower-income people look a lot like an ordinary MA plan?

So my one thought would be, if we could just lump them all together, broken out appropriately by MedPAC geographic unit, stratify them based on SSI percentage, and just see if the peer grouping mechanism -- I'm not saying, you know, do that at all cost. But it would be interesting to have an initial look and see if peer grouping alone got us over that hump.

The other thing I noticed, it was kind of a clever sleight of hand because the peer grouping mechanism

that I thought I heard you propose wasn't just SSI percentage. It was SSI and percentage of disabled. It almost sounded like we shifted toward a composite measure.

MR. ZARABOZO: That is the current MA system.

DR. DeBUSK: Right.

MR. ZARABOZO: Right.

DR. DeBUSK: But if we're going to use that in peer grouping, you know, we're not going to use it in the index, and the determination of the index to make the adjustment, I'm under the impression that we're going to peer group to make the adjustment going forward. Or was that just wishful --

MR. ZARABOZO: Well, I mean, you can peer group, you can say for -- you can combine the two and say the peer grouping would be based on -- well, the extreme would be percent of EGWP, percent of low-income, percent of disabled, that's what determines the peer grouping.

DR. DeBUSK: I thought it was -- it was nice to see us move toward a composite measure because, you know, you could be critical of using just SSI percentage for your peer grouping mechanism. I'm just wondering if you go to a composite measure, put all the data together, and then

stratify into deciles as opposed to having three separate compartments or trying to treat EGWP as a parameter. Does that make sense?

DR. MATHEWS: Brian, I think this is something we can absolutely entertain. We'll go back to the office and figure out, you know, the analytics here.

DR. DeBUSK: Okay.

DR. MATHEWS: And I think our tentative plan is to come back in the spring, and we may have something for you there.

DR. DeBUSK: Okay. Out of the weeds then. All good.

Let's see. Final point. I really do have a large bias toward using domains that can cut across the different payment systems. So, for example, when you were talking about the readmission measure, if the random effects model is what they're going to go with, I think we should probably go with it across both payment systems. So there needs to be a large bias toward that.

And then, finally, on the bottom of Slide 14, I do support the budget-neutral component. I think, to Paul's point, that's a good idea.

Thank you.

DR. CROSSON: Okay. Pat.

MS. WANG: Again, great work. Just going through this somewhat, the issues that you've outlined, on the cliff and the plateau issue, I agree with the others, the cliff is a terrible thing, and I actually think it's driven some of the contract consolidation work because it's such an all-or-nothing, so continuous scale for bonus payments, all for it.

Tournament model, you know, I appreciate Paul's comments on this, but I will tell you, at least from a sort of like having experienced it, it's -- I understand what Paul is saying in theory. If you actually look at the changes in the cut points on certain measures year to year, though, they're just not explicable. And I think that that is part of the puzzlement. You know, if CMS is -- you know, we've seen double-digit jumps in, you know, cut points for certain measures that seem impossible, and I don't know on a population health basis how you'd make that kind of -- how you achieve that kind of change in a year. So the CMS proposal may be to at least put parameters around content changes. It's really an issue. You know, I

appreciate what Paul is saying, and you pointed out the difficulty with one of the measures in setting a set threshold. But there's probably something in between there.

The EGWP issue is really an interesting one. The solution that you suggest in here makes sense. I would just note that there are other subsets of Medicare Advantage that you could -- I would suggest further examination. I mean, you had noted something about the EGWP and the disenrollment and the irrationality. You know, the fact that if you're an employer group program, you're not disenrolling because your employer is saying this is the plan you're in, this is how you get your benefit. And the strangeness of excluding the disenrollments from the numerator for EGWP but leaving them in for the denominator are things that -- I just would -- it raises the issue that even underneath that, there are other subsets. So if you're a D-SNP, there is -- starting in 2019, you can change plans every quarter. If you're an I-SNP, you perform really, really well on the readmission measure because all of your members are custodial in a nursing home. There are differences like that also that

drive some of the cut points for the different star levels, and I think it's worth looking at.

CAHPS, thank you, because every year we've looked at this and said this just doesn't make any sense. There's like a point difference between the different star levels. I am with Dana in sort of wanting to figure out if there's a better way to capture the member experience of care, but the CAHPS survey to me is -- and this just is hanging the bell on the cat. It's irrational to assign a star level -- I'm not even comfortable with the potential solution that you put forward, which is to sort of say if you're below this level, you're 1, and everybody's in the middle, and then there's a 5.

If you look at Slide 10, the difference that separates 1 star to 5 stars on CAHPS customer services, 4 points. That's barely significant. And to say if you're at 88, you're 1 point, and if you have 4 points -- that doesn't make sense. I mean, I think in the short term, this is a star measure that is weighted at 1.5. I would down-weight it because of the unreliability of this phenomenon and work towards something better.

On HOS, I think it's a similar -- again, you

know, the sample size is so small. HOS is very important, and I think that it's something that plans look at for signals about what's going right, what's going wrong, where's there a potential issue. But when sample size is so tiny that, you know -- and I can speak from the experience of a plan -- is so small that the 90 percent confidence interval includes both the 1-star and the 3-star cut point, and the plan is assigned 1 star, you just question the validity of that result. So there's got to be a better way to either get a better sample size or have a better measure of that.

On readmission measures, this is very, very important, and I think that you raised something very important with the issue around death. The one thing I'd urge us to think about with the readmission measure is to try -- this is one where hospitals really are getting signals from their own fee-for-service readmission incentive program, and to the extent that we possibly can align the readmission measure with what hospitals recognize as their performance or their score in fee-for-service, it would be really important.

So right now, obviously, you know, in MA plans

it's all-cause. In fee-for-service it's certain conditions. Fee-for-service, thankfully, moved to peer grouping, but I had to spend a lot of time on the phone with a very important provider serving a very underserved community who as a result of the first round of peer grouping said, "I just got my results, and I am at the top," you know, "And how come you're telling me that I've got all of these problems?" Just trying to even explain through that thicket of people who are busy, you know, trying to do the best for their patients, like it's measuring this, it's measuring that, it's peer-grouped, it's not peer-grouped.

You know, I wonder when we talk about the very important topic of SES whether we can build on some of those things. For example, in the readmission measure, if there's a recognition that the hospitals are in peer groups, maybe we can adapt that construct in developing the star measure that plans are evaluated on rather than coming up with something completely different, simply to make the conversation with very busy providers easier. In the short term, though, the idea of excluding outliers, as you describe on Slide 11, I think is really a good idea.

Moving towards budget neutrality and looking at the recommendation on Slide 13, you know, I appreciate the response that you provided before, Carlos, because when the Commission developed this approach, we have to really remember something. The way of setting MA plan premiums was completely different than it is now. There was one approach that applied to all plans in the country, whatever it was, the AAPCC or whatever it was. Bruce will remember. There is now a variation of benchmarks that plans bid against, from 95 percent to 117 percent, 115 percent of fee-for-service that, candidly, has no scientific or empirical basis. It was a political -- you know, that was what the ACA kind of produced at the end, and I think that it was being negotiated up until the end.

I think that the discussion of budget neutrality and kind of redoing the concept of the bonus is a very important discussion, but that it really has to be accompanied by a reexamination of fundamentally how the benchmarks work, and in Carlos' response, he sort of posited everybody is at a 100 percent-ish benchmark to fee-for-service. And then you can start talking about a rational way to make it budget neutral and do withholds and

paybacks. But absent that, I would just caution us from kind of making an irrational situation with the current benchmark system worse.

The points that you made about the measurement at small areas, especially for the CAI, which is sort of the SES adjustment now in MA, were really important, and I think that the issue of sort of small sample size and, you know, the contract consolidations, geographic limitation would help. But I would just, you know, underscore the importance of moving to even better SES adjusters. ASPE is working on this; others are working on this. And, you know, I think perhaps at some point we can get past the CAI and on to better measures, and I think that we need to keep pushing on that.

Finally, I agree with the comments made before about trying to really recommend an end date for the low enrollment plan phenomenon and the new plan phenomenon. I think it invites gaming, and it's just not a good thing.

And I think that was it for my comments, so thank you. Also, I do agree with the comments that Dana and Jon made and that Jay brought out. An insurance company is not a provider, and I think that we have to be careful about

assuming that the approaches towards quality metrics for providers just translate. There are -- HEDIS and many of the Star measures I believe have really improved care for beneficiaries, and they particularly have in the case of plans that are sort of getting the credit for it themselves as opposed to getting the credit for work that was done by a plan on the other side of the country. But I don't want to lose sight of the fact that just because we're very discouraged by the contract consolidation phenomenon -- as a regional plan, I've been hurt by that, and I think that it's distorted the whole discussion around stars. But underlying that, it's important work for plans to keep doing.

Thanks.

DR. CROSSON: Okay, thank you. Kathy.

MS. BUTO: Okay, so I'm going to express a minority view, which is I am not a fan of quality bonus plan approaches. In other words, I think Medicare has a lot of bonus programs. I think what Medicare doesn't do very well is set quality standards and then hold everybody or all plans to those standards. That would be my preference, recognizing that's difficult to do. But I

especially am troubled by them when they don't affect, don't seem to affect beneficiary choices. So the original intent, which was to provide information to help beneficiaries choose plans, doesn't seem to be realized, yet at least.

And so as I look at the paper, which I thought was brilliantly done, I wondered if we could flesh out the budget-neutral approach further, because I note the original work was done in 1999, but it seems to me that the idea of really trying to move the bar and reward exceptional performance and penalize subpar performance is something we should seriously look at.

I think a lot of these other changes are important, but it strikes me we'll be in the same situation where most plans -- or most beneficiaries in plans will be in plans that meet the new criteria and then sort of where are we.

The other thought I had -- and I really liked Dana's suggestion about sort of the, I guess, net promoter score -- is that what you called it? And Pat mentioned as well other measures that would capture beneficiary experience better. Jonathan and I were calling it the

"Yelp measure," something that would actually help you make these choices, and that people would look to.

So as I think about a withhold system, a budget-neutral system, and I think somebody mentioned that ACOs are moving in that direction, if we were to pursue that approach for MA -- recognizing I think Pat has brought up some important points about some of the limitations, given the way the payment for MA plans is structured under ACA. If we were moving in that direction, I think we ought to consider possibly a half percent or some smaller withhold from fee-for-service payment that would not be available for bonuses, that would be a withhold to go into payment for high-performing managed care plans or plans that better manage beneficiary care -- again, the idea being to try to migrate some of the incentive for providers to join more organized plans.

So just a thought. As long as we're thinking about withholds in the managed models, I think we ought to consider that. And some of that could go back into, say, the hospital readmissions reward system or other fee-for-service systems or just be withheld and then redistributed through more managed approaches.

So those are my thoughts, and I really like the work here, but I would like to see us think about a more robust system that would try to move the bar and reward high performers and penalize low performers.

DR. CROSSON: Jon.

DR. JAFFERY: I want to reiterate my support for trying to move to better alignment with the ACO metrics, and I appreciate the points that have been made about some specific health plan metrics that we shouldn't lose sight of.

I don't know that I would see that it would be absolutely necessary that we have 100 percent alignment between ACO measures and the MA measures, but the more that that Venn diagram has overlap, I think would be advantageous and not just so that we could do comparisons or even beneficiaries might be able to make comparisons. But provider groups are increasingly taking care of beneficiaries who are in both ACOs and MA plans, obviously not an individual beneficiary, but they have patients in their practices in both types of programs.

Being able to align towards improvements in the measures that are very related to clinical care would be, I

think, helpful for -- good for beneficiaries, helpful for providers, and frankly helpful for the MA plans as well who sometimes struggle to move those measures when they're really dependent on the provider groups.

Just a couple other quick points. I would be very supportive -- I am very supportive of the smaller geographic units. I'm not sure what the best approach is, but I think in the absence of anything right now, the MSAs and health services areas seems to make some sense.

Then in terms of budget neutrality and maybe to follow up on a couple of Kathy's points, looking at this and talking about reasonable equity between MA and fee-for-service, I think we do want to get there and move more in this direction, but again, that doesn't get us to real equity in the ACO programs, which are now operating on either some sort of withhold of which you can maybe get up to 100 percent benchmarked against yourself of that back. And, generally speaking, I think programs don't get quite 100 percent, the way it's structured, or you have some sort of small reduction in your shared savings, a percentage based on your quality scores.

It is a different model than even I think what's

proposed here. Over time, I'd like to see those things come together more consistently.

DR. CROSSON: Great.

Bruce.

DR. PYENSON: Well, thank you. This is very thought-provoking. My compliments to you, Carlos.

I'd like to convince my fellow Commissioners to try to look at this almost backwards from the ultimate results of what we're calling quality measures and how that flows into the bid process that drives whether a health plan survives or not or makes money or not because the particular quality measures, which are often put together with an embroidery needle, are averaged, scored with questionable data and fed into a vast engine called the annual ritual of the bid process, where a health plan struggles to produce a rebate that a bid below the benchmark that it can use to provide extra benefits and get members.

And that's the financial consequence of these decisions, that a health plan -- not so much the profitability. That's there, but the ability to provide those extra supplemental benefits to buy down the Part D

premium, all of that is the ultimate result of a plan star rating, and that's a very onerous, difficult process, an iterative process. It goes through lots of cycles annually.

And if we think about that and the kinds of incentives it's created for plans, the MA plans that do well on that have a lot of really smart people looking for every angle they can and working intensely to model the different options and the different opportunities and the different threats in that process.

So while we're talking about a particular measure that might be -- we're arguing whether or not it affects quality. The ultimate -- the reason MA plans care about that is the ultimate bid process.

So, if we start from that kind of approach, I think we can resolve many of the issues along the lines of the short- to medium-term solutions, but also come up with a much, much better system of developing bids that would actually really do something to promote quality faster.

I think this is very much connected with the next presentation on encounter data because this could all, in my opinion, be driven by encounter data if we only had it.

So I'm sympathetic with a lot of what was said. I think it's a great discussion, but if we flip this on its head and have a bit more information, almost looking backwards at what Carlos characterized as out there on a different way of doing bids, I think we can go backwards and really fix the system.

DR. CROSSON: Okay. Further comments?

David.

DR. GRABOWSKI: Great. Thanks, Carlos, for a great chapter.

I agree with others that the Medicare Advantage quality bonus program is broken, and I like a lot of the fixes that we've been discussing.

I wanted to push us a little bit on what's the goal here, and I've kind of heard two goals. The first -- and I think that's the main focus of the chapter -- how do we create a better mousetrap? How do we create a better measure to use to award plans?

There's also some discussion -- and Karen and others have picked up on this -- as how do we create a measure to help beneficiaries choose higher quality plans, and the point I want to make is you could fix the first and

do very little about the second.

And I think Dana is pushing us in this direction with your net promoter score.

I think this goes beyond measures, however, that we could even get the measures correct, and still, there's a lot of other barriers here, the complexity of the decision, decision aids, the choice architecture.

So I would push us to think a little bit more about how MA beneficiaries or beneficiaries more generally choose plans. What are the variables that go into that? Are they actually using the star rating, and would they use a star rating even if it was one that sort of reflected measures that they care about?

I think the problem is probably deeper than that, so I just want to have us kind of think more broadly about kind of choice here and quality from a beneficiary perspective.

Thanks.

DR. CROSSON: Jon.

DR. CHRISTIANSON: Yea. Just a couple of comments on the comments.

Back to Paul's comment on tournament models, I

think you did a good job of talking about what the pluses of tournament models are. In the private sector, the world is littered with fee-for-service-based, pay-for-performance programs that have used benchmarks and found that the payers are not happy because they find they're paying for historical quality, but they're not seeing the improvement at the low end that they had hoped for.

But I think that just kind of illustrates, in my opinion, at least sort of a false dichotomy to say we're going to have to use benchmarks or tournament. So I think the private sector, it's usually a meld between the two, some sort of incentives to reward the low-end performers for improving, but at the same time acknowledging that really high-end performers can't improve much. But we want to reward them for being high-end performers, and that's where the benchmark comes in.

So we need to think about not is it benchmarks or is it tournament, but is there some combination again, as Paul, I think, pointed out, depending on the type of measure where we can be smarter about designing or recommending rewards?

Then I want to go back to Karen's earlier comment

in the question period, which I think was right on target, the comment about, well, do brokers use these stars in their recommendations, and it's not just that.

The way we sort of get this information about how stars are used is through specific surveys where the questions tend to be "Have you seen X?" and then "If you've seen X, have you used X?" So we sort of funnel down, and what we miss there are situations where people are getting advice from others.

Do people go to hospitals and compare websites to look at X? Is that how I ask a question? US News and World Report has a comparison among health plans, and they distill their comparison down from the Star System, so maybe that. Maybe you go to your neighbor, Jerry, and say, "What plan are you in?" and Jerry tells you. And you always trusted Jerry, so you go with Jerry's plan. Jerry might have used the Star system. That doesn't turn up in the survey.

So, in some ways, when you look at these survey results, you've got to think of them as really baseline data on how useful these stars are, how they're used in terms of choosing plans.

Paul probably wouldn't be happy about that if we don't think the start system really represents something we want people to choose plans based on.

The other thing is more along David's line, which is this is a very confusing and time-intensive choice on the part of beneficiaries. If you think about it, it's not do we want to choose one MA plan versus another and let's go look at the stars. It's there's traditional Medicare, and there's a supplemental plan, and then there's a drug plan. Then when we put that together, let's compare it to our Medicare Advantage plan, and we want to get the drug plan through that.

By the time you go through all of this, how important do we really expect or want that Star system to be in people's choice?

Then the choice costs are very high. Who is in play at any given year, it doesn't really make sense for a lot of beneficiaries to go through this process every year. It's just too expensive relative to the benefits for them.

So back to what you were saying, David, I think it's a very complicated overall process, and we sort of get hung up in the stars.

The other thing about stars is there are two components, two things we might want to have happen. We want people to -- if they were good measures of performance, to start into high-star plans. Great.

The other thing we'd like plans to do is compete for beneficiaries where part of that competition is based on stars. We don't have to have everybody choosing based on stars to have robust competition. In any market, if you have a few well-informed consumers that are in play, you have an incentive for people to deliver a better product.

So who knows? If 12 percent of people say they choose based on the Star system, that may be enough for this second thing we want to have the Star system to accomplish, which is to get plans to compete based on quality.

So I think it's a really complicated situation here, and I think we need to get the Star system right, but as David was saying, it's part of a much broader issue that we probably need to address in a more comprehensive manner.

DR. PAUL GINSBURG: Yeah. I've heard a lot of really good comments around the table, and something Jon said just made me think to bring up the point that usually

when we talk about consumers' better information, we're initially mostly concerned that the market is driven to produce value, quality. We're not so concerned that each individual consumer makes the right decision, and we may find tradeoffs in this area between making sure the plans have the right incentives and being as helpful as possible to a large number of consumers.

I think Jon's point that basing something on what your neighbor recommends and the neighbor used the star rating, that's as good as you using the star ratings.

I had one other comment on what Pat said about the budget neutrality. I'm not sure that having the quartiles with the 115 down to 95 is a problem with that. If it was, I think it would be pretty simple to fix it, so that the 1 percent was based on the 95 percent rather than -- or the 115 percent rather than on 100 percent.

I think Carlos could probably figure that out so that that's not a problem.

I'm really glad I brought up the tournament model because they really had a lot of wise comments that I agree with. In addition to that being Pat's model on stability and commenting on stability, I think it's really important

that there be some stabilizers so that there aren't unexpected jumps in what cut points are from year to year, and that might make the tournament process much more acceptable to the people being rated as well as I think, hopefully, everyone else.

MS. BUTO: Jay, can we ask Carlos how many of these would require legislation versus can be done now?

DR. CROSSON: Sure.

MS. BUTO: Done now, given a year of rulemaking.

[Laughter.]

MS. BUTO: Do you know, Carlos? Are they all --

MR. ZARABOZO: Well, I would say rulemaking, in general, I think --

MS. BUTO: Including --

MR. ZARABOZO: The one about consolidation legislation.

MS. BUTO: Legislation, Okay.

MR. ZARABOZO: Yeah.

MS. BUTO: And the budget-neutral one would require --

MR. ZARABOZO: Yes. Sorry.

DR. CROSSON: Warner?

MS. TABOR: If the domains change.

MR. THOMAS: Just a brief comment. I mean, I agree with the alignment of the measures between especially the ACO models and MA because, as Jonathan indicated, from a provider perspective, it would certainly provide more ease.

And I would agree with Dana that, I mean, if you look at these measures, we are improving care, and we do continue to improve on these measures across the industry.

If you compare to traditional fee-for-service, not measuring these things -- we measure them in APMs. We measure them in MA. We don't measure them in fee-for-service, and think about how many people we have in traditional fee-for-service.

So we're sitting here kind of debating back and forth some of these measures, and I agree that they could be better. But then we have a whole large piece of the population that we really don't measure ambulatory quality, and there's really not a lot of risk associated in the fee-for-service area.

I mean, we've got MIPS now, but it's not material. It's not as significant as what you're talking

about here in MA.

I think having better alignment makes a lot of sense.

And I also agree with Pat's point that even when you get to a certain cut point and on the CAHPS measures, I mean, I think that's a key piece. If you get to a certain cut point, maybe you're good enough. Maybe that extra point or two points between a 3-star and a 5-star and the CAHPS are probably not a material change in the experience of the member, frankly. So I think this idea of you've got to hit a certain threshold, and maybe you're high enough. I think that's something that we need to think about, especially when we have such a tight range.

I mean, going from a 1-star to a 5-star and having four points, that's -- I mean, it's pretty hard to discern that from an experience perspective. So I think those are things that need to be looked at as we finalize the chapter.

DR. CROSSON: Dana.

DR. SAFRAN: Just a couple of quick reactions to those important points.

One is that on the last point that Warner was

just making, one of the things that we've done -- and we do use absolute performance targets, as I've talked about before -- is that as the gap between the Gate 1 target and the Gate 5 target starts to get very small, we do just shift to having like one target and call it Gate 5. You have that cliff issue, so you have to deal with that carefully, but I'd be happy to share sort of offline how we've handled those and how I think it's played out in terms of provider response. Do we see like erosion of performance and kind of what happens?

But the stability point of having absolute targets and the willingness to share best practices has been one of the really important benefits of everybody having the same performance targets and knowing they will not change over the X years of the contract -- in our case, five -- and that Gate 5 represents the outer limit of what is empirically shown to be possible to achieve. So we don't have to worry that we're settling for mediocrity.

The other thing I just wanted to say, because I think it's important, it relates a little bit back to our conversation yesterday, where we were saying like should we care whether the MA plan passes on risk or shares risk with

a provider organization.

There was something in what Warner was just sharing that reminded me to share with all of you that in our experience with our MA plan providers, some are at risk. Most are not. And my team is responsible for the ways that we share performance improvement data, and we do a lot of that on the commercial side.

And I just heard two weeks ago from my team that for over a year, we've been sharing the same king of gaps-in-care data with our providers for Medicare Advantage, and the providers aren't even pulling down the lists.

So it just does strike me that, yes, these measures matter, and plans, I can tell you work like crazy. It's very competitive right now to try to perform well on Stars. Getting four stars and getting the bonus that is associated with that is extremely important. Getting five stars and having an open enrollment period all year long, very important, though some plans worry about whether that will bring them adverse selections, so just to share that perspective.

But we should not kid ourselves and think that these things don't matter and plans aren't working on them.

I think they're working hard on them. I think you've heard a lot that there are aspects that matter, and there is this interesting data point that we have that our providers are hungrily gobbling up all the data we give them on the patients where we have put them at risk or created incentives and not even looking at the data we're sharing with them, where we're not offering those benefits.

DR. CROSSON: Okay.

DR. DeSALVO: I just want to second that last point that Dana made, and that's all I'll say.

DR. CROSSON: Okay.

DR. DeSALVO: The provider risk really matters. I missed yesterday, but I would think we have to consider the whole continuum and the integration of services.

DR. CROSSON: Okay. Marge.

MS. MARJORIE GINSBURG: I wanted to just comment briefly on the topic of the consumer being the wise decision-making about what plan, what type of plan they join.

I know that MedPAC does a lot of research and a lot of focus groups, often with clients themselves, and I speak with all bias as a SHIP counselor to ask whether --

and suggest you do if you haven't -- whether you've ever done really targeted surveys or focus groups with the people that run the SHIP programs in various parts of the country because they are the ones.

I mean, I can tell you, of my clients, what do they ask about when they're newly enrolled in Medicare, about how they make their decision if they're newbies or what their issues are when they need to change their mind or they move to the area and they're brand-new?

But it's the people who run the SHIP programs and who have hundreds, if not thousands of case examples of how people -- what they think about when they make their decisions because everybody knows the SHIP programs are completely nonpartisan. We're not there to direct but to give them the tools to decide.

So that's really a question for you Carlos. Have you talked to SHIP programs before on this area about how consumers make decisions?

MR. ZARABOZO: We do talk to SHIP counselors. For example, one comment was, well, we used the starts as tiebreakers. So if we have two plans that are seemingly good for the beneficiary, if one has a better star rating,

then they'd point out it's a better star rating. But we do talk to SHIP counselors on these issues, yes.

DR. CROSSON: Okay. I know we've run over significantly. I think we'll be able to catch up in the next discussion. That will be interesting to watch.

But I do want to make a couple of comments to add a little perspective here. On the issue of moving to budget neutrality, I was actually here on the Commission in 2004 when we first put the issue of Medicare bonuses on the table in a boldface recommendation to Congress.

The thinking at that time was relatively simple. We were embarking at that point in a multiyear attempt to bring the revenue in Medicare Advantage into alignment with fee-for-service Medicare. In fact, it had exceeded -- that what Medicare was paying through Medicare Advantage for the care of beneficiaries had vastly exceeded the expenditures in Medicare fee-for-service.

In so doing, I think the sense of the Commission at the time was if we're going to do that, don't we need to make some statement about quality? And, in fact, while over a period of years, resources were being pulled away from the MA plan -- and I think appropriately so -- would

there be a place for a counter -- a set of counter-incentives for plans to focus their resources on quality? And this is consistent with, I think, positions that the Commission has taken on almost all issues.

What transpired subsequently -- so the idea was relatively simple, as has been laid out. It was let's do a withhold, a budget-neutral payment that could be redistributed, and the intent at the time was to a relatively circumscribed number of plans who were really exceptional in quality. That was the idea that we had at the time.

As this has evolved over the last 14 years, as a number of people have pointed out, it's become quite different. If you had asked me in 2004, do we intend for 75 percent of plans to receive extra payments above and beyond the baseline? Not at all.

Now, that having been said, I think as Pat pointed out, much has changed in the way Medicare Advantage is being paid over that period of time as well.

So I just want to make clear to everybody that there's some aspects of this we have not discussed here in terms of if we go to budget neutrality, what is the

baseline revenue assumption that would be used in then setting that new program and that new budget-neutral program? We do need to discuss that.

And I would draw your attention to the last two lines of the final bullet point there, which is as we move in that direction, it's going to be essential that we do it in a way that is consistent with our fundamental principle that we are trying to move towards an environment in which there is -- and you can use different terms here, a "level playing field" or "reasonable equity" among the different Medicare payment mechanisms. Jonathan, I would include ACOs in that.

As we move forward with this -- and I think we're going to come back in the spring, Jim; is that right? I just want to point out that this will require due consideration to how we do it and what the impact is, and that it's consistent with our long-term goals that we've expressed many times over many years for this idea of a level playing field.

With that, thank you, Carlos, for an excellent chapter, and this was a great and detailed discussion.

We'll move on to the final presentation.

[Pause.]

DR. CROSSON: Okay. So are you guys ready? We're going to move ahead to an issue we've been discussing for a number of years here and that is the current state of Medicare Advantage encounter data and what could be done to improve that and speed it along. Andy and Jennifer in here. Jennifer is going to start off.

* MS. PODULKA: Great. Thank you. Today Andy and I will present information on Medicare Advantage encounter data, and this is in follow-up to the more detailed presentation on these data that we gave this past April. We will begin with background on how the data came to be collected and summarize the findings from our efforts to validate the encounter data files. We will discuss the expected outlook for encounter data going forward. And finally, we will introduce some proposed policy options for the program for your input.

And first, though a note on terminology. MA organizations sign contracts with Medicare to deliver the MA benefit to enrollees. These contracts can include one or multiple plan benefit packages, and all of our analyses were conducted at the contract level, but we will also use

the terms "MA organization" and "plan" interchangeably today.

MA encounter data have a long history that began with the Balanced Budget Act of 1997, which required the collection of encounter data for inpatient hospital services and also permitted the Secretary to collect encounter data for other services. Efforts to collect these data proceeded with some starts and stops.

Then, in 2008, CMS amended MA regulations to resume collection of detailed encounter data for all services from the MA organizations for risk adjustment and other purposes. Finally, in January 2012, CMS began collecting such data from plans.

We now have access to MA encounter data for 2012, '13, '14, and preliminary files for 2015. The preliminary files for 2015 are the same data that CMS recently released for public use. Data are collected through each of the six provider types or settings shown here, and encounter data are similar to claims data in that they are expected to include diagnosis and treatment information for all services and items provided to enrollees.

We have validated the MA encounter data files to

determine if they are ready for use in various analyses and risk adjustment. Our methodology includes two main categories. First, we checked if each plan successfully submitted any encounter data for each of the six settings. We also compared the plans' reported enrollees to CMS's database that tracks MA plan offerings and beneficiaries' enrollment.

It is important to know that when plans submit encounter data, CMS's system performs automated front-end checks before accepting each record. Errors or problems cause the system to reject the submission, which means no record will appear in the encounter data files unless the plan resubmits the data. In other words, if encounters are not present in the data, we can't tell if that is a result of the plan not submitting or the system not accepting the record.

And for the second step of the validation, where available, we compared MA encounter data to other data files that include information on MA utilization. For these comparisons, rather than trying to validate all data elements, we instead focused on first- and second-order questions. First, we checked to see that the same

enrollees who received a service that is documented in the encounter data are also identified in a comparison dataset. And also, where possible, we checked that dates or service matched or were at least similar.

Our validation efforts found three broad categories of issues in the encounter data. First, plans are not successfully submitting encounters for all settings. In 2015, only 80 percent of MA contracts have at least one encounter record for each of the six settings. Second, the encounter data include a small number of records that attribute enrollees to the wrong plan. The paper goes into more detail, and the key takeaway is that this issue will require a change in data processing to address it. And third, encounter data differ substantially from data sources used for comparison. We will focus on this one on the next slides.

We compared the encounter data to other sources that document MA utilization, and these four are the independent or external data in that they are derived from information reported by providers, including hospitals, dialysis facilities, home health agencies, and skilled nursing facilities.

For 2015, 90 percent of enrollees reported in encounter data as having an inpatient stay were also included in data reported by hospitals. However, of these inpatient stays in encounter data, only 78 percent had dates or service that matched to the hospital-reported data. Similarly, 89 percent of enrollees reported in encounter data as having dialysis services were also included in data reported by dialysis facilities, and the enrollee match rates were 47 percent for home health and 49 percent for skilled nursing.

There no independent data source for assessing the completeness of physician visits, outpatient services, and certain other Part B services. The best available comparison for some of these comes from Healthcare Effectiveness Data and Information Set or HEDIS, which is not an external data source but is based on plan summaries of their internal utilization data that they report to CMS. So we compared the encounter data to these three plan-generated sources that document MA utilization.

We found that 46 percent of MA contracts reported the same total number of physician office visits, plus or minus a factor of 10 percent, in both HEDIS and encounter

data. Match rates for emergency department visits and inpatient stays were lower at 10 percent and 27 percent, respectively. And for those contracts that report outside of this range of matching plus or minus 10 percent there were errors on both side, so contracts can report both extra encounter visits and extra HEDIS visits.

And now I'll turn it over to Andy for the next section.

DR. JOHNSON: I want to start by highlighting the value complete encounter data could have for the MA program. Detailed encounter data are the best vehicle for learning about how care is provided to MA enrollees. An important function of the program is ensuring that the Medicare benefit is administered properly to all beneficiaries.

Second, plans use flexible payment methods, care-management techniques, robust information systems, and beneficiary incentives to provide efficient care. We would like to evaluate these policies using encounter data in order to inform and improve Medicare policies.

Finally, administering the MA program requires the use of fee-for-service claims and many single-purpose

data submissions from plans and providers. Complete encounter data could replace several data collections and would ensure that the program relies on data that are internally consistent and conform to program rules.

Even though we found the 2015 encounter data to be incomplete in several ways, the results do show a small, incremental improvement over the 2014 data. Given the current incentives, we anticipate that this incremental improvement will continue; however, we are concerned that data completeness is not being assessed, and there isn't a framework to look for items and services that are not reported in encounter data.

Given the potential value of complete encounter data, we consider completeness is addressed by current feedback and incentives. Report cards show plans the total number of submitted, accepted, and rejected records by service category, and include regional and national benchmarks for each. Report cards also compare inpatient encounters to those reported by hospitals, but the metric only has an informational purpose, and is not linked to an incentive for improvement.

CMS recently implemented a set of encounter data

performance metrics assessing the timing of submissions, and comparing each plan's encounter data to the plan-submitted risk adjustment, or RAPS data. Thresholds for these metrics are designed to identify outlier plans with data submissions substantially below reasonable expectation. Plans that did not meet the thresholds could be required to follow a corrective action plan, but would face no other penalty.

Finally, encounter data are used to identify diagnoses for risk adjustment, which provides an incentive to submit some physician, inpatient, and outpatient encounter records. However, it does not provide an incentive to submit records for other types of services or for encounters that do not reveal additional diagnosis codes.

Based on the current feedback and incentives, plans and stakeholders report that more recent years of data are better. However, we believe CMS and plans should now focus on encounter data completeness.

To do this, we start by considering how to data completeness. There several opportunities to improve upon the current situation. The best strategy is to find

evidence of MA service use in independent data sources. External data sources come from providers in the form of patient assessments and information-only claims. Constructing metrics of completeness based on external data sources gives a measurable sense of whether all MA encounters are being reported. Available sources mostly cover inpatient and post-acute services; notably lacking is information about physician and outpatient services.

Data generated by plans can also be used to assess encounter data. However, comparisons to plan-generated sources test whether plans' data processing is internally consistent. Inconsistencies could identify missing encounter records, but such comparisons cannot determine that all encounters have been reported. Available plan-generated sources cover a wide range of services.

For all comparisons, metrics could be constructed with an appropriate degree of specificity, ranging from matching beneficiaries in both data sources, to matches that require consistent providers, dates, procedures, and other data elements.

Finally, providing feedback to plans about the

completeness of their encounter data based on these metrics is a necessary step to encouraging more complete submissions.

Over the next few slides, I will discuss policy options for increasing incentives to submit encounter data, starting with expanding the performance metric framework. The other options include applying a payment withhold for encounter data submission and using Medicare Administrative Contractors, or MACs, to collect encounter data directly from providers.

These options are not mutually exclusive. An overall strategy could apply a mix of options in varying degrees.

Performance metrics currently focus on the timing of encounter submissions, and comparisons to plan-generated RAPS data. Their purpose is to identify outlier plans with poor submissions. One way to expand this framework is to add completeness metrics based comparisons to external and plan-generated data sources. Reporting for these metrics could also be improved beyond whether or not a threshold was met, to include specific information about missing encounter data.

Finally, the current enforcement mechanism

focuses on low-performing outliers. Although, this mechanism could be strengthened, we find that the use of a single threshold to identify outlier plans does not address the scope of incompleteness in encounter data.

Our analysis found the lack of completeness to be a broad issue with nearly all plans needing at least some improvement. Therefore, applying a low threshold would leave many plans with incomplete data to go without an incentive to improve, and a more strict threshold would classify the majority of plans as low-performing outliers. An enforcement framework that might fit this situation better is a payment withhold.

A payment withhold offers a direct financial incentive to submit complete encounter data. It could build off the performance metric framework by replacing the current set of outlier thresholds and penalties. To implement the policy, a percentage of each plan's monthly payment could be withheld, thus correlating the size of the withhold with enrollment in the plan and the number of expected encounter records to be submitted. A range of withhold return rates could tie each plan's performance with the amount to be returned to the plan.

For example, plans with good performance could receive their full withhold in return, plans with near good performance could receive most of their withhold, and so on. Hence, the withhold return would be proportional to the performance of each plan, and any penalty would match the level of incompleteness in their data.

Withhold return rates could start at a generous level, with a high rate of return being easy to attain, and then become more strict so that either encounter data become more complete or less of the withhold is returned. If all MA plans collectively submit complete encounter data, the withhold policy could be phased out.

Finally, providers contracted with MA plans could submit encounter data directly to Medicare Administrative Contractors. This option would fundamentally change the structure of encounter data collection, and should be considered a fallback option. MACs currently process fee-for-service claims for all A and B services, and hospital information-only claims for MA enrollees. Hence, providers are familiar with the process.

For A and B services in MA, MACs would apply fee-for-service data edits to ensure that submitted records are

complete before forwarding them to plans for payment processing. For MA supplemental services, MACs could forward records directly to MA plans without any processing. MACs currently forwarding claims to Medigap plans and Medicaid agencies with cost-sharing obligations.

There are two options to implement this policy. The first would require all MA plans collectively to meet a timeline of completeness thresholds. A missed threshold would trigger the use of MACs to collect encounter data from all MA plans, thus maintaining consistent data collection policy for all MA encounters. The second option would apply completeness thresholds to individual MA plans. A missed threshold would result in the use of a MAC for that plan, but other plans would continue to submit their own encounter data. Under this option, plans that prefer to use a MAC to process and submit encounter data could elect to do so.

Here is a summary of the options for assessing completeness and increasing incentives to submit complete encounter data. Aspects of all three incentive options could be applied together by expanding performance metrics to better assess completeness, applying a payment withhold,

and establishing a timeline of completeness thresholds that would trigger the use of MACs to collect encounter data.

If encounter data become complete, the withhold policy could be phased out and the use of MACs would not be triggered. However, if encounter data continue to lack completeness even with a withhold policy in place, the trigger would result in using MACs to collect encounter data. In any scenario, the assessment of completeness will continue to be relevant as the uses of encounter data expand.

Back to you, Jay.

DR. CROSSON: Thank you, Andy and Jennifer. We will be open for clarifying questions.

Bruce and John.

MR. PYENSON: Thank you very much. This is really a terrific examination of the challenges with encounter data. And in reading through the various methods you use to try to test is the data complete or not I'm reminded that that's a very frequent problem for actuaries who have to certify financial amounts or calculate reserves, that is how do you know if the data you've been given is complete. And that's true whether it's an actuary

outside the company or inside the company.

And there are several techniques that are used. You're always trying to find other sources that you can compared to, but one of the advantages in using company data, company claims data is to compare the total amount paid to the checks that the company has written. So if there's money going out that's more than what's in your claims data there is problem. You know you're missing something, and if you can't reconcile it maybe it's a different kind of problem going on.

So I'm wondering where that kind of technique, looking at the actual dollar amounts and getting that -- I recognize different plans have different ways of paying and so forth, but a lot of them and a lot of the categories are fee-for-service. So what would it take to get the actual dollars through the system as a way of validating the completeness?

DR. JOHNSON: That's a great question and the current barrier is that situations where the arrangement between the plan and the provider is capitated, the payment amounts are not required to be submitted on encounter data. So any analysis would have to take account of that and I

think get fairly complicated quickly.

DR. CROSSON: Okay. Jon.

DR. CHRISTIANSON: So a comment and a question. The comment is just that, you know, this chapter, like a lot of stuff we've been writing about encounter data, it tends to come across as just sort of a lot of technical problems, and I just want to reaffirm that as we pass a third of our beneficiaries in Medicare Advantage plans, and that rate, if not going up steadily may even be increasing, this becomes less of a technical problem but more of a real strong concern I think that we should all have about knowing what's going on in the Medicare program.

The question is for you, Andy, and maybe I just don't remember this from the chapter very well. Why is MAC the fallback position? Can you give me an argument for why it maybe should be our first strategy in trying to deal with this problem?

DR. JOHNSON: I think mainly practical, that the current situation is plans submitting encounter data on their own. Some of them have set up their internal processes to submit counter data. Others contract with third-party vendors to process the data and submit to CMS.

So considering that we're in that framework now it's considering it would be a major change to the program.

MS. BUTO: Also I think --

DR. CHRISTIANSON: My thought about that is it needs a major change, and hasn't worked, and we've been trying to get it to work for years and years and years. So I guess I would encourage us to think about whether there are real advantages to the MAC program that would increase the likelihood we would get good data, and I'm not sure about that, I guess. I don't understand that part of it.

MS. BUTO: Jon, if I could just interject here, I think we'd also have to do an assessment of the cost of the MACs to do this.

DR. CHRISTIANSON: Sure.

MS. BUTO: Because the data are, you know, not in good shape particularly for the kind of processing they do, and a lot of what they do is automated. So I think we'd have to do some kind of an analysis or get feedback on how big a burden is that going to be for them.

DR. CHRISTIANSON: Yeah, exactly. And that would all be part of thinking about MAC as an option, not so much as a fallback, if this continues to not work and how much

longer do we want to say continues to not work.

DR. CROSSON: Okay. We'll start with Jon. Questions?

DR. PERLIN: Thanks. Again, terrific work on this chapter. My comment really tags on to Jon's, but in a slightly different way.

In the materials, on page 46, you noted that, "Although we did not speak with providers about this idea, we believe providers would experience no greater burden than providing services to fee-for-service beneficiaries and potentially could experience significant simplification in submitting claims."

I would just offer that may be worth a conversation because I would like to understand the basis for that, at least in some of my preliminary discussions. I mean, it's doable, but it is -- according to the reconnaissance I did, it would substantially change the process. And to the other impact, I think it's worth really understanding the impact on the MAC in two dimensions. One is in the dimensions discussed as to what's automated and what's not, but the second is what's the impact on their work flow with respect to the remainder

of the claims. And, third, what's then the derivative impact on cash flow for all the providers who are then working through the MACs who have increased their burden substantially, as I agree with Jon, at a growing rate?

Thanks.

DR. CROSSON: Questions? Warner.

MR. THOMAS: So maybe I'm just not totally understanding this, but it seems like for traditional fee-for-service Medicare, the MEDPAR data we feel is pretty good. Is that accurate?

DR. JOHNSON: Yeah [off microphone].

MR. THOMAS: And so what is -- I mean, is it the plans that are a challenge here? Where do we think the issue is and the process of why it's hard to get the data? I guess what we've heard, when we've talked about this previously -- I think Craig brought this up. I don't know if Dana did, but I know Craig had when he was here, that the plans are trying, but they seem like they have a tough time interacting with whoever the intermediary is to accept the data. So do we have a sense of where the challenge is, and is it really the plans are not trying to do it? Or is it a process issue?

DR. JOHNSON: I don't know that we can pin down the exact issue, meaning allocating which areas are of more importance, but certainly providers not submitting all of the data elements is one issue. Whether or not plans are looking at collecting every record for all items and services might be an issue where some of the feedback to plans is currently about the overall volume of records being submitted, and increasing volume is seen as good, so it's just a framework of how plans address their encounter submissions. So I don't think that's a great answer to your question.

MS. PODULKA: I'd add that, in case this was part of your question, based on our conversations with stakeholders, earlier in the process CMS and their contractor may have been introducing some significant obstacles. We don't hear that that's the case anymore, so we can't say, oh, if the agency changes the way they accept and process the data, this would clear up. If that was the situation, we'd be coming to you today with a different set of policy options.

In addition to what Andy noted, we've also heard from plans and other stakeholders that some of the issue

might be initially submitting a record, getting it bounced back for some error or issue, and then the plan needs to decide how many resources to devote to chasing down and correcting the error. And, you know, the incentive is built right now, if you've got your risk scores in sufficiently to match up with RAPS, then, you know, maybe there's some residual of problem claims that you find that the juice really isn't worth the squeeze to go fix them and get them resubmitted.

DR. JOHNSON: A final point I think that we've heard is where the arrangement between the plan and the provider is capitated, the payment is not tied on a fee-for-service basis, so there's not an individual record coming through, and that may be one of the areas where there's more missing data.

MR. THOMAS: So they're capitated, they're not -- essentially, providers aren't dropping claim because they're just getting the capitations so they don't drop claims. Okay. Thanks.

DR. CROSSON: Yeah, I mean, I have to say in my own experience, that was a significant issue for our organization where, you know, our medical group is

capitated, we just delivered the services. We had plenty of oversight and quality and everything of that nature. But the notion of having the physicians have to, you know, fill out and code for the services, once that became a requirement -- and it came from the commercial side as well as Medicare -- it was just an added expense, and essentially we were training -- we had to retrain -- not even retrain, but we had to train physicians in something that they didn't have to do previously and was not viewed, quite honestly, by physicians as adding any value.

On this point, or just -- yeah, go ahead.

MS. BRICKER: Just to clarify then, so once you're receiving a capitated payment, how does the plan or the provider know if that was sufficient or not if there's no detail of care sort of provided? Wouldn't you want -- wouldn't the plan want to know, like did I give too much or wouldn't the provider say, whoa, that's not even coming close to covering it?

DR. JOHNSON: I think that's a good question. I don't have an answer except that if the capitation is for all services, it could be just a portion of the total revenue coming into the plan passed directly on. That does

not include the administrative costs of plans providing their service.

MS. BRICKER: So we're not aware that plans require that level of detail from providers to suggest that the capitation is adequate.

DR. JOHNSON: That's right.

DR. CROSSON: Pat.

MS. WANG: If I could just respond to that? A very typical form of capitation is for primary care physicians, and so unlike fee-for-service, you're right, you know, you're not getting an individual claim in for every office visit or what have you. But what plans will do or many plans will do is look at the quality metrics that we just described for the members who have chosen those folks as their PCP. You know, you can tell a lot from gaps in care and whether the care is being well managed.

The whole point of capitation is to allow a primary care doctor to get away from it's got to be, you know, an office visit that I can bill because of this and this, and they may instead want to spend like an hour on the phone with their member just talking through an issue.

So we tend to view it more from sort of, you know, frankly, quality as the backstop to whether the care that's being delivered is good.

DR. CROSSON: On this point, Jon.

DR. PERLIN: Absolutely. In doing my homework for this section, I asked exactly that question: How does it happen, Amy, in terms of providing the information? What I found out, at least in our organization, is that provider submit claims versus encounter data to the MA organization, the claim submissions, electronic transaction, consistent with coding and reporting guidelines, report on diagnosis and procedures that are specified in guidelines for each patient encounter, that is, the specific instructions from that MAO.

Actually, in our organization, we don't differentiate the code assignment based on whether it's Medicare fee-for-service or MA. But understand there may be other situations in which information may be less complete because that was fundamentally the question I was trying to understand. One, where is the breakdown in terms of getting the information? Two, wouldn't the MAO need certain levels of detail?

So, you know, it might seem at one level it's a distinction without a difference, but it would introduce a parallel process which may have tracks of reporting both at the MAO as well as potentially a MAC, with potentially different requirements in terms of specifying, and with respect to the transaction with the MAC would have, as you so nicely articulated, a degree of not only requirements for information submission, but validation, checks, and concomitant edits and things of that sort that really do make it less than a trivial process.

Thanks.

DR. CROSSON: Okay. Karen.

DR. DeSALVO: So in the first place, I'm all about data liquidity, and when I was in government, in the federal government, our policy agenda was about making this information available for research purposes, for clinical care, et cetera, and that sort of leads me to my question for you all, because I didn't really see it in the chapter, and I don't know if I'm off on a tangent here. But how do things like Blue Button or MyHealthEData and the expectations that CMS is going to have in 2020 for MA plans to share data impact this need?

DR. JOHNSON: That's not something we've looked into yet, but we certainly can. I think the decision to release encounter data publicly to researchers might signal that there is a similar process available for beneficiaries, but that's something we really need to look into before --

DR. DeSALVO: Yeah, because I think the test use case is to intermediaries that can make it available for business cases but also for research cases and then for individuals. And that's certainly the pathway of continuity policy that CMS is still on that we were on before and that, frankly, the Hill put into 21st Century Cures.

So thinking about is that already, you know, a runway and that's going to make this work easier? The accuracy isn't solved by that, I understand, but the availability and the timeliness might be.

DR. CROSSON: David.

DR. GRABOWSKI: Just in case people aren't aware, ResDAC recently made the 2015, I think, encounter data available to researchers, and my understanding is a lot of researchers are lining up to get those data. So there are

going to be a lot of people working with these data.

DR. JOHNSON: And as Jennifer mentioned, I believe that's the same version of the files we used in our analysis.

DR. CROSSON: Warner and then --

MR. THOMAS: This is actually on -- I'm not sure. What is Blue Button?

DR. DeSALVO: So Blue Button is an effort to create doorways to the data via an application programming interface, which is an API, that makes it easier to release data initially for the beneficiary to know what kind of utilization and encounter information they had, and then has been extended so that now it is using more modern technology to release it to allow us to aggregate and present the data in a more experienced, friendly way. I say "we" as a country. So Blue Button 2.0 is the version announced in this calendar year, I think, by the Administrator to improve that work.

There is, as part of that suite of expectations, a platform called MyHealthEData, which is also CMS-led, and she announced it at Datapalooza last spring, that is designed to not only see that the Part A, B, and D data is

available, but then they also want to encourage C, so Medicare Advantage. And Medicare Advantage plans by 2020 will need to have that data released and our experience is we're sort of gearing up for that to be the case. And, again, that's about data availability and thinking that it definitely changes the landscape of who can aggregate data. so not only for research and for policy purposes but for an individual to have a long-term health record to know all of the care experience that they had. And that you see manifested in some of the smartphone applications that are creating long-term health records.

And, Warner, that grew out of a recognition that when we digitized the care experience through implementing electronic health records, that was going to be one bucket of data, but there was a lot of other richness in the claims information that could be helpful. And I mentioned Congress and 21st Century Cures because though from a policy standpoint we require these doorways to the data, these APIs, and electronic health records, and we were pushing it also for claims data, Congress in 21st Century Cures added an expectation legislatively in statute that the EHR systems have these nonproprietary APIs, these

doorways to the data that people could easily get a key to, but there are also some additional expectations on the provider community about sharing.

So there's a policy pathway that I think is sort of a modern technology approach that's designed for appropriate data liquidity not only for individuals but for other use cases, and, again, it doesn't get you so much to the accuracy issue, which I fully appreciate -- and maybe while I've got my mic on, I'll just mention something about that, which is that to this point about capitation, there's a small percent of these individuals who are probably in some kind of a really capitated or flexible model, and it raises for me over the long term this interesting concept that the notion of an encounter is changing dramatically on the front edge of the way we deliver care. And to Pat's point, it could be a phone call; it could be a group visit. There are experiential ways that we're going to be working on improving patient outcomes that may not even be captured in the data. So the encounter stuff is great, but it's like the today world, and to make sure we're moving the system to a future world where outcomes and experience are better, we're going to have to already start thinking about

what data will we need to make sure that people are getting the right amount of service for the right outcomes.

MS. PODULKA: Could I just jump in? One thing I wanted to clarify, Andy mentioned capitated arrangements between plans and providers, and that's certainly one area that impacts the sort of price data that might show up in the encounter data.

There are also numerous situations where MA plans carve out certain benefits and maybe subcontract with an entire entity. You might carve out behavioral health or some of your post-acute care, and so that's not just a capitated arrangement with a provider group. That's a whole segment of your benefit package that's under a separate subcontract that might also affect data availability.

DR. CROSSON: Thank you. That's helpful. Pat.

MS. WANG: Have you guys had recent conversations with CMS over the level of reporting that they may be planning to give back to plans? Jennifer, you had noted that some of the early obstacles that plans had reported, you know, of sort of data exchange or just feedback were clunky. It's still pretty sparse, the reporting back from

CMS, even for plans who scrub, scrub, scrub. Do you know whether they have plans to increase the frequency, level of detail, specificity so that plans that try to hit 100 have enough information to know what's not getting through and why?

DR. JOHNSON: I think they're planning for changes to the feedback is in process right now. Actually since writing the chapter, several memos have come out adding new potential plans. So far, it does seem to be like the report card is proposed to be expanded to include the number of missing or values in error for a certain set of basic data measures, which makes sense. I have not seen in any of that planning a focus that would specifically focus on completeness, though. Still, the comparison of inpatient stays to the MEDPAR data that's provided in the report cards is the only real metric of completeness.

DR. CROSSON: Okay. No more questions. I think we'll start with the discussion. I think we have the final slide up there, so I would ask that folks think about providing input into these two areas to help Andy and Jennifer perhaps come back with some more narrowed recommendations at some point. And we'll start with Bruce.

MR. PYENSON: Well, thank you very much, Andy and Jennifer. This is a terrific presentation and terrific work, and I think it's just one of the most important things for the future of Medicare to -- future of Medicare Advantage, which, as we all know, is no small portion of the program and growing year after year. So having that kind of information on an encounter basis, and as the interactions, what actually happens to patients, is incredibly important.

I would like to just say a couple of things to frame my view of answering these questions.

In the real world of data, we know the data is never perfect, and it changes -- the information and what the information represents changes over time because the world is changing. And there's a balance between wanting perfect data and wanting it all, and I think the balance that happens in the rest of the private insurance world is worked out in favor of having lots of detail and then figuring out what parts of it are reliable and what parts aren't.

And so I think the framing of assessing completeness as compared to some of the other

characteristics is the right way to go and to find ways to make that data as complete as possible.

I think the use of that and the carrot and the stick that we have for the plans could be very much tied up with the resources the plans are spending on risk adjustment and Stars, and the previous session identified a lot of the detail in the process, much of which is very expensive because it's not based on claims. So to tie the two together I think is very, very important and gives us an opportunity to offer something to the plans, a bit of a carrot as well as a stick.

I've certainly been frustrated with the lack of availability of the data and even the quality of the data that's available privately. But in the commercial world, by contrast, there's huge databases commercially available, you know, well-known names -- Truven MarketScan and others -- that have been out there for decades and, yes, sometimes the data is not as clean as others, and there's ways to deal with that. The lack of that on the Medicare Advantage side is puzzling because so many organizations use the same systems for both. So I'm thinking this issue is not nearly as hard to solve as many of the other things we talk about,

but finding the right carrots and the right sticks can get us there very quickly, and then leave it up to the organizations and the people doing the work to figure out what's good quality and what's not good quality in terms of the data itself.

So I'm very encouraged by this discussion, but I would focus on let's make sure we get the data, and even if it's not perfect, let's go for completeness first.

DR. CROSSON: Okay. Pat, Warner, Dana.

MS. WANG: Thank you for bringing this back to us. It's a really good -- it's much deeper and, you know, you keep going deeper and deeper into the subject which I think is really, really helpful. It's incredibly important that this happen and that we find a way to collect as complete and then as ultimately as accurate data on the MA programs so that people know what's going on in it.

A couple of suggestions. I do think that it would be important. You mentioned in the report the importance of reporting from CMS. I would just encourage us to sort of make more specific, robust suggestions. As you note, the only report that comes back is for inpatient shadow bills, so if we expect completeness, you know, plans

need a lot more information than that to try to understand what wasn't accepted, why wasn't it accepted. I think you had mentioned an idea in the paper about doing a report with a beneficiary matched by data service. I mean, so just so that there's an appreciation, the work to make sure that this flows correctly is painstakingly detailed.

I mean, you know, people who work on this are going to look by beneficiary, date of service. They would love to get an annual report that actually matches accepted encounters with dollar amounts so that they can actually go back to paid claims and validate to see that things are going through. And if they are not going through or somehow the dollar amount, for example, is coming out a different way then can do a deep dive, understand what it is, talk to CMS, and try to figure out how to improve that reporting.

But I think this is really critically important. And CMS is really busy, but if this is a priority then I think, you know, a very specific focus and set of expectations has to be matched by, you know, accurate reporting to the plans and faster reporting than currently exists.

The idea of sort of carrots and sticks, as Bruce said, I mean, I do think that it's important for the progression that started and then kind of went backwards about doing risk adjustment based on an increasing reliance on encounter data is very important and shouldn't be forgotten in the recommendation. So just kind of plow forward with that. It will create a lot of attention that.

For the other elements of it I would be inclined to say let's get the other sort of provider types, the ones that you profiled that are particularly missing -- the home health and the long-term care, things like that. There's no reporting source for a plan to even see what's being accepted and what's not, and why it's not being accepted. I think that we have to accelerate the process of helping plans to understand what's going on so that they can get the information in.

The idea of the MACs is a very interesting one. I would hold it out as a last resort. I have concerns about it. You know, frankly, I think the way that it was posited in the chapter is the providers would actually send their claims to the MAC, which would then take those, submit encounters, and then forward the claims on to the MA.

Speaking for myself, I have enough trouble making sure that every claim I pay is accurate and timely, and it's just the prospect that there might be yet another party in the middle makes me really nervous.

The other thing is that, you know, in addition to scrubbing things and doing analytics for up-front payment integrity issues, you know, prepayment reviews, sort of maybe adjustments after the fact. I am not sure that the quality of the information that you would get if you just relied on a first pass MAC encounter submission -- you know, I think that there would be gaps there. So I would hold that out as the ultimate stick if there were a plan that just really showed that it could not do this.

But to somebody else's point, some plans have built tremendous infrastructure around that. If they are Medicare plans they have been submitting encounter data to the state for years and years and are very comfortable with encounter data submissions. On this one, for Medicare plans with that sort of infrastructure, it's more a matter of tell me, give me more information and I will make everything right. But, you know, for a plan like that I think kind of thing, you have to go to a MAC now would be

extremely inappropriate.

DR. CROSSON: Warner.

MR. THOMAS: So I would concur with Pat that I think MAC would be a last resort.

I guess when I first started hearing this I always thought that this was really a plan issue, and the more we hear about it the more we understand there's a lot of opportunity for improvement probably in both sides of this equation, and I would just hope that our report about it is very balanced about that and clear that there's -- you know, I think we're hearing from Pat that there's just not a feedback mechanism from the entities that are receiving this data and don't even know if it's correct.

So I think it's hard for a plan -- I think we've heard this from a couple of folks that are in the insurance world that it's hard for a plan to do this well when they don't have a willing participant on the other side working with them to get the data. So I think we need to be balanced about that.

But I do think, kind of going back to the discussion we had earlier this morning, where we talked a lot about 5 stars and incentives and payments, I mean, we

just need to tie this whole situation into the same discussion. And I think if we put dollars around this, whether it be a withhold or whether it be upside -- and I think Bruce's point about some should be a carrot and a stick probably depends on, you know, give people a certain amount of time but then if they can't get it done, you know, they can't be 5 stars, they can't be 4.5 stars. I think you'll find that people get a lot more motivated.

I think the other thing it just says that's striking me is that if we have a lot of plans that are not getting fee-for-service data, you know, we're not able to really do a fair fee-for-service comparison on MA. You know, it strikes me, I mean, there may be a lot more things being done in MA plans that we just don't have claims data about, and then we compare to fee-for-service where we do have all the claims data and I'm not sure we're necessarily an apples-to-apples comparison of how the MA products, you know, compare to a fee-for-service situation if we have a lot of providers. And I agree with you, Jay. I mean, if you're capitated, I mean, why are you submitting claims? I mean, we are capitated and we do it because we like to look at the equivalent of it. And I do think that would be

important data for the plan to have as well as for CMS to have in kind of evaluating these plans going forward.

So I think we need to tie specific upside and penalties to it over time. I think we need to be clear that the government needs to kind of step up and do their rightful job here and provide the right feedback. But it is -- you know, it's hard to assess these programs if you don't have -- and assess how, you know, members are doing in the programs if you don't have the information about what's happening.

DR. CROSSON: Thank you. Dana.

DR. SAFRAN: Yeah, so great discussion, great chapter. I'm struggling with what feels like almost a paradox that we're dealing with and that I think has been touched on by a few people's comments, which is, on the one hand, the idea of not having complete and accurate information about the care that beneficiaries are receiving, and an increasing share of beneficiaries, in part of the Medicare program makes us all very nervous.

On the other hand, as we're trying to encourage alternative payment models, including Medicaid Advantage but ACOs, and moving toward big dot measurement, I worry

that we are kind of perpetuation a fee-for-service mindset by the, you know, document and tell us everything you do. And I can, in my own experience, I've seen this and watched physicians in our network struggle with it as they say, "Well, I would love to, you know, do more over the phone with Blue Cross members, but you don't pay me for that." It's like, but you are in a global budget contract, so if that's the best way to deliver care, just do it, right? And so I feel like we have to find a path forward that doesn't undercut the very challenging shift away from that fee-for-service mindset, but at the same time doesn't leave us, you know, without information about what's happening to beneficiaries.

So it feels like a pretty tough conundrum and I don't know the answer. I know that, you know, technology is going to be an important part of the answer, and I know that, you know -- I heard recently about a company called OODA that may allow for real-time claims adjudication so that patients don't get surprises in their bills, so that providers are able to like get assurance right in the moment about what the payer is going to pay. And I don't know. As I'm sitting here, like some sort of real-time

something that happens when a person is getting some kind of service, wherever it is, even if it's remote, is starting to feel like maybe that's a way we capture information.

But the last piece of it, in addition to not wanting to perpetuate a fee-for-service mindset, I worry about adding administrative burden, right. Like we hear all the time about one of the biggest drivers of our higher costs, and I don't know if I believe this but I know it is a very big driver relative to other countries, is the administrative aspects of care.

You know, and I was recently told by one of our folks who came over from a provider organization that for every doctor they hire they hire one medical assistant to help with getting patients in the room and one medical secretary to help with all the paperwork and all the coding and all the everything else. And, you know, that was stunning to realize. And so that's the other worry is how do we make sure we have the complete information we're talking about and not add to burden.

The last thing I'll say is I think we need to get really crisp and clear about what are the reasons that we

need complete data, and, you know, what are the purposes? We need data for risk adjustment. We need data to evaluate, you know, what's happening with beneficiaries and which systems are doing better, and once we know our purposes then what are the data fit for purpose and how much data and how complete does it actually have to be as we try to solve for this.

So those are my thoughts.

DR. CROSSON: Okay. Further discussion?

[No response.]

DR. CROSSON: Seeing none, Andy, Jennifer, thank you for the presentation. I think you've got some good input here and we look forward to hearing from you again in the future.

That said, we have completed our work for the November session. Now we have time for a public comment period. If there are any of our guests who would like to make a comment please come to the microphone.

[Pause.]

* DR. CROSSON: Seeing none we are adjourned until our December meeting. Safe travels, everybody. Thank you for the good work.

[Whereupon, at 11:20 a.m., the meeting was adjourned.]