MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, April 5, 2018
9:13 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
ALICE COOMBS, MD
BRIAN DeBUSK, PhD
PAUL GINSBURG, PhD
DAVID GRABOWSKI, PhD
JACK HOADLEY, PhD
DAVID NERENZ, PhD
BRUCE PYENSON, FSA, MAAA
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CRAIG SAMITT, MD, MBA
WARNER THOMAS, MBA
SUSAN THOMPSON, MS, RN
PAT WANG, JD

AGENDA PAGE

P R O C E E D I N G S

[9:13 a.m.]

DR. CROSSON: I'd like to welcome our guests. This is the April meeting, which is the last meeting of the MedPAC work year.

I do have one request both of the Commissioners and staff and the audience. There's apparently going to be a test of the Emergency Broadcast System in the D.C. metropolitan area sometime between 10:00 and 11:00, and as I understand it, everyone's cell phone is going to screech at the same moment. So I would ask you, if you don't have a pending emergency, to turn your cell phones off from 10:00 to 11:00 so we don't have the meeting totally disrupted and everybody deafened at the same moment.

That said, we'll proceed with the first order of business, which is a continuation of work that we've done on the availability of emergency room services. Jeff, Zach, and Sydney are here to begin. Who's going to start the discussion? Sydney, it's yours.

* MS. McCLENDON: Thank you.

So good morning. Today we revisit our discussion on ways to ensure appropriate access and use of emergency

care in both rural and urban areas.

We have discussed stand-alone EDs on multiple occasions over the course of the last few cycles. We published report chapters on this topic in the Commission's June 2016 and 2017 reports, and we anticipate publishing another chapter in June 2018 containing the Commission's policy recommendations, which we will vote on today.

We will begin today by reviewing recent growth in ED use, stand-alone ED facilities, and payment incentives related to ED use. Zach will then walk through concerns about urban stand-alone EDs, and Jeff will discuss rural ED access concerns. The Chairman will then lead the discussion and initiate a Commission vote.

In recent years, the volume of overall ED cases in Medicare has grown rapidly. From 2010 to 2016, emergency department use in Medicare grew faster than ED use nationwide and Medicare physician visits. As a part of this, we have seen the Medicare volume of the two highest-paying levels of ED visits, Levels 4 and 5, grow as a share of all ED visits.

Together this higher volume of visits and the growing share of high-paying visits means that between 2010

and 2016 Medicare outpatient ED payments per beneficiary increased 72 percent.

Over the same period, we have seen a new trend emerge, which is the development and use of stand-alone EDs. In 2017, we counted approximately 550 to 600 of these facilities, most of which have opened since 2010. Approximately two-thirds of stand-alone EDs are affiliated with a hospital and deemed provider-based, which allows them to bill Medicare.

There may be incentives in the Medicare payment system driving the greater use of ED services.

The first incentive is that Medicare pays two different rates for ED services. There are Type A rates, which are for EDs open 24 hours a day, 7 days a week, and most Medicare ED claims are for these Type A rates. The less common Type B rates are for facilities open less than 24/7, and on average Type B rates are approximately 30 percent lower than Type A rates. The difference in rates encourages the development of Type A facilities, even when they may not be appropriate.

The second incentive is that Medicare payment for ED services provided at a facility off the main hospital

campus are dependent on distance criteria. Currently, if an OCED is within 35 miles of the hospital it is affiliated with, it will receive the full Type A rates. If the OCED is more than 35 miles from its affiliated hospital, however, the facility cannot bill Medicare for ED rates and instead would only receive physician fee schedule payment rates. Therefore, hospitals are disincentivized from having OCEDs in isolated areas because they cannot receive the higher ED payment rates.

I'll now turn it over to Zach to discuss concerns related to the growth of stand-alone EDs in urban areas.

MR. GAUMER: So among the facts the Commission has discussed about these facilities in the past are that the number of stand-alone EDs in several markets has grown rapidly in the past few years. Multiple studies indicate that these facilities tend to locate in higher-income areas where patients with higher rates of private insurance reside.

In addition, Medicare payment rates to stand-alone EDs may be too high because studies show that stand-alone EDs have lower patient severity and lower standby costs than on-campus hospital EDs. In interviews and in

site visits, we observed for ourselves that most stand-alone EDs are open 24 hours a day, but do not maintain operating rooms, trauma teams, or have specialists on call. In addition, ambulance drivers typically bypass stand-alone EDs in favor of the on-campus emergency department. Despite their lower standby costs, stand-alone EDs receive Medicare payments that are equal to on-campus hospital EDs.

At our March meeting some Commissioners asked how we arrived at our proposed 30 percent reduction to Type A payment rates.

In the course of our research we observed that the patient acuity mix of stand-alone EDs in three states was reasonably similar to the patient acuity mix of Medicare Type B claims. We also estimated that Type B payment rates are approximately 30 percent lower than Type A rates, on average. However, the Type B rates contain an anomaly where lower-acuity Level 1 ED visits are paid more than higher-acuity Level 2 visits.

Therefore, the Commission came to the conclusion at the March meeting that reducing Type A rates by 30 percent is more consistent across the five 5 levels of ED services and also more consistent with our policy

objectives of payments reflecting patient severity and standby costs.

In November, several of you asked us to look at the proximity of these facilities from on-campus hospital emergency departments. And after looking at five large markets where stand-alone emergency departments are common, we determined that roughly 75 percent of stand-alone EDs were located within six miles of the nearest on-campus hospital ED. We also estimated that the drive time between these facilities averaged about ten or fewer minutes. So this is the origin of our six-mile threshold.

Informed by our analyses of the Medicare ED payment system, trends in stand-alone EDs, and the proximity of these facilities to on-campus EDs, the rationale for the Commission's policy is threefold:

It would align payments with standby costs of the providers currently supplying emergency services at lower cost.

It would reduce the incentive to build new OCEDs near to existing sources of emergency services.

And it would preserve essential access to emergency services in urban communities isolated from other

emergency care options.

So after incorporating your thoughts from the March meeting, the Commission's draft recommendation reads:

The Congress should reduce Type A emergency department payment rates by 30 percent for off-campus stand-alone emergency departments that are within six miles of an on-campus hospital emergency department.

The Congressional Budget Office estimates that the spending implication of the urban recommendation is that it will reduce spending by between $50 million and $250 million annually.

For beneficiaries, the implication is that those treated at urban OCEDs that are near to on-campus hospital EDs will experience lower cost sharing.

For providers, the implication will depend upon the proximity of the OCED from the on-campus ED.

OCEDs that are within six miles of the on-campus ED will have their payment rates for ED services lowered by 30 percent. This will apply to approximately 75 percent of the OCEDs that we've identified.

By contrast, OCEDs that are more than six miles from the on-campus hospital ED will see no change in their

payments for ED services, and this would apply to about 25 percent of the urban OCEDs.

With that, I hand it off to Jeff to discuss rural policy.

DR. STENSLAND: As we discussed last month, the overriding rural objective is to preserve access. However, the current payment policies focus on supplemental inpatient payments for small rural hospitals and cost-based payments for critical access hospitals.

A key problem with both these policies is that they become increasingly inefficient as inpatient volume declines. And, more importantly, higher inpatient rates do not always result in financially viable hospitals, which can threaten emergency access in rural areas. As we discussed in your mailing materials, rural closures have increased in recent years.

A key reason for closures is the decline in inpatient volumes. The top yellow line shows that the median critical access hospital saw its volume of admissions fall by almost half over the past 13 years. The lower green line shows that by 2016, 10 percent of critical access hospitals had 71 or fewer admissions per year,

almost down to one per week. Having one admission per week causes cost per discharge problems and can raise quality concerns.

Last month Jon asked whether critical access hospital ED volume has also been declining like its inpatient volume. As we can see from this graphic, the answer is no. ED volume in critical access hospitals has actually increased.

The result is that the delivery of care in these small communities has shifted away from inpatient care toward outpatient care. But the only payment options available to rural communities continue to be inpatient-centric models.

The idea we discussed in March is to offer a new option of a 24/7 outpatient-only facility with an emergency department. A key is that the option would focus on isolated hospitals that are more than 35 miles from another hospital. We use the 35-mile cutoff because this would target hospitals that currently do not have the ability to become an outpatient department of another hospital.

To help fund the facility, Medicare could do the following: First, the outpatient-only hospital would get

PPS rates. Second, there would be an annual fixed payment amount on top of the PPS rates. The additional funds could be used to help fund standby costs, maintain emergency services, and recruit physicians.

And this brings us to the draft recommendation. It reads: The Congress should allow isolated rural stand-alone emergency departments more than 35 miles from another ED to bill standard outpatient prospective payment system facility fees and provide such emergency departments with annual payments to assist with fixed cost.

There are three key implications.

With respect to spending, the program would result in a slight increase in spending. Preserving hospitals that otherwise would close does add to the cost of the program. But the cost is modest because most of the program's costs would be offset by the efficiencies gained by shifting acute inpatient and post-acute patients away from expensive critical access hospital settings toward higher-volume facilities.

With respect to beneficiaries, the main benefit would be a preservation of emergency access. The one drawback is patients will have to travel further for

inpatient services, although many are already doing that. A second benefit is that outpatient coinsurance will fall substantially for beneficiaries. Coinsurance on PPS rates is usually less than 50 percent of critical access hospital coinsurance.

For providers I want to emphasize that this is an optional program. If they want to continue with the status quo, they can. However, in cases where a traditional inpatient-focused hospital is no longer an efficient way to deliver care, these communities could convert to an outpatient-only hospital and then maintain emergency services for members of their community.

This brings us to the discussion topics.

The first recommendation involved urban OCEDs and aligning their payments with their resource needs.

The second recommendation we discussed involved preserving access to emergency services in rural areas.

And now I turn it back to Jay to start the questions.

DR. CROSSON: Thank you, Jeff, Zach, and Sydney.

We'll take clarifying questions. I see Brian first.

DR. DeBUSK: I have a number of questions on the urban off-campus ED section. I'd like to start with Chart 5. You talk a little bit about the lower patient severity and the lower standby costs. And this isn't a rhetorical question. Just when I was reading the chapter, I was thinking through this. If I substituted small community hospital for off-campus urban emergency department, how would this argument change?

MR. GAUMER: Well, so, you know, here I think we go to the site visits and the observations and interviews that we've made here going to some of these facilities and seeing what they look like and talking to folks in the industry. And there appears to be a difference in the severity between the pop-up -- you know, I'll particularly say the freestanding EDs that we saw in Texas or have talked about in Texas and doing a small number of cases, 20 privately insured cases per day, versus the community hospitals that are doing -- you know, especially in urban areas that are doing significantly more cases on a daily basis.

DR. DeBUSK: So is it fair to say there's at least a graded response, though, you know, from a Level 1,

say a Level 1 trauma center to a community-based ED to an urban OCED? Is it fair to say that there is a graded shift toward lower acuity and lower standby costs as you move along that spectrum?

MR. GAUMER: Yes, I think that's right.

DR. DeBUSK: Okay. Also, I had a question on Chart 6. You were talking about the acuity of off-campus emergency department patients being similar to the acuity mix of Type B cases. Currently in the claims structure, we can't differentiate services that were provided in an off-campus emergency department versus something on-campus. How could we do those analysis if we can't differentiate the site of service?

MR. GAUMER: Great question. So we have examples from three states, and we also have interview data. So the information we have from three states -- this is Texas, there's a peer-reviewed journal article on using 5 million privately insured claims that, you know, to overgeneralize here, says that the severity of patients being treated in these facilities, and this includes both the IFECs and the OCEDs, okay, so that's --

DR. DeBUSK: So there's some contamination in --

MR. GAUMER: There's some contamination there for sure, but this is the best information we have. -- show that the severity of the patients being treated in these facilities falls somewhere between the on-campus hospital ED and the urgent care center. And as you know, urgent care centers are paid essentially as physician offices.

DR. DeBUSK: So what is that, a plus or minus, what percent swing? Sixty, 70 percent?

MR. GAUMER: In payment?

DR. DeBUSK: Mm-hmm.

MR. GAUMER: Yeah, so if we were to start paying urgent care facility rates, it would be about 65 percent reduction in payment rather than the 30 percent reduction in payment that we've talked about.

DR. DeBUSK: Okay. On page 7 you talk a little bit about these driving distances and the six-mile radius. Could you speak a little bit more to how you actually calculated those drive times and how you looked at that? Were those peak drive times in the middle of rush hour? Or were those drive times at, you know, 2:00 a.m. in the morning?

MR. GAUMER: Okay. I'll give you the broad

overview, and if you want to jump in -- Sydney did a lot of the work on this. So what we did was we picked out five markets that had a couple of criteria: lots of stand-alone emergency departments. They had both the Texas trend and the non-Texas trend. We didn't want to do this only in Houston, Dallas, and San Antonio. So we picked these markets specifically because they've got these facilities, and they were distributed around the country. So we have gotten some criticism on which markets we've picked. Some folks in the industry, the hospital industry, have said we did not pick places that are very, very congested like Boston and New York and Los Angeles and San Francisco. Boston and New York have very few, if any, of these facilities. California has outlawed stand-alone emergency departments, so we couldn't go there. So that's how we picked our markets.

So what we did was we had to find the location, the actually address of each one of these facilities in these five markets. After doing so, we have a program that tells us the distance, using the ArcGIS software, of a certain address to a hospital, and so we calculated that. And then the best available information for finding the

actual drive time was going to Google Maps and punching in the addresses of these facilities, and what we tried to do very diligently was to do this at a time of day -- our analysis was done at a time of day where there would be peak flow of traffic.

So, in a way, what we're saying here with our drive times of somewhere in the ten-minute range is somewhat conservative.

DR. DeBUSK: Okay.

MR. GAUMER: You know, or may be realistic or applicable to rush hour, morning rush hour. Right? We didn't do an afternoon rush hour.

I've missed something. What have I missed?

MS. McCLENDON: No, I think you're right on.

DR. DeBUSK: That's great. That's great. The other question is: Have we considered the industry response to this? Micro-hospitals? What's the other shoe that drops if we go forward with this?

MR. GAUMER: So, Jeff, why don't you talk about micro-hospitals, but we have factored in the industry response to this. For example, we got some pushback from the industry about using drive time as a threshold, and so

-- and I think that that sentiment was shared with you all.

So we pulled back and went back to Miles as a result of that, and we've been in conversation with both the hospital industry and the stand-alone emergency department industry for the last three years on this topic. So we have been talking to them, and this is not coming out of a vacuum.

But, Jeff, do you want to talk micro?

DR. STENSLAND: Yeah. So I think micro-hospitals is something we'll have to look in the future because this is the concern of we're going to pay you less for your stand-alone ED. Well, then let's make it a micro-hospital.

And there is this kind of a little bit of a balancing act too. I think the fact that we're reducing the rates by 30 percent and only for the Medicare share, they might say, "Okay. Well, maybe we'll still stay in emergency room."

Initially, there was some discussion of moving it all the way down to like an urgent care center. Then I think you even have more incentive to become am micro-hospital. So there's a little bit of balancing of trying not to promote a lot more of these emergency rooms out

there, but not trying to also promote a lot of new micro-hospitals.

With that said, I think in the next years of our analysis -- and I think Jay brought this up at a couple meetings ago -- that that's one of the issues you'll have to follow up on, is the micro-hospital expansion.

MS. McCLENDON: I think one other point I'd add to that, you were talking about potential, other incidents that could be created with this policy. I think it was also something that Pat has brought up in the past, is that, well, if we set this six-mile criteria, are people just going to go right outside of those six miles and set up shop there? And while that's not something that's included explicitly in this recommendation, I do think we talk a little bit in the chapter that this is something that if Congress wanted to move forward, that they should be cognizant of and maybe include some additional threshold or some way to try and potentially prevent against that gaming.

DR. DeBUSK: When you were picking that radius, was there any consideration of maybe like, say, the HCAHPS score of the hospital that would be affected by this? I

mean, if I have terrible HCAHPS scores and eight-hour ED wait times, does that color your view? And I'm asking this as a question. Does that color your view on whether the six miles becomes three miles or becomes nine miles?

MR. GAUMER: We haven't given that consideration in the selection of the six miles.

DR. DeBUSK: So quality and wait time were not incorporated into any of these criteria?

MR. GAUMER: No. No, they were not.

DR. DeBUSK: Okay.

DR. REDBERG: Zach, just related to the drive time estimates, do we know what percentage of these patients are coming in by ambulance? Because what if they put sirens on and go faster?

MR. GAUMER: We don't have hard data on this nationally. The only study that really -- okay. So anecdotally, we know that very few patients are coming into the stand-alone EDs via ambulance, and that there's variation.

So we visited one in Virginia where it seems like they actually do take a little bit more ambulance traffic than others, and it's just because it's a larger stand-

alone emergency department, so there's some variation.

But overall, it's very low, and Maryland did a study on this of the -- at the time, the three that were in their state, and these were relatively large stand-alone EDs. And what they found was that the ambulance traffic was very minimal, like less than 5 percent of the patients coming through the door, and I think the national number for all emergency departments, hospital, is something in the 30 percent range. Thirty-percent of patients come in by ambulance. Seventy walk in. I could be wrong. The industry will probably kill me for getting that wrong, but that's the number in my head.

DR. CROSSON: Okay. So I have Jack. All right. Okay. So I'm going to do Jack, and then we'll start with Kathy and go around this way.

DR. HOADLEY: Thanks for this analysis. I had a couple questions on the Type B anomaly kind of issue on those two level payments, and I realize by moving a recommendation away from that, it's not as germane.

But one is, does that anomaly -- those dollar amounts, they do change, and so could that nonlinearity or whatever you want to call it, anomaly, go away at some

point in the future or get worse?

MR. GAUMER: It could. So, Dan? Yeah. Do you want to jump in? Yes, please.

DR. ZABINSKI: It can, but it hasn't, is the answer to that.

DR. HOADLEY: Okay. It's been around for a while?

DR. ZABINSKI: It's been around for a while, and there's -- the reason why it occurs, it's not entirely clear. We'd really have to dig down into the actual data to do it, but yeah, it's been around for a few years.

DR. HOADLEY: Okay.

And then I guess my other question, had you thought about making sort of just an adjustment to say if you have these situations, we'll treat the two as equal or whatever, we'll average the two, or do something else to basically take that anomaly out of the system?

DR. STENSLAND: Yeah. I think that that might be a future activity, but we try to focus on what are we going to do about these freestanding EDs as opposed to saying, "Now let's dig into how we're going to fix the Type B ED rates, but there certainly is work to be done there.

DR. HOADLEY: Yeah. That's what I was just thinking. I mean, again, you avoided the problem by basing the recommendation on the Type A, but at some point, it seems like if there's a -- I mean, it's like you would do in the fee schedule. You'd say, "Well, this is something where the RUC should look into. Why are these things out of line?" And it seems like something you might do at some point.

DR. CROSSON: Kathy.

MS. BUTO: Yeah. And I'm trying to think beyond the mileage issues whether there is some real distinction between the stand-alone EDs and urgent care centers. So if you were to look at them, do the stand-alone EDs really meet additional conditions of participation or requirements that are associated with the overall COPs for hospitals that somehow creates another -- not barrier to entry, but a standard around the ED that an urgent care center wouldn't have to meet? Because otherwise, particularly where there's big overlap in the acuity of patients, it just appears that they really ought to be paid very similarly.

So I'm wondering if that's the case, if we are seeing standards that apply to EDs because they're part of

hospital outpatient departments that you wouldn't see in an urgent care center.

MR. GAUMER: So these facilities that are OCEDs associated with the hospital are kind of under the COP of the hospital itself. So I don't think that they're -- they're not a separate facility type, so they don't have their own COPs, and so that -- maybe I'm just restating what you just said --

MS. BUTO: Yeah. Because it's --

MR. GAUMER: -- but that could be something that could be considered.

MS. BUTO: If they were just under the umbrella, they wouldn't have to be really anything special. They could look exactly like an urgent care center or a physician's office practice, right?

Do they have EMTALA requirements?

MR. GAUMER: They do have EMTALA, yeah.

MS. BUTO: They do, okay. Well, that would be different.

MR. GAUMER: Yep. So -- yeah. What?

MS. McCLENDON: Yeah. And I do think it varies a little bit state to state as well because, obviously, some

of these states haven't even allowed them, but the ones that do have different conditions, I think, for what the ED has to meet in order to be certified as an ED.

DR. CROSSON: Warner.

MR. THOMAS: On the data that you looked at, going to a little bit follow up on Brian's question, that you looked at the data from a few locations to determine the 30 percent, was that commercial or Medicare data? It was commercial data; is that right?

MR. GAUMER: So when we were looking at the severity issue, the three states, Maryland's data was a mix of all payer, so that included private as well as Medicare and Medicaid in there. The Texas was only private, so that those 5 million people, I noted those were just privately insured, and then Colorado, another small sample, just privately insured.

MR. THOMAS: And why do you think applying that to all of Medicare is the right approach? I mean, why do you think there would be a consistency from that? It seems like a relatively small sample size compared to the rest of Medicare patients.

MR. GAUMER: Absolutely. So there is a

difference between the privately insured and Medicare.

MR. THOMAS: Right.

MR. GAUMER: And I don't know what the extent of that difference is.

I think that at this time, though, we know that this is a growing trend. We have seen the same general message for the last three years about what these facilities' business plans are and how they're growing, and identifying these concerns, I think we've moved on to recommendations at this point because we feel like we were getting ahead of the problem before it becomes every hospital in America has an OCED.

MR. THOMAS: And then just real briefly for the Type A for the OCEDs versus -- you were kind of doing some comparison to say a community hospital, regular ED. Was there a big mix in the level, the percentage, distribution of Level 1 through 5 between an OCED versus, say, a community hospital ED?

MR. GAUMER: So when we talk about Maryland and what they saw, there is a big difference between --

MR. THOMAS: Just kind of less acuity, so you're kind of geared more towards Level 1, 2's?

MR. GAUMER: Yeah. And I'll kind of flesh this out a little bit, but if you compare Type A and Type B, what you get is essentially -- in Type A, you get essentially -- I think it's 65 percent of cases are Level 4 and 5. Those are the highest acuity. If you compare that to Type B, it's about 20 percent fall into 4 and 5's. And in the Type B, the majority of the cases -- well, 38 percent of the cases fall in Level 3. That's the largest group, okay?

When I looked at Maryland, when you consider you see similar stuff, when you look at Texas and Colorado, we don't have the benefit of having those five levels. What we have to go off of is the diagnosis, and there, we see that the diagnoses of the patients in OCEDs or in stand-alone EDs are lesser, lower severity than in the on-campus hospital ED. So there is a jump that's occurring.

MR. THOMAS: So isn't there a payment differential already because you have a lower acuity payment? I mean, they're taking a lower payment without an adjustment because they have lower acuity patients or --

DR. STENSLAND: I think that's true, and that's why I think we emphasize the standby capacity cost. We

looked at the data, but also I want to say data -- Zach and Sydney and I, we talked to a lot of folks at hospitals and also the ambulance drivers.

MR. THOMAS: Right.

DR. STENSLAND: And the ambulance drivers, what they told us really corroborated with the data. They basically said, "Well, if I think they're going to need to be admitted, we're just going to bypass this freestanding ED and go to the hospital, or if they have a gunshot wound, we're bypassing. If they have a stroke, we're going to the stroke center." So it's all very consistent.

MR. THOMAS: Okay.

DR. CROSSON: Okay. Amy.

MS. BRICKER: In the appendix in the chapter, you mentioned 350 urban off-campus EDs and growing. Do you have a sense of what the "and growing" is?

MR. GAUMER: So we don't have a number to put on the "and growing." We're estimating now that there's 550 to 600 of them, total, out there, and what we've seen recently is that we're seeing them pop up in markets like Jacksonville and Charlotte and other markets around the country that we haven't seen recently. Ohio is getting a

bunch.

And what we also see is that in the annual financial reports that are submitted to the SEC, in the for-profit hospital entities, we're seeing stronger statements about where their dollars are being focused -- on convenience care, on stand-alone EDs and urgent cares, and those types of things.

So that's part of the reason we feel like this is a growing trend because the big for-profits have gotten into this game, and they see the value of these things.

MS. BRICKER: Yep. And I don't want to go into Round 2, so I'll try to pose this as a question.

You mentioned gaming -- and we can talk about that, meaning just outside of the six-mile radius, and I know that we're trying to -- we're just trying to make a recommendation that gets at need and trying to straddle how long it would take someone and what's reasonable to drive there. And I understand why we've made the recommendation we have.

Have you considered any other recommendations that we haven't seen here that get at -- I think some of what Brian was saying, just that there's an adequacy of the

other hospitals or something else that would be considered. You mentioned Congress might want to consider additional factors if they take up this recommendation. Is there something else that we're not considering here that maybe we should to prevent the gaming, to make it not arbitrary, like six miles because we think that that's reasonable? And if they all went to seven, are we just going to reconvene in next year and then say, well, there should be eight miles? I mean, that's the thing I'm concerned about.

MR. GAUMER: So I guess my take on this we haven't come up with any recommendations that we're holding back on necessarily or you guys haven't come up with any recommendations that have been put out there.

I think the open question that Brian brought up and others have last time is what about urgent cares and what about micros and what about in general, what's going on with emergency department use for low-severity cases, and that's the only thing that -- and we reflect that in the chapter, which you saw.

DR. STENSLAND: There is no magic number that we can come up with. So six is kind of this compromise, and we had even talked about using travel times, I think, in

the first time we discussed it. But the idea of CMS having to implement the travel times and then having big fights over what's the real travel time, and people would -- even the industry said people would probably litigate that, what the real travel time is.

So just to make it feasible for CMS to administer, we had to come up with a number, and this was the best we could come up with. But whether somebody could say no, it shouldn't be six, it should be five or it should be seven, we really can't argue with that.

DR. CROSSON: Okay. Just let me point out we've used up the majority of our discussion time. We're still on questions on an issue we've discussed in deep depth rather recently. So let's move along.

Questions? Pat and then Jon.

MS. WANG: Do you have information on -- and it's been mentioned before. Do you have information on the type of, quote/unquote, ancillary services that will -- that can, if they wrap around an OCED, be eligible for OPPS rates under the exception in the statute? If you don't have that, are there rules about what constitutes a service that can be associated with an OCED and receive OPPS

payments? Okay. So do we have information or do you have a sense based on your interviews when you look at this what proportion of revenue for the OCED plus the ancillary wrap-around services come from the emergency service versus that OPPS layer?

And what I'm getting at, obviously, is that we're talking about changing the rate for the emergency service itself as a way of perhaps creating a different kind of incentive or blunting the incentive, and I'm just wondering whether the ability to kind of plant something that's reimbursed, that OPPS rates is more than compensating for that.

DR. STENSLAND: We had talked a little bit about this in our first meeting when we talked about this, kind of the 603 exception. You could even get higher hospital rates for your E&M visits, which wasn't aligned with our E&M recommendation. But to keep things simple, we moved it back just to talking about this, but that's certainly an issue to bring up I think in the future.

We're talking about some of the future issues -- micro-hospitals -- I think this is also one of these -- become outposts where it's a freestanding ED, and the real

purpose of the freestanding ED is that you can have all these other affiliated services getting higher rates.

MS. WANG: Exactly.

Okay. And the other question I had was I realize that you were focused and kind of driven over the last few years as you've watched this trend of these freestanding EDs in high-income areas. Along the way, have you had the opportunity to look at freestanding EDs in urban areas, in underserved areas that may have been put there, for example, when a community hospital has closed and just sort of factoring that into the mix?

MR. GAUMER: So we have seen some examples of that in the past, and we talked to some folks in Richmond that gave us a great example of one stand-alone ED that was placed in a really hard-to-get-to urban place, in between rivers.

So that is part of the reason that I think we were so interested in this six-mile threshold and providing exceptions for some urbans that are isolated from other hospitals.

DR. CROSSON: Jon.

DR. CHRISTIANSON: So the Urban draft

recommendation requires Congress pass legislation, and so that legislation would tie the reimbursement rates for Type A emergency department rates forever to the rates that are charged at on-campus emergency departments, right, or they be 30 percent less?

MR. GAUMER: That's right.

DR. CHRISTIANSON: Yeah, and that's based on the notion that there's more standby capacity so the costs are higher, if I hear you right, in the on-campus emergency departments. Have you contemplated a way to -- I mean, that ratio or those costs could change, will change probably over time. But we've put in law 30 percent less. Do you contemplate like the Commission will periodically reassess whether that 30 percent is the right number or whether it should be 25 percent and then make a recommendation to Congress that then they would have to pass new legislation to change that from 30 percent to 25 percent? I'm just trying to understand how you see this process once you put into law adjusting to changes in the market, changes in costs and so forth.

MR. GAUMER: The staff have not considered how updates would be made, and I don't think that topic has

come up around the Commission table yet. So we would like to hear your thoughts on that.

DR. CROSSON: Okay. Questions? David.

DR. GRABOWSKI: Thanks. I wanted to come back to this potential for unintended consequences around the six-mile rule and this idea if you pay differently based on that six-mile threshold, you're going to get lots of stand-alone EDs popping up just outside the six-mile radius.

You raise in the chapter one way to sort of address that dynamic is actually to trigger it not based on just the on-campus emergency department but any other stand-alone emergency department, which I found kind of compelling. Have you run those same sets of numbers that you have up on Slide 7 using that same sort of -- changing the anchor, if you will?

MS. McCLENDON: No, we haven't, and part of the reason we haven't done that yet is, again, because with these stand-alone facilities, we kind of have our own internal working database, but we don't know where all of them are currently. So we could be missing some if we were to even rerun the data with the few addresses we do have versus the hospital data that we do have is a lot more

solid.

DR. CROSSON: Dana.

DR. SAFRAN: So I had a similar point, and let me just make sure, Sydney, that I understood your answer just now, because at least what I took from your idea in the chapter that I thought was a good one was not whether it's within a certain distance of another freestanding, but whether it's within a certain distance of any other emergency department. So do you not -- you don't have the data to assess that?

MS. McCLENDON: We don't have full data. We would have some of it that we could potentially try to run with the addresses we do have for some of these just stand-alone ED facilities, but we also could potentially be missing some.

DR. SAFRAN: Okay.

MR. GAUMER: Yeah, so I think that, you know, another way to say it is we haven't run the data yet on that issue, and it kind of came up -- this idea of using any ED came up late in the process, and we haven't run the data.

We do feel confident in the 550 to 600 stand-

alone EDs that we think are out there, and we have addresses for those facilities in the five markets that we've looked at, but we haven't had the data -- you know, we just, I think, have some suspicion that there may be more of these out there than we know because for us to know that they're out there, either the state has to record them and regulate them -- and there's only a couple states that do that -- or the hospital essentially has to advertise it, and we did a thorough search of who's advertising and, you know, which websites they pop up on. But there could be more out there.

DR. SAFRAN: Okay. My other question sort of ties a little bit to where I think Jon was going, but also relates to this point, and that is that, you know, I think you haven't heard questions about the rural because that issue of sort of addressing this through the lens of access seems really important. And so I haven't heard even in urban areas of serious access problems around EDs. And what we do see springing up in urban areas, at least, you know, the ones I'm most familiar with, is a lot of new urgent care. And we also know that there's a lot of emergency room care that is really appropriate to non-

urgent settings, that is, non-urgent EDs.

So I wonder, have you considered, rather than kind of the idea of reducing by 30 percent how these centers would be paid, tying their payment somehow to the acuity of the cases that they're seeing or even to their rates of non-urgent ED as a way to try to incentivize them to, you know, maybe have on-site urgent care and emergency room care if they're going to exist at all so that the cases that come their way that actually don't need emergency room care could be seen in the urgent care setting and paid for that way? Has that been something that you've been looking at at all, this line between urgent, non-urgent -- urgent care centers and ED?

DR. STENSLAND: Yeah, I think that's a hard one for us to go down the path of saying this is urgent or this isn't urgent or the patient should have known this was emergent, the patient should have not known this was emergent, and putting that on the hospital for when the patient shows up with something that they thought was emergent is difficult. And I think we're also a little bit taken aback by some of the push that came through the RACs, the recovery audit contractors, on the inpatient side when

they were trying to tell hospitals what was an appropriate inpatient admission and what wasn't, and so we're just going to pay you this observation rate for this rather than -- because now we've decided that that wasn't an appropriate inpatient admission. And there was just a whole lot of disputes over that and a whole lot of challenges going up to administrative law judges and everything getting clogged up in the system.

So from an administrative simplicity standpoint, I think we thought it was much easier to try to do it through the payment rates than through some of these judgment calls of what's needed.

Now, if the private industry ends up with a lot of success in doing that, then maybe Medicare could follow later. But I think we'd at least want to wait until we see somebody being successful.

DR. CROSSON: Further questions? Bruce.

MR. PYENSON: From a regulatory or legislative standpoint, what would it take for Medicare to have a moratorium on payments to freestanding -- the OCEDs or new ones? If you know the answer.

MR. GAUMER: I think -- I think -- what would

have to happen is CMS would first have to pass regulation that identified stand-alone emergency departments as something separate, a different kind of facility, to do that. Or they would have to, you know, put a moratorium on visits occurring -- and I'm not sure if this can happen, but emergency department -- claims including emergency department codes in off-campus settings. That might be possible, but I'm not sure it is.

So I think they'd have to more specifically define the off-campus emergency departments as a separate facility type in order to pass a moratorium, or something like that, which isn't possible, and we've recommended that they do that before this.

MR. PYENSON: So that would be entirely within CMS. That wouldn't be Congress.

DR. STENSLAND: I'm not sure that they can do that regulatorily. I'm guessing it's a law you'd have to change in order to stop paying these places. But, you know, I'm not going to be CMS' general counsel here, but I doubt they can do that regulatorily.

DR. CROSSON: Okay. Seeing no further -- yes,

Jon.

DR. CHRISTIANSON: Really quick. So the 30 percent number, does that come specifically from the Ho study? Because that's the only place I could see any actual empirical estimates of standby costs.

MR. GAUMER: No, so the 30 percent comes from the difference between Type A and Type B rates.

DR. CHRISTIANSON: So it's not a standby cost estimate. It's a rate. It's based on what rates we pay.

MR. GAUMER: That's right.

DR. CHRISTIANSON: The Ho study says the standby costs are somewhere between urgent care centers and hospital-based emergency but they don't make a specific estimate of what --

MR. GAUMER: The Ho study says that the severity of patients is somewhere between the on-campus and the urgent care.

DR. CHRISTIANSON: I think in your chapter it says actually the costs, the standby costs, so I'll correct you on that.

MR. GAUMER: Okay. But the 30 percent comes from our estimate of the difference between Type A and Type B.

And then, you know, we say that the similarity between the Type B cases and their patient mix and the off-campus or stand-alone EDs appears to be similar.

DR. CHRISTIANSON: But you didn't actually do a standby cost estimate?

MR. GAUMER: No.

DR. CHRISTIANSON: But that's the justification for having the different 30 percent reduction, is the standby costs, right?

DR. STENSLAND: There is no clear empirical study where we came up with a point estimate and said it was 30 percent, and 30 percent is basically in between what the urgent care center is getting paid and the on-campus facility would be paid. And, you know, somebody could argue it really should be 25 or it should be 35, and there really would be no way to say that that would be a wrong judgment either.

DR. GINSBURG: If I could come in on this issue that Jon raised before, isn't it possible for the legislation to say 30 percent but then authorize the Secretary to, you know, analyze cost data and change it as needed?

DR. CROSSON: Okay. So we have a little time issue here. But we have two recommendations on the table, and I'm going to take discussion on both at the same time for efficiency purposes. We have discussed this issue for several years. I just want to compliment Jeff, Zach, and Sydney for the thoroughness of this work. I think you all heard in the answers that were given the depth of thinking that has gone into these recommendations.

So we're open for discussion. Brian.

DR. DeBUSK: First of all, I want to echo that. Thank you all for an excellent chapter. I think the questions that we all had, the quantity and quality of questions that we had, particularly around the urban off-campus emergency departments, speak to just how difficult this issue is to address. And I appreciate the fact that you guys were working on something that has no clear solution.

The proposal on the urban off-campus emergency departments as it stands, I think it is an imperfect solution, and I'm hoping that this is a jumping-off point to a much larger body of work around appropriate ED use. I'd like to build on our site-neutral payment policies.

And in looking at how emergency care and primary care, you know, how they mesh together, I'm not comfortable with the 30 percent. I do think that we need more data to have a number. And I'm not completely there on the drive times, but I will support the measure as written with at least my understanding that this is part of a bigger solution and that this is a stop-gap measure, this is a way point, at least in my mind.

So, again, thank you on an excellent chapter.

DR. CROSSON: Other comments? I see Craig, Kathy, Jack, Paul.

DR. SAMITT: So I would double down on Brian's comments as well. I support both recommendations actually, but I do believe that this is just the beginning of additional work that we should do looking at appropriateness of emergency room use. The two parts of the chapter that I believe we don't underscore enough is both on the utilization side as well as the reimbursement or level of care side.

On the utilization side, it's ironic that we're having these discussions about expansion of freestanding ERs when we're generally underinvesting in primary care, in

telehealth, and potentially in urgent care, when those are often far better alternatives for urgent, non-life-threatening cases, that we should be sure to reference in the chapter because I think we need more work there.

In terms of the cost side, what was striking in the chapter but we just have not addressed is the increase in Level 5 visits, and I would be interested in understanding or the future generations of the Commission understanding what's driving the increase of Level 5 visits. My understanding is that facilities bill based on the intensity of the services delivered rather than the severity of the illness of the patient for these visits, and it feels as if that warrants additional study to determine if there are other recommendations that should be offered to really counter what may be upcoding or may be other drivers of an increase in Level 5 visits, which is obviously also driving up the cost of emergency services.

DR. CROSSON: Thank you, Craig. Kathy.

MS. BUTO: So I support both recommendations, and I'm more enthusiastic about the recommendation involving rural OCEDs. Like Brian and Craig, I have reservations about the urban recommendations. I don't have a better

approach that I can think of. It does bother me, though, that whatever we call it, if this were enacted by statute, it's going to need not just updating but potentially totally -- some total revision.

It seems to me that what we're paying for, the additional increment of a freestanding emergency room capacity, is just some sort of 24/7 coverage, and otherwise it looks just like a physician's office in many respects. So I'm wondering -- that bothers me, especially since we're trying to encourage people to move away from emergency room care to primary care, as other people have pointed out.

So my hope is that we can delve more deeply in the next iteration into whether, in fact, the urgent care option ought to be built on rather than this payment being tied to a decrease in the on-campus emergency department rate that in some ways that's really what we're looking at.

But I would also, in response to Craig's comment about Level 5 visits, I actually think we ought to consider maybe suggesting that this is an area that ought to be not just analyzed but maybe audited going forward. There are a number of areas in this realm that should be looked at by program audits, it seems to me, and this is one of them.

DR. CROSSON: Thank you. I've got Jack, Paul, and Dana. I see Warner, Sue, Pat. Okay.

DR. HOADLEY: I'll be very brief because I think my comments are pretty consistent with what we've already heard. I think the recommendations are good. I like the rural one particularly. I think it's one we've spent a lot of time on and gotten to a good place on, but the other one, you know, as people said, there's still some uncertainty, but it's a good way to go forward.

I like the fact that you do raise in the chapter, based on our discussion last time, the micro-hospital issue, and I think, you know, what this really calls for in the future agenda, sort of how to balance the gaming potential versus the legitimate innovation, whether we're talking about micro-hospitals, urgent care centers, minute clinics, all the other kinds of facilities that people will use for sort of unscheduled care, but also things like the six-mile threshold, if we have this phenomenon of things popping up right in or outside of a mileage. And I think it's just something both to flag and maybe even more of a statement right close to the recommendation that just sort of says there's a need, you know, for both us, for CMS, for

whoever, to watch these issues and sort of look at that balance of legitimate innovation and gaming potential.

DR. CROSSON: Paul.

DR. GINSBURG: Yes, again, phenomenal work went into this chapter, and I want to praise it. I support the recommendations.

I just want to point out there's a paragraph on page 11 and 12 about micro-hospitals, and I want to urge that a few sentences be added to outline the possible -- the concerns about micro-hospitals and be a little stronger about the Commission wanting to take this up in the future.

DR. CROSSON: Thank you. Dana, Warner, Sue, Pat, and David Grabowski.

DR. SAFRAN: Thanks. I'll be brief. I support the rural recommendation wholeheartedly. I support the urban with some more trepidation. Many of the comments around the table have already indicated that.

I'd love to see -- the current language says "within six miles of an on-campus hospital emergency department," so that could be interpreted to mean any, not just that hospital. And I'd love to see it interpreted that way to address the issue we were talking about before.

Then my other comment relates to where I started to go on non-urgent care, and that is, I do think that -- I understand the challenges of identifying individual patients and saying this was or wasn't worthy of an emergency room visit. But I think we have some good and quite well accepted population level measures of non-urgent ED use. And what I'm suggesting is that we consider applying those at least to these facilities, and rather than that blanket sort of 30 percent number that you've heard some questions about in terms of their rate, having their payment rate somehow related to non-urgent ED.

But the real thing I'm trying to drive at here is some way to encourage these facilities to have, you know, one part of them that is for urgent care and one part that's for emergency care so that we aren't just seeing this escalation of more and more ED visits but, rather, getting people access to urgent care when they need it at urgent care prices.

DR. CROSSON: Dana, I just want to be clear on your first point. Were you suggesting that the recommendation language be changed to "any emergency department," or is it you want language supplementary to

examine or lay out the question that maybe that's another consideration?

DR. SAFRAN: I was saying that one reading of the language that's here is, you know, that it could be any -- that just as written, I could interpret as meaning not just the emergency department of my own home hospital, but any on-campus --

DR. CROSSON: I see, I see.

DR. SAFRAN: And that I liked that interpretation.

DR. CROSSON: Okay.

DR. SAFRAN: So it's fine as written if we could interpret it that way.

DR. CROSSON: All right. Thanks for that. Warner.

MR. THOMAS: So I support the first recommendation, on the urban recommendation. My concern here is that, you know, we're setting a policy with pretty limited data that we're not sure, you know, how that applies in a broader sense. But probably more importantly, I think we're setting a precedent of setting a policy on something we think is going to happen, and, to me, if we're

going to do that then that's fine, then we ought to do it in other cases as well. And if we see a trend, we ought to preemptively be acting across anything that relates to Medicare payment, not just in this situation.

So at least since I've been on the Commission, I haven't seen us really do that, and if that's a new approach then I think that's great, but it seems like we're setting a new precedent here by being preemptive versus having data, really analyzing it, and then making a decision. So because of that I'm very concerned about, you know, this approach.

DR. CROSSON: I have Sue, Pat, David, and did I see Bruce as well? Yeah. Sue.

MS. THOMPSON: Well, may I be the first to make comment on the rural side. I mean, I'm quite enthusiastic and very supportive of this recommendation, and I see this as a very, very positive policy for rural America.

And with that, just a couple of comments. In that recommendation I just heartily support encouraging these standalone EDs that are very remote to have economic and/or clinical relationships with larger systems or entities that can provide them the support needed. I think

that language is always good. In fact, I think standalone anything in our language today is counter to the principles of MedPAC, so I just call out the fact that we used standalone in both of these -- in the discussions around both of these recommendations. I think that's just worthy of note.

I am, again, disappointed in the "within 35 miles." I think we're not going far enough, fast enough, because I think there are critical access hospitals that are within 35 miles of other emergency departments that would benefit from, and I think it's in the interest of Medicare to think about how do we eliminate subsidies to a whole lot of inpatient beds that aren't being utilized, simply because they need to maintain inpatient beds in order to have health care presence in their community.

So, again, I call out my concern about the "within 35 miles," and I point out, on page 23 of the chapter, the unintended consequence of 35 miles that is illustrated in that example. So again, while access to the emergency department is the focus of that chapter, I just really want to call out those. We are really limiting our opportunity here.

But, again, a great recommendation, very, very positive, and I enthusiastically support. And, additionally, I just want to underscore that for a critical access hospital that chooses to leave that designation, to have the opportunity to go back if it doesn't work is absolutely imperative to this recommendation. So thank you for this, and thank you for your good work.

DR. CROSSON: Thank you, Sue. Pat.

MS. WANG: I enthusiastically support the rural recommendation. As with others, I really struggle with the urban recommendation. You know, six miles is, by definition, arbitrary. Six miles does not equal 10 minutes in many, many jurisdictions. And I do, in particular, have concerns about the specific situation that we just talked about, you know, freestanding emergency rooms in underserved areas that are there specifically because a community hospital has closed.

That said -- so I'm really on the fence on that one. I'm going to support it with the caveat that -- of this concern about kind of further work, particularly in the area of underserved urban areas and whether that six-mile radius should be adjusted or changed in some fashion.

I mean, the problems in those kinds of communities are much larger. Medicare volume is probably low to begin with, which is -- you know, there's a whole confluence of things there.

The other thing that I think is very important is to collect and track the information that we were talking about, about the non-emergency OPPS reimbursed services. And for that, as well as the basic emergency room services, I'm wondering whether the urban and the rural recommendation needs to be amended or whether something needs to be added to recommend that this be broken out on cost reports, that the off-campus services, et cetera -- because I don't believe right now it's broken out on the cost reports. That was one of the problems of doing the analysis. Does that need to be specified, is a question, because I think it's extremely important to get at that.

I also tilt towards supporting this simply because, with some exceptions, we do not need more emergency rooms. I mean, the next topic of conversation is going to be potentially preventable hospital admissions. There are potentially preventable hospital emergency room visits that start with this kind of capacity being

available, where people are going to emergency rooms instead of to more robust primary care capacity.

So I think that it's important, as we continue the work -- and, you know, I'm where Brian is about like a commitment to keep looking at this -- I would hope that one day we could come up with a recommendation that makes it as attractive for a hospital or anybody to sort of start a freestanding, you know, very robust, primary care practice, or augment that capacity in a community to replace a closing hospital, to augment access, et cetera. You know, urgent care, emergency rooms are important to kind of, like, relieve the access problem, but the real solution is better with primary care.

DR. CROSSON: Thank you. David.

DR. GRABOWSKI: Great. Thanks. I'll be brief. I'm supportive of both draft recommendations. I wanted to make two points. Number one, with the urban recommendation, I share some of the concerns that have been expressed around the table, especially around the six-mile rule, anything we can do to address some of the unintended consequences. I really liked Dana's suggestion. There may be other ways to kind of build language in there to make

certain that we're not just seeing places crop up right around that six-mile threshold.

Point number two is a broader comment. I really like the way Brian framed this as a starting point or jumping-off point for us, and I would love to see us do more work in this area. Here we are, paying different rates across different settings for sometimes very similar patients, and it sounds a lot like what we're going to talk about later today, and we've been talking about, around post-acute care and site-neutral payment. And so I think this is a great topic for the Commission and I hope we'll continue our work on it, and I'd love to see us try to apply some of the framework that we've used in post-acute care to this area as well. Thanks.

DR. CROSSON: Bruce.

MR. PYENSON: Yeah, thank you very much, and I really appreciate the work in getting ahead of this emerging trend. I find myself agreeing with both Pat and Brian on looking at this as almost an interim measure, but I'd like to say that I would also see an appropriate interim measure being a moratorium on payment for expanded ED capacity. I understand there's uncertainty. I see the

danger more on the inappropriate and reimbursement-driven growth than on a lack of capacity.

So if we're talking about interim measures, that would be my preference. Thank you.

DR. CROSSON: Thank you. Seeing no further comments, we're going to proceed with the vote in a minute. I'd just make a couple of comments, again, complimenting the staff on work which, you know, based on the questions but also based on the very good considerations that the Commissioners have brought up, it was a difficult topic, particularly the urban recommendation. Nevertheless, one that I think we all, more or less, think is needed and is timely as well.

I think some considerations that we may want to add to this, as we write up, have been brought up as well. Concern about the particular situation where, in urban settings, underserved populations could be adversely impacted and that might go into a consideration of how any legislation is constructed. The notion that Jon brought up, and Paul talked about, which is the fact that we would like to see it written with some flexibility so that certain numbers are not installed in perpetuity that might

be relatively less apt at some time in the future.

That there should be some work done, and where that would be, maybe us or CMS or others, to actually track the impact if this gets legislated, both in a positive way, to see to what extent it is has actually helped solve the problem, but also looking at potential negatives, in terms of negative impacts on certain populations, again, but also, you know, the evolution of gaming many hospitals and other things like that. I don't think there's any sense here, and I heard, at least from a number of Commissioners, that this is the solution for all time and it was exactly the right, but at the same time, we need to proceed as best we can.

And then the last point that, you know, even though we're talking about one aspect of emergency room services and its impact on Medicare expenditures, there are, in fact, many other issues in terms of utilization and proper site of care, as Brian has described, that would be appropriate for future work.

So I'm going to proceed with the first draft recommendation, page nine. I'll allow you time to read that again.

All Commissioners in favor of the draft regulation please raise your hand.

[Show of hands.]

DR. CROSSON: All opposed.

[No response.]

DR. CROSSON: Abstentions.

DR. NERENZ: Just note, Rita had to step out. She said she supports.

DR. CROSSON: Yeah. This is often awkward. We'll figure out how to deal with it. Thank you.

So I see unanimous that, notwithstanding unanimous support.

We'll move on to the second recommendation, which is on page 15. I'll give you time to read that.

All Commissioners in support of the draft recommendation please raise your hand.

[Show of hands.]

DR. CROSSON: All opposed.

[No response.]

DR. CROSSON: Abstentions.

[No response.]

DR. CROSSON: Seeing none it passes unanimously

as well, at least with respect to Commissioners present and voting.

That ends this particular topic. Thank you again to the staff for the presentation. Thanks for the excellent discussion, and we'll move ahead with the next agenda item.

[Pause.]

DR. CROSSON: Okay. Just before we start the next session, since we haven't begun the next session, consider the voting on the two resolutions as -- two recommendations as still open.

Rita, how do you cast your vote on these two?

DR. REDBERG: I support both of the recommendations.

DR. CROSSON: All right. Thank you. That will be recorded.

Okay. We're going to continue our discussions on the issue of Medicare Advantage encounter data and its uses, availability, and the future, and Andy and Jennifer are going to begin the discussion.

* MS. PODULKA: Thank you, Jay.

Today, Andy and I will present information on

Medicare Advantage encounter data beginning with background on how the data came to be collected. We'll summarize the findings from our efforts to validate the encounter data files. We'll discuss the different uses of data, and finally, we'll introduce some potential recommendations as next steps for next cycle.

First, a note on terminology. MA organizations sign contracts with Medicare to deliver the Medicare Advantage benefit to enrollees. These contracts can include one or multiple plan benefit packages. All of our analyses were conducted at the contract level, but we'll also use the terms "MA organization" and "plan" interchangeably today.

MA encounter data has a 20-year history that became with fits and starts in data collection. Then, in 2008, CMS amended the MA rule to resume collection of detailed encounter data from MA organizations for risk adjustment and other purposes. In January 2012, CMS began collecting such data from plans.

We now have access to MA encounter data files for 2012, 2013, 2014, and preliminary files for 2015. We expect them to be updated with revised 2015 files later

this year.

Data are collected for each of six provider types shown on the screen here, and note that 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.

Our validation methodology included two main categories. First, we checked to see if each plan successfully submitted any encounter data at all 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's important to know that when plans submit encounter data, CMS's system performs automated front-end checks before accepting each record. Errors in records cause the systems to reject the submission, which means no record will appear in the data files unless the plan resubmits the data. In other words, if encounters are not present in the data, we can't tell from our end if that's a result of the plan not submitting or the system not accepting the record.

Second, where available, we compared MA encounter data to other data files that include information on MA utilization. We checked to see if the same enrollees appear in both datasets, and where possible, we also compared enrollees' services documented in the encounter data to these events documented in the comparison data. For example, by matching enrollee's inpatient visit reported in the encounter data to the same inpatient visit included in the hospital Medicare Provider Analysis and Review or MedPAR file.

Our validation efforts found three broad categories of encounter data issues, and we'll go through each one of these three on the subsequent slides.

First, there are some plans that are not submitting or the system is not accepting any encounters for all six settings. Even after excluding plan types, such cost plans, that are not required to submit encounter data, we found that by 2015, some plans had no encounter data at all for certain settings.

We also found, on the plus side, that plans are generally submitting encounter data, albeit with lower rates of reporting for SNF and home health encounters, and

that reporting rates improved from 2014 to 2015.

Note the bottom row of the table that in 2015 only 80 percent of MA contracts had encounter data for all six of the file types.

Second, MA encounter data includes a small number of records that attribute enrollees to the wrong plan. MA plans submit data via the Encounter Data System, and the EDS accepts the submitted record if the beneficiary is actually enrolled in the plan according to the agency's information plus some other checks.

However, Medicare sometimes changes a beneficiary's enrollment retroactively. The beneficiary can be moved between plans or even back to fee-for-service. When this happens, the system does not require any change to already submitted record, so the beneficiary continues to appear to be enrolled in the original plan in the encounter data.

It's true that these retroactive enrollment changes are rare and they affect a small number of ED records, but unlike other issues with the encounter data like underreporting, there isn't a possibility that this issue will solve itself over time.

DR. JOHNSON: The final broad issue category is the comparison of encounter data to other sources of MA utilization. Although some of these sources are themselves incomplete, the comparisons provide some indication of encounter data completeness. I will note that we could not assess physician encounter data, as there is no good source of physician utilization for MA enrollees.

We compared both the 2014 and preliminary 2015 encounter data to the MedPAR, risk adjustment, OASIS, and MDS data files. I will provide a summary of each as we go.

On the following slides, you will see a match rate. This statistic indicates the proportion of a comparison dataset that matches to the encounter data. Match rates may be reduced by missing encounter data or mismatched data, due to an incorrect beneficiary ID or date, for example.

The MedPAR file contains information about inpatient hospital stays and is used to calculate disproportionate share hospital and graduate medical education payment amounts.

For MA inpatient stays, hospitals submit to

"information-only" claim records for CMS. Between 2014 and 2015, we found that the total number inpatient encounter records increased, and in 2015, there were more inpatient encounter records than MedPAR stays.

When comparing individual stays, we found that the proportion of MedPAR stays with a matching encounter record increased from 73 percent in 2014 to 78 percent in 2015. Similarly, when comparing unique beneficiaries with any inpatient stay, we found that the encounter match rate increased from 84 percent to 90 percent. All indicators show that inpatient encounter records appear to have improved between 2014 and 2015.

Our next comparison focuses on dialysis services. Dialysis facilities submit a medical evidence form to CMS when a patient with end stage renal disease begins dialysis. The form triggers an indicator, which, for MA enrollees, results in Medicare's payment being based the dialysis risk adjustment model.

Of the MA enrollees with the dialysis indicator, about 86 percent had a dialysis encounter record in 2014. The match rate increased to 89 percent in 2015 and is similar to the match rate found in fee-for-service

Medicare. This analysis suggests that the encounter data for dialysis services are relatively complete.

Next, we turn to a few post-acute settings where we found less complete encounter data. An outcome assessment and information set, or OASIS assessment, is required for all Medicare beneficiaries at the start of a home health episode and at several points thereafter.

Overall, for both years, we found that too few enrollees had a home health encounter record; however, the number of enrollees increased by about 30 percent in 2015 and was much closer to the number of MA enrollees with an OASIS assessment.

Consistent with the low number of enrollees with an encounter record, we found that the match rate for beneficiaries with a home health encounter to those with an OASIS assessment was below 50 percent for both years. These results indicate that although submission of home health encounters improved, many home health encounters are missing.

And finally, a minimum data set, or MDS assessment, is required for all MA enrollees on the 14th day of a skilled nursing stay as well as quarterly and

annually.

We again compared MA enrollees with an MDS assessment to those with a skilled nursing encounter record during the year. Given that some MA skilled nursing stays ended before an MDS is required, we expect and found that many more enrollees had a skilled nursing encounter record than an MDS in both years.

In addition, the number of enrollees with a SNF, skilled nursing encounter, increased by about 10 percent. However, in both years, only half of the enrollees with an MDS had a skilled nursing encounter record, suggesting that many skilled nursing encounter records are missing or mismatched with MDS data.

Given that we found missing encounter data for some types of services, we conducted similar comparisons at the contract level to see if a subset of MA contracts submitted complete data. We limited our analysis to contracts with 2,500 or more enrollees in 2015 and then focused on contracts with a MedPAR inpatient stay match rate of at least 90 percent. Fifty-two contracts met these criteria and had an enrollment of about 2 million beneficiaries.

Of the 52 contracts, average match rates for the other services were 94 percent for dialysis but only 65 percent for home health and 68 percent for skilled nursing. Only seven contracts had match rates of at least 90 percent for all four datasets.

Using a subset of contracts to analyze MA utilization would require researchers to consider the generalizability of any findings. For example, the seven contracts with high match rates are all sponsored by health systems, covered about 200,000 enrollees, and operated in a small number of health care markets. Staff will continue to assess the possibility of analyzing a subset of MA contracts, particularly as we gain access more current data.

We are now going to turn to a discussion of data uses, the data used to administer the MA program, and consider whether encounter data could improve or replace the current data sources.

Through regulation, CMS has chosen to limit the use of encounter data to specific purposes. Your mailing material includes more information about each. Over the next few slides, I am going to focus on three. Two of them

are uses for encounter data for risk adjustment, and the third is use for activities that support program administration and integrity.

First, calculating risk scores. Medicare payments to plans are adjusted for health status using diagnostic information included in a risk score. Since 2004, MA plans have submitted diagnostic information through the risk adjustment processing system, called RAPS data.

The risk adjustment data validation, or RADV audits, are the only review of RAPS data. In a given year, 5 percent of MA contracts will be audited. So far, audit results of RAPS data are only available for 2007, and the results show overpayments of more than 10 percent for 34 of the 37 contracts audited.

CMS has begun to use encounter data as a source of diagnosis for risk scores. In addition to the system of encounter data checks mentioned earlier, CMS ensures that diagnoses from encounters meet risk adjustment criteria.

In contrast, for RAPS data, plan officers attest that the risk adjustment criteria have been made. Starting in 2015, CMS began using a blend of RAPS and encounter data

to calculate risk scores. The transition from RAPS to encounter data has moved more slowly. For 2019, CMS will base 25 percent of risk scores on encounter data, with the caveat that encounter data will be supplemented with RAPS data for inpatient stays.

Next, to calculate risk scores, CMS adds together the relative treatment costs for all conditions identified with diagnostic data. Fee-for-service claims have complete diagnostic and spending data, and CMS uses those to estimate a relative treatment cost for each health condition in the risk adjustment model.

Estimating the model's relative costs using MA encounter data instead would offer a couple benefits. First, the estimated cost to treat each condition would better reflect MA plan spending, meaning payments to plans would better align with plan costs. Second, using encounter data would alleviate the need for one current adjustment that accounts for differences between fee-for-service and MA diagnostic patterns.

One reason MA encounter data are not used to estimate the model is that spending data are not complete. Spending data are not submitted for encounters for which

the provider and the plan have a capitated arrangement. Staff will continue to monitor efforts for this use of encounter data.

In addition to the datasets already mentioned, plans also submit bid data, which includes an estimate of a plan's prior year spending patterns for all services.

When plans submit data for bids, risk adjustment, quality measurement, and other single purposes, plans often summarize their own internal encounter data. One consequence of administering the MA program with single-purpose datasets is that the datasets are unable to be linked together. Having complete encounter data would allow CMS to generate a complete picture of how plans administer the Medicare benefit. Similarly, policymakers and researchers could evaluate plans' innovations in care management and delivery.

Finally, once plans submit complete encounter data, CMS can summarize data consistently across all plans rather than relying on each plan to summarize and submit their own data. To illustrate why this would be an improvement, we turn to our comparison of HEDIS and encounter data.

In the Health Effectiveness Data and Information Set, or HEDIS data, plans summarized their internal encounter data and submit counts of office visits for their enrollees. We compared 2015 HEDIS counts to our summary of the encounter data using HEDIS specifications.

First, we found that 80 contracts that had the requirement to submit beneficiary-level HEDIS data did not do so.

Next, for contracts that submitted both HEDIS and encounter data, we aggregated the count of office visits to the contract level and found significant variation between the datasets. Less than half of contracts submitted a count of office visits through HEDIS that was within 10 percent of the number of visits reported in encounter data. Of the remaining contracts, about half reported more than 10 percent too many office visits, and the other half reported more than 10 percent too few office visits in the HEDIS data relative to the encounter data.

Finally, we compared counts for individual beneficiaries and found that only 58 percent had a count of office visits in HEDIS that was within one of the number reported in encounter data.

In summary, CMS has continued to revise the process of identifying encounter data submission errors and providing more specific feedback to plans about the disposition of encounters. For 2015 and 2016, CMS has extended submission deadlines to accommodate these revisions.

In regulations, CMS has identified specific uses for the encounter data, including the few we discussed today. Encounter data are already used to calculate MA risk scores. This use requires a lower level of completeness because diagnoses need to be submitted on only one physician inpatient or outpatient encounter during the year. Other uses, such as comparing to fee-for-service utilization, would require more complete encounter data for all services.

Our analysis shows that preliminary 2015 data generally improved over 2014. While we believe that this sort of organic improvement will continue, it will take a long time for encounter data to be complete, if relying only on current incentives to submit encounter data.

Therefore, we identified some options the Commission could pursue during the next cycle that would

provide CMS direction on ways to improve the completeness and accuracy of the data.

First, CMS could compare encounter data to other sources of MA utilization and require plans and providers to address missing or mismatched data. CMS already conducts an inpatient stay comparison with MedPAR data and provides feedbacks to plans, but CMS could expand comparisons to the other datasets.

Next, CMS could collect a summary of plans' internal encounter data and report whether all encounters were successfully submitted. This information would supplement the feedback CMS already provides.

A third option is for CMS to develop measures of encounter data completeness and accuracy and include them in plan star calculations.

A fourth option would encourage CMS to continue increasing the portion of risk scores based on encounter data.

And finally, CMS could use encounter data to inform plans' bids. For example, CMS could check that spending data included on each bid is consistent with the submitted encounter data.

We would be happy to discuss each of these options on question, and if there is interest, we will bring more detailed discussion during the next cycle.

That concludes our presentation. Thanks.

DR. CROSSON: Thank you.

We are open for clarifying questions. I see Brian, David, so we'll move up this way. Brian.

DR. DeBUSK: First of all, thank you for a really great report.

On page 10 of the reading material, something caught my eye. They were talking about $1,850 per sampled beneficiary of error in the 2007 RADV audit summary. If I extrapolate that out -- and maybe I'm just being really naive, but 59 million beneficiaries, 31 percent MA rate, that's like $34 billion. Are they just that good at finding the bad actors in these RADV audits, or is that a ballpark figure for what we're really looking at?

DR. JOHNSON: There was some attempt to focus on plans that might have had increases in their HCCs that were increasing faster than other contracts, so there might be some selection there that you would not have the same extrapolation to the entire AM program.

DR. DeBUSK: Okay. I had always worked with a ballpark figure of about 10 percent, you know, about $17 billion or so. Is that closer to the -- I know this is an imprecise --

DR. JOHNSON: I don't think we know for sure. This is the only year of data for the RADV audits that the results have been published.

DR. DeBUSK: Okay. Thank you.

DR. CROSSON: David.

DR. NERENZ: Thanks. I just wanted to make sure I understood correctly a point you made. I think you're on the bottom of Slide 17. Is it so that plans don't have or don't submit encounters when the providers are in capitated arrangements? Did I hear that correctly?

DR. JOHNSON: They're not required to submit that spending data for those encounters, that's correct.

DR. NERENZ: Okay. So not required to. Do they?

DR. JOHNSON: Generally, no, we believe.

DR. NERENZ: Okay. How big a gap is --

DR. MATHEWS: Andy, sorry to interrupt. Can you clarify, they do submit the encounter record, but it does not contain the payment field or payment data.

DR. JOHNSON: That's correct, yes.

DR. NERENZ: Okay. Now, that's an important distinction.

DR. JOHNSON: Yes

DR. NERENZ: That's why I wanted to get into this. Okay. So it doesn't include the payment. Do you have any idea, as a percent of total, how much is missing there? Which is essentially how many providers are in capitated arrangements.

DR. JOHNSON: On an earlier year of data, we did a back-of-the-envelope calculation to figure out how much total dollars we thought were spent to providers based on assuming that 85 percent of total payments to plans go to medical services, and then we summed up the spending amount in encounter data. I believe this was for 2014. I'll have to check the exact year. But it was about 30 percent lower total in spending data summed from the encounter data on that back-of-the-envelope --

DR. NERENZ: And it's attributed to -- that missing 30 percent is what's in the capitated arrangements? Is that --

DR. JOHNSON: We believe so. That's our best

understanding.

DR. NERENZ: Okay. And do you have any idea, is that going up or down over time?

DR. JOHNSON: We have not looked for 2015.

DR. CROSSON: Bruce.

MR. PYENSON: A question for Jennifer. I was very puzzled by the issue with encounter data because I think of very large claims databases like Truven MarketScan or the Optum database that have, in effect, full encounter information on, you know, tens of millions of lives longitudinally. And it seems as though the process of submitting encounter data for MA plans is somehow dramatically different from the normal processes that drive the industry, you know, the full industry of health care and health insurance and benefits. And I'm wondering if you've flow-charted or something what's this EDS system that's creating such a disconnect or a comment on that.

MS. PODULKA: It's a good question. We have a comment, but not necessarily a full answer for you. We did try to note that we obviously can't tell exactly where the issues originate, if it's the plans not submitting or the system not accepting. We have heard from some plans about

issues with the system accepting records or processing records. CMS acknowledges these and is working to change them over time.

We are a few years in, so I think it would make sense for a government contract to evolve over time and not be at full maturity level yet. Even things like Truven MarketScan did evolve over years, and they do make refinements over time. They have been in place a bit longer than the encounter data system is. I think it's improving. I can't tell you exactly like this is how much of the issue -- share of the issue that centers on the system and how much centers on the plan.

DR. CROSSON: David.

DR. GRABOWSKI: Thanks for this work. This is incredibly important, so I'm very supportive of this effort.

I was really interested, maybe on Slide 9, you undertook all these different comparisons using MedPAR, the information-only claims, the OASIS, the MDS, the dialysis comparisons. That was really interesting. And I don't mean this to crowd out this current effort because I think getting encounter data is really important. But as a

question, does MedPAC -- how much has the Commission relied on these sources to compare utilization in the past? And is that an effort that -- as a sort of interim step could we make better use of these different sources? And I'll give an example. Some of Jon's colleagues at the University of Minnesota had a paper, I think last year, in Health Affairs, led by Peter Huckfeldt, where they looked at for post-acute-care use, what's the difference across Medicare Advantage and fee-for-service, just using the information-only claims from MedPAR. And so could we be doing more here to do MA-fee-for-service comparisons while we're waiting to get the comparison data right?

DR. JOHNSON: We may be able to do more. That's something certainly to explore. I think it's important to also distinguish that for all of the data sets we compared to, we also did some comparisons for the fee-for-service claims data just to see what we would expect, and they across the board were much better. There were very high match rates, in particular for the OASIS and MDS, where we found low match rates in the encounter data.

Was there a second part that we haven't addressed? Okay. Thanks.

DR. CROSSON: Okay, questions. Pat.

MS. WANG: This actually is the follow-up to Brian's question about the RADV audits. Can you remind -- CMS was working on a fee-for-service normalizer or adjustment or something like that. Can you remind us what that was supposed to do? Because I think that that's one of the reasons that a lot of these things have not been finalized.

DR. JOHNSON: I'm not aware of how the adjustment would function or what exactly it is adjusting for. So, unfortunately, I can't. But that is something that hopefully we'll learn about in the next round. I think that came about in a sampling methodology that's supposed to apply to future audits, so I think we'll find out more as information about those audits becomes available.

MS. WANG: The other thing is that in the paper, towards the end there were a few next steps to perhaps, you know, like increase the accuracy as well as the completeness of encounter data submissions. I'm just curious whether -- because, obviously, this is a very important topic. It is excruciatingly detailed and difficult, and I don't know why, Bruce, but to get the

complete match, you know, I'm wondering. Truven, it's like a one-way submission as opposed to Truven coming back to a plan, for example, and saying this is what I have for you, does this match exactly what you think you submitted? And I know that there have been problems back and forth. Do you have a view, like what things should CMS really focus on to have the biggest bang for the buck, understanding that this is very, very detailed and complicated and kind of agonizingly -- so, for example, you know, on page 24 one of the next steps was that plans submit records for each of the provider data types and, you know, have the feedback and everything. I think there's probably more -- there might be more juice in the lemon if we just went deeper on one provider type, let's say inpatient, you know, because right now I think that what CMS gives back to plans is still pretty high level.

So do you have a view on that? I had concerns about just increasing the amount of sort of lackluster work that's going on, on both sides right now, as opposed to trying to hone deep.

DR. JOHNSON: I don't know that we have a best option of the ones we've presented, but I think that for

the feedback that CMS does provide, particularly on the MedPAR comparisons, I think they provide information about the rates of matches and extra encounters that were matched to MedPAR and generally the mismatch as a summary piece of information, but those comparisons could be expanded to other data sources, as we mentioned, but also could provide specific information about, you know, which encounters were not matched or which inpatient stays in the MedPAR data are missing any information that would provide some better effort to adjudicate the two data sets together.

MS. PODULKA: And one thing that we talked about at the staff level that we're sort of missing from our perspective is why, so we can show you these statistics. We're not best situated to answer OI question. CMS is a little better situated. They have regular contacts with the plans. So if they shared this type of information, the comparisons that we've done here, and asked why is there a mismatch on your plan from what you submit to HEDIS versus the encounter data, they might have a very different answer than what we might hypothesize, and that could be very informative about what the next steps should be.

DR. CROSSON: On this point, Kathy, or just in

line? Okay. So we're coming down this way. Jack.

DR. HOADLEY: So I had a question on Slide 14. You talked about the seven contracts that had at least 90 percent match, and I think you mentioned they were integrated systems, integrated health systems with health plans?

DR. JOHNSON: At least all health system sponsored.

DR. HOADLEY: Sponsored. Are there other such organizations of that category that didn't do so well?

MS. PODULKA: There were even contracts from the same parent organization that didn't do so well, so we couldn't even say these did well, the parent organization must really know what they're doing for submitting data. Some of their contracts did better than some of their other contracts.

DR. HOADLEY: So that actually goes right to the second part of my question. I was just wondering whether there's any ability to sort of look across the submission quality measures that you do and say are there certain plans, certain organizations, certain types of organizations that are doing better, which might give us

some clues to the infrastructure or the sort of organization characteristics that make it easier for them to do this well.

MS. PODULKA: We will definitely check that when we get the revised 2015 and see if it changes.

DR. HOADLEY: Good. Thank you.

DR. CROSSON: Alice.

DR. COOMBS: So Jack actually stole my thunder.

[Laughter.]

DR. COOMBS: I was going straight for the money. One is that did you have any adopters or poster child, this is the five-star category in terms of encounter data from -- but it sounds like within each entity there's good performing and bad performing on all levels. Is that correct?

MS. PODULKA: There was one single contract where the parent organization only had one contract. But this would be a single contract from one organization that did a really good job, and they just don't have other contracts from the same parent organization. So that would be a really, really small subset to get into.

DR. COOMBS: Right. So as I read this, I was

wondering, how do they do bundle -- how do they do episodes of care if they don't have accurate data? And how do they come with a bid if they don't have accurate data? I'm just thinking, this is like the swap meet.

MS. PODULKA: Well, this is one thing where we think there's a disconnect between their internal encounter data or their internal data and the translation or transmission of that to CMS. And we don't know then with that transmission is it the plan or is it CMS' system. But we're not saying that the plan's internal data is --

DR. COOMBS: There's just a gap between --

MS. PODULKA: We hypothesize there's a gap.

DR. JOHNSON: Yeah, and to add to that, we've heard anecdotally that getting information from providers to the plan is sometimes a challenge as well at the level of completeness and all of the data elements that are required for CMS. So it is not necessarily just from the plan to CMS, but provider to plan --

DR. COOMBS: SO when plans come forth with a bid, they actually have some information. How good is that compared to what you're seeing on the other side?

DR. JOHNSON: We haven't compared any bid

information to the encounter data. I think at a minimum plans would know how much money they paid out to different provider types, and so a good chunk of the bidding information would rely on that data, which is not -- there is no one-to-one link to the encounter data for that --

DR. COOMBS: So it's fair to say that they have some internal information that we don't have access to because there's a gap between the information that actually CMS receives?

MS. PODULKA: It's possible that some of their information, such as bid information, might be in a form that they've more aggregate than is required for the encounter data so that the plan might have difficulty in translating their internal data into the correct form to submit. Again, we're going off a lot of hypotheses here, though.

DR. COOMBS: Okay, okay. And then the last question. When David asked the question about what percentage of providers are under the capitation, what percentage of overall providers could you say that we don't have accurate encounter data? Could you give us a number of...

MS. PODULKA: We haven't flipped it to do the encounter -- the provider perspective.

DR. CROSSON: Okay. Kathy.

MS. BUTO: I was really intrigued by Slide 21, the last bullet, use MA encounter data to inform plans' bids, because it's always true that if encounter data has anything to do with payment, it will get better. So the question is: What did you mean by that? And is this something we could really pursue? Because I'm just curious, that was -- that's always been the experience in Medicare, that the data don't get better until you link it directly to payment.

DR. JOHNSON: I think that option was derived out of our attempt to answer another question which comes up a lot: How do you know when the encounter data are complete? And so looking at the fee-for-service space, there's a direct link between payment and claims, and we analyze fee-for-service utilization broadly. I think the most closest analogy for the MA encounter data would be through the bids, and that there is a less direct but at least a linkage to the amount of data going in and the basis for the bid --

MS. BUTO: So you're not thinking of something as specific as an adjuster to the bid. Or are you? You haven't --

DR. JOHNSON: That's farther than we --

MS. BUTO: You haven't fleshed that out yet, okay. I think this is one that we -- it would be worth...

DR. CROSSON: Okay. So seeing no further questions, we're going on to the discussion period. I would ask you to put up Slide 21. It's already up. There are a number of potential directions here. They more or less increase in intensity, if you want to call it that, as we go down the list. So I would be interested in discussion about where on this list people feel we ought to be focusing, if you have a thought about that, and we're going to start with Craig.

DR. SAMITT: Thanks, Jay. So I was hoping, given that this is my last MedPAC meeting, that I would have all of my questions answered about encounter data, but, alas.

[Laughter.]

DR. SAMITT: At least we've made a significant start.

You know, while I recognize sort of all the

questions and all the processing about the accuracy of the data, we really just need to jump to the recommendation slide right away, and with the presumption, I would assume, that we all feel the data is good and that you get what you pay for. And so I think the question is: Of all of these recommendations, which ones will enable us to fill out the comprehensive portfolio of encounter data that we need to really put it to good use?

You know, I think I would even defer to you, given sort of prior experiences, which of these measures do we think will most motivate the submission of data, comprehensive data? And I'm inclined to say all of the above. But I suspect that that's not an elegant answer, and that there are some here more than others that are going to be more effective, and I'm more inclined to be on the bolder side, which may be on the lower element of this. And so I am very much in favor. I just think we have to pick our poison and figure out what's both going to be the most effective means of getting the data, but also the most efficient for those that are making the submission that we don't create perverse incentives in any way.

The thing that's more interesting to me is really

Slide 15. I wonder while we're waiting for perfect data to understand how we can use the data as it exists today without worrying about an incomplete data set, and you alluded to that a little bit. You know, I think we should not wait until we get all the data, but begin to understand where this data can be put to good use. And you referenced that to some degree, but I also just wonder what else is missing on this list. When we in early years began to ask for encounter data, I think it was also because we presumed that when we looked at MA encounter data, we would see sort of pockets of excellence in how systems or plans or providers were actually practicing health care in a more optimized, higher-quality, more efficient manner, and that encounter data would point us to examples where we should be thinking of new payment policies, because high-performing capitated MA groups, which we presume are delivering great results, are demonstrating utilization savings in areas that we should be paying more attention to. And for some of the topics that we talk about, like site neutrality, and some of the ambulatory-sensitive conditions and other things that we've been reticent to sort of expand lists, I think it's because we haven't

really looked at the encounter data to feel save that in certain settings most things are being done in an outpatient setting, not in an inpatient setting. And without the comprehensive nature of the encounter data, we can't see, I think, where there are opportunities to encourage and incent a different clinical practice model. And I don't know if we need perfect data to really look at those opportunities. The data set that we've got today may be sufficient.

So I'd love to expand this list of MA encounter data and really -- and whether that's at the July meeting that the Commissioners have or what have you, to think about it, if we have this good encounter data, how else would we put it to use other than just this very narrow scope that we see here.

This is great work, by the way. Thank you.

DR. CROSSON: Thank you, Craig. We will now start the discussion. I think -- I can't remember what I've done here but I think I have to start on this side, with Alice.

DR. COOMBS: Thank you so much, Andy and Jennifer. I think you'll have job security.

[Laughter.]

DR. COOMBS: I think that the bottom line on the recommendation slide strikes me as probably one of the most effective means of dealing with this, and that is to use encounter data as a part of the bid. And I was hoping to see something a bit more robust in terms of going forward. And, you know, this is great discussion in the paper regarding how this data can be used, but one specific thing was the whole notion of the relationship to fee-for-service and comparing how one does over the other. And I don't use the word "promising" when that discussion comes up, because I think it does not give me what I would have hoped to have seen with this process.

And the other piece of it is I have long had this bias regarding MA plans in terms of how well do they look in terms of risks and in terms of demographics, and I don't get a clear-cut answer. A 10 percent difference may seem like a good performance on the test but I will compare it pulse oximeter. If you had a 90 percent oxygen saturation, that's actually failing.

So the key thing is I think our bar for MA plans encounter data has got to be risen higher, because I don't

think we would probably have the same group of flexibility in other industries, and that, to me, was the most striking thing, is that this process of encounter data collection has been going on for a long time, and we were hoping that we would also use some of the data to look at population health measures as well. That's not here. We're not in that lane yet. And so, for me, I look at it as like a lot of opportunities for improvement, but you might be around for a very long time.

DR. CROSSON: Jack.

DR. HOADLEY: So reflecting on that very long time, I remember sitting at HHS 20 years ago and hearing the discussions about, you know, we're about to get started on getting the encounter data rolling, and, you know, it won't take all that much time. I can remember, I think it was the first meeting of our class, when Craig raised the question of whether we'd have a discussion about encounter data, and six years later we're having that discussion, which is no fault of the staff. It's the fault of what the data have been like.

And so for a process that's got 20 years going, I think it's very frustrating that these data are still not

broadly usable, although I also agree that we should do the best with what we've got. I mean, I certainly don't want to lose that point. But we should continue to document and test both what works but also, you know, where the shortcomings of these data are. And I think, you know, looking to this list of recommendations, I think, you know, we should look to be as aggressive as possible.

You know, the links to payments, obviously several people have noted are -- whether that's through the bids or other sorts of payment aspects, the risk adjustment -- are important, because where there's payment the data become more complete. The stars certainly, you know, could help. That eventually becomes a link to payment because if you fail on your stars you don't get the payment bonuses.

But I think we also have to consider whether there should be some kind of movement towards, you know, some stronger penalties or enforcement mechanisms that basically says, you know, you're not going forward, in some manner. Again, I don't know quite what the right penalty is to assess. I mean, as an extreme you can say you don't get to participate in the program unless you demonstrate -- you know, if you have two years of failing at these 50

percent of the home health encounter kinds of levels, or even at 90 percent, you know, you're going to get kicked out of the program. That might get their attention really fast.

So I think, you know, thinking about being as aggressive as possible is important here.

DR. CROSSON: Okay. Pat.

MS. WANG: So I think that this is really important and thank you for all of your good work on this. I think it's critically important to, like, race towards this, because we are all flying blind right now, with respect to the MA program, without this information.

To me, of the recommendations on Slide 21, I'm just trying to think about how to be most helpful to the process and to CMS. I would encourage us to, you know, maybe probe a little bit more deeply about more specific recommendations for improving -- because part of the problem now, as I understand it, and this is like way over my head, is that, you know, I mean, plans, Alice, have tons of information. Like, please don't think that plans just, like -- I mean, they pay bazillions of claims every year. They submit, you know, their star HEDIS measures in a very

excruciatingly structured way that is audited.

I mean, it's, like, really -- the issue is, to my understanding, you know, from the beginning the submission of this information, basically, which is administrative, and rejections, there are filters that CMS applies. There's an algorithm that folks didn't know what it was, didn't understand it, so it would get rejections back and would not know why. So this has been a process of working through.

I think, though, it is really important for both sides to have a date, because I agree that otherwise it just keeps going on and on and on and on. And, to me, the one that is most promising is the fourth bullet, which is risk scores, because that is a process that's already kind of underway, and we were supposed to be blending increasingly RAPS and encounters. And, you know, this year CMS even pulled back and now they're going to go forward to 25 percent. It probably would make the most sense to just sort of say my date -- it has to be entirely encounter based and then everybody will kind of pull together and get the work done.

You know, there were -- I don't know what the

state is but there were industry groups where, you know, CMS was sitting down with the plan associations, et cetera, to try to get through this stuff, and I think that's the only way to get it done, is a big slog, but it really has to happen.

But it would also encourage -- this is what a mentioned before, because I think that it's hard, even with the current -- even if you're just talking about inpatient, and it's less about where the care is, it's more about let's just match one service type so that everybody understands, like, what's being accepted, what's not being accepted. Maybe CMS can just take one service type and provide back more detailed information.

So, for example, if it's inpatient and we're submitting counter data, maybe CMS can let us know what they actually are recording as the claims payment, the dollar amounts, so that we can compare them to our claims lag information, to see if that's matching. You know, just more data elements of one provider type could perhaps advance the process, because I think right now it's just -- it's kind of high level and people are having trouble digging down underneath.

So that's why I would be more in favor of going deeper into one provider type service than kind of spreading it out, because then we just get this sort of like mediocre back-and-forth, like, well, we don't know, and it's rejected and we don't know why, for more provider types. So I would encourage us to continue to be as precise as possible, but I do think that the risk or blend needs to have a firm date, and at a certain point it's just -- there's no pulling back, and that will motivate people to get it done.

DR. CROSSON: Thank you. Jon.

DR. CHRISTIANSON: Yeah, I agree with you totally. I think we're talking about a lot of technical points. This is a great chapter, by the way. It really helped me kind of get my mind around what's going on here.

I have a longer time horizon than you, Jack. I can think back 40 years trying to get good encounter data with health plans, unsuccessfully.

The technical issues are really difficult. I think we need to keep in mind that, on a fairly rapid rate of growth, more and more Medicare beneficiaries are in Medicare Advantage plans. We know less and less about what

the Medicare population is getting for care. So this is not just a technical problem. I think this is really a fundamental problem for the program.

As you guys know, there have been other proposals out there, in addition to yours, about what should be done with the encounter data, and one recent one was release it, with all its warts, and let researchers deal with it and point out where the problems are.

I would even go further and say I just don't understand why this whole process can't be more transparent. Why can't we publish every year which plans are delivering which data, where the data are complete, where they aren't, and let the public, let the -- hold plans accountable for this. I don't see -- and it will also hold CMS accountable. If the problems is -- you can't tell now, but if the problem is CMS just has some -- you know, is constantly turning back data on this point or that point, and then so the plans are actually submitting the data but the problem is that CMS isn't, let's find out about that. Let's make that public. And if the problem is that plans just aren't working at it, or maybe we have two or three or four plans that are really bad, let's make that

public, and let's put some pressure on plans. Why are you so bad? Why can other plans do this and you can't do that?

I think that would be a recommendation if we're moving forward towards recommendations at some point in the future, that I could really get behind.

DR. CROSSON: Okay. David.

DR. GRABOWSKI: Thanks. Hear, hear to Jon's point about transparency, and I would love to see that added as an additional bullet here.

I wanted to go back and just echo Kathy's truism she gave us earlier, around the closer data are tied to payments, the better are those data, and I think among these recommendations -- and I think, Jon, yours would very much fit in this vein -- those towards the bottom of the list, the MA stars, the risk scores, the plans' bids, that help influence payment, are really going to lead us towards better encounter data. And so until we do that we're just not going to get there. That's point one.

My other point, in the meantime, and I think Craig mentioned this -- I want to go back to my earlier comment -- I do think there's data we currently have that we might be able to use. It may not be accurate across the

country, for all plans, but what can we do with the existing encounter data, and then along with that, what can we do with the information-only claims, from MedPAR, what can we do with the MDS, what can we do with the OASIS, these other sources. So I hope that we can move towards a recommendation down the road that encourages the plans to submit more accurate encounter data by tying the data to payment, but beyond that, I think, in the interim, we should look towards some steps with the existing data. And so I hope we can sort of take a two-track approach here. Thanks.

DR. CROSSON: Dana.

DR. SAFRAN: Yeah, just a couple of thoughts, which mostly have been mentioned. So I, too, like this list, and in particular really like the idea of tying the encounter data to stars and risk scores and on down from there, because I do think that, you know, Cathy is the one that made the point first, that, you know, until these matter for payment we'll continue to struggle.

That sort of connects to a question that I've had, which is -- or maybe it's more of a point -- that, you know, I think it's CMS's framework that has four different

stages of payment reform, the sort of, with the fourth point of the model being where there's, you know, actual capitated payment. And I've wondered, always, how, when we're in that space, we really understand and have information about what's going on with individuals and their care.

So I know we're not talking about the ACOs right now, but I do have a question about how all of this works in Next Gen, because I believe that is a model like MA, where there's a capitated payment, and I'm curious whether we're similarly blind there about what the care is that beneficiaries are receiving.

And I'll just end by underscoring, you know, a point that Craig raised that I think is really important, which is, you know, given that we will, for the foreseeable future, be in this situation that we're in now, where we have a real plurality of models under which beneficiaries are receiving care, I think it's absolutely critical for us to be able to compare across -- to understand the quality of care across them, to understand utilization across them, to understand risk scores, and everything else that we want to know, to understand the effectiveness of these programs,

and which members are being served well by certain types of programs and others, that whole list of questions, and we cannot get there until we have universally complete and accurate encounter data across all of our programs. So I would just underscore that point.

DR. CROSSON: Okay. Thank you. Bruce.

MR. PYENSON: Yes. As someone who works with tens of millions of lines of data on a daily basis, I want to emphasize the difficulty of figuring out where challenges originate. I've heard some of the Commissioners assume that it's the health plans. I haven't heard the -- I haven't read that in the analysis here. And I've heard from authors, a series of hypotheses, and another one, in my mind, a reasonable one, is that the system that CMS has set up is dysfunctional, or is not designed to be functional, or is not being functional in the way it should be.

So I think before we make an assumption on that, I mean, is to -- I'd encourage the Commission to take a hard look at what the process is. Perhaps flow-chart it, and to see if these recommendations, which are really, I think, terrific, are being served by that process, or if a

different process would get us there a lot faster. So I think understanding this odd disconnect.

Now the truth, I think, is likely that, you know, there's problems on both sides, but it's not clear to me that, based on the information we have, that we're going to get there any time soon, given the existing structure, or if we're going to keep kicking this down the road.

DR. CROSSON: So just on that point, Bruce, and I may be wrong, but as I was thinking about this it seemed to me that, you know, given the variability that we had in the presentation of results, where I guess you said you had one plan that all, you know, was 100 percent on everything and there are others that are 100 percent on this part but not another part, that I guess on that basis I was making the assumption that it was more likely to be the submission rather than the acceptance, because if it were the CMS part of that it would be hard to explain why.

MR. PYENSON: I mean, it could be, but it could have been the day of the week that the data was submitted on. Look, I mean, you see things like that --

DR. CROSSON: Yes, I --

MR. PYENSON: -- in data. I mean, you just don't

know. And a system that doesn't report its failure rates or rejection rates is questionable.

DR. CROSSON: Okay. That's a fair enough point, and I think if there's a way to sort that through, as you are suggesting, it would be dispositive of what direction we take, for sure.

Okay. Next. David.

DR. NERENZ: Thanks. This is going to end up being really a question to my colleagues who are in health plans, so Pat, Dana, Craig, and it started with Craig's opening comment.

I'm curious about how the current system for getting and using encounter data allows for innovation in new forms of delivery and new forms of encounters, or whether, sort of as a corollary to that, the requirements actually might serve as a barrier to innovation.

Quick background. My own organization has had a tight link between a health plan and a big medical group for over 30 years, full cap payment through most of that time. My observation, as a member, as a patient, and as somebody who thinks about these issues, is that 30 years ago there was a very clear difference between that

arrangement and typical fee-for-service. It is much less different now. Why would that be so?

Well, for example, in the HEDIS system, you're scored on the extent to which an encounter of one type is followed over a period of time by an encounter of another type, and these are defined types. If you introduce a second, different kind of encounter you use points on your HEDIS score.

I'm wondering now, transferring that thinking in here, if I'm an organization and I move aggressively to capitation, and then within that arrangement I encourage all sorts of innovation -- I want e-visits, I want home visits by different kind of providers, I want all sorts of encounters that don't match the template -- it seems to me that the existence of this requirement might serve as some drag on that process. But I don't know. Is that a legitimate concern?

DR. CROSSON: Pat, on this point, and then Dana on this point.

MS. WANG: Just very simply, I think that that is an area of opportunity for the encounter submission process. I think that that is one area that is in need of

development, what goes in and what comes back as recognized or accepted, or two different things in our experience. And just talking about primary care cap, if you're talking about larger, you know, global capitation arrangements that have different types of services underneath, it gets complicated.

But that's the kind of thing that I think we don't -- is a chicken and the egg -- we don't get there unless there's, like, some pressure to get there. But I would say the state of that is in need of development.

DR. SAFRAN: I don't view it as a drag on innovation. I think that in those situations you recognize that the measures have to evolve and the way the measures are specified have to evolve.

But the flip side of the problem that you're pointing to is a problem that I experience as worse, which is in that situation where you're still running on fee-for-service architecture, then you have providers who say, "Well, I want to do telemedicine but what will you pay me? Can we invent a billing code for all the different ways I want to innovate?" And people, you know, providers, have a hard time getting off that sort of mindset, that for

everything they do there needs to be a way to code it and bill it.

And so that feels like a much worse stifling of innovation than I think the stifling of innovation that I've seen happen in our market, where, you know, they feel freed up to do all kinds of innovative things. And, you know, it may not get counted the way that we might like, as a plan, and we're accountable for it, but I think that's a much less severe problem.

DR. NERENZ: Okay. Well, just to follow quickly on that, and I'll be done, you know, that actually was sort of part of my thinking, that if I'm a provider and I want to do something unique but I'm under a capitated arrangement, I may not bill for that at all. I may need no code, and that may be a good thing, but then there's no recorded encounter with which to ultimately report unless a system is developed to capture it that's not billing.

DR. CROSSON: Last word. Brian.

DR. DeBUSK: Actually, it's a great point, and I want to talk about that in just a second.

I do support all the bullets on Slide 21, and I want to echo the sentiments of Kathy and others that unless

we tie this to payment or some penalty, I don't think we're going to get the data. So I think that's inevitable.

Really to build on something, David, that I think you were talking about, as we get this data, I think getting the encounter, but also properly cost accounting for how you record the cost, for example, of capitated payments or other incentive payments, capturing that cost data is going to be very, very important as well because it will ultimately give us a look under the hood of MA because I'm always interested in where MA efficiencies come from. Is this excellence in price negotiation and network narrowing, or is this real case management? Is it real, using less PAC? Is it really avoiding hospitalizations and admissions or -- and ED visits?

So I do think as we try to get this encounter data, I hope the staff will keep their eye on how do we even properly do the cost accounting for how some of these payments are made because it isn't fee-for-service. That's the whole point, is these aren't one -- this isn't do something, get paid, that type of an arrangement, and we will have to capture that.

The final thing I wanted to touch on, I always

like to see the debate on coding appropriateness and RADV audits and EDS versus RAPS and everything in the MA world, and I think that's fantastic work and work that has to be done.

This is my opportunity, though, to put my standard plug in that I hope we actually code fee-for-service appropriately, eventually as well, because I think a lot of the issues that we have in calibrating these models and coding intensity adjustments and some of all the mechanics that we do trying to sort this out, I think if fee-for-service were coded properly -- not over-coded, not under-coded -- I think some of these issues would resolve themselves as well.

Thank you.

DR. CROSSON: Thank you, Brian, for that, and thank you, Andy and Jennifer, for good work. We will be seeing you again. Thank you to the Commission for a good discussion.

We now have an opportunity for a public comment period. If there are any members of our audience who wish to make a comment, please come to the microphone.

[Pause.]

DR. CROSSON: Seeing a couple of individuals.

I will make a couple of points. Number one, this is not the only opportunity or even the most effective opportunity in providing feedback, particularly before the Commission addresses some of the issues before it; however, it is one. We would ask you to identify yourself any organization that you belong to, and please limit your comments to two minutes. When this red light returns, the two minutes will have expired.

Thanks very much.

* DR. HENSLEY: Thank you.

Good morning, Mr. Chairman and MedPAC Commissioners. My name is Dr. Justin Hensley, and I am an emergency physician for Code 3 Emergency Partners that owns and operates an isolated rural independent freestanding emergency center ED in Rockport, Aransas County, Texas, a recently declared federal disaster area since Hurricane Harvey last August.

I'm following up on our company CEO, Dr. Carrie De Moor's comments at the last meeting concerning the independent ED facility in Rockport, which is currently the only emergency services access point in a rural, isolated,

80-mile stretch of the coastal bend. It does not get recognized by Medicare and does not receive any funding at all.

Interestingly enough, with your 35-mile rule, we are 32 miles from the closest hospital-based ED in the southwest direction, 38 miles in the northwest direction, and 52 miles in the northeast direction. And then east of us is the Gulf Cost, so there's not much there.

We are a very real example of the need to preserve and maintain emergency services in that rural community that does not fit neatly in that 35-mile radius.

What I'm talking about today is not simply modeling, but current real-world experience of how one such facility can replace a shuttered critical access hospital. Our closest hospital actually was devastated by the hurricane and is completely gone now.

Our rural isolated freestanding center is the functional equivalent of a hospital-owned ED and meets the same standards, actually has higher standards according to Texas law. We have a goal of preserving and maintaining access to that area, but we currently don't get reimbursed for any of the patients we see.

I have in my hand a list of the 687 patients we saw in the last 128 days of last year that were Medicare or Medicaid. 475 of them were Medicare.

We billed a total of $888,000 for those patients, got reimbursed zero because we're not recognized because we are outside of legislation. Independent freestanding emergency centers are not recognized.

So I ask that in order to preserve this and maintain this rural access, we work together to get Medicare to recognize these independent rural freestanding emergency centers.

Currently, one of the biggest banes of existence in that rural area, as Ms. Thompson mentioned and others, EMS does not bring us patients, but that's not because we don't want them. It's because they don't get reimbursed on Medicare for delivering them to us either, and so instead, they drive 45 minutes away. So if you happen to have a heart attack in my parking lot, great, I can take care of you and call a helicopter. And you can go away. If you're on the other side of the road and you call 911, they will pick you up, and they will drive 45 minutes before you see a single physician because there's no other facility.

And we've talked to them about this, and apparently, they're not bound by EMTALA from what they've described to me. So they don't have to bring to the closest center.

Thank you.

DR. CROSSON: Thank you. Thank you very much.

MR. MORAN: Good morning. My name is Christopher Moran. I'm here on behalf MSP Recovery, which is a data company that analyzes claims and encounter data to analyze and identify recoveries and secure them.

Given the increasing role that encounter data plays in the assessment of risk adjustments, Medicare Advantage plans are being asked to provide more and more care and being provided less resources to do so.

This impacts physicians, providers, and beneficiaries by creating incentives for more limited forms of care and creating increased future uncertainty and an inability to prioritize quality where it's needed.

One area that MA plans could see to recoup losses that they face as encounter data is increasingly utilized is by achieving reimbursements for medical services that were provided where a primary payer is responsible.

Encounter data provides a basis for the identification of instances where a beneficiary was provided care that a primary payer was responsible.

The MSP Act -- and CMS has made it clear -- MA plans and Medicare are payers of last resort, secondary to any primary plans that might exist. This should make recovery for instances where primary payer is financially responsible a straightforward proposition. However, because of statutory ambiguities and judicial uncertainty and confusion, there is a significant economic barrier to the recoveries available by MA plans in instances where primary payers are ultimately responsible for the care.

I would ask that this Commission consider that when a primary payer skirts his responsibility to provide payment for services and ask an MA plan to pick up the bill, Medicare beneficiaries suffer, providers suffer, and the system as a whole suffers. Stronger statutory language needs to be implemented to make sure that those who would unjustly burden the MA plans are punished and are dissuaded from taking advantage in the future.

Thank you.

DR. CROSSON: Thank you.

Seeing no one else at the microphone, we are adjourned. We will reconvene at 12:45 today. Thanks very much.

[Whereupon, at 12:45 p.m., the meeting was recessed for lunch, to reconvene at 12:45 p.m. this same day.]

AFTERNOON SESSION

[12:46 p.m.]

DR. CROSSON: Okay. Let's see if we can get seated and get back to our task here.

We'll start off the afternoon session with Carol Carter, who's going to take us through a discussion about potential uniform outcome measures in the post-acute care setting. Carol.

* DR. CARTER: Okay. Good afternoon everybody.

For those of you who are new to this broad topic of post-acute care in the audience, I wanted to provide a little context for where the Commission has been over the last several years.

In response to a congressional mandate, in 2016 the Commission recommended features of a prospective payment system to span the four post-acute care settings. And since then, the Commission has continued to work on several implementation issues, including the level of payments and the need for a transition to the new payment system, an approach that would begin to increase the equity of payments prior to implementing a PAC PPS, paying for sequential PAC stays, and aligning setting-specific

regulatory requirements.

With a unified payment system, we need uniform outcome measures to compare provider performance across PAC settings. We've started to develop them, and I'll be presenting three today as a kind of proof of concept. Before I get started, I wanted to thank the researchers at Providigm and at the Urban Institute for their excellent work on the measures.

There are three reasons to develop uniform PAC outcome measures. We and others have noted the overlap in the beneficiaries treated in different settings, so we need uniform measures to compare the care furnished in the different settings. Uniform measures allow the program, providers, and beneficiaries to compare outcomes across settings. The program will be able to evaluate the quality and the value of its purchases while providers and beneficiaries will be able to directly compare outcomes for different types of PAC providers.

Second, when CMS implements a unified PAC payment system, it will be critical to monitor provider performance, including whether providers maintain quality of care and furnish appropriate use of post-acute care and

other services.

Last, uniform outcome measures could be used in a value-based purchasing policy for all PAC providers. By tying a portion of a provider's payments to its performance on quality and resource use, providers would have an incentive to achieve good outcomes while using resources efficiently.

Today I'll review our findings for three cross-setting measures: readmissions during the PAC stay, readmissions during the 30 days after discharge, and a measure of resource use. Then I'll discuss a couple of approaches to increase the accuracy of measures for low-volume providers and end with asking you for your thoughts on additional outcome measures staff should explore.

Working with researchers at Providigm, we developed risk-adjusted measures of readmissions from home health agencies, skilled nursing facilities, and inpatient rehabilitation facilities. The measures do not include hospital admissions for beneficiaries admitted directly from the community, and I'll come back to that at the end of the presentation. The measures also exclude readmissions from LTCHs for two reasons: First, some

readmissions from LTCHs to acute-care hospitals are not reported due to the interrupted stay policy, and the patient assessment information used in the risk adjustment was not collected by LTCHs when this analysis was conducted.

The rates of readmission during PAC stays gauge the quality of care furnished during the beneficiary's entire stay while rates of readmission during the 30 days after discharge detect premature discharges and gauge how well the provider managed the transition to the next setting or home. For each provider, observed rates were risk-adjusted using characteristics for each stay, including age, gender, comorbidities, functional status, and cognitive status. By law, CMS has developed measures that are similar to these, but they differ in two important ways: First, we use identical definitions of the during-stay measure for the three settings, and we use an identical risk adjustment model. Therefore, our rates are directly comparable.

This table shows the potentially avoidable and all-cause readmission rates for the during-stay and during the 30 days after discharge. We found that the risk-

adjusted rates of readmission during the stay varied considerably by setting, looking either at the potentially avoidable or the all-cause rates. On average, home health agencies had the highest during-stay rates and IRFs had the lowest rates.

The differences across settings reflect two factors:

First, stays vary considerably in length by setting, so the risk of readmission will vary simply as a function of how long the beneficiary was in the setting. For example, SNF stays are about twice as long as IRF stays.

Second, the settings differ in their infrastructure and that affects their readmission rates. For example, IRFs are licensed as hospitals and, with their staffing and physician presence, are more likely to detect and manage conditions that elsewhere could develop into a hospitalization. Home health agencies have less continuous monitoring of patients, and patient compliance with prescribed treatment may be more difficult. Until lengths of stay are more similar across settings, the differences in the during-stay measures could influence whether we

compare providers within a setting or compare providers across the three settings.

Turning to the rates of readmission during the 30 days after discharge, the rates were more similar across the three settings, indicating that once beneficiaries are not under the care of a provider, they are exposed to similar risk of readmission. SNFs had the highest rates and the IRF and LTCH rates were pretty similar.

Looking across all providers in the three settings, the readmission rates varied widely. Across the during-stay rates, there was almost a four-fold difference in the potentially avoidable rates comparing providers at the 90th percentile and the 10th percentiles. The all-cause rates varied less, but still almost three-fold.

The rates of readmission during the 30 days after discharge were a little more variable. Rates at the 90th percentile were almost six times those at the 10th percentile for the potentially avoidable measure and almost three-fold for the all-cause measure.

The Commission could use the uniform PAC readmission rates in two ways. In its annual assessment of the adequacy of payments, we could include these

readmission rates when considering the quality of care. Also, over the coming year we plan to develop ideas for a PAC VBP. The readmission measures could be included in a composite score for VBP, either under current setting-specific payment systems or under a PAC PPS.

Now we turn to a provider-level measure of resource use: Medicare spending per beneficiary. The MSPB-PAC is a provider-level measure that captures Medicare spending during the initial PAC stay and the next 30 days. Low MSPB is considered desirable. To keep its value low, a provider has an incentive to furnish high-quality care to avoid unnecessary hospital use, make referrals to the necessary level and amount of subsequent care, ensure safe transitions, and discharge beneficiaries to providers that have low readmission rates. Under a MSPB-PAC measure, each PAC stay triggers an episode. By including the spending during the next 30 days after discharge, the incentives of PAC providers are aligned for those beneficiaries who are discharged to a second PAC provider within 30 days.

And here's a chart that tries to illustrate that. In this example, we have a beneficiary whose post-acute care begins in an IRF stay and then is discharged to home

health care. Each stay triggers its own episode, and those are in green. By including the 30 days after discharge -- and those are in yellow -- the spending amount for Stay 1 includes the spending for Stay 2. The second PAC stay will trigger its own PAC episode. Because the spending periods for the two stays overlap, the providers have a common interest to keep spending low, such as avoiding hospital readmissions.

Before we focus on the results, let me explain how this measure is derived. Spending was summed for A and B spending and then standardized for differences in wages across the country and for add-on payments and then were risk-adjusted. Because total spending will vary considerably due to setting differences for the initial PAC stay, we compared a provider's average spending to its setting average. Otherwise, home health agencies would be more likely to have good performance given the initial stay's relatively low spending.

This table shows the MSPB-PAC values by setting. The average value for each setting centered on 1. Values below 1 indicate below-average spending, or better performance, and values greater than 1 are above average,

or worse performance. In the top row, you see that the values varied between 0.76 at the 10th percentile and 1.28 at the 90th percentile. There was more variation across SNFs than in the other settings, and the comparison between the 90th and the 10th percentile were about 1.8-fold. And by comparison, the IRF and LTCH variation was 1.3-fold.

To get behind these numbers a little bit, we looked at the spending for providers with better and worse performance relative to their setting average. Providers with low values -- those in the 25th percentile, with better performance -- had average spending that was 20 percent lower than spending for providers with high values. The spending for the initial PAC stays were not that different. They varied about 7 percent. The biggest difference was in "other PAC" in red, which was 34 percent lower for providers with low MSPB values. Spending for hospital and other were each about 29 percent lower, and "other" here includes dialysis, outpatient, ambulance, hospital, and Part B drugs. And I guess DME would be in there. Providers in the highest quartile -- that's the worst performance -- were disproportionately freestanding and for-profit while providers in the lowest quartile -- or

better performance -- were disproportionately nonprofit and hospital-based.

In any given market, there will be providers with a range of MSPB values, and we expect markets to vary in their mix of low and high MSPB values. After ranking providers in each setting nationally by their MSPB values, we examined the rankings of home health agencies and SNFs in two markets to illustrate the variation. On the left you see Phoenix, and 45 percent of SNFs had low MSPB values -- that is, they were in the bottom or "best" quartile of the national distribution of SNF values, and those are shown in green. And only one SNF was in the top -- or the worst -- quartile, and that's shown in red. And the next bar over you see the mix of home health agencies: over one-third of the 76 home health agencies were in the best quartile nationwide and only 5 agencies were in the worst quartile. By comparison, in Orlando, only one of the 66 SNFs was in the best quartile nationwide, and almost half were in the worst quartile nationwide. Similarly, 45 percent of home health agencies in Orlando were in the worst performance quartile nationwide. This example illustrates that opportunities for improvement will vary

considerably by market.

Before we use the measures to evaluate provider performance, we need to have confidence that the measures are accurate and can discriminate between providers, and here I'm using a couple of terms specifically. Accuracy refers to whether the value reported for a provider is a fair representation of its "true" performance. A different attribute of a measure is its reliability, and as CMS uses this term, it's referring to how well the measure can distinguish one provider from another. This term has various definitions, but we're using the term the way CMS uses it. Measures that are reliable are able to distinguish one provider's performance from another, and an unreliable measure cannot. Because reliability and accuracy capture different dimensions of measures, a measure that is accurate is not necessarily reliable and vice versa. Measures are more likely to be inaccurate and unreliable for small, low-volume providers, and both dimensions increase with more observations.

Setting minimum observation counts will always involve judgment about our willingness to tolerate errors. We want a minimum count that is high enough to have

accurate and reliable measures yet low enough to calculate measures for as many providers as possible. When a measure is not accurate, we risk concluding that a provider's performance was "good" or "poor" when it may not have been, actually. It's also more likely that performance, especially of small providers, will vary from year to year. The paper includes an analysis of each, using the MSPB measure as an example.

There will always be a tradeoff between having accurate, reliable measures and wanting to calculate performance measures for as many measures as possible. One way to help ensure that measures are reliable and accurate would be to first evaluate whether the measure displays enough variation across providers to be able to distinguish them. Once a measure has been evaluated as having enough variation for further development, CMS could calculate the minimum observation counts for a measure to be not only reliable but accurate. These minimums are likely to be different depending on the measure.

Since measures get more reliable and accurate with larger observation counts, CMS could consider pooling data for small providers. This could be done in a couple

of ways: Data over multiple years could be pooled, and the paper shows an example of how much smaller the standard errors are when you get a second year of data.

Alternatively, PAC providers could pool their observations. For example, providers in the same market, health system, or company could be combined and measured as a group.

Over the coming year, staff plan to explore other outcome measures. With a preference for claims-based measures, other outcome measures could include discharge to the community or a combined measure of preventable admissions and readmissions. The combined admission-readmission measure would be a more complete picture of hospital use because it would include hospitalizations for beneficiaries who are admitted from the community, which make up two-thirds of home health stays. We could also develop a risk-adjusted count of the number of days between when a beneficiary leaves her home and returns after a hospitalization and/or a PAC use. To gauge patient experience, staff could explore an instrument to be used by all PAC providers.

We'd like to hear your thoughts about strategies

to increase the accuracy of measures, either by pooling data across years or across providers. And we'd like to get your reactions to possible other measures to explore.

And with that, I look forward to your discussion.

DR. CROSSON: Thank you, Carol. Very clear, as usual.

We're open for questions. Questions for Carol? David, Brian.

DR. GRABOWSKI: In terms of patient satisfaction, we're going to talk later about the CAHPS data, and there is a nursing home CAHPS. Has there ever been any thought about trying to extend that to the post-acute care setting? I'm just not aware of that, and how well does nursing home CAHPS capture post-acute versus long stay?

DR. CARTER: CMS has developed that measure, but they haven't -- there are a couple of different versions of that, so one I think is focused on short stay and one's on long stay. That would be one idea we would like to look at. I think the home health also has a patient experience survey, and so we could start to see what are the common elements across those.

So I think -- there's certainly nothing right off

the shelf to use, but it is an area for exploration.

DR. CROSSON: Brian, Sue.

DR. DeBUSK: Thank you for a great report. I really enjoyed the way the measures are being calculated. I think you're definitely on the right track.

I had a question, though, on page 33 of the mailing materials. You talk a little bit about the risk adjustment that's done for the readmissions, and you talk about the comorbidity index. First of all, I'd be curious to see how portable and durable that -- is that something that we see repeatedly, this particular comorbidity index used in other risk adjustments, or is this something developed specific to the readmission adjustment that we're doing here?

And then also on the following page, 34, it looks like the MSPB PAC is risk-adjusted similarly, but at least materially differently. Could you speak to the opportunity to maybe standardize the risk adjustment throughout the PAC PPS? Is that even possible? Am I being naive?

DR. CARTER: No, I don't think that's a naive question. I think it's reasonable. The comorbidity index that is in the readmission measure is something that was

developed for this project, but it's not unique. I mean, you see comorbidity indexes in other measures, and I could send you an article or two that has a different measure.

The MSPB, we were trying to build off of what CMS does, and so this is their version. We just wanted to standardize it across the settings, and with a couple of tweaks. But it isn't -- like in terms of the clinical comorbidities, it's not an extensive, although we did test this using DRGs, and it wasn't significantly different, so we sort of pared it back to what we started with, which was sort of more or less what CMS had done. But it's a reasonable ask, I would say.

DR. DeBUSK: So it is feasible to develop a standardized risk adjustment?

DR. CARTER: Well, they're certainly the same factors, right, and captured maybe in the same ways.

DR. DeBUSK: Yeah. Different coefficients --

DR. CARTER: Right, but --

DR. DeBUSK: -- but at least the same --

DR. CARTER: Well, I mean, I could imagine by measure. So, for example, I think in the 30-day measure, we have the post 30. We have one more variable in there

than on the -- so you would think that there would always be some differences in what you're trying to capture.

So what I meant was I think it might be -- you could probably have more standard ways of capturing comorbidities. If you thought comorbidities was important, let's use the same technique for doing that, but the things you might include in the model, I would think would vary.

DR. DeBUSK: I've read in previous materials that you refer to the measurement of disease burden, and I was just wondering if the comorbidity index and the disease burden, are those two --

DR. CARTER: Yes. Yeah. I mean, what we're looking for is sort of what did you bring before you even got admitted. What's the picture of the patient before the incident started?

DR. DeBUSK: Are those the same calculations? When I read "disease burden" in other mailing materials, can I assume that's the comorbidity?

DR. CARTER: Well, that's not a term I use.

[Laughter.]

DR. CARTER: But I would think so, yes, because I think it is sort of what a patient is bringing to their

health care encounter.

DR. DeBUSK: Thank you.

DR. CROSSON: David.

DR. NERENZ: Just on that point, I think it's sort of yes and no on that because some of the comorbidity or simply constant comorbidities, and that's something you can do from claims data. But also, there are different ones that add a severity factor, and so you get additional points for having a severe level of a comorbidity.

And the second one is probably a little more faithful to the concept of disease burden than the first, although you might use the term, so it's just tricky business when you get into it.

DR. CROSSON: Okay. I'm sorry I've lost track now. Dana, Warner. I see somebody else. No? Oh, Sue. Sorry, sorry. Sue. I'm sorry. Dana, Sue, Warner.

DR. SAFRAN: My question was if you could put back Slide 6, and you touched on this quickly, fleetingly. I just wanted to bring you back to it and understand.

So it's so striking that after discharge, the rates are so similar across these settings, and that before discharge that the IRFs are looking so much stronger.

And you said something about access to physicians and the difference that makes, but can you just elaborate on what your hypotheses are about what's happening after discharge that's so different, or what are they doing so well while somebody is in the IRF that others maybe could learn from?

DR. CARTER: Okay. Well, first of all, IRFs are licensed as hospitals, and so they have physician presence and staffing that is consistent with being licensed as a hospital. And so just that factor is going to make them different. They're already hospitals, so you would expect their readmission rates to be low.

Second, beneficiaries spend about half the amount of time in an IRF than in a SNF. Even though readmissions are a little bit front-loaded to the early part of the stay, you do see readmissions that occur later in stay. So the fact that patients are in IRFs just a shorter period of time would also contribute to their lower rates.

I mean, for home health, given that you don't -- home health care is part-time and intermittent care. Somebody is not there every day, and they're not there all day long. And so just the patient monitoring and ensuring

patient compliance with treatment is just very different, and so you would think just the infrastructure and kind of what's happening in each of those settings would be different. It would result in different during stay rates.

Now, the after, the post 30-day, I think they're so similar because basically once you're not under anybody's care and you don't have eyes and ears on the patient, you've kind of got the same ambient risk, and that's I think what you're seeing here.

DR. SAFRAN: Okay. I mean, to me, what you just described about the IRF would make me think that the post-discharge readmission might be higher for that population because they're having a shorter stay, and so that's your -- you're sort of using an exposure hypothesis to explain why they have fewer readmissions or just less time while they're there. But that might suggest that once they're discharged, they would be more likely to wind up with a readmission.

So I think this is actually probably pretty rich information for us to learn from and see if there are some best practices in some of these settings that might actually help make the top lines look better.

DR. CROSSON: Sue.

MS. THOMPSON: And as a segue, I would agree. I think there is something really rich.

In the ACO experience, what we've observed is where we have a real opportunity to reduce total cost of care is in reducing utilization of post-acute care, and there seems -- I hear as we're -- as we're looking to really take a hard look at readmissions, an opportunity to take a look at hospitals that are appropriately using the home care sooner, in place of post-acute facility care. And I think there's a piece here that we need to really grapple with that has to do with reducing the overall total cost of care because we're monitoring readmissions. We're monitoring the quality. So I do think there's something inherent in that piece.

So your comment, please.

DR. CARTER: What you're talking about is, I think, consistent with the 30 results of the BPCI, where they're seeing comparable -- the fact that bene is using PAC hasn't changed that much, but what they're using is different and how much they're using. They're moving more patients into home health care when they can, and the SNF

days are shorter.

MS. THOMPSON: So what you're thinking, if any, about, including a measure here to capture that because I think this is a piece we'd like to stay ahead of. Do you have a thought about that?

DR. CARTER: So what would be the measure?

MS. THOMPSON: I don't know. That's what I'm asking you.

[Laughter.]

DR. CARTER: Oh. Well, I could imagine for a market or a population-based measure, you might look at incidence of PAC use for a market, right? But for a provider, they only know what hit their door. But I could imagine for having a population at risk or for a marketplace, that would be a good measure.

MS. THOMPSON: One more question. Are you thinking about the readmission measures as a composite or as separate measures?

DR. CARTER: I would be interested in your conversation. I do think they capture different dimensions of the care. One is sort of within your purview, and the other is how well you're doing in transferring a patient

onward. And so I do see them as different, so I could imagine them both being in a measure. But I'd be interested in your thoughts.

DR. CROSSON: Okay. Warner.

MR. THOMAS: Just a quick question, and I may have missed this. But just refresh my memory on -- so I've seen in the acute care area, we have penalties around readmission that Medicare applies. How is that applied or not applied in a post-acute world?

DR. CARTER: So right now, it's not. In the SNF space, starting in October of this year, there's going to be a VBP that includes one measure, and it's readmissions.

The home health has a demonstration VBP, and it's in, I think, nine states, and it includes 24 measures or something like that. And there isn't anything in the other two settings.

MR. THOMAS: And I know this is focused on quality, but once again, we're looking at quality as -- readmission as a function of quality. So is the thinking that these would just be bundled measures, or is this leading to potential payment implications either as part of this recommendation or down the road?

DR. CARTER: I'm thinking that it will be part of a value-based purchasing with a withhold and then payouts based on their performance.

MR. THOMAS: All right. Thank you.

DR. CROSSON: Okay. Seeing no further questions, we'll proceed with the discussion. Could you put up the last slide?

I'd just make the point that the last slide included some discussion points, but actually, I think the whole presentation needs commentary, including the measures that Carol has proposed in more detail.

David, start off.

DR. GRABOWSKI: Great. Thanks.

Carol, thank you for a great chapter, as always.

If we're going to move towards uniform site-neutral payment, then we're going to need site-neutral uniform quality outcomes, and so this is a really important chapter.

I'll start with the readmission measures. I'm supportive of both of those measures. I have been studying post-acute care a long time. I had never seen data like that, to be honest, where it was risk adjusted and uniform

across the setting, so that was really interesting. And I think some of the points Dana was pushing you on are really important here. Why are we seeing such big differences, and then why does it look relatively uniform at time of discharge? I think we want to unpack that, and I think that will be a nice part of our ongoing agenda. But I think we're on the right path with the readmission measures.

The second measure or set of measures you presented was really around Medicare spending per beneficiary, and I always have trouble with this as a performance measure, given it's a resource-based measure. I know it's used elsewhere in the Medicare program and in different payment systems.

What I struggle with in this context is really how to interpret it in that if we're anchoring on a fixed payment for post-acute care across settings, we're kind of leveling the post-acute care. And you showed on Slide 12, some of the variation and what's kind of driving sort of differences across high- and low-payment settings.

And a lot of that difference, once you controlled for the anchors or the initial index, post-acute stay and

then the subsequent stays, if that's all controlled for in the payment system and leveled, then it's really readmissions that's driving the variations. Well, we already have a --

DR. CARTER: Right. Another PAC.

DR. GRABOWSKI: Another. And is other PAC paid for in an episode, or is it paid for kind of -- is that all paid together in the system, or do we pay the sequential stays differently? And that's kind of an --

DR. CARTER: Yeah.

DR. GRABOWSKI: -- open question. But if we pay them all together, then that other PAC is no longer on the table and part of the variation. Its' really the readmissions.

And so I guess I'm pushing a little bit on -- does Medicare spending per beneficiary add new information here and alongside the readmission measure? And so that will be something I think we'll want to --

DR. CARTER: For double counting?

DR. GRABOWSKI: Yes. Is this a unique measure? If we're anchoring on all the post-acute care in the payment and then also having a readmission measure

separately, do we need this? Do we need a belt with the suspenders? So that's something I think we'll want to consider.

In terms of these other potential measures that you were considering, I feel strongly that we should have a patient satisfaction measure there. I do think the CAHPS could give us a good start here. I know it has some problems, but I do like that it's being collected, and maybe there's ways to modify it and make it uniform such that we could use that information.

We've talked a lot at recent meetings around community discharge-based measures. I think that would be really important here. Sometimes I struggle with is that just the inverse of the readmission measure and is it also giving us new information, but I think there might be something there.

And the final point I'll make is that we've invested a lot in making the assessment instruments, the OASIS, the MDS, the FIM in inpatient rehab, uniform in terms of how they measure functioning. That was a huge effort to just get those kind of similar, and that's still ongoing.

Do we want to use that information here in terms of what is functioning at admission into post-acute care, what is it at discharge? How does that look across settings?

Problem one is getting consistency in the measures, of course. Problem two is that it's self-reported, and do we want to trust that here? That's an open question, but I do think given the investment we've made and given it's used in a lot other ways for payment, at least currently, do we want to think about leveraging it here in terms of quality outcome.

I'll stop on that point. Once again, this is great work, and I'm excited to see it move forward. Thanks.

DR. CROSSON: Thank you, David.

Other comments? Alice, Jack, Dana, David.

DR. COOMBS: Yeah. Carol, thank you so much for this chapter. I think it's a long time coming, and it looks like we're getting to a better place.

One of the issues regarding -- the question that Dana asked on that Slide 6 actually has to do with the 30-day-after-discharge issues. I think that in IRFs, it's

kind of different. It's not apples to apples. It really is different in that the IRF requires that you have a patient, regulatory requirements, of three hours of rehab. And so for that in and of itself, it's going to say you can pool the patients, but they're not exactly the same. And so the fact that it's a shorter period is one piece of it, but the other piece of it is that it's not the same type of patients on the bus. So that these patients have to be able to undergo three hours of rehab a day, and that in and of itself precludes. So you kind of self-select for a different type of patient in that situation.

And then it leads me to the next point, which is on that slide, pooling data across providers. So we have to be sensitive to that if we're going to pool data with this group of IRF patients looking slightly different than the others.

Now, we have tried our best to kind of put all the patients on the same scale for resource utilization, but I think, still, we have to tease out this other group of more well patients at the IRFs, and that's not exactly the same as what we intended.

They're not Chinese patients that are more

predominant at the other place, but it's just that this place may have very different type of patients going into the IRFs. So I think that may be a challenge for us for pooling data cross providers, whereas pooling data across the years are great.

And I like what you did with using the averages for home health and saying let's go from the average and standardizing on a scale because I think that's very fair in terms of comparing the four. If I was in the industry, I would think that that would be something that would be a great equalizer.

DR. CROSSON: Okay. Jack.

DR. HOADLEY: So I have two things I wanted to talk about, both of which are not sort of fully formed into my mind, so I hope I can be clear about it.

One is trying to think about -- and it sort of triggers off some of these earlier questions about whether we should be thinking about a time period relative to the hospital discharge as opposed to the discharge from the PAC provider, so part of this issue in sort of the shorter, more intense day in the IRF. So if you're in fact discharging them at a sicker level in some sense or a less

restored level and then they go home, maybe do home health, whatever, have a second stay, versus somebody who is having a more extended course of treatment just in home health, would it help to measure 90 days post hospital to get a different kind of uniformity? I'm wondering if that's something worth trying and whether it would help to get some things.

The other thought I had, which is how this looks across different diagnosis categories. Again, I'm not a clinician, so I start to struggle when I try to think about this all the way through, but clearly, there's a different kind of pathway for an orthopedic case, a neurological case, an infection case. First of all, obviously you could test these measures in subcategories of diseases, so that's a straightforward thing to do to test and see if there are differences, but if there are, then should we be looking at these within at least some kind of global category of the initial problem that started this whole path of care? Do we expect that somebody -- if it's an ortho case, is that less likely to lead to the kinds of things that could trigger readmissions or could trigger higher level of spending per stay compared to a neurological case or an

infection case or whatever else? And if so, at some level, if you're comparing providers that all have a mix of those patients and you do risk adjustment and you do some of that, how much of that is already covered by the risk adjustment, but should we be just looking at whether there are different patterns in some of those kind of global categories?

It seemed like those are two different dimensions where some experimenting with some different variations on these measures could have some value, either to help reinforce why the original one works well, where its flaws are, or that they might provide some improvement.

So I hope that's clear. That's what I've been thinking about.

DR. CROSSON: Thank you, Jack.

Dana.

DR. SAFRAN: Yeah. So I'll add my thanks for great work here.

I would make a couple of comments. On this matter of whether to pool across years or pool across providers, one of the challenges of pooling across years is that it holds providers back in terms of showing

performance improvement. So while I like it better than pooling across providers for something like this, where I think we're on a path to try to create provider accountability, so how you do that if you're pooling across providers, I'm not sure.

But I wondered, as I was sitting here, whether you could do something that we've never actually done in our work because we've avoided pooling across years, but maybe you could do it. Maybe you could do it and weight the years differently, so that you -- you know, 75 percent weight is on the current measure and if -- current year, and if that doesn't blow your standard errors up, then you could still preserve your good reliability that you're getting out of that. So that's just an idea there.

But if you couldn't do something like that, then I'd be -- it's a hard call whether to just not measure versus measure in a way that really prevents people from being able to demonstrate their improvement, so is it so demotivating that you're measuring, but they're not really working on it. So that would be my thoughts there.

And then on the possible measures to develop, I agree with David that doing a CAHPS-like measure is a

really high priority here. You'll have to grapple with the question of whether proxies would be okay or not okay, and so we'll leave that for another day to discuss.

Separating patient experience from patient-reported outcomes, meaning health status, I think that's the measure I see missing from here that I think is most important.

So if we could get measures of functional status, basically on the start of the admission and at discharge, and really start to understand how these different organizations are able to improve the functional status of the patients they're taking care of and which kinds of patients benefit most in terms of improvement in functioning or reductions in pain or improvements of cognitive well-being, any of those elements that can get captured by good PROMs measures, I think that would just be enormously valuable.

And then the last comment I'd make is that some of the other measures get tricky if they aren't paired with something like the measure I was just talking about. So discharge to the community, you could imagine the unintended consequences of rushing to get people discharged

to the community and then unless you've paired that with a readmission measure, you're kind of looking good on that measure but doing poorly by the patient, et cetera. So there's something around successful discharge to the community, whatever success means, that I think might be interesting to explore.

Those are my thoughts.

DR. CROSSON: Thank you, Dana. David.

DR. NERENZ: Thanks. I was basically going to make the same points Dana just did, quite eloquently, so I'll just second those. But just a couple of additional elements of spin on it. I do have concerns about both the pooling approaches, and I've made similar comments on other topics in the past.

You know, when you pull data across years you get additional confidence about the way things have been but you don't have additional confidence about how things are now, if there's improvement going on. And the same thing with providers. With pooling you have additional confidence about what a group is doing but it doesn't give you any more confidence about any one.

The only thing I'd add, then, is I like the idea

of potentially weighting the more recent. I wonder, also, I'm not an expert on this, but I wonder if in the world of Bayesian methods there might be some possibilities, where, for example, you might bring a prior probability into the measure of any one entity in any one year, say, perhaps given where this entity has been, you know, the prior probability is this, and then you sort of adjust that based on the current observation. And, you know, maybe that's just a fancy way of pooling and you're right back where you started from.

But I think there may be some kind of exotic ways of getting at this, just because I don't -- I'm not confident that pooling gets us where we want to go. I think we basically want to know how is a given entity doing now.

DR. CROSSON: Thank you. David and, seeing no -- Warner.

MR. THOMAS: Yeah. My comment would be on the readmission. I would not tie the acute and post-acute readmission together. I mean, I think part of that is that -- I think depending upon what the post-acute readmission rates are, they're going to either be referred to or not,

based upon their performance, is my guess, going forward. And I think it is -- you know, unless you want to just create more integration, which that may force more integration if you go to that measure, but -- and you tie them together. So that would just be, you know, part of my thinking on that.

I do think the concept of, if we're going to go down this road, I think, you know, tying it to reimbursement sooner than later would be important, because that's obviously where you're going to see the biggest change. And, yeah, I think to have this portion of the delivery system not having this type of information tied to reimbursement just doesn't make a lot of sense. So I would just encourage us to push that faster.

DR. CROSSON: Thanks. I'd just make one comment myself, having to do with the pooling across providers. I mean, as David pointed out we have talked about that in another setting, in terms of pooling within the physician provider community. I think this is a little bit of a different idea. I mean, I think both in terms of the physician part of that idea, there is both a reality, in a sense that, you know, for many patients with chronic

illnesses, including a lot of Medicare patients, a lot of different physicians take care of those individuals. Plus I think, you know, over the years we have promoted the notion of coordination of care among providers, right, among physician providers, particularly -- not solely but particularly.

But I think here, in this setting -- and I might feel differently if you're talking about entities that are owned by one organization. But I think -- at least I don't think of post-acute care as something that is coordinated -- you know, except for transfers -- is coordinated among different entities within a community. Now I could be wrong about that. But I think that it feels a little bit of a lot like a different idea to me.

Okay. Seeing no further discussion, thank you, Carol. I think you've gotten a lot of good input. And we will proceed with the next presentation.

[Pause.]

DR. CROSSON: Okay. Let's move on with the next presentation. We're going to be taking a look again at the question of how we measure quality in a hospital setting, and Ledia and Jeff are going to take us through some, I

think, interesting in many ways, novel ideas.

* MS. TABOR: Good afternoon. During last month's meeting we reviewed the Commission's principles for measuring quality in the Medicare program and applying those principles to the development of population-based outcome measures. We are now going to continue discussions that apply those principles to hospital quality incentives. All three topics are included in your mailing materials but today we will focus on hospital quality incentives.

In October, we began discussions about MedPAC's design of a new Hospital Value Incentive Program, or HVIP. The HVIP is simpler than the current programs, focuses on outcomes and promotes the coordination of care, and overall aligns with the Commission's principles for quality measurement.

Last October we reviewed the concerns raised by past Commissioners and stakeholders about the current hospital quality payment programs. I'll briefly review those today. I'll then review the design of the new HVIP which incorporates feedback from the October discussion. Then I'll present analysis using current hospital quality data to model the HVIP design for the Commission's

discussion today.

In the past, the Commission has expressed four main concerns about the design of the current hospital quality programs. First, there are too many, overlapping hospital quality payment and reporting programs, which creates unneeded complexity in the Medicare program and for hospitals.

Second, all-condition mortality and readmission measures are more appropriate to measure the overall performance of hospitals, rather than the condition-specific measures that are currently used in the programs. I'll discuss this more in a moment.

Third, some of the programs include process measures and provider-reported measures that may be inconsistently reported, such as hospital-acquired infections.

Fourth, the programs score hospitals using "tournament models," meaning hospitals are scored relative to one another and not on clear, absolute, and prospectively set performance targets.

For simplicity, hospitals should have their payment adjusted based on one HVIP program as opposed to

separate programs. As illustrated on the left-hand side of the slide, an option is to combine the current HRRP and VBP into one program, and to eliminate the IQRP which is an obsolete pay-for-reporting program.

We also suggest eliminating the hospital-acquired condition reduction program which ties payment to infection rates, because of concerns about the accuracy of hospital-reported data. However, as discussed by the Commission in October, it will be important that hospitals continue to be required to report infection rates to the CDC, and for the Secretary to continue to monitor opportunities for improvement and publicly reporting patient safety results.

Looking at the right-hand side of the slide, we would incorporate four existing, all condition quality measures into the HVIP: readmissions, mortality, spending, and overall patient experience. Providers may choose to use other granular measures, such as other patient experience components, to manage their own quality improvement.

Per the Commission's principles, the HVIP would translate quality measure performance to payment using clear performance standards that account for differences in

provider populations through peer grouping. In peer grouping, each provider is only being compared to its "peers," defined as providers that have a similar patient population.

Like the current VBP, the HVIP would redistribute a budgeted amount to hospitals based on their performance. We assume that Medicare would continue to publicly report results of the HVIP on a website like Hospital Compare.

The movement to all-condition measures will improve accuracy of quality measurement and balance incentives across the four measures. With respect to accuracy, CMS currently uses condition-specific readmission and mortality measures with as few as 25 cases involved.

To limit the influence of random variation on hospital scores, CMS shrinks each providers performance toward the mean. The net result is that small providers, especially those that are not close to the current cutoffs, have a limited incentive to improve because the score CMS gives them will be close to national mean due to the shrinking factor.

In contrast, with the all-condition models, 92 percent of hospitals will have over 1,000 observations over

three years. Random variation is less of a problem with 1,000 observations than with 25 condition-specific observations. Also, with 1,000 observations, shrinking toward the mean is not necessary and incentives for small providers to improve quality are increased.

We will also have greater balance across incentive measures. With respect to readmissions, the current system only affects six conditions, but has large penalties per excess readmission. In contrast, the HVIP would have an incentive to reduce readmissions across all conditions, but would have a smaller penalty per excess readmission.

Similarly, the HVIP mortality incentive would apply to all conditions rather than a limited set of conditions. In addition, the relative weight placed on readmission and mortality rates could be set to equal. In contrast, the current system weights readmissions more heavily than mortality.

I'll now review the scoring methodology we used to model the HVIP, starting with how measure performance is converted to HVIP points.

We treat each of the four measures as an equally

weighted, separate domain worth 10 points for a total of 40 possible HVIP points.

In early discussions about the HVIP, the Commission commented that hospitals should be able to earn a continuous scale of points for each of the measures, so that most hospitals have the opportunity to earn points for their performance on each of the measures and that scale should be set so that even top performing hospitals have room to improve. This offers a greater balance between poor and top performer incentives to improve than the current hospital programs.

Therefore, for each measure we created a continuous performance to points scale based on the 2nd percentile of performance, worth no points, to the 98th percentile of performance, worth 10 points. Per the Commission's principles, hospitals will know in advance what performance targets they need to reach to achieve a certain amount of points for each measure.

In our modeling exercise, we assigned each hospital a total number of points based on their performance against our continuous performance-to-points scale. An illustrative example of the continuous

performance-to-points scale, developed using current hospital quality data, is shown on this slide.

So moving across the table, if a hospital has a readmissions rate of 16 percent, they earn 4 points; risk-adjusted mortality rate of 7 percent, they earn 8 points; Medicare spending per beneficiary value of 0.95 which, is less than the average earns 6 points; and 73 percent of a sample of the hospital's patients rated the hospital a 9 or 10 earns them 6 points. So this hospital receives a total of 24 out of 40 possible HVIP points.

The Commission believes that the Medicare program should use peer grouping to take into account differences in a provider's population social risk factors. Based on these principles, we modeled the HVIP where quality-based payments are distributed to hospitals within 10 peer groups. Each peer group has about the same number of hospitals and those hospitals have about the same share of Medicare beneficiaries that are fully dual-eligible.

Since the HVIP is designed to be budget neutral, each peer group will have an HVIP bonus pool based on a 2 percent total base payment withhold from each of the hospitals in the peer group. This pool will be

redistributed to hospitals within the peer group based on their HVIP points.

We used a 2 percent withhold which is the same as current VBP program, but policymakers could raise or lower that withhold amount.

I'll walk through an example of converting HVIP points to payment adjustments within a peer grouping.

Let's assume there are two hospitals in a peer group that were assigned because of a similar share of fully dual-eligible beneficiaries. First, we convert each hospital's quality measure performance to total HVIP points based on the continuous performance-to-points scale described on a previous slide. As seen at the top of the table, Hospital 1 has higher total HVIP performance with 40 points, compared to Hospital 2's 30 points.

We withhold 2 percent of each of the hospital's total base IPPS payments. Since Hospital 1 has less discharges, their 2 percent withhold is less than Hospital 2's withhold. As shown in the middle of the table, the total HVIP bonus pool to be redistributed for the peer group is a sum of the two hospitals' withholds, or $1.3 million.

We then created a prospective exchange function for the peer group which converts total HVIP points to dollars and results in spending the entire $1.3 million budget. So for every HVIP point that a hospital in the peer group earns they can receive a 0.065 percent payment adjustment.

Based on the hospital's HVIP performance and the peer group's exchange function, Hospital 1 will earn a payment adjustment of 2.6 percent which is equal to $130,000, or are a reward of $30,000 greater than the hospital's withhold. Because Hospital 2 had lower HVIP points, it will have a $30,000 penalty compared to its withhold.

The Commission has a principle that it is important to take into account social risk factors, but that adjusting measure results may mask differences in quality. We have described an approach to account for social risk factors by using peer grouping to determine payment adjustments for providers. This is the first time we have modeled this approach in a provider quality payment program.

As seen in this table, the peer groups generally

have the same range of payment adjustments. For Peer Group 1 hospitals, which have the lowest share of fully dual-eligible beneficiaries, the payment adjustments range from a negative 1.1 percent to a positive 1.1 percent. For Peer Group 10, which have the highest share of fully-dual eligible beneficiaries, the payment adjustment range is slightly larger, with the lowest penalty being 1.3 and highest reward being 1.6. By design, no one can lose more than their 2 percent withhold.

Most of hospitals that receive rewards under the current programs would continue to receive rewards and the same goes with penalties.

To understand differences between hospital performance in the current programs and their potential HVIP, we assigned hospitals to quartiles based on their performance in the current programs and then for their performance on the HVIP. About three-quarters of hospitals were in the same or within one quartile of performance.

Since one goal of the HVIP is to adjust payment in a way that accounts for differences in social risk factors, we closely examined how hospitals serving a large share of poor patients performed under the HVIP. This

figure compares the current quality payment program adjustments to modeled HVIP payment adjustments by peer group.

All the HVIP adjustments, the orange bars, are zero relative to the average, since the adjustments are budget-neutral within each peer group. Hospitals in Peer Group 1, with the lowest share of fully dual-eligible beneficiaries, on the left, receive a 0.39 percent positive adjustment under the current programs, the green bars, while Peer Group 10 hospitals, on the right, with the highest share of fully dual-eligible beneficiaries, receive a negative 0.41 percent adjustment, under the current programs.

So compared to the current quality payment programs, the HVIP approach makes payment adjustments among hospitals that serve different populations more equitable. We find a similar result when comparing payment adjustments for groups of disproportionate share hospitals.

In summary, the HVIP is simpler than the current four overlapping hospital quality programs, and promotes the coordination of care by using measures that capture care during and outside of the hospital stay.

In line with the Commission's principles, the HVIP we modeled uses a small set of outcome, patient experience, and value measures. The HVIP also sets clear and absolute performance targets for hospitals using a continuous performance-to-points scale. The HVIP converts those points to payment adjustments relative to groups of hospitals that serve similar shares of fully-dual eligible populations, or peer groups.

The HVIP appears to reduce the differences in payment adjustments between groups of providers serving populations with different social risk factors.

This brings us to your discussion. After answering any clarifying questions, we would like your feedback on refining the design of the HVIP, other analysis you would like to see, and whether the Commission should continue to work on the HVIP over the next cycle, with the goal of making recommendations.

Thank you, and we look forward to the discussion.

DR. CROSSON: Thank you, Ledia and Jeff. You know, this is really good work, I mean, seriously, and it gives us not only some interesting thoughts but some meat to kind of dig into here. So thank you so much for this.

Dana.

DR. SAFRAN: I do have a question. Yeah.

DR. CROSSON: Oh, I'm sorry.

DR. SAFRAN: Yeah. Yeah. Are we doing the questions now?

DR. CROSSON: I lost track.

DR. SAFRAN: It is really great work.

[Laughter.]

DR. SAFRAN: It is really great work. I have one or two questions. So my main question has to do with the methodology that you used around the social risk factors. So as you outlined in the chapter and in the summary that you just walked us through, the rationale behind not just simply doing adjustment for social risk factors is we don't want to hold providers to a different standard of care, based on the population they serve. I couldn't quite tell from my reading of the methodology that you used whether we might actually still be doing that.

So here's my question. You've got the 10 strata, based on social risk factors. Within each strata -- is everybody being compared within that strata? I mean, it sounded like there's a 2 percent withhold for each strata

and then based on performance within that strata you're either winning or you're not.

If that's the way it works then I'm afraid we should go back and rethink how we do this, because we have, then, created different standards, because what it takes for me to be successful in stratum number 1 is different from what it takes for me to be successful in stratum number 10. And I think our idea was we want the same bar. We don't want to say, you know, we're okay with a higher mortality rate because you have high social risk factors. What we wanted to do was to say we understand hospital, that it might take a different level of effort to achieve low mortality rates, low readmission rates, high patient experience in the population you serve, and, therefore, for achieving a given level of performance you're going to get a greater reward.

So the fact that we've sort of equalized the rewards across this didn't seem like such great news to me. It seemed like we hadn't actually done what I thought we were setting out to do. But I could be misunderstanding so I wanted to reality-check that with you.

DR. CROSSON: Okay. Thank you. Oh, sorry.

MS. TABOR: I guess one thing I will say is that we did use the same performance-to-point scale for all hospitals, so they did all have the same standard of, you know, you're going to get 2 points if your mortality rate is X. But then the rewards themselves were kind of doled out within the peer groups.

DR. SAFRAN: So let me just make sure I understand that. So was there like an absolute -- because one of the things I love in here -- but I know this is questions, not comments -- is about the absolute performance targets, right, that are in the principles. So are you saying that for readmissions, let's say, that let's say a good number is 5 percent, that you're looking within all 10 of the strata at how well the hospital is able to achieve that bar of 5 percent readmissions or better, and then rewarding them for that, and where that bar is set is the same, regardless of what strata you're in?

MS. TABOR: Yeah. So this continuous performance-to-points scale that is on Slide 7, we applied to all the hospitals in the modeling exercise, so all 3,000-and-change hospitals were given points based on this scale.

DR. STENSLAND: Another way to think of it is everybody gets scored the same and everybody's public reporting score will be the same, but if you serve a lot of poor people we're saying, well, it might be harder for you to reach those higher scores. So we're giving you a little bit more money for every point you achieve.

DR. SAFRAN: That was what -- okay, perfect. That's what I know we set out to do, but I was -- I couldn't get from the reading whether that was what we actually did, so that's great. I'm excited. Thank you.

DR. CROSSON: Okay. Now I'll do my own reality check. We are doing clarifying questions. Brian.

DR. DeBUSK: First of all, I really, really liked the chapter.

If you guys could just run me through, one quick time, because I'm almost certain I have the order of operations, but one time for the record, we measure, then we risk adjust, then we scale it to a prospective target range, then we peer-group it, and then we calculate the payment adjustment.

MS. TABOR: Yes.

DR. DeBUSK: Measure, risk, scale, peer group,

adjust.

DR. STENSLAND: Yeah, I don't know how -- if we've got the same terms, but we're scoring, then we're peer-grouping, then we're adjusting the payment.

DR. DeBUSK: Okay. But you take the measurement, then you risk-adjust it, I would assume --

DR. STENSLAND: Yeah.

DR. DeBUSK: -- traditional risk adjustment, then you score to the absolute scale, then you peer-group, and then you make -- perfect.

And then I had one other question that sort of built on what Dana said. I was under the impression that the individual deciles for peer-grouping were like compartments, like the 2 percent stayed within that compartment. Have you contemplated the idea -- you know, if I'm serving a very low portion of Medicare, or of dual-eligible, fully dual-eligible beneficiaries, if I'm serving a low portion and I do a really poor job, would you consider me taking an ever greater penalty and maybe using some of that excess, letting that spill over into one of the lower compartments, say someone who is serving -- who is doing a good job serving a higher at-risk population? I

mean, what was your logic around keeping that 2 percent within the compartments?

MS. TABOR: We did have some internal discussion about that, and we liked the idea that the number of -- the size of the hospitals in the peer group would inform the -- how the budget is used or how much of a budget there is. So we wanted -- you know, if you're a small hospital, you're going to contribute a small amount to the pool and get, you know, a reward or penalty based on that small input into the budget.

DR. DeBUSK: What I was asking is if you treated the 2 percent collectively -- and, again, I was just curious about your logic. If you treated the 2 percent collectively across all the hospitals, but then the way you distributed it within the peer groups wasn't necessarily proportional -- I mean, a ridiculous example. In the most well-to-do hospital class, peer group class, maybe you distribute nothing but penalties; whereas, in the most difficult class, you would distribute only -- and I know it's a ridiculous example, but you'd only give bonuses.

DR. STENSLAND: We had thought about that, but we kind of liked to separate our shifting of money between the

hospitals serving the poor and not serving the poor, because that's really what comes out of the DSH payments. So there's a separate -- if you have a lot of disproportionate share payments, you get these DSH payments. So that's the mechanism we'll use for that, and then this will be a separate mechanism.

DR. DeBUSK: Great point. I concede to the superior logic.

[Laughter.]

DR. CROSSON: David.

DR. NERENZ: I just want to follow on Dana's question, because I thought we were going to end up saying, well, yes, in fact, there are different standards. And you said no, and okay. But let me just try a test case. If you're a hospital in the decile that has the fewest duals, and let's say you score 28 points, and let's say also in this hypothetical you're in the worst -- or the highest, and you also score 28 points, would it work out that in the first case you would lose money, in the second case you'd get money? Is that a way that this would play out?

MS. TABOR: [off microphone].

DR. NERENZ: Okay. Then we can still quibble

about this different standard thing, but okay.

DR. CROSSON: Questions, coming up this way? Bruce.

MR. PYENSON: A question on Slide 4 and the right-hand portion of that has the four measures that you were proposing, and it seems to me three out of four of those are universal across payers. Those could be measured for commercial, could be measured for Medicaid. And I'm wondering if you could -- mortality, overall patient experience. I'm wondering if you could comment on the availability of data so that these measures could extend beyond Medicare.

MS. TABOR: We haven't looked into the availability of the claims and Medicaid data to calculate these. You know, we've been focused on it with the Medicare lens. But that's something we could look into.

I will comment that the overall patient experience is actually collected on a hospital's total patient population. It's not just Medicare focused. So that's already calculated, regardless of coverage, whether it's commercial, Medicaid, or Medicare. But we can look and think about uniformity across the other payers for the

other measures.

DR. CROSSON: Okay, questions? Sue.

MS. THOMPSON: A comment on 2 percent. Why not 3 percent? I mean, if we're really serious about making a statement, what -- have you thought about that? Or what's your thinking?

MS. TABOR: Yeah, I mean, I think that's one of the topics we were hoping the Commission would talk about today, is that we chose 2 percent because that's what the VBP uses. You know, but the Commission before has had discussions about what's kind of the right incentive to drive improvement. I know the Commission has also talked about kind of scaled approaches. You know, you can start out with 2 percent and then the next year bring it to 4, next year bring it to 5. So we'd like your input. We just picked a number to model.

DR. CROSSON: Craig.

DR. SAMITT: My question tags on to that exact question, which is when we model the distinct prior measurement programs versus now the bundled measurement program, and we think about sort of the maximal gain or the maximal loss from the prior methodology versus this new

bundled methodology, is it comparable or are we watering down the potential incentive here at the 2 percent level when we compare before and after?

MS. TABOR: I will say that for our modeling, when we did the comparison of the current programs to the new HVIP, we did a budget neutrality adjustment since the current programs right now do overall penalize hospitals. It's not budget neutral.

DR. STENSLAND: I think the range is smaller with this than it was with the other, because the other, you could get a 3 percent penalty on readmissions alone, and here we just have a maximum of 2. So that's another consideration to think about when you think about how much you want to size it. Your question and Sue's very much go together.

DR. SAMITT: Yeah, and we can come back to it in Round 2, but then in many respects, you'd asked the question, what percentage would it have to be other than 2 percent to get the impact ranges to be comparable to the current total program base?

DR. CROSSON: Okay. Questions? Jack.

DR. HOADLEY: Also on the peer grouping, in the

case where you're using the dual-eligible percentage to divide into the deciles, you know, that's something that obviously is data driven and a hospital could be in a different decile. But I'm thinking it's relatively stable over time. Do you have any data to suggest how much a hospital might be moving, you know, be in Peer Group 8 one year and in 4 the next?

DR. STENSLAND: In the past, whenever we looked at these DSH percentages, they don't move that much. You know, you might move from decile 9 to decile 10, but you're not going to be going from decile 10 to decile 2.

DR. HOADLEY: Right. And is there any concern about any kind of gaming in terms of -- obviously, you have more potential -- if you can perform the same way and you get yourself in a different decile, it's going to affect your scoring. I mean, given the measures you're using, it feels like that's not a big problem, but I wondered if you had thoughts or had thought about that.

MS. TABOR: I don't think we've given much thought to it, but I think we did pick the measures that were, you know, claims-based and tied to payment. So we're going be less game-able.

DR. HOADLEY: It's probably something worth at least mentioning, but it might be able to be mentioned very briefly.

DR. CROSSON: Questions? Warner.

MR. THOMAS: Talk a little bit more about how this would apply to MA, and I think going to Bruce's point, could it be extended into the commercial world?

MS. TABOR: So I think one of the things that we did when we were developing this is, you know, we were trying to replace the fee-for-service payment program, but we did think about, you know, MA as plans are currently being held responsible or accountable for readmissions. So kind of the same concepts. Also patient experience and kind of spending. So we did kind of want to align like as one of the Commission's principles across payment models. But we did think about this in a straight fee-for-service way.

MR. THOMAS: So is the thinking that this would be a requirement or a request to MA plans, you know, implement a similar model?

MS. TABOR: I think, you know, that would be for the Commission's discussion, but I think, you know, based

on our principles, we'd want to have as much alignment across providers on the types of measures that are used.

MR. THOMAS: And do you feel like the measures can be calculated in the MA world?

MS. TABOR: Yes.

MR. THOMAS: Okay.

DR. CROSSON: Okay. Now we'll proceed to provide feedback to Ledia and Jeff. We'll start with Dana.

DR. SAFRAN: This is a terrific chapter. I really commend you on this great work, and it will transform the way that we think about and hopefully the way CMS engages hospitals with respect to measurement and the payment incentives tied to measurement. The simplification that, you know, you're proposing I think is elegant, and the principles, and seeing the principles applied here and, in particular, moving to absolute performance targets and the way that -- now that I understand it, the way that you've been able to incorporate that into the social risk factor stratification really seems like a very important advance in the field. So it'll be exciting to start to get some feedback on that. But I think the way that you've incorporated that is really exciting. Having absolute

targets and having them be fixed, you know, so there's transparency from the payer to providers about what is expected, and it's not a tournament, is, you know, just a tremendous advance and should enable best practice sharing in ways that are almost always inhibited when there is a tournament style of incentives. So I really commend you on that.

I love that the proposed HVIP model moves to big dot measures, you know, and just for big dot measures, and, you know, CMS has been increasingly moving away from process measures. We all know that providers are sort of screaming louder every year about too many measures, and, you know, that's what the fee-for-service system had brought us, was, you know, measuring each thing that got done. And so now in this era of paying for value, the fact that we could really have a program that really modeled what it would look like to pay for the big dot measures I think is really exciting and a great example.

So I'll just offer three comments about things I'd suggest thinking about. One is in terms of what might be missing from our list of four, I think we might have talked about this last time, but -- and I know you've

looked at it, but I'll just throw it out there as something to consider going forward, even if it doesn't exist today as a gap to be filled, which is measures of harm. So that's one of the things that we really need to pay attention to with respect to hospital performance, and I know from the chapter that you've looked at things like PSI 90 and, you know, some of the things that do measure harm, and none of them are ready for prime time. But I think we should hold that out as a gap that should get filled.

End-of-life quality measurement, I don't know that that's appropriate for a hospital value incentive program, but maybe it is. And so that's a gap for us to fill.

And then I know in the chapter, you know, you have this kind of lead-in that sort of fits with this chapter but sort of doesn't about the PPA and the home and community days measures. Something like home and community days, even though it didn't show differentiation across providers in the work that you've done here, or as we were talking about in the last segment, measures of functional status improvement or change, that might be harder for hospitals. But something that's sort of a positive

indicator of successful care is -- feels like it's missing here, too. So those are the four things.

And my last two comments, one about weighting, I see that you're suggesting to weight these four things equally. I had different thoughts about that, didn't land anywhere specific that I would say, Really? You know, are you going to say readmissions and mortality are really equal weight? But it'll be interesting to hear if there's some conversation about that today.

And then a final thing is on HCAHPS, I'd ask you to consider whether -- I know there's elegance to choosing just one measure and that, you know, if you're going to do just one measure, having a global 0 to 10 rating is a good measure. But I think hospitals find that not very actionable and not very clinically meaningful. And so I would just offer up the idea that you could consider creating a composite of the other clinically meaningful composites like quality of doctor communication, quality of nurse communication, quality of discharge instructions. You know, just two or three of the ones that really are actionable, really are clinically important might be a better way to represent patient experience. But fantastic

work. I'm really excited about it.

DR. CROSSON: Okay. Further feedback? We'll start with Jon and go around this way.

DR. CHRISTIANSON: Yeah, I'll go back and talk about the home and community days measure again, but it applies to something you just said, Dana. And I'm hoping David nods his head when I say this because -- when you use these composite measures, I think there are two critical conceptual issues. Which measures go into the composite? And then how do you weight the measures that go into the composite? And I think we spent some time in the past talking about whether home health care should go into the composite, and I was glad to see it disappeared. But then we went right to the statistical properties as the reason to say, okay, we're not proceeding with this right now. But when we talk about it on page 18, we say just in half a sentence, oh, and CMS may want to do something other than weight equally.

So I think that's an incredible difficult conceptual problem. I think it would be very useful to provide CMS with some -- or anybody with some background on that. That's a critical part of the measure. Weighting

equally, of course, implies a certain value set. Not weighting equally applies another value set. I think we don't talk about it much because we don't really know how to come to grips with it very well. But I do think in this chapter or this discussion we need to at least have a couple of paragraphs talking about this part of the conceptual part of the measure, and what have people done, how do you come to a notion that a certain set of non-equal weights is the right way to go, how do you come up with those weights. And this gets back to your comment, Dana, in terms of the same thing will continue to reappear. And so far I don't think in our discussion of these composite measures we really address that in a very straightforward way. And so somewhere here I would like to see us have a discussion of that at a conceptual level.

Are you nodding up and down?

DR. NERENZ: Can I respond? No, I agree absolutely. I'm glad you made the point. And we ought to talk about that more. In fact, one of the things that we could consider as one of many methods of feeding a weighting system would be, say, beneficiary focus groups. I'm imagining a question with a group of people. You say

there's two bad things that can happen to you going into the hospital. You can get readmitted, or you can die. Which one matters to your more?

[Laughter.]

DR. CHRISTIANSON: Or one day you can go to the emergency room for two hours or you can die.

DR. NERENZ: Exactly. And I'm obviously designed to provoke there, but there are ways of thinking about the weighting that really have to be taken up seriously, and, you know, as Ledia pointed out, it's true that in the current system, readmitting is weighted more highly in the mix, and people have raised the question: Is that really the thing that matters most to beneficiaries? And then is that the criterion upon which you set the weighting? So it needs more attention.

Thanks, Jon.

DR. CROSSON: Craig.

DR. SAMITT: This is wonderful work. Thank you very much. I have two quick comments. One relates to the measures themselves, and Dana I think prompted this for me, but I think we just want to stare at each of the four measures that we've recommended here to determine whether

they actually capture the outcome we really want from the hospital system and whether even some of these measures, while they may look benign on the surface, could actually result in clinical choices we don't want to make or even some patient harm. And the one that I will focus on is HCAHPS, patients' overall rating of a hospital. In a prior life, one of the systems that I worked in had determined that the greatest correlate with overall patient rating was pain control, which resulted in liberalization of opioid prescribing, which generates what you know exists today with the crisis that exists, or at least contributes to it.

So I think it would be worthwhile just looking at these and determining whether we should get more specific, because, again, to Dana's point, when we're generic, we may not be concentrating on the exact type of rating that we would want from the patient about their hospital experience, or any of these measures, for that matter.

And then the only other one is the one that we asked in Round 1. I do question whether the percentage, the 2 percent, is adequate. And I'd be interested that the gears start turning whether I'm more likely to win as a hospital by generating many readmissions than I would be at

risk for a 2 percent savings. And so when I do the math, sort of do I really even care about these things? And I think that the number has to be large enough to really focus on the outcomes we want to achieve.

DR. CROSSON: David.

DR. GRABOWSKI: I think if you ever wanted to convince somebody that the Medicare system and our health care system was fragmented, all you'd have to do is tell them we have four overlapping hospital value-based payment programs. It's hard to fathom. And so I really like the simplification here, and I really like the proposal that you put forward.

I wanted to come back to a point that several of the Commissioners raised around other kind of data and other payers. When you have a big broad program like this one, it's going to have tremendous spillovers. It's hard to just, you know, treat, as a hospital, your fee-for-service Medicare patients one way and everyone else another way. And so thinking about leveraging those spillovers would be really important here. And to the extent there's any way to align this -- Warner, you raised Medicare Advantage, but other payers as well, Medicare could

experience those positive spillovers as well. So I'd love to think about that because undoubtedly, like every other big broad program that we evaluate, there are these spillovers to other groups of patients at these providers. This would be really nice to try to leverage some synergies here.

DR. CROSSON: Dana.

DR. SAFRAN: Just a comment on that to say speaking for one commercial payer, we use Medicare's measures for hospital anyway because we don't have enough -- even as Blue Cross, we don't have enough sample size in our market on hospital for commercial to do anything other than use Medicare measures.

DR. CROSSON: Further comments? Bruce and Rita.

MR. PYENSON: I'm delighted to see mean time between failure discussed.

[Laughter.]

MR. PYENSON: No, really. But would encourage further view of healthy days without interacting with the health care system as a -- to explore that more, which means just about any day interacting with a health care provider is a negative.

DR. CROSSON: Okay. Rita, I think I saw your hand.

DR. REDBERG: I also want to compliment you on a really nicely done chapter, and I really like the kind of big-picture focus on population measures and getting away from all the individual measures.

I was thinking about harm before Dana said it and wondering whether it got incorporated in readmissions and mortality, because it's so hard to measure harms. And I don't know, I certainly think we can think and talk more about that. And then I thought, well, with putting healthy days at home, the kind we talked about for post-acute care, would that also help here?

Just to comment on the patient experience, I do share some of Craig's concerns that patient satisfaction sounds good, but right, so did, you know, are you pain-free? And then it did -- there were a lot of things that contributed to the terrible opioid epidemic, but certainly that patient measure of being pain-free did contribute to it. And so I was thinking, you know, measures that are focused more on communication, things that are very -- you know, did your doctor -- did you understand your

medications at discharge, why you were having procedures? I mean, it's just astonishing how patients really don't understand why they get most of what happens to them when they're in a hospital, and that seems like something that would be valuable and is more meaningful than, you know, how was the food or -- which is also important. I'm not saying it's not, but more of the hotel qualities of the hospital.

And if we were going to weight, I think it would probably, to me, makes sense to weight mortality and spending more. I'd like putting spending in there because with the other patient quality measures -- readmissions and mortality -- it's not like you can save money if patients aren't doing well because patients still have to be doing well. But to me, that's also an indirect measure of harm because patients that have harms become very expensive.

So I'm very excited about this work.

DR. CROSSON: Yeah. Thank you, Rita.

Brian, is there anything left for you to say?

[Laughter.]

DR. DeBUSK: First of all, congratulations on a really well-written chapter. There's a lot to be excited

about, and let the record show that I have not raised the mean time before failure as an integral decision.

[Laughter.]

DR. DeBUSK: Thank you, Bruce.

The one thing I do want to focus on, I get really excited about this idea of a standard vehicle or framework for doing this, again, measure, risk adjust, scale, all that, and I hope that that shows up again and again, even outside of the hospital program because there's a lot of power in having that standardized framework.

I mean, it's not quite a MedPAC principle, but I would hope that we could elevate it to something fairly close to that because when I look at -- and I'm not going to name the example, but for example, one of the other -- the reading material actually did use regression to account for or to explain some race and dual eligible status in one of the other chapters just from this meeting, and it's a little frustrating because you're digging through appendices. You're digging through footnotes trying to figure out what did we do and what order did we do them in, and it's really refreshing. If you guys could build this out as a standardized treatment, I know the measures are

important, but I would argue right now that equally important is standardizing the methodology so that we aren't wondering when this adjustment got made, when and where and why.

So congratulations. It's a great chapter.

DR. CROSSON: Thank you.

Okay. Kathy.

MS. BUTO: I want to say that I think that it's an excellent framework and a lot clearer than the last time we talked about it, which I think there was more confusion around what we were trying to get at. I think this is much more clear.

I'm still, I guess, regretful, I guess I'd say, that we can't have some form of the hospital-acquired conditions measure in here. I know we don't want the tournament model. I know that the data are self-reported, so that makes it unreliable.

But it seems to me -- I started looking at the DRGs to see if there were anything in the DRG system itself, which could give us clues as to whether certain hospitals are having a bigger issue here. And I don't know how septicemia is coded and so on and how MCCs and CCs are

coded, but it just seems to me there might be a less self-reported route to looking at infections and hospital safety. And it kind of goes to the harms issue that Dana was talking about.

I just regret that because I know as a consumer, hospital infections are one of the most important things to me. It's to understand what the safety of that hospital is for a loved on.

So it just strikes me that there must be a way we could pick something like that up or look into it and see if there's something we can pull in at a later date.

DR. CROSSON: Warner.

MR. THOMAS: So directionally, I like the fact that we're collapsing the programs and consolidating it.

A couple of comments. One, I would agree with Kathy that -- and I can't believe I'm saying I want to add measures, but I think it's important to. I mean, certainly, mortality and readmission is important, but you can be discharged from the hospital and not be readmitted. You could have passed in the hospital, but you could still not have a great outcome. There could be still something that has happened either in the hospital or post.

So I think looking at, whether it's patient safety measures, hospital-acquired conditions, I do think there should be something, and it doesn't have to be a lot, but there could be a small bundle. There could be a couple that are looked at, and maybe they're grouped together so there's a patient safety indicator or something that's in there. So I just think that would be important.

I like the idea around kind of grouping pairs, but there's a lot of complexity around that. I'm hopeful whatever we do can be understandable so people can think about how they improve and they understand kind of where they're going to be in the pair groups and that sort of thing.

I'm a little concerned about just in the chapter, the scores for academic medical centers and coronary care centers and kind of how that's going to -- how are they going to be aligned or in certain pair groups because, obviously, in those where you see higher end care, lots of times you do see higher readmission rates with big transplant programs and that sort of thing. So I think that needs to be thought about as to how this impacts academic medical centers and whatnot.

The last thing I would say is I would really be hopeful that whatever we do, we are very clear that we expect it to be in the MA program as well, and that we also -- and that becomes part of the program. The MA plans have to adopt whatever it put forth, and that we also do something that could be applicable in the commercial arena as well, so we can start to simplify measures across all the payers.

DR. CROSSON: Thank you.

Paul.

DR. GINSBURG: Also, I thought the work was superb, and I'm enthusiastic about the HVIP.

One thing that Ledia mentioned briefly, but nobody else has brought it up, that I think is a real asset is the fact that incentives to improve in this program are continuous. They affect all hospitals. They affect all the things that are being graded on, and that's a big improvement over where we were, certainly with readmissions, where lots of hospitals were off the hook just because they weren't close to the thresholds.

I'd also like to endorse as many of these things as we can do to make them workable for other payers to

adopt them. That would deal with a longstanding problem.

I also agree that I think we need to be larger than 2 percent in a program like this, particularly with all that it's covering.

The final thing I want to say is that I am extremely relieved that home and community days is being put aside at least for a while, and I think it all comes down to this was a measure that was extremely dominated by mortality. That if someone dies early in the year, that's just going to overwhelm days in SNFs or hospitals.

And I think the fact that you didn't find much differentiation is because -- let's remember that when we talk about mortality or even chronic disease burden, medical care is not that high on the list of what's important as determinants, so I think that's really what we're picking up when we compare areas.

DR. CROSSON: Thank you, Paul.

Pat.

MS. WANG: I echo others' praise for the report and the approach that's taken. I am in the same camp as Kathy and Warner around the hospital-acquired conditions. We had talked about this earlier, patient safety measures.

It really feels like those should be part of any kind of formal evaluation of quality of hospital.

I also want to express, since the sort of framework at least that is in here, at least for first consideration, as equal weighting of the measures. Patient experience is important. In this example, is it 25 percent important? That seems a bit high. I personally would like to understand more about what drives patient satisfaction. It's clearly really important, but I think that there are a lot of factors that go into that.

For example, if an institution were able to blow it out of the water for patient satisfaction but really didn't do very well on mortality and admission and patients, I mean, like do we really think that it should be weighted so heavily to maybe tip them into a category where an institution that had the opposite profile grade on patient safety, readmissions, mortality, et cetera, that those would be considered equal institutions? It's possible that that kind of think happens.

Also, the idea of peer grouping for social factors is very important. I actually think that there are some things that influence the way that patients respond to

these CAHPS surveys that are not necessarily related to social risk factors but are related to cultural place of residence, area of the country factors that are kind of mysterious and maybe an evaluation that compares institutions across the board on this measure. That this is a little bit less locked down and precise and measurable.

So I have some real caution about -- I think it's important to include, but I don't think that it should be equally weighted.

And just the final thing, on the Medicare Advantage point, I think this is really important. Obviously, there would be many steps to be taken for this to be incorporated, but the biggest difference, which I really think is important, is that this is not a tournament model, and the one overlapping measure in here on readmissions -- and the MA program is a tournament model, this is being -- it's also not adjusted for social risk factors. In this program, this is a big advance that it would not be a tournament model, and that it would be adjusted.

So right off the bat, there's big disconnect

there, and maybe there's something in the future, reports that can address that, because that one measure is in both programs, and now they'll be treated completely differently, the right here, in my view.

DR. GINSBURG: I agree with Pat about the weighting, being against the equal weighting, and to go a little further, with this equal weighting, there is a possibility -- and maybe Ledia and Jeff already know the answer -- that it's taking the readmissions penalties and actually moving less money around for readmissions than we are today. And since we've had evidence that readmissions is working, we would really want to avoid that.

Also, I think part of it is not necessarily our values, but our confidence like in the patient experience. I don't think we're as confident in the meaning of the data we have on patient experience as we are about the significance of the readmission sake.

DR. CROSSON: And I forgot who made the point over here. It may be necessary that we do some work in examining the elements of the measurement of patient experience and try to understand the relative -- and I would say objectivity. It's not really right, but there

may be some things that are more objective than others, and then the issue of unintended consequences as well.

The last point, Dana?

DR. SAFRAN: Yeah. Well, since I used to make my living on patient experience-measured development, I'll just comment that I think that's part of why I want to steer us away from a global rating to the more clinically specific because we know a lot about those measures actually, and it's interesting to hear that even this incredibly educated group of health care experts doesn't realize how much we know about the patient experience measures. And they are in fact equally reliable and valid, and you need smaller sample sizes to get a very strong signal about the performance of one institution versus another on things like communication, quality, discharge instructions, and in fact, those measures have been shown in a number of well-done studies to be important predictors of outcomes, including readmissions.

So I think we need to look at how these measures relate to each other, but I just wanted to mention that because I'd be -- actually love to down-weight patient experience, so long as we put the right ones in the mix

here.

DR. CROSSON: Okay. Excellent work. Again, excellent discussion, and I think we've got the platform for moving forward in this area, no question.

So thank you, Ledia and Jeff, and we'll move on to the final presentation of the day.

[Pause.]

DR. CROSSON: Okay. Our final presentation today is a continuation of our work on low-value care, and we're going to be looking at low-value care and Medicare coverage policy specifically. Ariel, Nancy, and Carlos have been doing this work and are here to present, and it looks like Ariel is going to begin.

* MR. WINTER: Good afternoon. I want to begin by thanking Emma Achola, Sydney McClendon, and Ledia Tabor for their extensive work on this project.

This presentation is related to prior work on Medicare's coverage policies and cost-effectiveness analysis.

Deficiencies in Medicare's coverage process allow coverage of services that are low value. The material we're presenting today, along with the prior presentations,

will be included in a chapter in the upcoming June report.

For today's presentation, we will discuss findings from the literature and staff analyses of low-value care, present three case studies of potentially low-value services, and conclude by describing policy tools that could be used to address low-value care.

So what do we mean by low-value care? Researchers define it as services with little or no clinical benefit or care in which the risk of harm from a service outweighs its potential benefit.

Low-value care is a concern for two reasons. First, it has the potential to harm patients, both directly by exposing them to the risks of injury from the service itself and indirectly when the initial service leads to a cascade of additional tests and procedures that contain risks but provide little or no benefit. And second, it increases health care spending.

According to a study by Schwartz and colleagues, there is substantial use of low-value services in fee-for-service Medicare. Other studies find that low-value care is also prevalent among other populations, such as Medicaid and commercially insured patients.

Some of those articles are listed here, and there are others in your mailing paper.

Evidence from some of these studies suggests that the amount of low-value care is more a function of local practice patterns than the type of payer.

We conducted two analyses of low-value care in Medicare. The first examined selected low-value services in fee-for-service Medicare, using 31 claims-based measures developed by Schwartz and colleagues. This is the same analysis we presented to you last April.

The examples of these measures include imaging for nonspecific low-back pain, stress testing for stable coronary disease, and spinal injection for low-back pain.

The second analysis examine a HEDIS measure of PSA testing rates in both Medicare Advantage and fee-for-service Medicare, and this is a new analysis.

Because we presented the results of this first analysis last year, I'm just going to review the results at a high level. There are more details in your paper, including results for each of the individual measure.

We present a range of results here. The low end of the range comes from the narrower, more conservative

versions of each measure, and the high end is from the broader versions of each measure.

In 2014, between 23 percent and 37 percent of beneficiaries received at least one low-value service. There were between 34 and 72 low-value services per 100 beneficiaries. And Medicare spending for these services ranged from $2.4 billion to $6.5 billion.

Our results probably understate volume and spending on low-value care, and thus, they represent a conservative estimate of the actual amount of low-value services.

This is because the measures are based on claims data, and there are a limited number of measures that can be calculated with claims.

In addition, our spending estimates do not include the cost of downstream services that may result from the initial low-value service.

We also looked at geographic variation in low-value care. We found that even after adjusting for differences in demographic characteristics and comorbidities, there is still substantial geographic

variation in the use of low-value services. Five of the six areas with the highest adjusted number of low-value services are in Florida.

And Carlos will now discuss our second analysis.

MR. ZARABOZO: As Ariel mentioned, we have done an analysis looking at a measure of low-value care that Medicare Advantage plans have been reporting for the past three years to the MA quality reporting system, or HEDIS. The measure is the rate of non-recommended PSA testing for men age 70 or older.

Regarding the rationale for the HEDIS specifications for this measure, they are consistent with a draft recommendation of the U.S. Preventive Task Force, which says that routine PSA testing for men over 70 is not recommended and that testing for men in the 55-to-69 age range should be based on a decision of the patient and his doctor. Pending the finalizing of the draft recommendation, the current Preventive Services Task Force recommendation is that routine PSA testing is not advisable for a person of any age.

Unlike the many HEDIS measures that are based on medical record sampling, for this measure, MA plans use

administrative data, such as electronic medical records and claims and encounter data to report the measure. The measure applies to a large population because it includes all men age 70 or older not qualifying for an exception, such as beneficiaries with a history of elevated PSA levels.

A comparable measure for fee-for-service Medicare can be computed using the HEDIS specifications applied to claims data in fee-for-service. The large number of beneficiaries to whom the measure applies in both fee-for-service and MA allows us to do MA-to-fee-for-service comparisons by market area.

For our analysis, we compared MA HMO rates reported in 2017 for the 2016 measurement year, with fee-for-service rates computed with 2015 claims data for 113 metropolitan areas with substantial MA HMO enrollment. Looking at the relative rates of PSA testing across metropolitan areas in each sector, we found wide variation in the rates across market areas in both MA and in fee-for-service.

Consistent with the other analyses of low-value care, metropolitan areas in Florida had the highest

relative rates of non-recommended PSA testing for both MA and fee-for-service. Miami, for example, had the highest percentile rank in both MA and fee-for-service for this measure. Some areas, such as Minneapolis and Albuquerque, had low relative rates in both MA and fee-for-service, illustrating that it was often the case that in a given metro area, community patterns of care were consistent between MA and fee-for-service.

We also found differences among MA plans within markets. This was particularly true if Kaiser Foundation Health Plan enrollees were a large segment of the MA enrollment, as in the case of Sacramento, California. Sacramento performs very well in MA relative to other markets because a large share of the enrollment is in the Kaiser plan, with very low rates of PSA testing. For the other HMOs with enrollees in Sacramento, the PSA rates were more in the range of the fee-for-service rates for the Sacramento area.

Our findings do not allow us to conclude whether or not MA HMO rates have an influence on PSA testing rates in fee-for-service; that is, whether there is spillover from MA to fee-for-service.

The case of Miami and Minneapolis show that what can be concluded is that the community patterns of care are consistent across MA and fee-for-service in those markets.

MR. WINTER: So now we're going to switch gears and talk about three case studies of potentially low-value services. We refer to them as potentially low value because there is uncertainty about their clinical benefits, but they have not been labeled as low-value services by the studies that we cited in our paper. And in addition, Commissioners have expressed interest in examining these three services in the past.

Our first case study is early initiation of dialysis.

The number of early starts of dialysis, or dialysis starts for individuals with higher levels of kidney function, increased from 13 percent in 1996 to 44 percent in 2010. Since 2011, there has been a slight decline in early dialysis starts.

The increase in early starts was due to a several factors, including early observational research findings and clinical guidelines advocating for earlier dialysis initiation.

Recent studies, including the only randomized controlled trial examining dialysis start times, have indicated that early initiation is not better for patients and in some cases may actually be worse.

The release of this comparative clinical effectiveness evidence has been linked to the slight decline in early starts. Not only do early starts appear to not benefit most patients, but they're also extremely costly.

For the Medicare program, rough estimates of the cost of dialysis treatments associated with early initiation ranged from $500 million to $1.4 billion in 2016.

The second case study is proton beam therapy. This was initially used for rare adult and pediatric cancers, but its use has recently expanded to more common cancers, such as prostate and lung cancer. However, there is a lack of evidence that it offers a clinical advantage over alternative treatments for the more common types of cancer. Nevertheless, the number of proton beam centers in the U.S. has increased rapidly since 2009.

Each center is expensive to construct. A large

facility typically costs between 150- and $200 million.

Medicare payment rates for proton beam therapy are much higher than for other types of radiation therapy. In addition, Medicare has few coverage restrictions on this treatment.

Volume and spending for proton beam therapy in Medicare more than doubled from 2010 to 2016. Spending grew from $47 million to $115 million, and volume increased from 47,000 treatment sessions to 109,000 sessions.

The most common condition treated by proton beam therapy in Medicare is prostate cancer, which accounted for almost half of total spending and volume.

The third case study is HP Acthar Gel. Acthar is an injectable biologic that is indicated for treatment of infantile spasms and eight other immunologic conditions, such as exacerbations of multiple sclerosis in adults.

When the drug was approved in 1952, the FDA did not require clinical trials to demonstrate its effectiveness. There is a lack of strong evidence that it is effective for adult conditions, and there are cheaper, effective alternatives, such as corticosteroids.

Even though Acthar has been on the market since

1952, its price increased rapidly after 2001, when it was acquired by Questcor. The average price per vial grew from $748 in 2001 to about $34,000 in 2014.

In 2014, Acthar was acquired by another manufacturer, Mallinkrodt, which further raised its price per vial to $38,000 by 2017.

Manufacturers have been able to increase prices for Acthar in part because there is no generic version, although another company is currently developing one.

As of 2017, most Part D plans did not include Acthar on their formularies. Those plans that did include it required prior authorization.

Nevertheless, gross payments for Acthar under Part D rose from $49 million in 2011 to $504 million in 2015. In 2015, fewer than 2,000 clinicians prescribed this drug to about 3,100 beneficiaries. And spending per beneficiary was $162,000.

We used data from open payments to examine the financial relationships between the prescribers of Acthar and the drug's manufacturer, and we found that 71 percent of the prescribers received non-research payments from the manufacturer related to Acthar in 2015. And there is more

information about these relationships in your paper.

Now we're going to describe five policy tools that Medicare might consider using to address low-value care, which are listed here.

The first tool is prior authorization, under which a provider must obtain approval from a plan or payer for a product or service before delivering it.

CMS has tested prior authorization in the three demonstrations listed here. They target items or services subject to fraud, unnecessary use, or improper payments, and all of these demos have produced savings.

CMS has also launched a national prior auth process for DME, which so far applies to two power wheelchair products. In this context, it's also worth noting a prior Commission recommendation that CMS require prior auth for clinicians who use substantially more advanced imaging services than their peers to ensure that they are used appropriately.

And this recommendation has not been adopted.

The second tool is clinician decision support and provider education. There is evidence in the literature that decision support and provider education and feedback

can reduce the inappropriate use of antibiotics. One study found that these techniques reduced inappropriate prescribing of antibiotics by 16 to 18 percent.

CMS has been developing a program that will require clinicians who order advanced imaging studies to consult with decision support software and obtain feedback on whether the study is consistent with appropriate use criteria.

In general, if Medicare is going to mandate the use of clinical decision support systems, an important issue to consider is that clinical guidelines, which are the basis of these systems, are sometimes in conflict with each other.

The third tool is altering beneficiary cost sharing.

Reducing cost sharing should encourage the use of high-value services, while increasing cost sharing should discourage use of low-value services.

In 2012, the Commission recommended that Congress give the Secretary the authority to alter or eliminate cost sharing based on evidence of the value of services.

CMS does not currently increase cost sharing for

low-value services in Medicare, but outside of Medicare, some plans and payers adjust cost sharing based on evidence of a service's clinical benefit. For example, a large public employer in Oregon created a program that increased cost sharing for services that were deemed to be low value, such as sleep studies, advanced imaging, and surgery for low-back pain. An analysis of this program found that it significantly reduced the use of these services.

The fourth tool is delivery system reform and use of new payment models, such as ACOs.

ACOs take responsibility for the cost and quality of care for a group of patients. One way to reduce costs while maintaining or improving quality is to reduce the use of low-value care.

There is limited evidence that two-sided risk ACOs, which share in both savings and losses, decrease low-value services, while other ACOs do not.

A study of Medicare Pioneer ACOs, which were a two-sided risk, found that they had a greater reduction in volume and spending for low-value care compared with a control group of other beneficiaries. However, a study of ACOs in the Medicare Shared Savings Program found that they

did not affect the use of low-value care during their first year of operation. At the time of the evaluation, all of these ACOs were at one-sided risk.

And Nancy will now talk about the next policy tool.

MS. RAY: The last tool is linking evidence on a service's comparative clinical effectiveness and cost effectiveness to the coverage and payment processes.

Comparative clinical effectiveness evidence compares the clinical effectiveness of two or more interventions. Clinical effectiveness evidence is the foundation for cost effectiveness analysis, which compares both the costs and clinical effectiveness of two or more interventions.

Fee-for-service Medicare's coverage process considers, but does not require, comparative clinical effectiveness evidence. Cost effectiveness evidence is generally not considered in the coverage process.

Medicare's payment policies generally do not consider whether a new service results in better outcomes than its alternatives. Indeed, there are cases in which the payment rate for a new service is higher than its

alternative, even when there is no evidence on whether the new service results in better outcomes.

Prior to 2010, there were instances for which Medicare used comparative clinical effectiveness evidence to set the payment rate for groups of Part B drugs assigned to separate billing codes that treated the same condition and produced the same outcome based on the least costly drug.

As a result of federal court rulings, since 2010, Medicare no longer pays according to the least costly alternative for Part B drugs. The OIG concluded that such a policy resulted in in savings for beneficiaries and taxpayers and recommended that Medicare apply least costly alternative policies.

Here is an example of linking comparative clinical effectiveness evidence to payment developed by researchers. Their proposal would assign a new service to one of three payment categories based on the availability of comparative clinical effectiveness evidence.

If evidence show that the new service improved outcomes compared with its relevant alternative, then the payment rate of the new service would be set according to

usual statutory methods.

If evidence showed that the new service produced outcomes that are similar to its relevant alternative, then the new services payment rate would be set equal to the treatment alternative.

If there was insufficient evidence on the new service's comparative clinical effectiveness, the researchers proposed that the new service would be paid at a rate based on usual statutory methods for the first three years, at which point Medicare would assess any additional clinical evidence concerning whether the new service improves outcomes compared with its alternatives. Based on this assessment, the new service's payment rate would then be adjusted accordingly.

So this concludes our presentation. This slide lists all the topics which we have discussed today, last month, and in September that will be going into the June report. Please let us know if there is any additional work on these topics that you would like us to pursue in the future.

DR. CHRISTIANSON: So are there clarifying questions?

DR. REDBERG: Great chapter. I was excited about the quality improvement chapter. I was falling out of my chair for this one.

[Laughter.]

DR. REDBERG: So my question, you had mentioned on page 71 in the mailing materials about an example of a previous attempt to use least costly alternatives, but it wasn't implemented. It was for proton beam therapy. Do you have any insights into what happened there?

MR. WINTER: No. We don't know why it was withdrawn.

DR. REDBERG: Okay. On Slide 16, do we have any data from the CMS program on advanced imaging and decision support?

MR. WINTER: No. It has not been implemented, and the current schedule calls for implementation in January of 2020. It's been subject to many delays. The initial statute -- this was mandated by PAMA, which was passed in 2014, and the initial implementation was supposed to begin I think in 2018. So it's behind schedule.

DR. REDBERG: Any insights there? It doesn't seem like that would be so hard to put in. There are lots

of decision support programs.

MR. WINTER: Right. CMS has had to go through -- they decided to do most of the process through notice and comment rulemaking, so they have to go through it step by step, and each step is a year apart because they're doing it through the Part B proposed and final rules, which are once a year. And they've taken -- they've done this very slowly and methodically, and I can't speak to why it's taken so long.

MS. BUTO: Are they paying for the decision support software?

MR. WINTER: No.

MS. BUTO: Okay. So it's up to the individual.

MR. WINTER: Correct. Correct. And I think they've designated -- on their website they've indicated that a couple of them are free -- yeah, a couple of them -- at least two of them have a free tool available. They've approved about a dozen clinical decision support systems.

DR. REDBERG: And the last, just a comment still on that slide. Clinical guidelines are sometimes in conflict with each other, which is confusing. But the other issue about conflict in clinical guidelines is

there's often a lot of conflict of interest on the guideline panels which is another --

MR. WINTER: Right.

DR. REDBERG: -- problem with using them for coverage decisions.

DR. CHRISTIANSON: Okay. For clarifying questions, let's go to David, and then we'll go around --

DR. NERENZ: Yeah, just on this point, though, there was a CMS demo on decision support for imaging recently; is that correct? That does have results?

MR. WINTER: Yes. So that was completed I want to say a couple of years ago, and they've released the final report, and it was different in that it was voluntary. It was a demonstration. It was mandated by maybe PPACA or prior legislation. And it basically gave convening groups money to go and enroll physician practices and provide them with feedback through the use of decision support. And there were lots of problems and issues with this model. I can come back to you in the future with more information about that.

One of the issues was that a lot of the orders or the imaging orders did not fit a clinical scenario in the

guidelines, so there wasn't a clear match. And so a lot of the requests or orders did not have any feedback, you know, based on the guidelines. That was certainly one of the issues.

DR. CHRISTIANSON: Brian, any clarifying questions? Kathy? Warner? Okay, Jack, it's you.

DR. HOADLEY: So on Slide 13, on the Acthar gel example, you said there on the slide that most plans did not cover this drug in 2017, and then you talked about the spending trend between 2011 and 2015. Do we know whether the coverage was different in those earlier years?

MR. WINTER: Unfortunately, we do not have that information.

DR. HOADLEY: Okay.

MR. WINTER: One thing I should say is in the paper we cited some numbers about what percent of plans covered Acthar gel in the formulary. They said 6 percent, or less than 6 percent of stand-alone plans about 25 percent of MAPD plans. These were not enrollment weighted.

DR. HOADLEY: Okay.

MR. WINTER: So it could be that actually a higher percentage of the enrollees are in plans that that's

covered on the formulary.

DR. HOADLEY: I mean, your third bullet says there's only 3,000 beneficiaries, so it would be interesting to know if keeping it off the formulary prevented that from being even larger and/or if a lot of these might have been done under exceptions to the formulary. So there could be a few things you could do to fine-tune this, but I realize there are data limitations.

MR. WINTER: Yeah, and once we get the 2017 and 2018 data, we can start to look at what impact the formulary decisions might be having.

DR. HOADLEY: It is possible to go back and get the formulary coverage from earlier years. It's just not as straightforward to do.

DR. CHRISTIANSON: Amy.

MS. BRICKER: I thought also it was very interesting. I imagined Rita reading the chapter with this smile that just -- you know. Is that how you were reading it?

[Laughter.]

MS. BRICKER: That's not my question.

DR. CHRISTIANSON: It's clarifying, though.

MS. BRICKER: So when you looked at the policy tools that were on Slide 14 and thinking then of the excellent example you gave of Acthar gel, which -- in, again, the construct of Part D, which of those policy tools would be applicable in a Part D setting?

MR. WINTER: So one thing we put in the paper is that those plans, Part D plans that do have Acthar on their formularies, they all require prior authorization, so that covers the first tool. And it seems like there's still lots of -- still a big increase in spending and volume. One thing that perhaps could be thought about is under the last tool on the slide is least costly alternative. So if Acthar costs $38,000 per vial but a comparable corticosteroid costs much less, perhaps the price could be set based on the cheaper corticosteroid.

MS. BRICKER: Okay. I can't wait for Round 2. Thanks.

DR. CHRISTIANSON: Well, you don't have to wait long, apparently.

So, Rita and Kathy, on this, too? Okay. Rita, why don't you start? Then we'll go to Kathy and then open it up.

DR. REDBERG: Thanks very much, and thanks for this work. I thought you chose some really good examples because they illustrate, you know, different aspects. There's so many ways to have low-value care unfortunately in Medicare, and we spend a lot of money -- I think these are very conservative estimates, but the numbers you gave -- and that's fine to have conservative -- but still, you know, 37 percent or something of Medicare beneficiaries get low-value service. Remember, low value doesn't just mean low value. It means -- I mean, to me, it's a lose-lose because it's a lot of money, but you're also talking about doing things that are hurting our beneficiaries. A lot of these -- we're not going to get into it right now, but we don't track adverse events or harms very well. But there are a lot of harms that come, and you know if you have a therapy that has little or no chance of benefit, all you're left with are harms. So, you know, working on this to me is really a win-win.

The hard parts, though, are that it's so baked into our system, particularly in fee-for-service, and so, you know, of the choices that you gave us, I think prior authorization, as you saw, highly motivated, it's not

necessarily -- it'll deter some use, but not really get rid of low-value use.

The coverage decisions, again, that's tough because we've -- there's not often a lot of connection between evidence and coverage decisions in Medicare, and Medicare is often in the position of paying and then paying quite a lot, like proton beam therapy, your example. I mean, proton beam therapy, it is really an illustration of so many problems because, first of all, as you talked about, PSA, you know, the task force already said there's really no evidence that any of the PSA testing is leading to benefit, and that maybe they're refining the age group. There was a big trial, the PLCO, that still didn't show a benefit on prostate cancer. So you're already talking about -- but Medicare pays, of course, for PSA, and all those groups, even though it's not recommended by the task force.

And then once you get the PSA, then you go on to get testing and treatments, and so they're not helpful because the studies all show you would have been just as well off without them. And then Medicare pays -- I mean, why does Medicare pay a lot of money for proton -- why does

it pay anything, you know, if we're looking at sort of reference pricing or least costly alternative, but having these very high prices when there has never been any studies showing a benefit for proton beam therapy in prostate cancer. And yet, of course, you see -- I mean, when I leave here and I take the train up to New York, I see that big -- and I went to the University of Pennsylvania Medical School. I think it's a fine institution. But there's that big proton beam therapy. And, you know, Zeke Emanuel, who's on their faculty, had that big op-ed in the New York Times about how proton beam therapy should not be commercialized because there wasn't -- it's not being commercialized for pediatric cancer. It's being commercialized because Medicare is paying a lot of money for it. And that would be okay if there was evidence of benefit, but there is none.

And then the Acthar gel, you know, gets into another issue. So they may have cancer screening, you know, inappropriate cancer screening that Medicare pays for that leads to more low-value care. And then we have the FDA, which has pretty lax standards for a lot of approvals of drugs and devices, and certainly Acthar gel -- I mean,

the only study that has been done was for infantile spasm, but Medicare's paying a billion dollars. So those other indications for possible multiple sclerosis, they're based on no studies, and I think they came much later. They weren't from 1952.

And then you have all of the problems that we've also talked about that there is no controls on drug pricing at all. So the company, you know, just picks numbers, it seems, out of the air. There's no R&D cost for this drug. It's been around forever. There's any of the usual reasons for -- and it has that funny history with the orphan drug use, and it got protection for seven years.

So those are all the problems. You know, I think we've talked before, alternative payment models, you know, where we're looking at population measures, you know, like we talked about at the last session, I think would also help to decrease low-value care because if you were thinking about, you know, readmission, mortality, patient satisfaction, and cost, it's a lot harder to be spending this kind of money on drugs that aren't helping people.

So I think it ties in nicely with the last list, and the idea -- the last thing I'll say is that coverage

with evidence development, I think -- and you gave some examples -- is a good model. It's just important that we actually use the evidence, you know, look at it, collect the data, and use it to feedback into the coverage system.

I think now there's a lot of interest in getting medical devices on the market more quickly and then using postmarket data. But that essentially means shifting the costs for clinical research from the device companies to Medicare, because once they're on the market, that means Medicare's going to pay for them, and then we're going to look and see were they any good. And then, again, we still don't have very good systems or a track record in collecting that data and acting on it, you know, to expand or to -- I've never seen us withdraw or restrict coverage.

So thanks. I think that this is a really important area to work in, but I think we have to really think innovatively about sort of alternative payment models which don't -- and getting away from fee-for-service to really make inroads in it. I'm sure Kathy will have some good ideas.

MS. BUTO: Yeah, I'm just thinking, if Craig is Mr. MA Encounter Data, you would be Dr. Low Value Care --

well, he's Dr. MA Encounter Data; you'll be Dr. Low Value Care, get it out of Medicare.

So I looked at -- I have to say this. I was very excited about this chapter because I thought you did both things you set out to do. One was to do a really good job of explaining the coverage process, which is very complicated and has many parts to it, and many people do not understand it. Secondly, your treatment of low-value care was, I thought, excellent, and the examples were illuminating and helpful to thinking about what do we do going forward.

I have to say it reminded me how very few national coverage decisions there really are. I think you said 4 to 17 per year. We used to say 12. You know, that was 20 years ago, so it hasn't changed much.

The greatest leverage that Medicare has on new technologies is at the beginning when they're first covered, and that's because it doesn't go back and revisit coverage. So I'll come back to that in a second. But the decisions that are generally made are cover, don't cover -- and there aren't very many of the don't cover's done -- cover with conditions, or coverage with evidence

development. And those last two are done fairly rarely, so there are very few caveats around coverage. And for many procedures, drugs, devices, the initial coverage is sort of the barn door you go through, and then it's whatever uses the medical system thinks are appropriate.

You know, the view we used to have at the time we were looking at coverage for regulations was you need to have flexibility because, actually, you don't know how useful some procedures, technologies, drugs are over time and they may evolve. But in exchange, Medicare never asked for data and rarely revisited coverage.

So I bring all this up because getting to the issue of low-value care, the menu of approaches that you laid out I thought were very helpful. They mostly were not coverage related. They were mostly -- so prior authorization, patient cost sharing, and -- et cetera. Let's see, oh, decision support tools, those are all important.

I think the reason for that is that it's very hard to know at the beginning of coverage that something's going to be low value. It may be covered for something narrow for which it has high value, and then it spreads.

So it's important to have those kinds of tools once technologies/procedures are covered to be able to actually monitor what's going on and assess.

What I would suggest is that part of the conversation needs to be about revisiting coverage after a certain amount of time. That I think will prompt additional evidence development. Whether it's done at the beginning where the agency says we're not going to cover this unless you give us more evidence, or whether it's done on an ongoing basis, if you're going to go back and revisit -- and I think you suggested in your last slide something like that, a three-year window for going back and looking, there will be greater evidence development. That's part of what's missing. But part of what's missing is the intentional revisiting of coverage by the agency.

The other thing I would say is there is -- the issue of the -- what is the name of the drug? -- Acthar drug is as a Part D drug, and I think this is another aspect of coverage that needs to be looked at, which is I think CMS takes the view -- I believe this is the view -- that they don't really look over the shoulder of Part D plans on coverage issues, that once the -- the rule is once

it's FDA approved, it's automatically covered for the labeled indication, and the rest is discretion. And I think the discretion is entirely left to Part D.

So one of the things that I think we could do is think about whether CMS ought to play a greater role in guiding that decisionmaking process. I don't think they necessarily have the authority to go in and actually do the assessment. But I think that's an area -- a gray area where Part D plans and CMS are not really interacting. So this to me was an illustration of that because, you know, they're using the tools they have, but really CMS should be doing something as well.

And then on PSA testing, it made me wonder why there isn't a non-coverage decision for patients over 70 unless they're symptomatic or, you know, whatever the exceptions are. There are very few non-coverage decisions. So if we're talking about coverage, there are tools. I just feel like there's an opportunity for us to take a look at whether we would advise CMS to take a look at using more of those tools more aggressively.

And on things like decision support, that's not just for low-value care. It just strikes me -- we've been

talking about opioid use and other things. There's some opportunities there where decision support would be really welcome, I think, by the physician community.

DR. CROSSON: Thank you, Rita and Kathy.

Further discussion. Let's start over here with Amy.

MS. BRICKER: Thanks again. Just a few points in response to a few things that Kathy said. So I don't -- you noted that you didn't have formulary status for prior years. In our experience, it doesn't really matter. It doesn't matter because when you think about -- and I'm just going to speak from my company's experience -- in the commercial space we have P&T committees that look at drug from a clinical perspective, and in the commercial space, if a plan chooses to cover it, it's covered for infantile spasms and it's covered, in some cases, for exacerbations of MS. That's it.

The FDA has granted a litany of other indications for this drug, and, as noted in your chapter, the drug never had to show that it was efficacious for any of those indications. CMS says that if it's approved, the indication is approved, it is, therefore, covered. So it's

actually hurting plans' ability to manage this type of drug, that has this, you know, grandfathered sort of FDA designation.

So it's a bit of an anomaly. It's ridiculous that orphan status was given to it. I understand why. Infantile spasms is, you know, there wasn't necessarily an alternative, so to protect the drug for that purpose, understand. But under that guise it was protected and, therefore, you know, for an extensive period of tie, even though it had been on the market forever and ever and ever.

So I think we need to do more, from a Part D perspective, to allow plans to manage drug coverage more aggressive, and in line with the commercial space. CMS has handcuffed them. That's why you see the spend, even though the status, the formulary status is the way that it is.

The recommendation to pay -- the example you used was to pay the same as like a corticosteroid. So the reason it doesn't work -- it won't work that way is the drug -- let's say the list price is $37,000. If I pay the pharmacy $100 I might as well just not cover the drug. I can't -- they can't buy it for $100. So to just say, well, that's how we'll manage it, just say it's not covered,

because essentially there's nobody that's going to dispense the $37,000 drug for $100.

Whereas in other conversations we've had around how do you encourage biosimilar use, how do you encourage generics in a multi-source brand space, well, you just, you know, pay -- you incent them by saying you have an alternative within that drug that is a therapeutic equivalent, that you could choose the lower-cost drug. This is a different scenario and it just won't work because the pharmacy is the dispenser, whereas in, like, a B space, the doctor as the prescriber, is the dispenser and can make these decisions. The pharmacy will just turn the script away. So then you have a patient sitting there going, "This prescription for Acthar, no one is going to dispense." So we're putting the bene in the middle and it won't work.

So we've got to think, I think, more about how to actually allow the plans to have greater control, have greater discretion over coverage decision, and so I think an additional policy option that's not listed here, from my perspective, needs to be considered. Thanks.

DR. CROSSON: Thank you, Amy. Jack.

DR. HOADLEY: So I think there's really a lot of really useful stuff in this chapter, just as a starting point. I think I'm really glad you brought all this material to us.

You know, I've been trying to think about these policy tools as well, and it feels like a lot of the challenge we face is that, you know, while there may be some services, including, you know, maybe the protime being the case, where the evidence is, like, absolutely lacking of effectiveness, that would lend itself to one set of solutions, potentially. But in a lot of the cases we talk about low-value care there's a, well, it depends on the age of the patient. It depends on the clinical thing. Even the Acthar gel, you know, if it's useful for -- if we actually had evidence that it's useful for these one or two conditions but not these other things, which are based on more anecdotal evidence, then you get that problem of the tools become blunt instruments.

So you do prior authorization. You create -- even if it works, and, you know, we can debate that. But at best, you put a situation where the patient, who legitimately needs that service or that drug, has a lot of

hoops to go through, has a lot of hassle to deal with. The persistent person, for the inappropriate use, may actually be as likely to get it because they just used more persistence. You could go through the same thing, the decision support things, again.

A lot of it is trying to sort out and get direction to which patient is it appropriate for, which one is it not. And, you know, it's a nice concept but how do you do it in practice without, again, creating a lot of barriers for the patient who legitimately needs it.

The example of the reference cost, you know, that Amy was just using, you know, is a dramatic example of that. So, you know, maybe that a good approach, but at some point it's not a realistic approach if it's a $37,000 cost versus $100. You come up with a way to say, "Well, if it's the patient that really needs it then they can get it for the $100," but you're back in that same thing of how do you adjudicate that?

And I think that's the thing that we really should try to think more about, is one thing for the situations where maybe there's no evidence that it's ever useful, and then you're talking about a coverage decision.

But most of the rest of these things, things are going to be covered. The question is for whom and in what circumstances, and there's lots of examples that I know in the drug area where, I mean, the PCSK9 drugs for cholesterol were, at least when they first came on the market, for a very specific subset of patients, but there was some potential to have them prescribed for a much broader set of patients, at a price tag that, you know, 100 times or more the price of other cholesterol drugs.

MS. BRICKER: $14,000.

DR. HOADLEY: Yeah, versus, you know, you can get Lipitor for $20 or something, the generic version.

So I think that's trying to think through how these tools, or are there other tools that couple apply to sort of bridge that gap between how to maintain the access in the appropriate cases versus trying to restrict use in the inappropriate cases.

The only other specific thing I'll mention, on the clinical support, somebody mentioned a minute ago the opiates, and I know there are some tools. I recently was on a panel that reviewed and approved funding for a new study of behavior economic sort of tools for opiate

prescribing. So, you know, build into the EHR a default of a very small number of pills rather than the sort of standard 30-day supply that would often be the default prescription. Clinicians could then go in and override it with the appropriate conditions. But at least that tries to build in the presumption, the easy answer.

And, you know, you could think about that in terms of things like the prior authorization, how to make it easy for, you know, appropriately prescribing four opiate pills for somebody to go home with after a surgery but not a 30-day supply that realistically they shouldn't be having, and probably won't use if they're responsible, and then it becomes pills that sit in the house, and all those other kinds of problems that go from it. And I think using some of those tools can be helpful but they still don't go at this first-order problem that I raised. Thank you.

DR. CROSSON: Thank you, Jack. Alice.

DR. COOMBS: First of all, thank you very much. The chapter was, I think, a real improvement in terms of being able to bring up issues on both sides of the coin, especially the discussion around PSA. As we mentioned

before, there are certain subsets, and I think it was well done in terms of that.

I'd like to revisit what Kathy said about a redetermination of coverage consideration. But I think in that you have to have a specific target of what you want to do when you say that you want to evaluate reconsideration of coverage. And so it's almost like there needs to be some criteria for which you would recommend that this is one of the things that we need to do, and it has to be squeaky clean.

One of the things, the cases, the examples that are used in the chapter is the early dialysis, and I just want to speak to that for one second. So I guess on page -- well, I'll get to that comment later. But in talking to many of the people who are in nephrology, they might dialyze someone earlier because the protein intake is so minimal that the patient experiences cachexia and failure to thrive because they're cutting back on their protein to stay off of dialysis, so that in doing that they become listless and fatigued, and some of them are working, with marginal CKD, and with that they become disabled.

And so one of the things that's a consideration

in this weight is, do I dialyze and allow this person to become functional -- continually go to work and get their Monday, Wednesday, Friday dialysis, or Tuesday, Thursday, Saturday? And so that's another piece of this, is that they'll make that decision.

The other decision is when you have fluid overload. You might have fluid overload and not be in full failure, and those patients, it's been shown that the mortality is very high if you postpone dialysis, even with the same GFR.

So when we consider what's -- if you just base early dialysis on GFR alone, that's kind of like a gray zone for many patients. So I just wanted to caution us to be careful in that, in that we clear-cut issues like protein B. I think we're probably right in the right chapter there, in terms of doing things like that. But you have to consider all the overall effect. The net effect of a group of physicians saying that "we're going to postpone dialysis until the creatinine gets to 5," then you might have that patient in a very precarious state in terms of their physical conditioning, to the point where they're now disabled, and the cost to the Medicare system is far

greater. So I think that's a piece of this.

And then the distribution of low-value care, geographically. I think that the states that you guys have outlined, it's phenomenal, because like close to the stroke belt, close to the crescent of what we call racial and ethnic disparities, it's, you know, go down on the East Coast south, down to the deep Mississippi, and so forth. And so they kind of follow the disparities and disparate groups in this country. And it's just interesting, if you were to do a map and overlap it.

And so in terms of the policy tools that you use for that, a lot of it is going to involve decision support, but I almost think that it should be shared decision. And in the instance of dialysis, patients are well educated in terms of knowing a friend or something like that. You ask them, "It's time for you to go on dialysis," they're not going to let you strap them to a chair for four hours and say, "I want to go on early dialysis." That ain't happening.

So that, you know, going on dialysis is a big thing, and so part of that is a shared decision-making. But it's almost like you need decision support tools, and

you need shared decision-making, and I think that's very different than just having an isolated icon that pops up and says, "Did you work up a patient for this?" And I think that's a very different kind of approach.

My greatest faith is in health care system reform and episode of care, because the endpoint will be that you're looking for an efficient system that has these quality measures that are on par with what you do in terms of being accountable for the financial piece of caring for patients.

And so I think that's very important, absolute things, also with the Schwartz study, in terms of we talked about this broad and narrow interpretation. One of the questions is, how did they risk-adjust for that? Did they do ACC -- and I didn't know if we depended on that -- or did they use some other risk factors, including how did they control for socioeconomic status in that study? So that would be an important piece for me.

MS. WINTER: Just to clarify, which study are you referring to?

DR. COOMBS: The Schwartz study.

MS. WINTER: The Schwartz study. Okay. The one

here on Slide 18, the Pioneer ACO?

DR. COOMBS: Mm-hmm.

MS. WINTER: Okay. Yeah. We'll look into that. I can get back to you on that. We'll get a little more information in the chapter.

DR. COOMBS: Okay. Okay. And a lot of the information that we're getting is on claims, and so claims don't tell you a lot. If you're talking about racial identification, the claims are going to be self-identified, and there's this large pie on the circle that says "other," and the other is the fact that the patient didn't report, if it's self-reporting. So you may not use racial as a proxy for socioeconomic status in that situation, so it's going to be very hard to get that kind of information and determine how the impact of socioeconomic status -- what it has on low-value care.

So I just wanted to touch on those things.

DR. MATHEWS: Alice, if I could ask one clarifying question. A few minutes ago, in response to Kathy's point about the need for reconsideration of coverage or the need to revisit coverage decisions on an ongoing basis, you said that ideally you would need

criteria in order to make those kinds of decisions, what you were going to look at and the evidence that supported why you wanted to revisit a decision.

Just for my own education, does such criteria exist or do they need to be developed?

DR. COOMBS: They would need to be developed, because some might say this is a new drug on the market and there's no competitor, and then you might consider what the landscape of health care looks like, in terms of the importance of that, and also in terms of the disease process, if there is a prevalence. It's like treating people with Tamiflu if there's epidemics.

So you have to consider a whole gamut of changing things within the environment, including the disease prevalence and what has happened with whatever the disease is that we're talking about.

But, no, there are not existing criteria that I know of. It has been proposed that we should consider that, especially when there are very costly drugs that are being released.

DR. MATHEWS: Yeah, understood, and it's just a very intriguing point with respect to, you know, future

work that the Commission might do here.

DR. CROSSON: Warner.

MR. THOMAS: Just one other thing I would recommend we think about in the chapter, or maybe in a different recommendation, is it seems like we ought to try to have the ACO models engaged in trying to take this issue on directly, if they've got the right incentive. Could we provide benchmarking for them about how they do against each other, or how they basically compare to, you know, the averages across the Medicare system?

I think the other thing that would be helpful is to potentially take some of these areas and challenge CMMI to take them on as specific project that could essentially a challenge to put out to folks that want to have CMMI grants. So I think we could use this information to inform other things that we want to do.

I agree with, you know, several of the recommendations up there around trying to -- especially Kathy's -- about going back and having a look-back on, you know, whether something should be covered or not. But I think there are ways that we could certainly use the ACO model, and especially downside risk ACOs that would

probably take these on and, I believe, probably have an impact.

DR. CROSSON: Okay. So we'll come up this way. Dana.

DR. SAFRAN: Yeah. Not a lot to add. I really like Kathy's idea of continuing to look back, or starting to look back, to look at evidence, and to just connect the dots back to our earlier conversation about Medicare Advantage and encounter data.

One might hypothesize that use of protime beam therapy for prostate cancer would be much less in MA than it's been in fee-for-service Medicare, and if we have the data to look at it, it would be really interesting to look at -- first of all, to answer that question, and then if it's true, to look at survival rates or other outcomes for prostate cancer in the two different systems, just, you know, as one interesting piece of evidence, since you made it clear that, you know, years are going by and we still have no evidence on whether this therapy does make any difference.

DR. CROSSON: Sue.

MS. THOMPSON: I just want to take this

opportunity to thank the three of you for this chapter and this work. We are spending a lot of money, and at the risk of restating what's already been said, in addition to the resources that are consumed, the potential for harm to the Medicare beneficiary, I just don't want that to get lost in all of this discussion. I just think it's work we need to continue to focus on.

I would underscore the recommendation Warner made about ACOs being very willing to take this on. I think it's a great topic, you know, to think about CMMI taking on again as another demonstration. But even without, I think ACO's downside risk, ACOs in particular are quite intrigued.

So I just thank you for that, and I also just want to call out -- you know, I think, as Rita leaves the Commission, the attention that Rita Redberg has drawn to low-value care is so important to the Medicare program, to Medicare beneficiaries, and I just want to thank you for that, Rita.

DR. CROSSON: Second the motion. Paul, last comment.

DR. GINSBURG: Last comment. You know, when I

look at these policy tools, with the exception of delivery system reform, new payment models, which presumably is something we're in favor of anyway, I don't see -- I think all of the other policy tools have merits to them. I don't expect any of them to be anywhere near as effective as the magnitude of the problem.

I do think what Kathy suggested is a whole new approach to coverage. I think I would call it an initial grants of coverage as provisional, you know, that CMS, when it has a new procedure or drug, it's coverage is provisional for a certain length of time, and then which would force them to revisit it, based on the evidence that they have at that time. If there's no evidence, the coverage end. If there's positive evidence, it proceeds.

But it's a very frustrating area, because it's so hard to get effective policies to address it. And I think the main motivation I get from this is to double down on the delivery system reform payment.

DR. CROSSON: And, Paul, I would assume, going back to some of the classification that Jack made, that provisional coverage could be rather specific or it could be broad, but then it could be subsequent to evidence,

narrowed, or removed entirely.

DR. GINSBURG: Yes. Just trying to think of something that gets to the coverage issue back in front of the decision-makers, as opposed to -- because otherwise it's not going to be stacked very well and very little will be done unless it's actually -- something has to be done or else the coverage ends. And, yeah, I think it can be specified that coverage is for certain indications. If there are new indications they have to come forward to get coverage approval for the new indications.

DR. CROSSON: Jack and Kathy, did you want to follow up on that?

DR. HOADLEY: I mean, in some ways, the local coverage decision process maybe has sort of played a little bit of that role, so something gets approved in one area but not necessarily another. But they are still not the sort of automatic "go back and look at it again," any more than there is inside the FDA process.

If post-market gets a drug like Vioxx, a decade or more ago, that had adverse outcomes, those examples here and there get pulled from FDA approval at some later point in time based on post-market surveillance, but it's not

routinely done, and a drug that gets approved for one indication either gets used off label to expand its use or get used more broadly.

You think about some of the thinking at the FDA more recently of approving drugs more quickly, to get them to the market more quickly, will exactly lead in the other direction, we'll say. Okay. Things that aren't at all well proven, they may be based on interim indicators or just a limited period of study. They get on the market, and then, again, the momentum is to keep it there rather than to get it off.

DR. CROSSON: Kathy. Kathy and then Rita for the last work.

MS. BUTO: Yes. Just a cautionary note that if we load too much on coverage and then revisiting coverage, there will be fewer and fewer national coverage decisions. There are already only about 12 or 14, and so I think -- back to Alice's point, I think some thought has to be given to if we wanted to take this forward. We have to do a lot more thinking about how would this work in a way that actually encourages more coverage decisions rather than discouraging and leaving to the carriers, which is the way

it used to be in the early years of Medicare.

And then I just wanted to go back to Rita's point about payment and delivery system reform, and I think Paul made the same point. That I really think that ultimately, coverage becomes a lot less critical, except as a framework, once we're in an MA kind of payment, ACO kind of payment accountability world, where there is a demand on the part of the local entity for more accountability and more evidence. So I'd just point that out because I really think that back to the earlier point, when payment is involved, you get a lot more focus and attention, and that will include evidence as well as service.

DR. CROSSON: Last word, Rita.

DR. REDBERG: Thanks.

I wanted to note in particular -- and Kathy said it's better to do things at the beginning of the coverage decision and particularly for things like proton beam therapy, where you've spent a lot of money on that, people don't walk it back after making that kind of investment, so for capital-intensive things, it's especially important.

But I also -- I just finished four years chairing the MEDCAC, and not all national coverage goes through

MEDCAC, but most do. And it was one or two a year at most.

But CMS also needs a lot more political cover because, for example, the cardiac CD decision, where there was clearly -- it was looking at cardiac CT for diagnosis of coronary disease, clearly no evidence to supports its benefit. There was a lot of political pressure on CMS not to issue a non-coverage decision, which would have been the decision following from that evidence, and so CMS did not issue any coverage decision. I think you cited that Health Affairs paper in this chapter that kind of tell that story, so it went to local carriers. The radiologists and the cardiologists quickly lobbied all the local carriers, and within six months after the lack of evidence, everyone was covering cardiac CT.

A few years later, CMS tried to walk back the coverage because it was just hemorrhaging money for cardiac CT, but there was no chance. Again, it was a capital investment.

The ICD decision when it got expanded, there was an ICD registry, which for some reason, now CMS has decided not to mandate anymore, although they weren't actually using the data to go back and look at the ICD coverage.

But that's the only time I can think of.

The point I'm trying to make is that even when there are restrictions on coverage, CMS doesn't enforce them. It's left to the carriers, and all the carriers are mandated or incented to do is to pay claims quickly. So they don't look at what they're paying for, and there are lots of ICDs that were clearly against the guidelines. They were being put in 30 days after an MI, when it showed that those are increased mortality, and the ICDs were more likely to kill our beneficiaries.

And eventually, because of a whistleblower, there was a lawsuit, and DOJ recovered some money for CMS, but it was never because CMS or the carriers went back and looked at the claims they were paying and noticed that they were paying claims that they should not have been paying to the harm of the program and the harm of beneficiaries.

And the last thing is the most recent of the lung cancer screening, MEDCAC, where the Committee voted that there was a lot of concerns about harms, lack of benefit in the Medicare population, CMS again had a lot of pressure to cover lung cancer screening. The task force had already given it a Grade B, and so they said, "Okay. We'll have it

with shared decision-making." Well, I bet you there was no shared decision-making going on in our Medicare beneficiaries."

The last data that we published in JAMA Internal Medicine, someone analyzed the national inpatient sample. There has been certainly an increase in lung cancer screening, but it's not -- and even smokers, it's in light smokers, never smokers, people that are not going to benefit and weren't within the Medicare guidelines.

So I think if we want to talk about coverage and going back in coverage, there has to be an actual mechanism where CMS has the political cover to actually enforce the coverage decisions that it makes because it's not happening now.

DR. CROSSON: Okay. Thank you.

Thank you, Ariel, Carlos, Nancy. Good material for us. Good discussion as well.

I think we are finished with this session.

And we now have time for a public comment period. If there's anyone in the audience who would like to make a public comment, please come up to the microphone.

DR. JAMESON: Thank you, Mr. Chairman.

DR. CROSSON: Let me just let the people clear out who want to clear out. Nobody wants to clear out? You must have something incredible here.

I would like to make a couple of comments that I usually make. This is not the best time or the most effective way of addressing the Commission. The staff makes itself available on a regular basis for that purpose. However, it is an opportunity. I would ask you to identify yourself and your organization, and if you would, limit your comments to about two minutes. And when this light comes back on, that would be that two minutes.

* DR. JAMESON: Thank you, Mr. Chairman. I am Jason Jameson. I'm a urologist from Phoenix, Arizona. This is my first MedPAC meeting. I'm part of the American Urologic Association Health Policy Program that they have, so this has really been great. I've been here all day, and I'll be back tomorrow.

I really appreciated this meeting and all the work, and I really wanted to just mention about taking caution in defining what is low quality, which can change and can have unintended consequences. I appreciate the comments just spoken about dialysis. Some things just

aren't so straightforward to try and make some of these decisions.

I want to just go back to prostate cancer, PSA screening. We sort of know what it was like in the 1980s before we had this test, and about 75 percent of men would present with metastatic disease. So I think it's something that we shouldn't forget about.

Also, we have a lot of very expensive medications that are currently being used for metastatic prostate cancer, so one of the fears we have is without any screening or acknowledging the benefits of screening, that there will be more advanced disease at a significantly high cost.

As things can change, as evidenced by the USPSTF, their decision actually, they already are changing their 2018 grading from their 2012 decision where they gave it a Grade D. So that's just an example of how different things can change, and I think that you don't want to be in a position where you're at this committee looking in five or ten years at the high cost of metastatic prostate cancer. And there have been some data suggesting that that is occurring even since the decision in 2012.

So I appreciate the chance to just share some of those comments and urge you to continue this process. I think it's great to continue to reevaluate all the decisions that are covered. And I suspect as the PSA, you will find that it definitely does have value and that the PLCO trial had about 90 percent contamination rate, and so that's probably why it didn't show much benefit. But there have been other studies showing about a 30 to 35 percent reduction in survival and a significant reduction in metastatic disease, which was uncommon in the PSA era.

Thank you.

DR. CROSSON: Thank you. And that concludes our day, and we will reconvene tomorrow morning at 8:30. Thanks very much.

[Whereupon, at 3:44 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, April 6, 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, April 6, 2018
8:32 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
ALICE COOMBS, MD
BRIAN DeBUSK, PhD
PAUL GINSBURG, PhD
DAVID GRABOWSKI, PhD
JACK HOADLEY, PhD
DAVID NERENZ, PhD
BRUCE PYENSON, FSA, MAAA
RITA REDBERG, MD, MSc
DANA GELB SAFRAN, ScD
CRAIG SAMITT, MD, MBA
SUSAN THOMPSON, MS, RN
PAT WANG, JD

AGENDA PAGE

P R O C E E D I N G S

[8:32 a.m.]

DR. CROSSON: Okay. I think it's time to get started. This is the final session of our 2017-2018 term. We have two presentations this morning. The first one is on long-term issues confronting accountable care organizations. David, Sydney, and Jeff are here to present, and Sydney is going to start.

* MS. McCLENDON: Good morning. In this session we'll be continuing our discussion from January on Medicare's accountable care organizations and discuss potential long-term issues confronting ACOs.

I'll begin today by giving some brief background on Medicare's ACOs and provide an overview on participation across programs in 2018. I'll then walk through changes for Medicare's ACOs that were included in the recently passed Bipartisan Budget Act of 2018. David will then discuss long-term issues for two-sided ACOs and provide some potential topics for your discussion.

As you know, ACOs are groups of health care providers who have agreed to be held accountable for the cost and quality of care for a group of beneficiaries.

The goals of Medicare's ACO programs are to increase provider accountability for their patient population, increase quality of care and patient experience, and lower costs. ACOs that are successful in meeting these goals are rewarded with shared savings.

As we discussed in January, there are a few basic concepts for ACOs.

The first is composition. ACOs can be comprised of whatever health care providers they choose, which could include primary care providers, hospitals, or specialty practices.

Next is attribution. Beneficiaries are predominantly attributed to ACOs according to service use. And starting in 2018, beneficiaries also have the option to voluntarily align themselves with MSSP ACOs by designating a primary clinician. Some ACOs have beneficiaries attributed to them prospectively, at the beginning of the performance year, while others have beneficiaries attributed to them retrospectively, at the end of the year.

To judge the financial success of an ACO, CMS creates benchmarks, and the benchmark is one estimate of expected Medicare Part A and B spending for an ACO's

beneficiaries.

Finally, we have financial risk. ACOs in one-sided risk arrangements can earn shared savings if spending in a given performance year is below the benchmark, but they are not responsible for losses above the benchmark. ACOs in two-sided risk arrangements, however, can earn savings but also face the possibility of shared losses.

In January, we discussed Medicare's permanent and demonstration ACO models, and today we'll provide more detail on the two ACO models that began in 2018: the Track 1+ ACO model and the Vermont All-Payer ACO model.

Track 1+ is a prospective attribution model that ACOs can participate in for only one agreement period. It's similar to the existing MSSP ACOs, but differs because it is an asymmetric model. The first asymmetry is the shared savings and loss amount. Track 1+ ACOs can share in up to 50 percent of savings, but they are only responsible for 30 percent of losses. Additionally, there is an asymmetry on the cap for savings and losses, and the savings cap is higher than the cap on losses, which was discussed in more detail in your mailing material.

The other new model in 2018 is the Vermont All-

Payer ACO model. The Vermont model brings together Medicare, Medicaid, and Vermont's commercial insurers into one ACO with similar goals. An example of these goals for Medicare beneficiaries includes attributing 90 percent of Medicare beneficiaries to the ACO by 2022 and keeping Medicare per capita expenditure growth below national Medicare growth.

Both the Vermont and Track 1+ ACOs assume risk and will qualify as advanced alternative payment models for 2018. We will continue to monitor these models moving forward.

In January, we also presented the number of Medicare ACOs participating in 2017, which on the slide above are depicted by the blue bars. We now have the numbers for 2018, which are presented in green. As you can see, the number of ACOs again increased across most models in 2018.

We first have MSSP Track 1, which is a one-sided model and continues to dominate with the largest number of participating ACOs. You can also see great interest in Track 1+, the asymmetric model I just discussed, which has 55 ACOs participating in its first year. To the right of

Track 1+ we also have the number of NextGen ACOs, which increased from 2017 to 2018. However, recent reports and updates to the CMS website indicate that seven ACOs have dropped out of the NextGen program since the start of 2018.

So in addition to providing an update on the status of ACOs in 2018, we also wanted to bring to your attention changes for Medicare's ACOs that were included in the recently passed Bipartisan Budget Act of 2018, and many of these changes align with previous Commission positions.

First, the BBA will allow two-sided ACO providers to create a beneficiary incentive program. The incentive program would allow ACOs to pay beneficiaries up to $20 for a qualifying primary care visit with an ACO provider.

The BBA also expands the use of telehealth for two-sided ACOs with prospective attribution. These ACOs will no longer be subject to a geographic limitation on the telehealth originating site and will be able to use the beneficiary's home as an originating site. This change aligns with our discussion of telehealth in our March 2018 Report to the Congress.

The BBA also expanded the use of voluntary attribution, and under current CMS rules, beneficiaries can

voluntarily align themselves to an MSSP ACO by selecting a primary clinician on MyMedicare.gov. But moving forward, the BBA has made this a statutory provision.

Finally, the BBA expanded the use of prospective attribution to ACO models that currently use retrospective attribution. Starting in 2020, ACOs in retrospective models, like MSSP Track 1 and Track 2, can switch to using prospective attribution.

We'll now shift our discussion to issues pertaining to the long-term sustainability of ACOs. To begin that discussion, I'd like to highlight some findings that we discussed in January related to whether or not ACOs are saving money for the Medicare program.

As a recap, using CMS data we found that one-sided ACOs generated a small loss for the program while two-sided ACOs, regardless of the model, generated savings on net. The savings for two-sided ACOs were relatively small, in the magnitude of about 1 percent across models.

We also looked at savings estimates for ACOs in the literature. When looking at the literature, some researchers found that both one-sided and two-sided ACOs generated small savings, with two-sided ACOs generating

slightly larger savings.

We have also included an appendix on quality in your mailing materials at your request. And, generally, ACOs appear to be maintaining or increasing quality of care for their patients.

I'll now turn it over to David to discuss potential issues for ACOs in the long term.

MR. GLASS: Thank you.

Well, as Sydney has just explained, ACOs seem to be having some success, and the two-sided variety of ACOs seems to be doing slightly better.

The other concept we need to introduce is advanced alternative payment models, and the point we need to remember here is that participation in A-APMs can help clinicians qualify for the 5 percent incentive bonus on their physician fee schedule revenue.

The only ACO models that can be A-APMs are those in which the model is at two-sided risk, so we are most interested in those models.

In addition, two-sided risk ACOs best meet the Commission's principles for A-APMs because they have a meaningful level of risk and they are at risk for all of

Part A and B spending. So we are focused on the two-sided risk ACO models as those of most interest going forward.

So the basic question for the rest of the presentation is: Are two-sided risk ACO models sustainable over the long run? And we are going to consider the following issues and how they may help or hinder their sustainability: First, MedPAC's proposal on the A-APM incentive payment. We are talking about hospital-ACO interaction, asymmetric ACO models, the role of specialists in ACOs, and ACOs in relation to MA plans.

So we have discussed the A-APM incentive payment in the past, and I'll just briefly outline the issue.

In short, the incentive is a 5 percent bonus payment on a clinician's entire pharmacy fee schedule revenue, and it's effective 2019 through 2024.

The catch is a clinician must meet the threshold on either payments derived from the model or the clinician's participation in an A-APM or the share of a clinician's patients coming through an A-APM. The payment thresholds are set in law, 25 percent in 2019 and 2020, and then they increase in later years. The patient share threshold is set in regulation and is lower.

There is an issue with the threshold approach because it creates a payment discontinuity or cliff at the threshold, and this creates uncertainty for the clinician and weakens the incentive.

For example, if one clinician has 24.9 percent of revenue through an A-APM, he gets nothing. If another has 25 percent of revenue, she gets 5 percent on all of her physician fee schedule revenue for the previous year. This seems inequitable, it introduces uncertainty, and thereby weakens the incentive.

As we discussed back in November, there is a different policy that could fix this problem -- that is, to eliminate the threshold and pay the 5 percent bonus only on clinicians' physician fee schedule revenue derived from A-APMs, but pay it with certainty. This proposal is gaining some traction; it was in the most recent President's budget.

The proposal makes the bonus more equitable and more certain. It also simplifies the program because it eliminates the whole mechanism that has been invented to calculate what share of patients is coming through A-APMs and, in particular, the all-payer variant which requires

CMS to investigate what kind of contract a clinician has with commercial payers and is it equivalent to an A-APM model. This proposal would reduce administrative costs. The point here is this proposal could strengthen incentives for clinicians to participate in two-sided A-APMs.

The next issue concerning long-term ACO participation is: Will hospitals want to participate or cooperate with ACOs? Can they coexist?

This issue arises because there is a potential conflict between hospital and ACO incentives. Hospitals want to maintain or increase their admissions. ACOs want to restrain spending, and when ACOs first started, reducing hospital admissions seemed to be a promising way to do that.

However, we find that reducing post-acute care not inpatient admissions has been the primary source of Medicare ACO savings, and this should not be too surprising. There is much less variation in inpatient use relative to PAC use. In addition, we found that ACO growth has not led to a material reduction in hospital admissions at the market level.

The take-home point for our purposes today is

that the apparent conflict has not been material and, if that continues, should not be a limit on the long-term future of two-sided ACOs in the program.

Another issue is: Should asymmetric models be continued?

The question here is whether asymmetry is needed to keep two-sided ACOs in the program long term. If so, under what circumstances should such models or aspects of those models be extended to encourage the long-term participation of two-sided ACOs?

Now, by asymmetric, we mean models that are tilted in the ACO's favor. For example, the share of savings can be greater than the share of losses, or the cap on savings can be greater than the cap on losses. Such models have the potential to increase the availability of ACOs and are thus of interest.

The difficulty is that those models have the potential to cost the program, particularly if losses outweigh savings. The extreme example is Track 1 of MSSP. It is very asymmetric because the share of losses is zero, and it has cost the program money each year relative to the benchmark.

The new Track 1+ is asymmetric both in the share and the cap. There are 55 ACOs in the first year, so it seems attractive to ACOs. Because it is a demonstration, it doesn't have to meet any test for savings, but it does have the potential depending on ACO performance to represent a loss for the program relative to its benchmarks.

One option would be to track the progress of the Track 1+ model to inform the Commission on the success or not of tilting payment toward ACOs.

Another issue that has concerned the Commission is specialist participation in two-sided ACOs. In the long term, will specialists want to participate and will they be welcome to participate?

This is particularly an issue if two-sided ACOs are the A-APMs of choice and clinicians are encouraged to participate in A-APMs rather than staying in traditional fee-for-service.

The concern is that if attribution is focused on use of primary care services, there will be no need to include specialists to gain attribution. In addition, there is a concern that specialists contribute to increased

costs relative to primary care clinicians.

However, we find that specialists are participating in ACOs. In fact, in MSSP about half the participating providers are specialists.

Conceptually, if specialists were more efficient in terms of overall patient welfare, specialists could help control spending, for example, by not doing low-value testing; they could get more referrals because primary care clinicians in the ACO could refer patients to them in preference to non-participating specialists; and specialists could also share in savings, although we do not think this is the usual model thus far.

Finally, some models are already specialty focused. For example, ESCOs must have nephrologists to qualify for the demonstration. Other models could be developed that require specialists if they retain accountability for all Part A and Part B spending.

So a final issue is: Are ACOs only a transition step to MA plans and thus there is no reason to worry about ACOs in the long term?

This concern arises if one thinks that MA plans are the more efficient model, and ACOs will eventually

evolve into MA plans without exception.

What makes this less compelling a vision is that MA plans have to enroll beneficiaries and have much higher administrative costs than ACOs.

In fact, in previous work we found that in some markets ACOs were the low-cost model.

ACOs have much lower administrative costs than MA plans, by about $1,000 per beneficiary per year.

Additionally, in some markets the ACO may be the dominant provider. In that case, the ACO may get the benefit of having a limited network without the "lock-in" that MA plans have. That is, in an MA plan the plan can require that beneficiaries use a limited network of providers, beneficiaries agree to be locked into that network, and the MA plan can keep its cost down as a result. Dominant ACOs may in effect accrue the same benefit.

Because there is some reason to believe that ACOs may be the efficient model in some markets relative to MA, their long-term future is still important.

So here are three points for your discussion.

Last November, there seemed to be some consensus

for changing the policy for distributing the 5 percent A-APM bonus. Thus, one question is: Should the Commission recommend a new policy for the 5 percent A-APM bonus that would increase certainty and eliminate the thresholds?

Next, under what circumstances should asymmetric risk ACOs be continued? If the Track 1+ model seems to work, for example, should it or aspects of it be continued?

Finally, what other issues would Commissioners want the staff to consider for two-sided ACOs in the long term?

We look forward to your questions and discussion.

DR. CROSSON: Thank you very much for the presentation. As many of you may know, or may not know, the Commission has been working on the ACO idea anyway for almost a decade, and we are continuing that work. So we'll take clarifying questions. David.

DR. NERENZ: Thanks. I have three questions. This is my last chance to ask picky semantic questions, so here we go.

[Laughter.]

MR. GLASS: By all means [off microphone].

DR. NERENZ: I will. Slide 8, please. Just at

the title, you know, the wording here implies that the model is what has the causal effect, which seems to in turn imply that there's perhaps been some studies with random assignment of ACOs to this model or that model so that you can say it's the model that causes that, and, obviously, the alternative is that some characteristic of the ACOs who choose to be in Track 2. So I'm just asking. Is there any evidence that the model itself has the causal effect here?

MR. GLASS: Well, just mathematically, the two-sided ACOs, you can't have --

DR. NERENZ: Well, it's correlation and causality.

MR. GLASS: You can't show loss anyway, right?

DR. NERENZ: Well, I'm just -- I'm try to understand --

MR. GLASS: So one would except them to be more successful on this metric.

DR. STENSLAND: I think you're talking about the ACO saving money, and David is talking about the government saving money. And in a two-sided ACO --

DR. CROSSON: I think David is asking the question about selection bias. Is that right?

MR. GLASS: Yes, that's fair.

DR. NERENZ: No, because it implies here that the model is what produces the benefit --

MR. GLASS: Right, no, it is --

DR. NERENZ: -- and that if in future policy we pushed everybody into this model, the benefit would follow. And I just -- I'd say, well, I don't see the evidence for that. So I'm asking is that -- has there ever been such --

MR. GLASS: No, I don't think so.

DR. NERENZ: Okay. I just wanted to ask.

Slide 15, please. The word "participation," talk to me a little bit about what we know about participation. It seems like that's a whole spectrum of possible roles, everywhere from a specialty group could be essentially the owner/manager, base of the ACO, run all the infrastructure, take all the risk, if there is some, receive the benefit. Or at the other end of the spectrum, a specialist could just be on a list and essentially not know he or she is even in the ACO. So when we say "participation," what does that mean, exactly?

MR. GLASS: What we are saying here is that they are on the list.

DR. NERENZ: Okay. So it doesn't imply anything more than that.

MR. GLASS: The list of TINs and NPIs in some cases or just TINS.

DR. NERENZ: Okay. So they may be a participant.

MR. GLASS: They don't have to be active.

DR. NERENZ: Thank you.

MR. GLASS: They don't have to be running it.

DR. NERENZ: They don't even know that it's going on.

MR. GLASS: May not know it.

DR. NERENZ: Okay, okay. Fine.

Last one, 16. The transition set and particularly the wording of the first bullet, tell me a little more about -- because an ACO is a delivery system entity. An MA plan is an insurance entity. You can't just move on a line from one to the other. It's like an elephant says, "I'd like to be a fish tomorrow." You can't do it.

So when you talk about this transition, what do you want us to think about that?

MR. GLASS: Well, this is really in reaction to

the Commissioners who have said that, "Oh, eventually, these should just become all MA plans."

DR. NERENZ: That's what I -- how -- I mean, how do you think --

MR. GLASS: How they're going to do that? Well, some of them --

DR. NERENZ: I'm inclined to think they can't do that, as literally stated. I mean, they have to -- an insurance entity is a certain kind of legal entity with certain requirements --

MR. GLASS: That's correct.

DR. NERENZ: -- that are subject to regulation. You just can't go from Tuesday to Thursday, from one to the other.

DR. STENSLAND: Sometimes they'll team with an insurance company. They'll say, "We have a group of physicians, and we're an ACO. Let's team up with this insurance company, and you offer a product in our market. We'll be your network. We'll take the risk. You pay the claims." There we go.

DR. NERENZ: Okay. That's what I'm looking for: What does this word "transition" mean? How does it happen?

DR. CROSSON: Well, in addition to what Jeff said, I mean, some of the larger integrated organizations have the capacity to develop an insurance function internally if they want to take that step, and it has happened.

DR. SAFRAN: Quite a bit.

MR. GLASS: Again, I'll fully admit. This is just a semantic picking point. When you say "transition to" or "wants to be," it seems like the required action is much more difficult and complicated than that.

DR. SAFRAN: There have been over the past couple of years quite a number of provider-led ACOs who choose to become a provider-sponsored health plan, and they almost always start with Medicare first because it's hard to be a health plan in a market for employers if you only have a network in a certain geographic area.

So you're absolutely right. They have to develop that insurance function, and they can't just sort of, presto, become a plan. But I think it's an appropriate concept to be describing because it's actually -- it is happening.

MR. GLASS: That's okay, and I didn't want to

leak into Round 2. I just wanted to sort of tee this up and say when we talk in Round 2, I just want to understand what does this transition look like, what does it require.

DR. CROSSON: Questions. Bruce.

MR. PYENSON: This is a question about the administrative cost, the approximately $200 per beneficiary for ACOs. I'm wondering if you could put that in the context of -- sort of line that up with the roughly $1,100 for an HMO for Medicare Advantage. So when you think of the -- round terms, $200 is about 2 percent. An MA plan might be 12 percent, 15 percent admin on a stable basis.

What kinds of functions does that line up with or correspond to?

DR. STENSLAND: I think what the ACO does, it's going to vary somewhat, depending on what their ACO model is, and I think of ACO models -- there's a continuum, but some are more like we're going to save money by not doing things. And other ACO models, maybe we're going to save money by doing things. We're going to bring people in for their annual wellness visits, and we think by doing more wellness, we're going to keep them healthy.

So how much administrative they're spending, I

think can vary a little bit, but most of this is -- you know, you're submitting your quality data to CMS. You are preparing your proposals for CMS, and maybe you're doing some sort of care coordination.

But for the HMO, you're paying the claims. You're negotiating the prices with everybody. You are paying a broker to sell your HMO product. So I think that's where a lot of the much bigger costs come in, from the HMO administrative cost. We are just reporting what they report on their bids.

MR. PYENSON: So some of that $200 might actually be things that the ACO would be doing anyway under the quality improvement program or things of that sort, and some of it might be extra analytics.

So for an ACO with about 10,000 lives, that's $2 million. If you think of FTEs, it depends, something like 10 FTEs for an ACO, 10,000. Okay.

DR. CROSSON: Okay. David.

DR. GRABOWSKI: Great. Thanks for this work.

Could you put up Slide 8, please? I just wanted to ask you. These two bullets, I think, are looking at very different things. The first bullet is about program

design benchmarks, whereas the second is about research design counterfactuals. And I think the second is about savings, and the first is not. I wanted to ask how you're thinking about those. Are you thinking about both of them as savings here?

You need benchmarks for incentives to pay bonuses, but it's not really true savings to the programs. I just want to think about how are we thinking about these two bullets alongside.

MR. GLASS: No, that's exactly right. So the benchmarks were developed for policy, for certain policy goals and reasons and may not represent the best estimate of the counterfactual, whereas the academic studies presumably are trying to do that. So, yeah, if you're looking at savings to the program, the second bullet is probably where you want to look. If you're trying to understand how are they doing relative to their benchmarks, that's the first one.

DR. GRABOWSKI: I want to follow up, but maybe I'll save it for Round 2. Thanks.

MR. GLASS: Okay.

DR. CROSSON: Sue.

MS. THOMPSON: Thank you.

Do you have any idea how many beneficiaries have voluntarily signed up to be a part of an ACO? Do we know that?

MS. McCLENDON: Yeah. We have a rough estimate from CMS. It's a couple thousand, but we also do know that those that have voluntarily aligned, most of them also would have been aligned via claims.

I do think they're trying to ramp up, but we're not 100 percent sure right now how big the push is to try and get beneficiaries to voluntarily align.

MS. THOMPSON: And, Sydney, you referenced that there were -- was it seven participants in the Next Gen program that have dropped out now?

MS. McCLENDON: Mm-hmm. Yes.

MS. THOMPSON: Would you just talk about that a little bit for everybody to understand the benchmarking challenges?

MR. GLASS: Yeah. I don't think we have any deep knowledge of why they left. One might speculate that they looked at their benchmarks and said that we're not going to make money on this, but that's total speculation. I don't

know.

MS. THOMPSON: Okay.

In the context of advanced APMs, how much have we thought about specialists who participate in bundles and the impact of those patient lives on the ACO and getting clear about who gets the benefit and no double benefit or at least one getting the -- and thinking about clarity in those two programs?

MR. GLASS: Yeah. Getting clarity would probably be difficult. It's really -- gets really complicated of who should accrue the savings, if you will, from saving money in an episode if -- the beneficiaries in the A-APM.

So the rule, I think, was that in Next Gen, Next Gen gets priority. So if the patient shows up in an episode in some place where they do episodes, that patient is not included in the episodes, and you can only do that if you have prospectively attributed patients.

So I don't know if they've extended that to all prospectively attributed ACOs or not. We'd have to check on that, but, yeah, this becomes a very complicated issue, and we've thought about it a little bit. That's the easy solution kind of, is to say this patient is an ACO patient,

therefore out of the episodes, but obviously, people who have run episodes don't like that interpretation.

MS. THOMPSON: It plays into the challenges we have with engaging specialists.

MR. GLASS: Yeah.

MS. THOMPSON: And last but not least, risk coding. Do we have any idea how much risk coding has played a role in the savings that ACOs have achieved?

DR. STENSLAND: I think up till now, probably not so much. Going forward, maybe more. It all depends on how they do a risk adjustment.

Like on the one-sided ACOs, you got credit. You didn't get credit if your risk score went up, but you got penalized if your risk score went down in terms of moving your benchmark, and so that was really protecting CMS to a degree.

As they move toward more blended benchmarks, where the benchmark is partially based on your regional score and partially based on your historical spending, then CMS is going to be much more exposed, and if we learn anything from MA, we should expect risk scores to grow and benchmarks to grow, and there need to be some sort of

correction for that.

MS. THOMPSON: Thank you.

DR. CROSSON: Yeah, just one point on one of Sue's point, the interface between ACOs and bundled payments, at least at the hospital level.

The other issue -- and we've talked about this before -- is the potential for really conflict of interest, particularly for a bundled payment entity, bundled payments where in general, it's profitable. So, on the one hand, you have the incentive that the institution is involved in to reduce overall cost per beneficiary, and yet if there's simultaneously a bundled payment opportunity for that institution that is profitable, there's an incentive, arguably, to do more of those procedures. And I think that issue, particularly if bundled payments grow, as a larger part of payment, we're going to have to wrestle with.

I actually have one question on page 12, where we're talking about the proposal for distributing the A-APM incentive payment. If that proposal were to go forward, we've got money moving in two different directions. Have you had a chance to model out whether that would be a net loss or net gain for Medicare?

MR. GLASS: No. I mean, we haven't really delved into it too much. To the extent they are paying more clinicians who would have been under the threshold, it would appear to increase costs a bit. To the extent they are not paying them for all of their physician fee schedule revenue, it would reduce costs a bit.

And there is the odd situation now where it seems everyone is getting past the threshold, and I'm not quite sure how that happens. But then it would save money.

DR. CROSSON: Okay. Thanks.

DR. COOMBS: Can I ask a question?

DR. CROSSON: On that, Alice?

DR. COOMBS: Yes.

My question, I was going to ask you, do you know the distribution of the APM revenue within the providers, the advanced APM revenue and the providers that we have right now? There's a distribution. I mean, some people make the 25 percent. Are there a lot of people who get to the 50 percent or the 75 percent? What does that distribution look like? Because that's what's going to help you to project going forward.

MR. GLASS: Yeah. I --

DR. COOMBS: I mean, that's something that I think would be incredibly valuable.

MR. GLASS: Well, early on, there seemed to be some distributions.

I think Kate may remember this better.

MS. BLONIARZ: So we don't have a real good sense. We have a little bit of information, and one thing that CMS has done to kind of get every participant in an APM, kind of getting the incentive payment, is they have this process where they say, "Okay. I'm going to see if you meet 25 percent of revenue at the entity level and then 20 percent of patients at the entity level and then 25 percent of revenue at the individual level," and on and on and on.

And they also do a couple of snapshots throughout the year, and if an individual gets in, kind of qualify for the incentive payment, at any point they qualify.

DR. COOMBS: Okay.

MS. BLONIARZ: So we think that's kind of how they're getting most people that are participating how they're determining that they qualify for the incentive payment.

DR. COOMBS: So if it's a multispecialty group and their overall revenue is at the 50 percent mark, then the individual would be reflected in that overall revenue for the multispecialty group.

MS. BLONIARZ: Yes.

DR. COOMBS: Is that correct?

MS. BLONIARZ: Yes.

DR. COOMBS: Okay.

DR. CROSSON: Okay. Continuing clarifying questions. Pat.

MS. WANG: Going back to Slide 8, can you say more about -- many of the important -- or at least one of the important questions that you pose on Slide 17 have to do with our attitudes towards asymmetric risk, et cetera, et cetera, which obviously is critically tied to how benchmarks and savings are calculated. There's been a lot of discussion about how the so-called CMS benchmarks are maybe difficult for ACOs to -- there's been opinions that it's not the best measure of savings, for example.

I'm wondering on Slide 8, on that second bullet, can you say more about the alternative approaches towards calculation of savings that have been used and whether you

think that this is -- whether there's a better, solidly better alternative out there? You called it the "counterfactual" that's -- you know, whatever it's called. Or is this like a work in progress where people are thinking about it? Has there actually in your view been a better approach proposed?

DR. STENSLAND: I think that it's important to think that there's two different purposes, and I think most of the academic studies, you'll see McWilliams and some others, colleagues at Harvard, have done some of these. And they're trying to say has the program generated net savings, meaning the reduction in service use, is that bigger than the shared savings that are going out? And in their mind, often the best counterfactual is let's look at the growth in spending of the people in the market versus some matched group of people in that same market to see what their spending growth is when they're not in the ACO.

And I think that's reasonable, and I think they generally find small savings, even in the one-sided model. In some cases, they found it bigger in the two-sided.

Then the question is like should you move that and should CMS use that for setting its benchmarks, and I

think it's not necessarily true that you would want the same thing for those two different purposes.

For example, one thing that's concerned me is if you started using local benchmarks, then all of a sudden, the benefit to patient selection gets very big because if you can slough off an expense to a person that's going to get a hip replacement and you kind of know they're going to and they end up going to a different practice, right now that doesn't really -- you lose that spending, but it doesn't affect your benchmark because your benchmark is based on overall growth. But if your benchmark is based on your local competitor and now you've gotten rid of the expensive person and now they're in the other group that you're benchmarked against, you kind of get a double incentive to slough off the expensive patients or patients that are going to cost more than they would, based on historical spending or risk adjustment.

So I think there's some caution that we should not necessarily think that when you have two different goals -- the one goal, trying to accurately measure are we saving money, and the other goal as trying to incent people to do the best for the program -- that we'd necessarily use

the same metric for those two different goals.

DR. CROSSON: Paul.

DR. GINSBURG: I've got two separate questions. One is that when you're mentioning in looking at what's the source of savings, that is, mostly post-acute care, very little, and hospital admissions, did you, by any chance, break it out between the physician-owned ACOs and the hospital-owned ACOs?

DR. STENSLAND: We haven't done that. It's a good idea.

DR. GINSBURG: Okay. The second question concerns specialists. To what degree can an ACO -- is an ACO allowed to steer referrals towards specialists that are either in the ACO or specialists that are not, but which the ACO believes are more efficient or higher quality?

MR. GLASS: Well, I think the physicians in the ACO, like any physician --

DR. GINSBURG: That they can do it on their own.

MR. GLASS: Yeah. Can suggest that.

DR. GINSBURG: But can the ACO help them?

MR. GLASS: Oh. I'm not sure.

DR. GINSBURG: Because the ACO presumably has

the ability to use data --

MR. GLASS: Right.

DR. GINSBURG: -- to say these are the specialists we should be using.

MR. GLASS: Oh, yeah. I think they can do that. Yeah. I think that's fine.

DR. GINSBURG: Okay.

MR. GLASS: And you can't say, "You can't go to that specialist" --

DR. GINSBURG: Yeah.

MR. GLASS: -- because the patient has free choice, but you could certainly recommend.

DR. GINSBURG: I was just thinking about post-acute care that the hospitals are very restricted as far as the steering they can do in a formal way at least.

MR. GLASS: Right.

DR. GINSBURG: So then next question is, what are the motivations either on the part of the specialist to be in the ACO or on the part of the ACO to have this -- to sign up the specialist for the ACO?

MR. GLASS: Do you want to turn to that slide?

Yeah. So we've just started to think about that

a bit, and presumably, if the ACO can discriminate between specialists who don't do a lot of extra testing and are conservative in their practice patterns, they could refer to those people.

DR. GINSBURG: Yeah. But the people they refer to, would they want them to be members of the ACO, or don't they care?

MR. GLASS: Yeah. That, I'm not sure whether they should -- whether it makes any difference whether they participate in the ACO and are on the list of physicians or not. I don't know.

DR. GINSBURG: Okay. We'll go into this in Round 2, but I just have the sense that there's not much understanding about what ties specialists to the ACO. It's good to see 50 percent somehow are affiliated. That's less than primary care, I presume, but it's not awful. But I think it's something I'd like us to dig into more.

DR. CROSSON: I don't know either, but I do have the sense that there's a supply and demand issue there. To a certain extent, when there is an oversupply of specialists, for example, in a marketplace, then there's an incentive for specialists to affiliate with the ACO for

volume.

Okay. Questions? Jack.

DR. HOADLEY: So perhaps not a surprise, I'm going to ask a question about the beneficiary side.

Sydney, you talked about the new incentive in the Bipartisan Budget Act, and it's so new, I suppose CMS probably has not said a thing about it yet. But do you have any sense of even just sort of mechanically what the expectation is in terms of making this payment? Is this a check written from the ACO to the beneficiary, and is there any sort of precedent in commercial or other ACOs for trying to do this?

MS. McCLENDON: So a couple of things on that. First thing I would say is yes. So for the beneficiary incentive program, it would kind of be -- our understanding now. CMS hasn't put anything out yet because I don't think it's set to be in plan till about 2020 at the latest, but it would entirely be coming from the ACO. And they would have to apply to participate in this program and kind of submit to CMS, "This is what we're planning to do. These are the services that we would be paying," this up to $20 on.

So I think the way that it's set up now, from what we can tell the ACO would have some flexibility with how they wanted to run this program.

In terms of like precedents set for something like this, within the Next Generation program, for instance, there is a coordinated care benefit that beneficiaries can receive for doing to their annual wellness visit with an ACO provider. There's a little bit of a difference there, though, in that that payment is coming from CMS. So there's a little bit of a difference.

I don't know that we've really seen anything else similar to this, obviously, within Medicare. I don't know if you guys have ideas on commercial.

MR. GLASS: Well, so we thought about this, you know, years ago. As you said, we've been talking about ACOs for approximately forever.

[Laughter.]

DR. HOADLEY: Right.

MR. GLASS: Anyway, so we've been thinking about this for a while, and we noticed that, you know, one problem with just lowering the co-pay, which seemed like the obvious solution to this if you went to the ACO

provider, was that a lot of people have supplemental so it doesn't have much power, and that we even had the specific supplemental plan, which I think you have at Blue Cross, for ACOs where you can get a supplemental with a lower premium because you're going to an ACO anyway. So we've talked about this in the past, and the NextGen actually tried to do something. And this is yet another approach --

DR. HOADLEY: Yeah, another --

MR. GLASS: -- and this one gets over the supplemental problem because you just hand them money.

DR. HOADLEY: Right.

MR. GLASS: So, you know, we can see how many ACOs choose to do it, you know, to have the -- are they making enough in shared savings to fund such a thing or not? So it will be interesting to see what the take-up is.

DR. HOADLEY: Thank you. That's helpful.

DR. CROSSON: Alice.

DR. COOMBS: I had a question regarding one of the appendices in the back on page 12. There's two questions I have. One is the relationship to the two-sided risk ACOs and if we have any information about whether or not -- because you do a comparison between the one-sided

and there's a slight savings, as you mentioned, with the two-sided risk. Did you look to see the distribution of the penetration in high-cost areas for the two-sided risk? And does that look different than the one-sided risk in terms of their ability to have a savings? Because this is really important, I think, going forward. We did some work a few years ago looking at --

MR. GLASS: Right.

DR. COOMBS: -- MA, fee-for-service, and ACOs.

MR. GLASS: That's a good question. In earlier work, we found that the level of service use, not spending but service use, in an area seemed to have the most relation to whether the ACOs saved money or not. So that was -- so that's very important. I don't think we've -- have we done it by two-sided versus one-sided?

DR. STENSLAND: We did that at one point, but I don't remember the results.

DR. COOMBS: Right. And I think it's more than three years ago the last time we looked at it, and I think the ACO world has changed dramatically. But one-sided savings are negligible compared to the two-sided risk. It would be important to know whether or not in markets where

two-sided risk ACOs are setting up in a high-cost region versus a low-cost region.

MR. GLASS: Yeah, we'd say high service use probably.

DR. COOMBS: High service use.

MR. GLASS: Yea, so we could look into that.

DR. COOMBS: I'll ask the other question in Round 2 [off microphone].

DR. CROSSON: Further questions? Brian and Bruce.

DR. DeBUSK: I had a question on the episodic models. Are we following the MA plans that do a blend of, say, the medical expense ratios and the bundled procedures? I mean, in the commercial space and in the MA space we do see some hybrids out there. Are we following those? And can you speak to anything promising where the two could coexist in any way?

MR. GLASS: I'm not familiar with those examples. We could look into it, I guess. Are you familiar --

DR. DeBUSK: I didn't know if that's an area that we're going to keep our eye on and track over the next few cycles, or if we're going to --

MR. GLASS: Yeah, we can look into it. I'm not sure where bundles are going in Medicare at the moment.

DR. DeBUSK: I'm not either.

MR. GLASS: But we can certainly -- we can see if there -- you think there's examples in the commercial or --

DR. DeBUSK: I know there's an MA plan actually in the area of the country that I live in that is doing a hybrid, where the primary care physicians work off medical expense ratios -- medical loss ratios and receive bonuses from there, but then the specialists do some episodic models It's almost like a sub-routine. And I just didn't know if that was something we were tracking or if there's even interest there in seeing what people other than Medicare are doing.

MR. GLASS: We'll get in touch with you on that [off microphone].

DR. STENSLAND: I think it's a good idea, but we also have to remember what Jay said, and there's a little difference that if you're in an MA plan and you have prior authorization, you can kind of limit the number of bundles. But as Jay said, if we look at the bundled savings so far, there are -- there tend to be some savings, but those

savings could easily be swamped if you end up with a lot more bundles.

DR. DeBUSK: I was just trying to get to the underlying philosophy. You know, I don't think anyone here would -- I think subjugating a bundle, an episode to an ACO is a given. I mean, I think that's not up for debate. I think the question is: Are we going to -- have you entertained the possibility that the two could coexist knowing that the episode has to be subjugated to the risk-bearing entity? Again, it's more of a philosophical question.

DR. CROSSON: Bruce.

MR. PYENSON: In a world where ACOs are a dominant model or perhaps somehow a required model, what portion -- I think we have some information on what portion of people would not be attributable to the current models. I think the experience reports there's the attributable population is used as a benchmark, but I can't remember what portion of people would not be attributable. Do you recall that? And the reason that's one of the big differences between an MA plan and an ACO, you know, the care -- the avoiders can't get attributed, but they can buy

an MA.

DR. STENSLAND: My best recollection is the last time we did it, it's somewhere around 15 percent or something.

MR. GLASS: So to be attributable, you need to have had at least -- I think a primary care physician visit in the last -- what? -- 12 or 24 months, depending on the model, I think, and you have to have some history, and you can't have been in an MA plan.

MR. PYENSON: So just to put that maybe in a context of the overall Medicare program, about a third of the people are in MA, I think about -- what it is? -- 15 percent are in ACOs.

DR. SAFRAN: About a third [off microphone].

MR. PYENSON: A third are in ACOs.

MR. GLASS: A third [off microphone].

MR. PYENSON: So a third, two-thirds, two-ninths, and about another 15 percent couldn't be attributable, so the portion that are actually in ACOs that could be in ACOs is actually pretty large.

DR. CROSSON: Okay. Thank you. No more

questions. We'll proceed with the discussion. As I mentioned in the beginning, we've been working on this for some nine years, and we intend to continue to do that. So what I think I'd like to see in the discussion is some guidance for the staff in terms of the range of ACO-related issues that come to the top in your mind in terms of particularly things that we could work on and why you would think that. And -- well, I guess that's it.

So we're going to start off with Paul and then Alice, and then we'll have a general discussion.

DR. GINSBURG: Well, thanks. I believe that there are real opportunities to improve ACO performance by improving the model, and I'd like us to spend time over the next cycle trying to improve the model.

Two areas I'd like to highlight. One is about the specialist relationships. I'd like us to learn more about them and start playing with some options of things that the program can define. You know, the ultimate specialist relationship that I would like to see but it may be too large a leap for Medicare to take at once would be something along the lines of a network model, that there are specialists in an ACO's network and specialists not in

the ACO's network, and that there are obvious incentives to be in the network, and, you know, at this point I guess only informally can beneficiaries be steered to the network. An ultimate network model would actually have financial incentives to use network specialists. But I think I'd like us to look into are there, you know, politically feasible ways to kind of enhance the relationship between the specialist and the ACOs by, you know, more significant steering and also, you know, I think the model is deficient in essentially saying, well, there's no clear difference from the ACO's perspective whether the specialist is in the ACO or just on the list of specialists that the ACO steers to, because I think that MACRA has brought up these issues about are there opportunities for specialists to do alternative payment models, and making the ACO a more significant opportunity for specialists I think is a way of doing that.

The other thing I'd like us to work more on is this kind of coordination between ACOs and other APMs when the same beneficiary is involved. You know, I think we have somewhat of a mess now. As David said, it's very complicated. I think the principle I'd like us to keep in

mind to strive for is having some other APM models like a bundled payment become a tool for the ACO to use. So the ACO already has the primary care physicians in the ACO, but to the degree that the ACO could use bundled payments, it could develop the payments to the physician say doing the bundle. It might actually be a more productive relationship in the long term.

And a final thought is that it might be worth, you know, some limited effort to look at ACO models in use in Medicare Advantage and in the commercial sector just to scan for ideas that might be suitable for the Medicare ACOs that would be an improvement.

DR. CROSSON: Thank you. Alice.

DR. COOMBS: Thank you. I just want to go to page 32 and speak in reference to the population-based quality measures. So one of the things we assume is that because PAC use is an easily targeted area for cost reductions, we looked at hospital inpatient use as something that's kind of fixed and unchangeable, but I think there's an opportunity here to go to the inpatient. And something Paul said earlier that I think is really important is to do an analysis of hospital-led ACOs versus

physician-led ACOs. And you do an excellent job in the paper summarizing the incentives based on who leads the ACO. And because of that, I think it's a missed opportunity for us to assume that we cannot make a dent in the inpatient readmissions and some of the quality parameters, you know, identified here. So I think that's an issue that we need to focus on as well.

And I know just from experience that some of the larger systems, they have a lot of arborization with other satellite community hospitals and even cottage hospitals that are located in remote locations. And if that entity is the main leader of the ACO, then, you know, it may not have the same kind of incentives as a physician-led ACO and the flexibility of the physician being able to do some innovative things in terms of reducing inpatient admissions.

I know of one practice in New Mexico where an office actually manages acute infections in oncology patients actually prevents them from being admitted in the hospital, and runs almost like an urgent care unit within an office. And that's incredible because that patient has continuity of care and has less likelihood of being

admitted to the hospital. So I think that that's a missed opportunity.

The other piece that I think is really important is actually looking at the distribution of where these two-sided risk APMs, as mentioned before, the advanced APMs, the ACOs, the two-sided risk ACOs, if they're gaming their savings by strategically locating in the places where you're going to be most prone to have a positive result, then I think it's unfair because then there's a distribution that may impair beneficiary access in some other areas. And I just recall that study that you guys did a few years back that was so well done comparing ACOs, fee-for-service, and MA plans. And after this and reading the encounter data from yesterday, I'm not sure that we have a continuum from ACOs to MA plans. I'm sorry. That's where I am. I think that ACOs in certain markets are probably going to be the poster child for the best standard of care, and then maybe MA plans in other markets. But I think for us to prematurely say this is the road map to the pie-in-the-sky MA plan, I think it's a difficult place for us to be right now. And I think we have to compare quality such as you outline here with robust, reliable, accurate

data from the MA plans. And I think that's a really important piece of it.

And as for the specialists, there are specialists who are kind of tangentially involved with some of the ACOs, and I know in the Boston area some of the primary care doctors will refer not based on what they see in terms of dollar amount, but they will refer on I'm going to this orthopedic surgeon because this orthopedic surgeon gets the patient out, they're in home health, and they're not going to stay in a PAC. They're going to be -- they're going to use whatever devices that they use to make sure the patient has little chance of returning to the operating room, little case of reinfection, and that that patient has the best post-operative outcome. So I know that for sure when that patient comes back to the primary care doctor, that is having an influence on that primary care doctor. And whether they put a Get Around Knee in or some kind of special knee from any other company, it doesn't matter. They're looking at how the patient does. And that will decrease costs versus someone who has knee replacement who has to come in for, you know, infected wound and have the complications. And I think that's probably more the thing

that moves the meter for the people inside the ACO and what they look at in terms of cost.

So the specialist that is chosen, it has a lot to do with local factors in terms of quality outcomes. I think that thing we cannot negate. I mean, that is an important feature. And whether or not bundles exist within the ACO I think is really an important piece. This whole notion of this ACO is very, very innovative and they have congestive heart failure, they have chronic, they have acute, they even have a relationship with maybe an anesthesia group that is running a perioperative surgical home or enhanced recovery after anesthesia, because all of those things will actually decrease the cost. Some people are going to need an appendectomy, and you want that appendectomy to be done in a fashion in which the patient has the best outcome, limited complications, whether they're anesthesia complications, surgical complications. I think the specialists are really important in this as much as, you know, the quality piece is as important, as much important as the cost piece. And I think that's something that we cannot negate.

I just think that this whole thing of geographic

penetration of where the ACOs are is really important as well.

DR. CROSSON: Thank you. Further comments? Let's start with Kathy.

MS. BUTO: So I guess one of the questions I'd like us to be able to answer is: Do we think that ACOs as an option is always better, always preferable to fee-for-service? And I know that the analysis that Alice is talking about showed that in some areas of the country, fee-for-service was the lowest-cost option. But I don't think even though we focus on cost in this paper and often that cost ought to be the driver here in every case. We've got to consider other factors in fee-for-service more, you know, disaggregated care, uncoordinated, et cetera, and the possibilities that ACOs provide.

So I'd really like us to think about that option as much as are ACOs the transition to MA, which I think is a decent question and one that we should try to address. But I'm really almost more interested in is the ACO an option we ought to be promoting and eliminating fee-for-service as it exists now, just a free fee-for-service system.

And then getting to the transition issues that David was raising earlier, I think it would be really helpful to all of us in our thinking about that transition if we thought about, you know, what are the steps that an ACO -- or what are the attributes of an ACO that would be required by taking on insurance risk -- I think Dana was mentioning other things -- in order to make that transition? And then what is the likelihood or what are the attributes that would suggest an ACO would remain an ACO? And I suspect when we've looked at that, we'll think that there will be a lot of ACOs that will never transition to MA.

And so I just go back to my first question. If that's the case, it strikes me, do we think that's a preferable option to what exists in sort of unfettered fee-for-service?

So those are just two things I'd really like us to pursue because it helps to crystallize our thinking about ACOs, and then I think the issues of refining the ACO model, trying to think about things like -- I guess Paul was suggesting more like a network model that allows for some differentiated cost sharing, more like a PPO, again,

not under a full-risk contract but maybe more tools that would make the ACO with a prospective attribution a more attractive option for beneficiaries. So if we could think about that, I think that would be really helpful.

DR. CROSSON: Paul, on this?

DR. GINSBURG: Yeah, on this one. A really intriguing idea by Kathy about eliminating fee-for-service, which, in a sense, another language would be making ACOs mandatory. That may be a big step to take, but often the Medicare program moves in these directions through incentives. And so, in a sense, you know, a somewhat more generous payment for ACOs than for outside of ACOs. And you could even think about the Track 1 ACO with the one-sided risk as a form of differentiating payment. Yes, it's a sweet deal to be in Track 1, but maybe that's actually part of the strategy, to, you know, set in motion a move, and it's been a fairly successful move of, say, a third of the fee-for-service beneficiaries in ACOs.

So, you know, I think we ought to think about these issues as well.

DR. CROSSON: I just want to clarify and make sure I understand here, because we tend to sometimes use

words that have multiple meanings. But when we're talking about eliminating fee-for-service, we're really talking about the mechanisms of traditional Medicare as opposed to ACO, rather than eliminating fee-for-service as a payment mechanism to end the entity.

DR. GINSBURG: Right. Oh yeah, absolutely.

MS. BUTO: Yeah, and that's exactly --

DR. GINSBURG: This is really just meaning that all beneficiaries --

DR. CROSSON: Okay.

DR. GINSBURG: -- would be in ACOs unless they opt for Medicare.

DR. CROSSON: Just for the record, I wanted to make that clear.

DR. GINSBURG: Yeah.

DR. CROSSON: Jon.

DR. GINSBURG: And I also agree with Kathy about we shouldn't be thinking about transition to Medicare Advantage. I think that the ACO program was created as something that involved value or management that was not Medicare Advantage, for those that didn't want restrictions on their network. So I don't see any attractiveness of

thinking in terms of a transition.

DR. CROSSON: Jon.

DR. CHRISTIANSON: Yeah, I just -- just a quick question for Scott and Carlos. So at one point Congress decided, if I recollect correctly, to pay MA plans at some percentage above the cost of a fee-for-service beneficiary in order to attract plans in the market and keep them in the market. Is that correct? Is my memory correct on that?

DR. HARRISON: Not explicitly.

DR. CHRISTIANSON: I thought it was explicit. No?

DR. HARRISON: It wasn't explicit.

DR. CHRISTIANSON: Okay.

DR. HARRISON: But there are quartiles. I mean, the quartile system has some areas where there --

DR. CHRISTIANSON: There was a --

DR. HARRISON: -- there used to be rural and --

DR. CHRISTIANSON: Yeah, so there was a concern that we didn't have enough MA plans, we raised the rates for MA plans, trying to attract more in the market. I don't think we have a similar strategy for ACOs, if you

will. I mean, what we want to do with ACOs is save Medicare money. What we want to do with MA plans was pay them more than it would cost for Medicare beneficiaries. So that aligns with what Paul was saying, I think, in the sense that if we really wanted to have more ACOs in the market and pay them more.

The chapter talks a lot about the cost structure for different kinds of ACOs and the transition from ACOs to MA plans. It doesn't talk at all about sort of the payment structure for ACOs. I think the right thing to -- question to ask is where is the profit? You know, if you can get a bigger profit from moving from an ACO to an MA plan, why wouldn't you want to do it, supplemental to the caveats that David outlined earlier.

And that's where I would look in terms of trying to think about transition. So it's not necessarily do we want them to transition, but given the payment structure we have now of MA plans relative to ACOs, why wouldn't a lot of ACOs try to work through this and move to MA plans? And I think that this payment structure has certainly worked to the advantage of MA plans, because otherwise why would we continue to see increased enrollment in MA plans, more MA

plans in the market, and so forth.

MS. BUTO: Jon, I just don't think a lot of plans -- ACOs have the same governance structure that allows for that kind of unified decision-making, to move toward a more favorable payment mechanism. It may be favorable in the aggregate but actually organizing to do that is a pretty difficult thing.

DR. CHRISTIANSON: Yes. I didn't explain myself. If the government had -- let's just say if the government, tomorrow, doubled the payment for ACOs would we expect to see more ACOs and less movement towards MA plans? Probably. If it doubled the payment towards MA plans we would see a lot of ACOs trying to put together government structures and so forth to try to become MA plans. So it's the direction of the incentives that exist in the present system that I think is, over time, going to cause ACOs to say "I'm not making money under this benchmark, but I'm going to collaborate with Aetna, I'm going to do something else to try to move my organization to a place where I can make more money."

MS. BUTO: So I guess you're raising a point for me, which is not only should we be thinking about the

incentives but we ought to be thinking about whether we're driving change that's undesirable, for the wrong reasons, if you will.

DR. CHRISTIANSON: Incentives are great. Level of payment trumps incentives, if you will, okay?

MR. GLASS: So if you're saying --

DR. CHRISTIANSON: Okay. Just let me be -- sorry. Go ahead, David.

MR. GLASS: Yeah. If you're saying that in an area where the MA benchmark is 115 percent of fee-for-service, and an ACO benchmark is fee-for-service or below, why would they do that? That's an interesting question.

But there are also -- I just remember when we were talking to ACOs early on, some were saying that one of the reasons they want to be ACOs is because they have beneficiaries who do not want to be in MA plans, and that they participate with MA plans but they want to capture these other beneficiaries who just do not want to be in an MA plan, for whatever reason. So you do have to keep those beneficiaries in mind too.

DR. CHRISTIANSON: Sure. I'm not saying every ACO will switch over, but you could have both. If you're

an organization, you can have both options.

DR. CROSSON: Okay. I just want to get back here to where we were. There are a number of individuals, I think, who wanted to comment on Kathy's. Is that right? No, you were just raising your hand for -- no, okay. So then we're moving up this way then. Jack.

DR. HOADLEY: So I want to go back again to the beneficiary side, and, actually, I think it goes to this last sequence of questions as well. But, I mean, to date, for the most part, I think it's safe to say that beneficiaries are not aware of whether they're involved in ACOs. You know, I asked one person who is a Medicare beneficiary, I said, you know, have any of your encounters with procedures sort of raised some notion that you knew that they were in an ACO? And they thought, well, maybe there was a case or two where, you know, there was something that might have suggested that.

But I think, in general, I can't remember if we've asked this in focus groups in the past, whether beneficiaries are aware of sort of being involved, being attributed to, you know, they might not know all those terms.

MR. GLASS: Yeah, we have asked, and they're not.

MS. BLONIARZ: We have asked and they don't know.

DR. HOADLEY: And, yeah, and they don't know. That's what I thought.

So it does seem like as this ACO interest is ramping up and we're seeing more people being attributed to ACOs, more interest from folks like this Commission in seeing them become more widespread, and, you know, and the kinds of things like Paul was talking about, sort of engaging, potentially, with networks and things where the beneficiary is going to have consequences for being -- right now, you know, it's okay that you don't know because, you know, maybe there are consequences of less money, less wasteful things are being done, more quality care. There may be some positive consequences, but they're not things that necessarily have to engage you. But as we're getting to ideas like networks, or like incentive payments, like the new incentive payment, there's more reason to become engaged.

So I think something that's important to do is to try to understand that engagement. We've talked a lot about that, and so, maybe, you know, something like this

$20 incentive payment is an opportunity to engage somebody -- why am I getting this check? -- and a chance to explain that. You know, I don't know if that's a good way but that's at least maybe something to think about.

You know, with the voluntary attribution program -- and you asked, I think, in the paper, you know, should you be tracking how many people are engaged in that, and you gave a number to one of the questions and it was quite small -- but, you know, going forward with more use of a voluntary attribution, identifying a primary care clinician, what is it that a beneficiary understands that's about? Is it just I got a chance to designate my primary care physician and that's just maybe for record-keeping purposes, maybe they think? You know, does that lead to any more understanding of why that's being done, or the consequences of that being done?

So, again, it seems like a good focus group kind of discussion, maybe even part of a survey, the surveys we do, or something like that, but, obviously, also trying to think through the things we've been thinking through from time to time. How do these payments, you know, if we wanted to do a differential copay, what would that really

mean?

If we want to go to a network, now we're talking about something both in the copay and the network, where, you know, maybe we're restricting the choices that that beneficiary has. Even though we think it's for a good reason, how does that play out? What does that -- can we explain that? Can we make that into a good thing, or do we have to worry about the downsides of that, that suddenly, you know, they could end up going to a specialist, because a friend referred them, and suddenly find out they're paying more for it, probably after they've actually had that appointment and maybe even had a surgery, or something like that, and it turns out -- and again, I know all the supplemental insurance issues are complicating that.

But I think that's something that's really important for us to try to engage. What does it mean and what is it reasonable for a beneficiary to understand about this? How do they think of it differently than an HMO, than an MA plan, and so forth?

And then I did want to make one comment, and somebody just -- Alice, you just referenced this too, on the hospital post-acute sort of question of -- and I guess

my question, you know, it's perfectly fine to say, you know, there's reduction in the post-acute care and that's probably a good thing. I guess my question is -- and I think, Alice, maybe this was your question as well -- is should there be a reduction of inpatient admissions? Are we comfortable that the results that we're seeing are, in fact, optimal results, that we don't need to change the amount of hospital use? And if we think there should be some further prevention of hospital use, you know, what is it that -- you know, that sort of re-engages that question of how does that hospital intersect, and all those questions about, you know, they get paid more when they get more admissions, and yet the whole point of this is to not have that, you know, to reduce some of the unnecessary admissions. And is there enough in the ACO shared savings, upside, downside, and all that, to actually make a difference for something as large a lump as a hospital admission is, as opposed to, you know, a few more days in a SNF or an additional home health stay, which is, you know, not as big a hit and it's a provider that may not be as integral to the creation of the ACO.

So it does seem like there are some important

things to engage there as well.

DR. CROSSON: Amy.

MS. BRICKER: Some of the things that Jack was just mentioning just raised some questions for me.

So you mentioned that such a small number of beneficiaries attribute themselves to an ACO.

MR. GLASS: Let me just say, they don't attribute themselves to an ACO. What they're doing is they're going on to Medicare Compare and saying "this is my primary care clinician," and that clinician is in an ACO, so they get attributed that way. But the beneficiary is not saying "I want to be in this ACO."

MS. BRICKER: What are the reasons, in your mind, that folks are coming out of MA plans? Is it network-related, primarily, or do you have a sense?

MR. GLASS: I'm not an expert on people coming out of MA plans.

[Pause.]

MS. BRICKER: It's okay. I was just trying to -- is there some -- what's the rationale for involving the beneficiary in the decision, if, in fact, they believe I will have less choice because now I'm a part of an ACO, I

have more freedoms to see whomever, whenever, if I'm in fee-for-service. Do we actually think that investing in -- you know, informing the beneficiary is going to have some sort of positive outcome, or does it have some unintended consequence? It was just more of -- I just wanted to understand your perspective on that.

MR. GLASS: Okay. So some of the history of this is, one of the reasons ACOs are set up as they are, where beneficiaries are passively attributed into ACOs is that very question. Well, they're not giving -- the reason why that seems to be an acceptable way of doing it is because they're not giving up any choice by being in an ACO. They can still go wherever they want. And the reason they wanted to make it passive was to get enough people into the ACO. It's a lot easier to do that through passive attribution than for a beneficiary to say "I want to be in an ACO," to active enrollment.

So that's kind of why the program is set up as it is. You wanted to get enough beneficiaries in there without -- and the only way you could do that is say, well, they're not giving up any choice, so if it's passive attribution it's okay. So that's kind of how we ended up

in this situation.

MS. BRICKER: That's helpful to me. I was, again, just thinking about if you were to actually then say "bene, you are a part of an ACO," what happens in their mind when they are informed of that?

MR. GLASS: So they tried -- when they started these things they had a letter that went out to beneficiaries and said, "Hey, congratulations. You're now in an ACO. You know, these nice things will happen," and it caused tremendous confusion --

MS. BRICKER: That's what I imagined.

MR. GLASS: -- and people were very upset, and they quit doing it.

MS. BRICKER: Thank you. Okay. Thanks.

DR. HOADLEY: Just as a quick -- I mean, what my point was really that if we started to engage more things with consequences then we're going to have to confront that question of -- you know, right now it seems perfectly sensible that you would keep them out of the loop on it.

DR. CROSSON: And/or, as I think you referred to briefly, we could be considering positive consequences, in other words, inducements, added value.

DR. HOADLEY: And that's why I thought the $20, you know, payment is a concrete example of something. Some of the others might be less concrete in the sense of better quality providers.

DR. CROSSON: Well, there's that. Pat.

MS. WANG: On the issue of should ACOs compete with MA based on administrative cost, should ACOs be viewed as transitioning to MA plans, I just -- you know, I don't -- it's an apple and an orange. ACOs are an efficient delivery system and they're critically important. To me, ACOs will -- there will always be folks who choose MA and there will always be folks who choose fee-for-service, and it's just until that rule changes and everybody in Medicare is required to join something, there will always, in my view, be a need for both.

And I think that even a very efficient and successful ACO who decides that they can do well in an MA arrangement, they could go the route of starting their own plan, that is not the only way to do it. They could decide to take a global risk contract with a licensed MA insurer. And even in that situation, they will still have an ACO because they will still be taking care of people who choose

to stay in the fee-for-service system.

So I just want us to be a little bit careful about setting up this dichotomy -- you're an ACO or you're an MA plan, or whatever. I think it's really -- they're two different things.

On this idea of the competition of ACOs versus MA, based on admin costs, again I would really caution us a little bit there, because MA plans are fully licensed insurance companies. They are subject to a huge amount of regulation from CMS and a huge amount of regulation from state insurance departments. So I would just be careful about saying $200 versus $1,200. They are really two different things and there are a lot of ways that efficient delivery systems can and have worked very well in partnership with licensed insurance companies.

And I would note that many providers have started their own full-service, full-thickness insurance companies, and there's, candidly, pretty high rate of failure. There are a lot of ways to have a successful global risk arrangement without going out and getting your own license.

That said, I think that ACOs are incredibly important, and I would like to add to Paul's request that

we work on improving the model for ACOs, to really develop them. And my wish list there for items to look at are, number one, the issue of benchmarks and the calculation of savings. It does really seem that this is an evolving field, but perhaps MedPAC could make a contribution to the development of a more effective benchmarking or method of calculating savings to encourage more organizations to become ACOs and to succeed as ACOs while protecting the public fisc.

The other item, and you've heard me say this before, has to do with inpatient utilization and the observation, which I appreciate you're going to parse about the sort of static nature of inpatient discharges per 1,000, whether you're in fee-for-service or in ACO.

The one element that I really think is part of improving the model that I would really like us to look at is the things in the inpatient -- in the Medicare reimbursement system that may serve as inadvertent anchors to keep people tied to their inpatient statistics. We've mentioned this before. There are a lot of special payments, whether it's GME, IME, DSH, which then drives your 340(b) status, that are tied to inpatient use in two

ways. One is that inpatient statistics are used to calculate what you're entitled to, and the second is that the inpatient discharge is basically the conveyance vehicle to get paid.

I would really like us -- those are just some examples, but I would like us to see whether or not we can identify whether there are things like that in the Medicare payment system that may inadvertently be tying folks to sort of protecting their inpatient volume, or at least setting up a cognitive dissonance and preventing people from going all out to kind of keep people out of their emergency rooms, keep people out of their inpatient beds. At least it's one element of it.

And just to be clear, I am not talking about changing or looking at payment policy for DSH, UCP, GME, or any of those things, because then we will be here for another six years. I'm not talking about that. I'm talking about whether or not there are ways to decouple the use of the inpatient statistics to allow folks in the ACO world, and eventually in the full risk MA world, to be relieved of the burden of having to generate inpatient statistics in order to get the special payments to which

they're entitled. Maybe there's some kind of variation in the CMMI model that uses the base year, that the benchmark is based on, and says this is was your DSH calculation, your GME, you know, and maybe hold those harmless from your actual inpatient statistics going forward in your ACO, and just see whether there's a change, and see whether it had an impact.

DR. CROSSON: Jon.

DR. CHRISTIANSON: A quick question for Jeff.

Jeff, your example you used about an ACO trying to -- I didn't quite follow it. Trying to offload patients that were expensive, was that a statement about the inadequacies of the risk adjustment process for high-cost patients? Is that what you were kind of implying? That the risk adjustment process of your ACOs doesn't work very well for high-cost patients?

DR. STENSLAND: I'm saying that there's a risk on both sides, the high cost and the low cost, and I think that offloading the person that's high cost and not fully accounted for in your risk adjustor, that is a risk to the program.

DR. CHRISTIANSON: Yeah, but you're saying that

it isn't. I mean, the evidence on the MA risk adjustor would suggest that it underestimates cost for high-severity patients. Is that what you're saying? The same problem with the ACO risk adjustment process?

DR. STENSLAND: Well, the ACO I was thinking about, the one currently where it's based on your historical cost, and so if the physician, for example, knows that the patient is going to need some procedure in the future, if they can offload that patient that's going to get the hip replacement next year and have them start seeing some other primary care doctor, that would be at risk to the program financially.

Because the risk adjustor is different in the ACO than in the MA, it's a little different.

DR. CHRISTIANSON: So this is more of a potential problem for the ACO than the MA as well? Is that what you just said?

DR. STENSLAND: At least this is an ACO problem. I think the MA might have different problems, but I think this would be the ACO problem.

MR. GLASS: Yeah. It's not a problem for the ACO. It's a problem for the program.

DR. STENSLAND: And there's the flip side too. I think Alice brought this up. If the ACO knows who their people are and the person hasn't gotten care all year long and it becomes around November or December and you're going to say, "Why don't you come in for your wellness visit," that's almost a guaranteed winner. So there's some potential for patient selection on the high side and the low side.

DR. CROSSON: Okay. We have exhausted our time. I'm going to continue this discussion because it's an important discussion. I'm going to urge brevity, and then I'm going to make now comments myself.

[Laughter.]

DR. CROSSON: And I will be brief.

I want to second what Pat said. Personally, I believe that unless we resolve the many issues involving the role of hospitals in ACOs and the incentives for hospitals not only to be nominally part of an ACO but to actually be participating actively, both in quality improvement and cost savings, then we're going to see this stall because eventually the amount of savings that can be extracted from post-acute care are going to be exhausted.

And I do agree that there are--I mean, we spent how long yesterday on low-value care services, and some of those take place in the hospital setting. And I think that if we have a situation going forward where the hospital is only nominally involved, then I think we've got a problem.

And there are many aspects of that. There's the interface with the bundles. There are the issues that Pat brought up about ancillary payments to hospitals being adversely affected, and then I think also the fundamental way that hospitals are paid needs to be altered over time. That's one point.

The second point is I'm not enthusiastic about the asymmetric incentive model. I understand why that is in place. I think the notion there is let's do something to incent the development of more two-sided risk ACOs, but I think -- I have to see how it plays out, but I'm concerned that it's inherently inflationary. And I think it's not the only model of two-sided risk that one can use because I'm quite familiar with the two-sided risk model that's based on -- that is symmetric, but it serves to buffer both the upside gain and the downside risk by building a layer of progressively increasing or decreasing

corridors, which I think would personally -- just myself -- I think would work as effectively as an asymmetric model but not create the model of Medicare overpayments in the future.

So I think those two things, I think are worthy of exploration.

Craig.

DR. SAMITT: So I guess it's appropriate at my last meeting to say I worry that we're losing sight of the problem we're trying to solve.

And my sense of where the whole ACO movement started is we saw this cadre of highly accountable organizations that were focused on comprehensive quality service and cost improvement, and I think our desire was to create an incentive system that would motivate delivery system reform and the direction of the Kaisers and the Deans and the HealthCare Partners and the CareMores.

And I question how much progress have we really made creating an incentive model to move organizations in that direction.

I think we also get lost in this notion of a continuum or a transition from ACOs to MA, and I think it's

a misnomer because I think what we found is that some of the most highly accountable organizations are provider-sponsored MA plans.

That's not to say that MA plan is the destination. I think the destination is accountable models, and I think the feeling was, is that ACOs were a step, a roadway to begin to help everyone to move from a less accountable fee-for-service model to a more accountable population health model.

You would not be surprised for me to say I just think we need to be bolder in our approach. I think we've created some undue complexity with perverse incentives, where on the one hand, you've got this notion of hospitals that want to be ACOs, but they're worried about cannibalizing their existing fee-for-service realm. And you also find the scenario where we're coupling bundled payments with ACOs and essentially making ACO less attractive to the broader population because we're giving margins to specialists in the form of bundles as opposed to thinking more broadly, like sub-capitation to specialist as opposed to bundled payment to specialist.

So it feels to me that the focus of the

Commission, to Paul's point, should be to fix the model in a way that really dis-incents less accountable approaches to care and further incents more accountable approaches to care.

And let me just be very bold. As it relates to asymmetric or two-sided risk, do we say that if you're a hospital-sponsored ACO, you cannot be in an upside-only model? That hospital-sponsored ACOs must take downside risk as a way to really advance the model.

And maybe we definitely do need to consider the notion of should fee-for-service, as we know it, not be an option, and should we essentially say the minimum accountable model is the ACO, and then we go up from there to more advanced models? It feels like we're stagnating, and we're in the continuum from less accountable to more accountable. We create such complexity and confusion at the very left side, barely above the fee-for-service threshold, that we're not allowing people to kind of find the merits to move further toward these highly accountable models.

So I just think we need to do more, and we need to be bolder, because after six years, I admittedly have to

say that I feel we've made very little progress.

DR. CROSSON: Sue.

MS. THOMPSON: I will be brief.

I just want to remind us as we look forward and thinking about ACOs, this concept of shared savings in theory, I mean, at some point in time, you get to a point where you have diminishing returns. So there has got to be an answer after this shared savings adventure that we're on.

To answer your questions on the board, yes, I do think we should eliminate the threshold. I think it adds complexity in an already very complex situation, although I would call out that this advanced APM bonus that we have available to us is a great attraction for specialists to want to become involved in this work. And that is important.

And so as we talk about hospital-sponsored ACOs, hospitals alone have no lives without physicians. So, in the perfect world, we need the capital that a hospital can bring and the lives that the physicians can bring in order for this experiment to work, and I think that's just really, really important.

Having said that, I'm very intrigued to see, if we can, the difference between the physician aggregators versus those that are led by hospital systems, if you will. I think that's important, and I think it's going to be important to understand because in addition to bonuses, the access to capital to get into this business is extraordinary, and for physician groups alone who typically do not have retained earnings to withhold for potential losses or the capital that's going to be needed to invest to run an ACO, I think it's a piece we have to think about, if we should learn that they are actually more successful. So I think that's a component, which too gets very complicated on how to help physician groups do that, but I think that's something we do need to think about.

Additionally, ACOs, we're in the land of risk, so there is something to be said about a sufficient number of lives in order to really be looking at is this a meaningful adventure or not.

DR. CROSSON: Thank you.

David.

DR. GRABOWSKI: I think we all know the ACO model has not been perfect. Yet even in the case of one-sided

risk, well-designed studies have suggested savings there, and I think the savings there don't account for any kind of spillovers to other patients in those markets. They don't account for any positive spillovers in terms of setting the Medicare Advantage benchmarks. So I think when we evaluate savings comprehensively, I think these programs look better off than we give them credit for.

That said, certainly we can make improvements, and I really think we're at a crossroads. And I see the tension here is really between designing models that are more accountable and are going to generate more short-term savings versus designing a model that's going to achieve long-term success. And I think a lot of the tradeoffs you have up here on the slide, do we want to make these models in the short term more accountable, yet less attractive to potential groups to join -- and I agree with being bold, and I'll say, Craig, that mandatory solves everything, yet I don't know if we're willing to go there with some sort of floor. But I find that very exciting.

But I also don't want to set up a model where we know its' going to show savings for participants, yet nobody wants to join this because it's just to have to get

over this huge hurdle, and so how do we strike that balance?

I thinking about how we set up the two-sided risk or asymmetric risk, Jay, that we consider kind of both, not just what are going to be the savings, but how can we attract groups to join these models.

I'll finally say -- and I just want to think back to our discussion around low-value care -- we had a lot of tools up on a slide yesterday. Our toolkit, though, isn't that broad, and this is a really nice tool. We all know that's a huge problem. This is something that works. The alternatives just aren't there great, and so I'd love to see us continue to push on this front.

Thanks.

DR. CROSSON: Thank you.

Dana.

DR. SAFRAN: Thanks.

I mean, I will be brief, and you'll hear me incorporating in my remarks our experiences because we've been at this for 10 years on the ground.

So the first thing I would say is I would like to see this chapter very strongly set the tone of expectation.

That the evidence so far shows us this is working, but we have to all expect to keep learning and refining as we go.

I say that because I do worry that with mixed evidence -- and I'll say in a moment, some thoughts about how do you define whether there are savings relative to benchmark, relative to the counterfactual. There can be a lot of confusion, and that confusion can lead those who would rather stick with the status quo to kind of build a loud voice that says, "Let's not go there. It's not working, anyway."

And so I think we have to be really decisive in setting a tone that like the evidence so far is promising and we can't expect to have solved this with the flip of a switch. We have to keep learning what the right incentives are, and it's complex for which groups, et cetera. So I would say that.

I would also say -- and I had this in my notes, and I was excited to hear Kathy say, "Let's put a line in the sand and say at this point certain, you won't be able to participate as a provider in Medicare anymore in a traditional fee-for-service payment model." I say that having been out there and in particular one recollection

which stands very strongly in my mind when a Secretary in the previous administration drew the line in the sand and said, "By 2020, we will have" -- whatever the number was -- 50 percent, I think, of payments in these models.

I heard CFOs of health care systems from around the country saying it was the first time that they -- they used the words "took their heads out of the sand" and said, "Okay. We have to embrace this now. We have to move forward."

So I really think that like being definitive about the direction is important, and that's a good way to get definitive and bold.

The second point I would want to make is that I think we can point to some real optimism that transformation is happening, and you've got stories about being out there. I would offer that we should consider for probably future chapters. It's probably too late for this one, but we could at least tee up the idea on this one, how to take a more holistic view of savings.

So, first, I think we have to educate folks that there is the idea of did the ACO earn savings, did the program get savings from that ACO relative to the

benchmark, but the big question is the counterfactual question. Is this program yielding savings against what would have happened? And for that, I think you need to have control groups, but you also need to think about spillover effects.

And I can tell you in our experience, and maybe this is illustrative, we've seen savings that happen because of the way that other providers are negotiating their rate increases with us because of wanting to have rates that aren't so high that others won't refer to them.

So there's spillover savings, and in fact, the Harvard Medical School team, of course, did a study that showed that our model, the AQC, was having spillover savings on Medicare before Medicare launched the ACO. So there are probably spillovers into Medicare Advantage because of the way providers are behaving, and I think finding ways to take a more holistic view of the savings and to educate about savings relative to the benchmark is not actually a good measure of whether the program is achieving savings is a really important thing that we need to do.

A third thing I'll say -- and it's been said --

the absence of an impact on inpatient care doesn't mean we can't have it, and I think Alice was the first one to make that point this morning, and others have made it too. I really think that's a very, very important point, particularly as more and more of provider organizations are owned by hospitals to do this work. You only have to have a couple conversations with hospital executive leaders to know that they are conflicted, and they're very honest about that, at least behind closed doors. I don't know if they would be for this kind -- and so I think Jay just made very passing mention, but I think we should spend some time on what is a new payment model we can put in place for hospitals.

We're doing some of that work at Blue Cross in Mass, and we've got a pilot that we just started that I'd be happy to share some other time because we really think that you have to fundamentally change the incentive for hospitals, but what the revenue model looks like if we really want them to lean in and start to do some of the reductions in patient care that we haven't seen, not because it can't be done, but because the incentives aren't there yet. And there have been other ways to achieve

savings first, so why not go for those less painful ones.

And then my last point I think I wanted to make was that our experience around this question of beneficiary notification has been one where it always seems like the right thing to do, and yet what happens is what the Medicare program experience when it tried to do that, which is you confuse the heck out of beneficiaries, and they wonder why are you telling me this, and what do I need to know.

I think we didn't feel compelled when people were in models that were incentivized to overuse care to say, "By the way, do you know that here in the system, that's designed to give you as much care as possible, and much of it will be low value" -- I'm going to pick up your baton for you, Rita, since you're going to be leaving us -- "and some of it could hurt you?" We didn't feel any compulsion to notify beneficiaries of that.

So what is it exactly we feel like we have to notify the beneficiaries about here?

DR. NERENZ: That's a very good idea, actually.

[Laughter.]

DR. SAFRAN: So those are my thoughts.

DR. CROSSON: Thank you.

Rita.

Oh, I'm sorry. You didn't raise your hand. Bruce.

MR. PYENSON: Sorry.

This is a terrific discussion. I've got four points.

Part D is not mentioned at all in this section, and I'd like to see it exhibited two ways. One way is with the MedPAC proposal, and the other way is with the status quo.

The ACOs are getting the drug data through CCLF files, so that's manageable, and the way of attributing that through the catastrophic is pretty straightforward. So there's really no excuse not to hold ACOs accountable for that.

The second point is I am struck by the incredible popularity of ACOs, despite the apparent lack of financial incentive. However, I think I'd like to see an exhibit of the financial power of patient referral potential in an ACO from outside the attributed lives. So I think that shows a very different financial stream incentivizing the

organizations.

My third point is that on page 2, there's a section that identifies the continuously improving nature of ACOs chasing their tail, in effect, with benchmarks that are reset based on their own experience, and I find it highly ironic that the health care industry is complaining about continuous quality improvement that the rest of the world's industries have been embracing.

And I'd point out in a related line that there's lots of ways to manage processes and set targets other than the academically preferred counterfactual approach.

My last comment is that one of the barriers to ACOs is the administrative complexity of the processes, especially attributed -- the attributable life process. We've had a recent example where a change of just a few CPT codes in who gets attributed has wreaked havoc recently. The importance of stability and getting things right from an administrative standpoint is real important.

Thank you.

DR. CROSSON: Rita.

DR. REDBERG: Thanks. With regard to those questions, I do think we should eliminate the threshold --

that makes a lot of sense to me -- and have a proportional policy. And I'll address the other two in a moment.

You know, in terms of -- and I think this is picking up from what Jack had said earlier, but from a beneficiary point of view, it makes sense to me that there's not a lot signing up for ACOs because, first of all, I don't know how many even have heard of an ACO or know what it is. A lot of physicians don't know what ACOs are and what's in it for me, you know, where MAs it's quite clear, you know, they have lower out-of-pocket, they maybe have vision and dental or other things. Those are not clear for ACOs, and so I do think we need to think about, you know, what incentives for beneficiaries, you know, and we talked about a few, I think, reducing co-payments, premiums, but -- because I do think there are a lot of advantages for beneficiaries to be in an ACO overall and individually, but it has to be a lot more clear if we want to really have increased interest in it.

And then the same point for a specialist and for doctors, but I'm thinking of specialists, picking up on what Paul had said, you know, right now I think -- I mean, there are reasons to prefer certain specialists. They're

very different practices. We control a lot of resources. But I don't think you have those incentives, and I don't think, again, specialists have a lot of incentives to participate in an ACO. And I don't know that specialists are, again, aware of -- even if they are in or not in an ACO, and they don't seem -- they don't have any particular education on it, and I don't know that they are sharing in the savings, even if they are in the ACOs. So, again, I think that if we do think this is a good model and we want to move forward with it, and I think it has potential, we really need to think about the incentives for everyone, both individually and then for the program.

So then getting back to the program, yes, it makes sense to me to have -- as Craig said, to be bold and say, you know, one-sided risk, I can't see what's in it for Medicare and the program moving forward, and asymmetric risk is kind of, you know, not really two-sided, so I think it's better to have two-sided risk but with clear guidelines.

And then I just want to agree with Kathy and Dana's suggestion about getting rid of fee-for-service and not making it -- you know, ACO has a fee-for-service model,

but to get rid of our traditional fee-for-service, which really just makes incentive for a very high-volume, low-value system with a lot of unnecessary care, unnecessary procedures. And in some ways it does solve the MIPS problem, too, because if everyone has to be in an ACO, we don't have to worry about that terrible MIPS program. And, you know, if we make ACOs something attractive for everyone, I think that would really improve our value-based payment program.

DR. CROSSON: Thank you. I just want to clarify one point with respect to the asymmetric risk corridor, particularly in view of your comment, David. I think that, you know, I completely support the notion, obviously, of making ACOs attractive. My only point is that in terms of designing a risk corridor, a two-sided risk program, the asymmetric way, which was an idea, as I understand it, to attract, you know, people into ACO models, to my mind it's not the best way to do that. There's another way I'm quite familiar with as to how to do that which both provides coverage on the downside and some -- in exchange for some limitation of the upside, which can create the same kind of incentives without the downside of potentially creating

higher costs for the program. That was just my point.

Okay. Brian, last one.

DR. DeBUSK: Last year when we had our ACO discussion, I think we were using the term "putting your thumb on the scale" for supporting these models and making them successful. I'd like to revisit that term because I would advocate for us being unapologetic. When you talk about putting your thumb on the scale, what you mean is spending money. And Jon and Scott were having this conversation about the launch of Medicare Choice and, you know, was it more money or was it less money? I don't think that anyone showed up and said, "Hey, let's consciously pay these new private plans more money," but they did get more money to them. I mean, they get more money to them today through things like the coding intensity adjustments and things like that. But to me, there seemed like there are two obvious ways to build some bias. Again, I'm not advocating for just showing up and saying, "Congratulations, you started an ACO, here's some extra money."

But I think there are two obvious areas where we could introduce some biases that would make ACOs more

attractive to systems to start them and would de-risk them. And I'm going to be really careful because one of them is the asymmetric risk corridors, and after what Jay said, I'm not going to talk about that.

[Laughter.]

DR. DeBUSK: If you wanted to -- now I'm just going to contradict myself. But if you did want to wisely spend a modest amount of money on some asymmetric risk corridors, I think they could be cleverly designed, and I don't think they need to be reckless where there's virtually no downside and lots and lots of upside.

But the other obvious area where we could introduce some biases -- and this is blatantly putting your thumb on the scale -- would be in the benchmark. And I think if we had something that looked like a geographic MA-style benchmark, and then we also had a historical benchmark, and we went to these plans and said you have the discretion, you can use up to 25 percent of this and up to 75 percent of that, you -- give them the discretion. I think that addresses some of the geographic issues that we've seen.

I remember the OIG report that came out, I guess it's months ago, maybe even last year, on ACOs, and basically what it looked like was the people who all had high service use and high costs did well. And, you know, there's obviously some favorable selection there. These people aren't jumping into ACOs unless they know they're going to win.

Well, imagine this, though: if you could blend that benchmark -- and part of it was MA, part of it was historical -- I think you could eliminate some of that because what it would do is really create more scenarios where it would be opportune -- I think more hospitals and more bodies would look at this and say, oh, I think we can jump into this because we can make this work if we rely more heavily on the regional benchmark or on the historical benchmark. I think it would broaden the appeal.

So my point was I hope we could explore some subtle ways to spend some money -- and, again, I think that's the part we need to be unapologetic about. We're launching a new product here. You know, companies don't launch new products and say, "Oh, gosh, we want this thing to be profitable day one and it has to generate all this,

create a value to the company." When you launch a new product, you know you're going to spend money. And in a sense, this is what this is.

So, again, I hope we will set aside -- even if we have to take money from other aspects of the program, find the money, set the money aside, and let's spend it on making these ACOs successful.

The other thing several people have talked about, making fee-for-service not an option, you know, and saying, "Well, is this the end of fee-for-service? Is the ACO the new standard?" I'd like to propose just a halfway point there. We already have -- and it's come up today. Beneficiaries have the opportunity to do a voluntary attestation to a primary care provider, and obviously, if the PCP is in the ACO, that rolls over and solves the attribution issue.

Why wouldn't we just tell people unmanaged care is expensive? If you want -- and I wouldn't even call it fee-for-service. For me it's called unmanaged care. But if you want and insist on unmanaged care, why aren't you paying $20 or $30 or even $40 a month in additional premium? Why aren't we using premium -- I mean, I

appreciate the fact that we have a beneficiary engagement mechanism now where there are these $20 payments that we can make for qualified primary care visits. But I think ultimately if we don't have some way to engage beneficiaries through premium, I think we're really giving up a very valuable lever that we could use.

So, again, I hope we can at least revisit that idea, and I'm not talking about MA and premium support and bids and all that. I'm just simply talking about a surcharge on unmanaged care, but, again, which would also encourage ACOs.

And then my final point, we've talked a little bit about episodic models. I completely agree with the sentiment that episodic models have no business being shoulder to shoulder with ACOs or any other type of large-scale risk aggregation vehicle. No business being shoulder to shoulder. But I hope we as a Commission would be willing to explore some ideas where these -- almost like sub-APMs. Like I would look at the OCM, the Oncology Care Model really is in some ways a sub-APM. BPCI to me could be a sub-APM. And I think one of the things that we could do, if we could help -- you know, an ACO is a large,

nebulous thing. If we could help flesh out some models, almost like sub-routines that could work within the ACO, and just provide a little bit of a framework, I think there's an opportunity there not to introduce all these would-be competitors to ACOs. I think that would be a horrible mistake. But I think refusing to acknowledge that episodic models might be there and that we could somehow integrate them, subordinated to ACOs, I think not at least exploring that possibility, I think we may be missing a tool that the MA community and the commercial payers have already picked up on.

That's it. Thank you.

DR. CROSSON: Okay. Thank you, Brian, and thank you, presenters, and thank you, Commissioners, for a really robust and complete discussion. But it's very important because I think, as I said in the beginning, it's going to help our work going forward.

So we will now move on to the final presentation for the day, and the final presentation.

[Pause.]

DR. CROSSON: Okay. We don't have everybody back. It seems like the earlier discussion has created a

run to the bathroom, but there's not much I can do about that.

[Laughter.]

DR. CROSSON: We will get started. Eric is here to give us a discussion about a variety of managed care and similar models that deal with the dual-eligible population. And I want to compliment you, Eric, on a very thorough analysis.

MR. ROLLINS: Thank you.

DR. CROSSON: You've got the microphone.

* MR. ROLLINS: All right. Good morning. I'm here to talk about managed care plans that serve dual-eligible beneficiaries, who are individuals that qualify for both Medicare and Medicaid. This presentation builds on last month's update on the financial alignment demonstration, which if you'll recall has focused largely on using managed care to integrate Medicare and Medicaid for dual eligibles. The material from these two presentations will appear as a chapter in the Commission's June 2018 report.

DR. CROSSON: Eric, excuse me. Could you move the microphone a little closer? Yeah.

MR. ROLLINS: How's that?

DR. CROSSON: That works.

MR. ROLLINS: Okay.

Before I begin, I'd like to follow up on an issue that Bruce raised at our October meeting during the presentation on Part D appeals and grievances. Bruce, you mentioned during the discussion that nursing homes might have an incentive to encourage their residents to change drug plans periodically so the residents could continue receiving 90-day transitional supplies of any non-formulary drugs. We looked into this a bit and found that only about 4 percent of long-term nursing home residents changed their Part D plan more than once in 2016, so if this practice does go on it does not appear to be widespread. As you know, CMS recently announced that it will shorten the transition period for enrollees in nursing homes from 90 days to 30 days.

I'd like to begin with a brief overview of the presentation. I'll start by discussing some challenges that have made it difficult to develop plans that provide both Medicare and Medicaid services, which we refer to generically as integrated plans. After that, I'll review developments in the use of Medicaid managed care that make

the development of integrated plans more feasible in many states. From there, I'll provide an overview of the various types of Medicare plans that serve dual-eligibles. Finally, I'll discuss three potential policies that would encourage the development of integrated plans.

Many observers have supported the development of integrated plans as one way to improve the quality of care and reduce federal and state spending on dual eligibles. However, despite their conceptual appeal, only 8 percent of full-benefit dual-eligibles are currently enrolled in highly integrated plans. The development of these plans has traditionally been hindered by several obstacles.

First, states had limited interest in integrated plans because they could not benefit from any of the Medicare savings that these plans might produce. Second, initial efforts to develop integrated plans relied entirely on voluntary enrollment, and plans found it difficult to generate meaningful enrollment. Third, plans had limited experience providing Medicaid long-term services and supports or LTSS, which account for most of Medicaid’s spending on dual eligibles but differ significantly from traditional medical services.

However, the financial alignment demonstration suggests that policy changes could spur interest in the development of highly integrated plans. The demonstration allows states to benefit financially from expected Medicare savings and to use passive enrollment to help ensure that plans have sufficient enrollment. A significant number of states expressed interest in the demonstration, and the experience to date indicates that many states can develop highly integrated plans.

States' interest in the demonstration is part of a broader shift towards the use of Medicaid managed care for dual-eligibles. The centerpiece of this shift has been the use of managed care plans to provide LTSS. The number of states that have what are known as managed LTSS or MLTSS programs has grown rapidly, from 8 in 2004 to 23 today, and other states are likely to develop them in the future.

The share of full-benefit dual-eligibles in MLTSS plans is still relatively low, roughly 10 percent in 2015, because many programs do not cover the entire state or exclude certain types of LTSS users. However, the 23 states that have MLTSS programs account for about 75 percent of all dual-eligibles, so the share enrolled in

MLTSS plans could grow substantially as states expand their programs.

One key feature of Medicaid is that states can require individuals to enroll in managed care plans to receive services, and many states with MLTSS programs now have mandatory enrollment for at least some dual-eligibles. In these cases, the development of plans that provide both Medicare and Medicaid services is likely the most feasible way to better integrate the two programs.

Using managed care to better integrate Medicare and Medicaid is a broad concept that can be implemented in numerous ways, and Medicare has four types of plans that serve dual-eligibles. The first type of plan is the Medicare Advantage dual-eligible special needs plan, or D-SNP, which is an MA plan that is open to dual-eligibles only and has a Medicaid contract that meets certain requirements. The second type is the fully integrated dual-eligible special needs plan, or FIDE SNP, which is a D-SNP that meets additional requirements for closer Medicaid integration.

The third type is the Medicare-Medicaid Plan, or MMP, which is part of the financial alignment

demonstration. The last type is the Program of All-Inclusive Care for the Elderly, or PACE, which is a provider-sponsored plan that aims to keep frail beneficiaries who live in the community from entering nursing homes. Unlike the other three plans, PACE is open to all Medicare beneficiaries who meet its eligibility requirements, but in practice almost all of its enrollees are dual-eligibles.

The next slide compares some key features of these different plans. For this comparison, we've split the D-SNPs into two groups: those that have the FIDE SNP designation and those that don't, which we refer to as "regular D-SNPs." The figures in this table have been revised slightly from the mailing materials because we received some updated information about which plans are FIDE SNPs. As you can see, MMPs are part of a demonstration while the other plans are permanently authorized. However, CMS is using its CMMI authority to conduct the demonstration, so MMPs could potentially become permanent in the future.

Regular D-SNPs are the most widely used plan. They are available this year in 40 states and the District

of Columbia and have about 1.7 million enrollees. In contrast, just 9 states have FIDE SNPs, and 3 states, Massachusetts, Minnesota, and New Jersey, account for about 75 percent of the overall enrollment. Less than 10 percent of all D-SNP enrollees are in FIDE SNPs. There are a similar number of FIDE SNPs and MMPs, but overall enrollment in MMPs is more than twice as high, partly because MMPs can use passive enrollment but FIDE SNPs cannot. Finally, PACE plans are available in 31 states, but they are typically small and total enrollment is fairly low.

These plans differ in many respects, such as contracting structure and payment methodology, that are discussed in the mailing materials. I'm not going to review them all here, but I would like to focus on one key difference, which is the level of integration between Medicare and Medicaid in each plan. We consider plans to be more highly integrated if they provide a broad range of Medicaid services and have been able to streamline various administrative functions such as the enrollment process and member materials. The level of integration in regular D-SNPs is generally low but varies widely, while the other

three plans are all highly integrated. We'll explore this a bit further on the next slide.

This slide lists the four plans in order from least integrated to most integrated. Let's start with regular D-SNPs. Since 2013, Medicare has required all D-SNPs to have a Medicaid contract that satisfies certain minimum standards. These standards do not require much integration between the D-SNP and Medicaid. For example, D-SNPs do not have to provide any Medicaid benefits on a capitated basis, although their contract must describe the steps they will take to ensure that those services are provided.

But states can go beyond these minimum standards if they wish, so there is also a fair amount of variation among regular D-SNPs. For example, a state might require its D-SNPs to provide some Medicaid acute care services, such as payment of Medicare cost sharing or dental services. Several states have gone even further by requiring the sponsors of their MLTSS plans to offer companion D-SNP products so that dual-eligibles have the option of receiving all of their Medicare and Medicaid

services from the same company.

FIDE SNPs are more highly integrated than regular D-SNPs because they must provide some Medicaid acute care services and LTSS, although they are not required to provide behavioral health. FIDE SNPs must also take steps to integrate administrative functions such as the enrollment and care assessment processes. The level of integration in MMPs is higher still because they cover all or almost all Medicaid services, use a single care coordination process, and have more flexibility to integrate their administrative functions. Finally, PACE is a completely integrated program because its plans are required to provide all Medicare and Medicaid services.

One potential drawback to having multiple types of plans is that they could interact in ways that undermine efforts to promote greater Medicare-Medicaid integration. Given the limited role of PACE, this concern largely applies to D-SNPs and MMPs. Every state that has MMPs also has, or had, D-SNPs, and having both plans in the same market has sometimes been problematic.

CMS uses two different methodologies to calculate the payment rates for D-SNPs and MMPs, and about two-thirds

of MMP enrollees now live in counties where MMP rates are generally lower than D-SNP rates. This may give plan sponsors an incentive to favor the less-integrated D-SNPs.

Competition between D-SNPs and MMPs has been an issue in three states we visited. California had a large number of D-SNPs prior to the demonstration, and the state promoted MMPs by transferring beneficiaries from D-SNPs to MMPs offered by the same company and freezing enrollment in other D-SNPs.

However, these policies have been opposed by many plan sponsors and enrollment brokers, who cannot receive commissions from MMPs. They have responded by diverting a significant number of dual-eligibles into regular MA plans that are targeted at dual-eligibles and known as "look-alike" plans. In New York, the MMPs serve the same population as an existing group of FIDE SNPs, which has led to confusion about each plan's role.

In addition, several companies offer both types of plans but may receive higher Medicare rates for the FIDE SNP. Finally, in Texas, the companies that sponsor MMPs also offer D-SNPs in the same counties. The state proposed phasing out these D-SNPs in favor of the MMPs but later

abandoned this idea due to opposition from the plans.

Stepping back a bit now, the development of integrated plans for dual-eligibles obviously requires the involvement of both state and federal policymakers. With the growth in MLTSS programs, many states now use capitation to pay for the services that account for the bulk of Medicaid's spending on dual eligibles, and are thus in a good position to develop integrated plans. At the federal level, Medicare has taken incremental steps to develop integrated plans, but this has resulted in an array of plan types that differ in various respects and could increasingly compete with each other if the MMP model becomes permanent.

Given this context, federal policymakers may want to reassess the role of the Medicare plans that serve dual-eligibles and consider new policies to encourage the development of highly integrated plans. This effort could involve consolidating some existing plans or giving each plan a more clearly defined role. This is a complex topic and more work would clearly be needed, but I'd now like to outline three potential policies that could be a set of "first steps" in this area: limiting how often dual

eligibles can switch plans, limiting enrollment in D-SNPs to full-benefit dual-eligibles, and expanding the use of passive enrollment.

Unlike most Medicare beneficiaries, who can normally change their MA or Part D plan once a year, dual-eligibles, until just this week, have been able to switch plans on a monthly basis. This slide gives you a sense of how often dual-eligibles change plans compared to other beneficiaries. The table shows how often the two groups voluntarily changed plans in 2011 and 2016, and does not count instances where fee-for-service beneficiaries changed their standalone Part D plan.

If you look at the two columns for 2011, starting at the top, you can see that the share of beneficiaries who changed plans at least once was about the same for dual-eligibles and other beneficiaries, between 6 and 7 percent. However, at the bottom of those columns, you can also see that dual-eligibles were between 4 and 5 times more likely to make multiple changes.

If you compare the 2011 columns and the 2016 columns, you can see that the share of dual-eligibles who change plans has increased. Focusing on the first row of

the table, the growth was particularly large in counties where the financial alignment demonstration is taking place, with the share making at least one change rising from 6.8 percent to 14.7 percent. This isn't entirely surprising given the use of passive enrollment and the large numbers of dual-eligibles who have disenrolled from MMPs.

However, there was also a noticeable increase for dual-eligibles in counties that aren't part of the demonstration. In contrast, when you look at the second row of the table, there was relatively little change in the behavior of other Medicare beneficiaries during this period.

The rules that allow dual-eligibles to switch plans on a monthly basis had been in effect since 2006 and were originally created as a beneficiary protection, to ensure that dual-eligibles who had difficulty seeing certain providers or obtaining treatment could change plans. However, the benefits of this policy may no longer outweigh the drawbacks. MA plans now have much more experience with dual-eligibles than they did over a decade ago, and improvements to CMS's risk-adjustment system have

reduced concerns that plans would avoid serving sicker beneficiaries. At the same time, allowing dual-eligibles to switch plans every month makes it harder for plans to provide care coordination.

One way to promote integrated plans would be to limit how often dual-eligibles can switch plans. This change would make enrollment in plans like D-SNPs and MMPs more stable and facilitate care coordination. CMS just issued a final rule that will limit how often dual-eligibles could change plans. Under the rule, dual-eligibles will be allowed to make one additional plan change per calendar quarter during the first nine months of the year, on top of the standard MA and Part D rules for changing plans that apply to all beneficiaries. This change will probably not have a significant impact on dual-eligibles since the number of beneficiaries who change plans that often is low.

The second policy involves partial-benefit dual-eligibles, whose Medicaid coverage is limited to payment of Medicare premiums and, in some cases, cost sharing. Most states allow partial-benefit dual eligibles to enroll in D-SNPs, and they account for about a quarter of all D-SNP

enrollees. In contrast, partial-benefit dual-eligibles cannot enroll in a FIDE SNP or an MMP and almost none are enrolled in PACE.

Given their limited Medicaid coverage, partial-benefit dual-eligibles may not need a specialized MA plan like a D-SNP. The challenges of coordinating Medicare coverage of acute care and prescription drugs with Medicaid coverage of services like LTSS simply does not exist for this population.

Policymakers may thus want to consider limiting enrollment in D-SNPs to dual-eligibles who qualify for full Medicaid benefits. This change would promote the development of integrated plans because it would require D-SNPs to focus their efforts on the dual-eligibles who stand to benefit the most from greater Medicare-Medicaid integration. It would also be consistent with the Commission's 2013 recommendation that the authorization for D-SNPs should apply only to plans that are clinically and financially integrated with Medicaid. In addition, limiting enrollment in D-SNPs to full-benefit dual-eligibles would make the eligibility criteria for D-SNPs and MMPs more similar, which would make it easier to

consolidate these plans in the future.

The third policy would be to expand the use of passive enrollment. This would support greater integration because it would encourage more dual-eligibles to receive their Medicare and Medicaid services from the same company, either by enrolling in a single plan like an MMP or enrolling in a D-SNP and a companion Medicaid plan.

There are a number of ways that passive enrollment could be used. One variant is "seamless conversion," where individuals who are enrolled in Medicaid plans would be passively enrolled in a D-SNP or MMP offered by the same company when they qualify for Medicare. Three states, Arizona, Tennessee, and Texas, are now using seamless conversion and have found that opt-out and disenrollment rates are low.

In 2016, CMS had put a moratorium on new requests to use seamless conversion in MA plans, but it announced earlier this week that it will allow seamless conversion to be used for certain D-SNPs. Interest in seamless conversion has been growing because many states with MLTSS programs require their plans to offer a companion D-SNP.

Seamless conversion would not affect many dual

eligibles, such as those who start as Medicaid enrollees but are not in a plan when they qualify for Medicare, or those who qualify for Medicare before they qualify for Medicaid. Passive enrollment could also be used for some of these beneficiaries, but policymakers would need to decide which plans would be eligible for passive enrollment and when beneficiaries would be able to opt out or disenroll.

That brings us to the last slide of the 2017-2018 meeting cycle, where I'd like to offer some possible topics for discussion. We would like your feedback on the three policies that I outlined in this presentation.

First, should there be limits on how often dual-eligibles can change plans? In 2008, the Commission recommended that dual eligibles should only be able to switch plans during the annual open season. However, as part of the recommendation, dual-eligibles could still switch to fee-for-service coverage or enroll in a D-SNP at any time. The Commission could revisit this issue given how the use of managed care for dual-eligibles has evolved since then. For example, the exception for fee-for-service coverage may no longer be needed and the exception for D-

SNPs could be narrowed so it applies only to highly integrated plans such as FIDE SNPs or MMPs.

Second, should enrollment in D-SNPs be limited to full-benefit dual-eligibles? This change would make the eligibility rules for regular D-SNPs more similar to those for FIDE SNPs and MMPs, and would make it easier to consolidate the plans in the future.

Third, should passive enrollment be used more broadly, and if so, under what circumstances? CMS recently announced that certain D-SNPs will be able to use seamless conversion, but are there other situations where passive enrollment could be appropriate? For example, should states be allowed to use passive enrollment for plans such as FIDE SNPs?

Finally, we would also like to know your level of interest in any other future work related to the financing and delivery of care for dual-eligibles.

Thank you for your time. I will now be happy to take your questions.

DR. CROSSON: Eric, thank you for this excellent work and presentation.

Before we begin the discussion, though, I would

like to take a moment. As you pointed out, this is not only the last presentation and the last slide, but it's the end of our work year. And as it often happens, we have Commissioners who are leaving after having completed six years of really very hard work to be members of this Commission, and each one of these individuals has been a significant contributor to our work. And the contributions that they have made will have a lasting impression not just on the Commission but on the future of Medicare policy.

So I'd like the five individuals to stand and be recognized for a moment, please. Alice Coombs, Jack Hoadley, David Nerenz, Rita Redberg, and Craig Samitt. Thank you for your work.

[Applause.]

DR. CROSSON: Okay. So we'll proceed with clarifying questions, and, Jon, I'm going to ask you to lead that for a moment.

DR. CHRISTIANSON: Any hands for clarifying questions?

This was really clear.

MS. WANG: Eric, when you pose the question about whether D-SNP should be restricted to full duals because it

would promote integration, how do you see that happening exactly? Why would it promote that?

MR. ROLLINS: I think -- so right now, where you've got a lot of your sort of regular D-SNPs that aren't very highly integrated with Medicaid, if you want to sort of consider ways that you can get those plans to offer a broader array of Medicaid services, the partial-benefit dual eligibles are really not part of that discussion. They're not implicated in that, and I think in some ways, they're kind of a distraction to efforts to try and sort of raise the bar for integration and sort of plans for full-benefit dual eligibles.

And given what Medicaid does for them, it's not clear that they need a plan like a D-SNP. They may be just as well served in a regular MA plan, and I think this was in the mailing materials.

Most of the ones who are in MA are actually in regular plans. I think about two-thirds of them were just in a traditional Medicare Advantage plan, and only about a third are in a D-SNP.

MS. WANG: But just to clarify, just because a full-benefit dual is in a D-SNP, even if that organization

wanted to create an integrated program that included long-term care for those who were eligible, they'd still have to set up a separate program and plan to be approved both by -- I mean, you can't take a D-SNP and just sort of say, "Oh, now I'm doing integrated care as well," can you? I mean, that's why the FIDE SNP designation exists.

MR. ROLLINS: You don't have to create a separate plan to become a FIDE SNP. You can evolve over time, and there are a number of FIDE SNPs now that started originally as just regular D-SNPs, but over time, the state expanded its sort of Medicaid responsibilities for those plans.

MS. WANG: So, in those situations, can that FIDE SNP also have D-SNP members who don't qualify for the MLTSS benefit? I mean, those who qualify for the MLTSS benefit are quite a subset of full duals.

MR. ROLLINS: They are, and there are FIDE SNPs that serve a broader array of dual eligibles. They don't just have to be those who at that moment in time need LTSS, but there is the understanding that they may have beneficiaries, for example, who are at risk of needing LTSS in the future.

MS. WANG: I suspect it's still quite a subset of

the whatever million-plus who are enrolled in D-SNPs. Don't you think?

MR. ROLLINS: Who --

MS. WANG: Who are qualified for MLTSS or on the verge of that you could identify as saying this person is about to need MLTSS. I mean, there are --

MR. ROLLINS: Yes. I think it is a subset.

MS. WANG: People call them "well duals." I don't like that term. They're not well, but they may not be eligible for MLTSS services.

MR. ROLLINS: Right.

DR. CHRISTIANSON: Other clarifying questions?

MR. PYENSON: Eric, thank you.

Is it clear that the MA portion saves the federal government money relative to fee-for-service in some areas where the benchmark might be lower, significantly lower than fee-for-service, or is there something else that might be going on with the MA -- with the dual eligibles in those areas?

MR. ROLLINS: Is your question specifically to the duals in MA or sort of an MA --

MR. PYENSON: The duals in MA. So is this a --

is it a good thing for the federal budget?

MR. ROLLINS: I think that depends partly on -- as you know, given the quartile system, it's going to depend partly on what counties you're talking about. But to the extent that you are talking about counties that do have benchmarks that are 95 percent or fee-for-service costs, those are probably areas where having duals in Medicare Advantage does save some money for the federal government.

Obviously, you would need to account for quality bonuses, up-coding, things like that, but on balance, there's probably some savings in those counties. Other counties, there may not be.

DR. CHRISTIANSON: Kathy.

MS. BUTO: Just to follow on that question, when he says the federal government, he means the federal share of Medicaid as well, right? So I think you'd have to account for whether there's savings on the Medicaid side as well as the Medicare side.

MR. ROLLINS: You would. I don't think we have a clear picture of what the interaction between what goes on, on the Medicare Advantage side, and how that spills over or

doesn't spill over to your Medicaid service use.

The theory, of course --

MS. BUTO: Yeah.

MR. ROLLINS: -- is that with an integrated plan --

MS. BUTO: That's the theory, yeah.

MR. ROLLINS: -- that's a theory.

MS. BUTO: That's the whole premise.

MR. ROLLINS: Right.

MS. BUTO: So my question was, how stable is dual eligible population? In other words, once an individual qualifies for Medicaid or comes into Medicare as a Medicaid recipient, is that individual likely to be dual for life? Do we know?

MR. ROLLINS: They will likely -- a large majority are likely to be dual eligible for a long period of time. Having said that, I want to say something like over the course of a year of your dual eligibles, 80 to 90 percent are dual eligible all 12 months.

That being said, it's a minority, but one issue that we have heard a lot about on our site visits to the plans that are participating in the demonstration is there

are a subset of dual eligibles who are dual for one period of time, and then they will lose their Medicaid eligibility. Then they will just be Medicare-only for a period of time. They'll get back on Medicaid. So there is a subset that sort of cycles on and off, and in a lot of cases, that is driven by the state does periodic redeterminations of their Medicaid eligibility, and it's not so much the -- some of them may no longer truly qualify for the program, but there seems to be a lot of cases where it's simply they didn't realize that they had to submit a form or provide more information to sort of stay on Medicaid. So it's sort of an inadvertent loss of eligibility.

MS. BUTO: So you don't think that's a big factor in considering -- sort of analogous to the question you raised about partial duals, that those individuals would create some instability or it would be difficult? Because they're fully dual while they're dual eligibles, right, for that D-SNP to be more compatible with the MMPs? It's not a big factor in your --

MR. ROLLINS: Well, I think to the extent that you do have -- you can look at it on a couple of levels.

So you have this -- to the extent that you have people moving in and out of full Medicaid eligibility, one change that you could consider, which is not in our Commission's purview -- it might be more of a MACPAC issue -- is would you want to have more situations where some dual eligibles are guaranteed to remain eligible for a 12-month period at a time, and so you reduce the number of times where you could have these occasions where they lose their eligibility, possibly just because they didn't turn in their paperwork.

Within the Medicare program, the way that D-SNPs handle this now is if you lose your Medicaid eligibility, there is a grace period in which you can remain enrolled in the plan if there is an expectation that you will at some point regain your eligibility, and so that could be a way to sort of handle that issue without having eligibility for partial-benefit duals broadly.

DR. CHRISTIANSON: Any further clarifying questions?

[No response.]

DR. CHRISTIANSON: Jack and David are going to lead our discussion. Do you guys have any preference of

who starts?

[No response.]

DR. CHRISTIANSON: Okay. David?

DR. GRABOWSKI: Thanks.

First, Eric, thanks for a great chapter, and I think this is a critically important area. These are obviously among our frailest and most vulnerable beneficiaries in the Medicare program.

There's an incredible disconnect between their Medicare services and their Medicaid services and that leading to fragmentation and the higher spending, lower quality of care, so real opportunities with these integrated plans.

Before taking on your questions, I wanted to say a little bit about the regular dual eligible SNPs. The question is often posed: What's so special about dual eligible special needs plans? And the unfortunate answer for those regular plans is not much. They're not so special. They do a really poor job of integrating Medicare and Medicaid services. Often, they have a very nominal sort of case management function that links between the two plans, but by and large, they don't really offer an aligned

integrated product.

So in addition to the ideas that you put up here, I would love to see us think about how can we move those 1.7 million individuals. I realize a quarter of them are partial duals, but many of them, three-fourths of them, are full duals. How do we think about pushing them towards a more integrated product? Is that moving those regular dual eligible special needs plans towards becoming fully integrated dually eligible special needs plans? I'd love for us to think about that as a Commission. Are there other levers that we might use here, recommendations, towards actually making that an integrated product? Because the number of full duals that are in regular D-SNPs is double the number of all those other models you had up on that slide.

So I think we're leaving a lot on the table there. A lot of beneficiaries have joined these models, but they're not actually getting integrated care. So that's my rant on regular D-SNPs.

Let me take on your questions. Should we limit the switching of plans? I think, sure, that's fine. My one concern in the work we've done, if you're going to

passively enroll individuals into these models, I think you have to be really careful to give them a grace period. Obviously, they have the opportunity to opt out, but as you know, there's been a big disenrollment in the early period as the beneficiary realizes that they're in a new plan that they've been passively enrolled.

So I would give the beneficiaries a grace period when they've been passively enrolled, but I'm okay with kind of limiting the switching across plans.

Towards your second question, should partial-benefit dual eligibles be able to enroll in D-SNPs, I actually like the idea of having them in those plans because I think it's an On Ramp as they move back and forth between being a partial dual and a full dual and maybe ultimately a full dual being a part of those plans. So I'm okay with having the partial duals in those plans.

And finally, when is passive enrollment appropriate, I do like the use of seamless conversion, and I do like the use of passive enrollment in the FIDE SNPs. I think we should be sort of broader in our use of passive enrollment. However, the work we've done on the Demo plans under the Financial Alignment Initiative suggests design

really matters here, as it does in all of health care, but passive enrollment is not passive enrollment. It's not passive enrollment, and so you raised some great points in the chapter, Eric, about how to do that in a smart way. And I think we really want to think about that going forward.

Finally, you didn't ask it as a form of a question, but I have tremendous interest in this topic, so I hope the Commission will continue to work on this. One area, I'll just point out quickly. I don't think we know a lot about the FIDE SNPs. Why do plans convert? What are those plans, and how could we think more broadly about those plans as a more national model? They're very isolated in certain states.

So as a part of a future chapter, I would love to see us explore that model and how we might think about broadening its application to other markets.

Thanks.

DR. MATHEWS: David, if I could just ask a clarifying question. You would be okay with continuing to allow partial-benefit duals to enroll in D-SNPs even if at the same time we started to make a push for those D-SNPs to

become more integrated products?

DR. GRABOWSKI: That's right.

So if we could -- so those two comments, thank you, Jim. We're in conflict. Thanks. It's our last meeting, Jim. We were getting along so well before this.

[Laughter.]

DR. GRABOWSKI: I think the latter part of that is more important of getting these plans converted to full FIDE SNPs, but I just think these partial duals, if we're going to continue with D-SNPs, I would love to not exclude those individuals. It's a quarter of the enrollees. I just think eventually, those individuals are going to be full duals, and so how do we think about that? I think we are going to consolidate. Then, obviously, we've got to stick with the full duals, but thanks.

DR. CROSSON: Jack.

DR. HOADLEY: Thank you, and thank you for a great chapter, Eric.

On the last point on the slide on sort of the interest in the topic, I think it really is an important topic, and I think we don't probably spend enough time talking about the dual eligibles in general for reasons

that not all of what they get from the federal government is in our purview. But I think we do have a piece of it in Medicare, and I think it's important. I think some of the comments that David made are very apt there.

I agree. I don't know a lot about the FIDE SNPs, like you said the incentives from the plan side of sort of what gets you to try to do this. I know more about the MMP, and of course, that was an explicit demonstration to try to do this.

I want to take one small step backward and talk about some observations I've made in looking at mandatory Medicaid managed care, not specifically the long-term support and services side of it, because I haven't looked myself specifically at that, but the more traditional non-dual Medicaid. But I think some of the issues are there, and I'd just make four quick points on that.

You mentioned when you talked about the LTSS plans that a lot of states do these things through a competitive procurement process, and that's one of the things that's different than Medicare, where we sort of let any organization that wants to come in and be an MA plan can do it as long as they meet sort of basic standards.

But states typically do a competitive procurement where they try to select often three or four organizations to offer managed care to their Medicaid enrollment, whether it's the MLTSS or the regular Medicaid.

And one of the results of that that I've seen in some work is that that can lead to pretty substantial turnovers. When they do a new procurement, they may have a situation where existing three plans lose the procurement or don't apply, and you have a brand-new set of plans or one out of three or two out of four, whatever it might be. And that can be very disruptive, and I think these are things that I think have some implications, both to how we think about some of the things around passive enrollments and some of that, so that's why I'm bringing some of these things up. But there can be really pretty substantial disruption when you have those turnover periods.

There's also, I think, been to some extent in Medicaid -- and I hope this is getting better, but plans that come into the Medicaid managed care market without a particularly good track record or particular experience serving the population, and hopefully, states, as they look at their -- particularly as they look at their MLTSS, are

paying more attention to that. But I think there's been some issues there as well of plans that come in, don't really know how to deal with the needs of the particular populations they're dealing with.

Generally, care coordination is part of what's going on with any of these Medicaid managed care plans, presumably any managed care plans in general, and I think I've mentioned this in other discussions, but sometimes the plan care coordination is duplicative of care coordinations that's already gone on with FQHCs or clinics or safety net hospitals or other provider organizations that are serving the duals. Unless it's a provider-based managed care entity, sometimes you get multiple layers of care coordination, and you start to need somebody to coordinate the coordinators.

And then, finally, provider network issues, there have been a number of cases where these Medicaid plans trying to maintain ability to win a procurement with a low bid accomplish that by having relatively narrow networks that has implications, and again, I'll talk in a second about the playoff, again, some of the enrollment issues.

So I think those are just some things. There's

obviously some positive things you could talk about as well, but those are some of the sort of problems that have come up at times within the Medicaid managed care world, some of which I've seen also in the MMPs and some of the other places that do involve duals.

So going to your questions on here, the first on limiting when duals can change plans, I still have concerns about loosening the current -- well, until recently, the current protections that allow duals to disenroll pretty much at any time and the notion that it is a beneficiary protection. And I think it's still important, and the fact that you show relatively low levels of disenrollment, hopefully when people are doing it, they're doing it because there's a reason. And I reflect back to those problems we've seen with narrow provider networks or narrow formularies or other kinds of things that people get into the plan. They start to go to use services, and they realize that the doctors they've been seeing aren't in the network or whatever.

Now that CMS has taken a step towards more limitations, I guess what I would want to say is let's not look at anything more extensive then what CMS has already

done to narrow that right to disenroll and maybe wait and get some reactions from the beneficiary community, some of the advocates, folks like Medicare Rights Center, Center for Medicare Advocate, who talk to beneficiaries on their call centers and get those kinds of things and see if we're running into issues there.

On the partial-benefit duals being able to enroll in D-SNPs, I came into this not being sure how to react, and I'm struck by David's -- and I'm kind of inclined to agree that maybe there is some potential benefit there. These people have signed up for a reason. Again, maybe we could talk to them in some way and find out what it is they saw -- was it some kind of marketing that was done? Was it they were looking for something that was more attuned to their needs? Why are they in it? What do they think they're getting out of it? -- and think about that. So I don't know that I'd be quick to agree to try to scale back that enrollment, but I'm really open to hearing more about that issue or at least having those of you who stay on hear more about it.

And then on the passive enrollment, I've always been a person who's concerned about passive enrollment in

part because I'm unhappy with rules that have greater restrictions on a dual eligible on a low-income Medicare beneficiary than we put on all beneficiaries.

It's not that I want to go the other direction and put more passive enrollment on the entire population, but the idea of sort of picking out this group and saying, "Well, we're going to decide what's best for you, what plan we want to put you in," even though we don't do that for beneficiaries in general, that concerns me.

The seamless enrollment, if it's done sensibly -- and I think I have less concerns about -- I'm more open to that. I still have some concerns. I'm concerned in some cases where if the principle of seamless enrollment is you're already enrolled in a plan with Company X and we can find an MA plan offered by Company X, sometimes Company X is kind of almost an umbrella organization that's acquired a subsidiary that runs Medicaid managed care plans, and their Medicare plans are not run by that part of the organization. So there are situations where it may not be as clean as it sounds when it's in the best situations, but I'm more open to that. I'm less open to the other types of passive enrollment in the FIDE SNPs or whatever.

And I think -- and, David, you brought this up. Trying to do a better job of how we do passive enrollment, if we're going to do it, the MMP, the financial alignment demo has tried to do, various terms are used, "intelligent assignment," and often they didn't really have the tools to do that. So in the concept, they wanted to put you in the plan that already had your providers, but maybe the state didn't know who your providers were because they didn't have adequate access to the Medicare claims records to see what doctors are you using, what hospitals have you been going to for your care.

If we can do a better job of aligning people -- but I've seen cases -- and again, this is not for the senior population, but for the general Medicaid population where people had five providers, maybe none of the plans had all five, but they might have been assigned to one that had one or none of their five providers, and then it takes a period of time to figure that out. Maybe you don't see some of those providers for three or six months, and you all of a sudden discover when you go there, oh, my goodness, they're not covered. And now you've got to figure out what to do about it, so it links back to that

changing plans kind of thing.

So I'm really happy we're taking on this issue. I think these are topics -- all the topics you have here are worthy of a lot of discussion and thought, and I hope we'll come up with some sensible ways to address them.

MR. ROLLINS: Jack, if I could respond just to one question you were asking. That's sort of why we had a partial-benefit dual enroll in a D-SNP. I think at least part of what's going on is that it's not so much about the Medicaid; it's that because the Medicare Advantage plan can limit its enrollment to a population that's dually eligible, they can sort of tailor their extra benefits and how they use their rebates in a way that they wouldn't necessarily do for the broader Medicare population. So, for example, they will know that all of the partial-benefit duals are getting the Part D low-income subsidy. And so they won't -- you know, they don't feel a particular compunction to say that we're a zero dollar premium plan because we know all our enrollees are going to be getting, you know, roughly $30 a month from the Part D subsidy. So they can sort of offer a slightly more tailored package of extra benefits that make sense for them. It isn't so much

about dealing with Medicaid per se. It sort of just takes into account, well, we know you get these other subsidies or, for example, the duals who are just QMBs. They get coverage of cost sharing. A plan in that case isn't going to allocate as much of its MA rebates to sort of coverage of cost sharing because they know that that's not really sort of a value add, if you will, for the enrollees.

DR. HOADLEY: I think that's helpful to have that kind of information in this discussion. And, you know, obviously, there's some degree at which low-income beneficiaries in general, whether they're actually partial duals or just low income, find Medicare Advantage attractive because they can't afford some of the Medigap options out there, and so they look at MA as a way to, you know, reduce their out-of-pocket responsibilities.

DR. CROSSON: Okay. Further comments and feedback? I've got Kathy and then Pat over here.

MS. BUTO: So, Eric, I think this work is terribly important. I mean, this is the most expensive and in some ways the poorest served segment of the Medicare and Medicaid populations in combination. So I'm really glad we're doing this, and I wanted to just touch on the points

that you've asked for our feedback on.

I agree with Jack on number one, which is CMS has already placed some additional restrictions on changing plans, and I would just let those play out, not take any further steps at this point.

On the second point, partial-benefic duals, I'm not as clear as David is on whether most of them eventually become full duals. Do we have any data on that?

MR. ROLLINS: We did look at some of that. I think it's mentioned in the paper. The share who go on to become -- I mean, some of them do go on to become full duals. It's kind of a question of how much do you think is a lot. I think after a year, roughly 6 percent of those who are partial duals have become full duals. And after three years, it was roughly 10 percent had become full duals. So some of them do transition, but by and large --

MS. BUTO: Okay. It's not a majority.

MR. ROLLINS: Correct.

MS. BUTO: Okay. So I'm really agnostic on that one. I don't have a strong feeling.

On three, I agree with Jack; I think the seamless conversion makes a lot of sense. The issue of passive

enrollment is more troublesome, but I'm wondering whether another way we could think about that is that the program strongly suggests or recommends, or something like that, enrollment in a FIDE SNP. And then it goes to some length to describe the benefits to the beneficiary, including simplicity and full integration of care between the two payment streams, so actually try to get them to understand that it really is potentially very beneficial.

On the last point, I am really interested in further work in this area, and really from the perspective of the types of beneficiaries who are dual eligible. So I feel like we could do more of this, so the two kinds of subpopulations I'm thinking about are the under 65 people with disabilities. I don't have a sense of how well they are served by any of these plans or whether there are other options that really ought to be considered for them, something more self-directed. And then, secondly, behavioral health is a huge component of dual eligibility, and I similarly don't have a feel for how well behavioral health is managed or coordinated for dual eligibles in these kinds of plans.

So both of those population groups are of

interest, and so I'd like to see more work there, or at least an analysis of what we know.

DR. CROSSON: Jack, on this?

DR. HOADLEY: I really liked the fact that Kathy brought up the behavioral health angle, and I know when I saw the -- took a look at the MMP in Virginia, which is now phased out, they had an emphasis on the plans coming in having that capability. When we went and looked at it, it was too early to see anything in the way of results, and I know Eric has looked at some of those questions, I think, for the demos. But I think that's really important in figuring out ways to get plans to focus on that. And that's then the kind of thing that you could do to help do that outreach to folks to say here's something you would really gain in this plan that you might not see as good a coverage of elsewhere.

DR. CROSSON: Pat.

MS. WANG: I don't really have a different point of view from Jack and Kathy on the first bullet.

On the second bullet, I would like to be able to get back to you, Eric. You know, I am really thinking through -- in some ways it would be a lot cleaner to just

have full-benefit duals in a D-SNP. I'm not sure that it promotes the goal that you're going for there, which is, you know, sort of the development of further integration for benefits that the person would have to qualify for in the first place because, again, you know, it's a subset, it's a subset of the general dual population.

I also am concerned about the movement back and forth because eligibility can be a little bit -- you know, it changes, and the overall statistics you gave are helpful. But -- so, anyway, I think that the -- this is important work, so I think that it's very important for us to continue to work on this. I think part of the complexity of this whole area is that every Medicaid program is different, and it's very difficult for Medicare to come up with, you know, a clean approach as it does in other areas where it really -- it owns that payment stream. And some of the ups and downs I think in the MMPs stemmed from the fact that, you know, in the context of a demo, you know, CMMI wanted to be very deferential to state preference. State Medicaid program directors in my experience know very little, if anything, about the Medicare Advantage program, and I think that that created

some of the disconnects that you pointed out here, particularly in jurisdictions where MA and dual SNPs were already pretty prevalent, FIDE SNPs were prevalent, PACE programs were prevalent, and then new demos came in that were sort of competing, and it was -- there was no alignment at all in benefits and the approach toward that. So I think that that is a difficult thing.

I am really for trying, despite the complexity of having many different Medicaid programs who want their programs to be handled a certain way, trying to streamline the approach here, at least from Medicare's perspective. Somebody asked about FIDE SNP. You know, FIDE SNP is -- the reason that plans might go into a FIDE SNP is that they already serve a lot of Medicaid beneficiaries and Medicaid clients, a lot of duals, and want to promote integrated care, and they also have partial MLTSS programs, you know, following state plan design. The FIDE SNP early on was a very attractive kind of virtual PACE network, model PACE program that had appeal if you were not a PACE.

I think it would be really helpful to identify ways to make the existing FIDE SNP program stronger because it exists in the Medicare Advantage program. I can think

of a few things right off the bat. One of the really good things about the MMPs was that they figured out how to deal with the discontinuity between state Medicaid enrollment processes and Medicare Advantage enrollment processes.

In New York, for example -- and I'm going to get this confused -- if a beneficiary signs up on the 5th of the month, Medicare rules would say you're enrolled from the 1st of the month, and Medicaid rules would say you're enrolled as of the 1st of next month. So there's literally about eight business days in a month where you can actually -- the windows, the universes overlap, and you can actually get somebody into your FIDE SNP. So I think that that has really limited enrollment.

The MMPs were very successful, I think, also at trying to figure out how to handle appeals and grievances and things like that, because each program has an exquisite set of rules that are intended to protect beneficiaries, which is great, but it doesn't make sense to, you know, administer to exquisitely complicated processes, which, again, are discontinuous with each other. So I think the MMPs have lessons for the mainstream FIDE SNP program that I'd like to see pulled in.

The third issue which has been mentioned here is behavioral health, and I candidly do not know why -- I suspect that it has something to do with states not just the Medicare program, the design of a D-SNP or a FIDE SNP, whether Medicaid behavioral health benefits are in or out. They were in for the MMPs. They are not in, at least in my state, for FIDE SNP or D-SNP. And so what we have tried to emphasize instead is seamless conversion in a parent organization because we have a gigantic behavioral health program for Medicare members who are aging into dual status who are going to lose that as soon as they -- I mean, it's a very disjointed thing, so I think that there would be a question just factually as why -- whether most states include the full Medicaid behavioral health benefit in the FIDE SNP, or even in a regular D-SNP, and if they don't, why not? Because the benefit still exists, but they're in the fee-for-service system.

I am really a little bit wary of passive enrollment just based on our own experience. If it's not done incredibly well, it is very disruptive for a population that really should not be disrupted in this way. Seamless conversion is a different story. The change that

CMS made in its reg where seamless conversion can occur with opt-out, a lot of notice, when enrollment is from a Medicaid plan into a D-SNP run by the same parent organization. At least in my organization, for example, there's an 80 percent network overlap. It's the same PBM. It's the same care managers. It's the same member services people. Like it's a very familiar environment for the members, and so we think that it should feel quite seamless to members, and if they want to opt out, that's fine.

I would note in states where folks are thoroughly Medicaid managed care, which is increasing, the idea that fee-for-service for those folks who are aging into Medicare is like a safe haven is an assumption that really needs to be examined. Folks have been in managed care plans from birth, perhaps, or for whatever point they became Medicaid eligible, they've been in managed care. The current assumption, the current default enrollment upon attainment of Medicare eligibility, so you go into fee-for-service, which means you have to pick a stand-alone Part D plan. I mean, people -- this is our experience and why we really support seamless. People are so confused when that happens to them, and a very high proportion of our Medicaid members

to whom that happens find their way back at a certain point, probably when they're trying to use their card, their Health First card, or go to the pharm -- and it's like, "They say I'm not a member anymore. Did you kick me out?" And, you know, it's like so poorly handled. I just want to make the overall point. Fee-for-service is not, you know, like the safe place for duals. That's my personal view.

I would like us to explore additional passive enrollment -- excuse me, seamless conversion go further. It's not just -- you know, CMS made an important first step, so it's Medicaid aging into dual status, but it's also dual status aging into the need for integrated care. In my situation -- I think it probably exists elsewhere -- we actually have -- you know, it's like one type of person that's like a dual-eligible beneficiary could be enrolled in our MA D-SNP, in our own partial cap MLTSS plan, or in another organization's partial cap MLTSS plan. I can't even get the folks who are in my own MA program and partial cap MLTSS program to get into my FIDE SNP because the members are happy. They're like, 'Well, why should I move? I'm part of your organization. I'm a member." But it

facilitates care management and joint administration, so seamless in situations like that member is already enrolled. I think there are more permutations of that to try to keep a person in one organized system to the greatest extent possible.

Again, I think that the issue of behavioral health is really quite important. It's another reason that I'm in favor of seamless, because if they're enrolled in our behavioral health programs and they've got seamless, then they'll still be enrolled in our Medicaid behavioral health programs and just pick up the D-SNP. But, again, you know, getting the state to play is a very big part of it.

So I'm in favor of like try to improve the FIDE SNP program. To the greatest extent possible, pull in the learnings from the MMPs into the main program. It's not to the exclusion of further MMPs, but it could enhance the basic structure and investigate some of these other issues.

DR. CROSSON: Further comments? Okay. I don't see any. I think the input that we've had from a number of individuals has been very good. Eric, again, thank you for the work, and we look forward to further communication with

you on this question.

So we've come to the end of the session. We've come to the end of our MedPAC year. We now have an opportunity for public comment. If there are any members of the audience who wish to make a public comment, please come forward to the microphone.

[Pause.]

DR. CROSSON: We've got one, and she fought her way through the crowd.

Let me just make a couple of introductory remarks. This is an opportunity but not the only one to provide information to MedPAC Commissioners and staff. There are other ways to do that, particularly ways that you can do it before the discussion takes place.

That said, I'd ask you to identify yourself and your organization, if any, and confine your remarks, if you could, to two minutes. When this light comes back on, the two minutes will have expired.

* MS. BRENNAN: Great. Thank you. My name is Allison Brennan and I'm with the National Association of ACOs.

I want to thank you for the discussion today, and

I really enjoyed your back-and-forth kind of about benchmarks versus inappropriate counterfactual, and we've really been trying to get attention on this and appreciate you also acknowledging the big disparity there between benchmarks and what we really need to look at when we're identifying Medicare ACO savings, which is a more sophisticated counterfactual. And I know that there is more research that's going to be coming out on that pretty soon.

A couple of comments I wanted to make about the benchmarks is that we are sorely in need of benchmark changes in the program, and I think that's evidenced by the continued difficulty that ACOs have with achieving shared savings. And I think that connects really closely with ACOs moving into two-sided risk. It's really difficult in an organization to go to your Board and your physician leaders and say, "You know what? We haven't been successful in three years but I think we're going to move to two-sided risk, and kind of jump into that, feet first."

So I think we need to see more predictability and stability in the model, in the one-sided track before ACOs feel confident to move to a two-sided track. So for that

reason we certainly support the asymmetric models.

And the final comment that I wanted to make is I'd really love to see the Commission look more closely at the differences and limitations for risk adjustment. ACOs really face an uphill battle with their ability to be successful, and a lot of that is due to the limitations around risk adjustment. And I don't think we see -- well, I know we don't see those similar approaches with other Medicare programs, and we do see risk adjustment benefits for other Medicare programs and for Medicare Advantage. And I think there should be some parity there, and at least an acknowledgment of how difficult that is.

So I think with some of those key changes it will be really important for us to work on those to ensure the long-term sustainability of the program.

Thank you.

DR. CROSSON: Thank you very much. We are then adjourned for the year.

[Whereupon, at 11:38 a.m., the meeting was adjourned.]