MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, NW
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9:31 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[9:31 a.m.]

DR. CROSSON: So I think we can get going here. Carol is with us again. I've suspected for a long time, given the amount of work that she seems to be able to do, that there's more than one Carol.

[Laughter.]

DR. CROSSON: She confirmed that actually to me today, that she's actually a twin. So one person named Carol is going to be presenting this morning. And take it away.

* DR. CARTER: Okay. Good morning, everybody. We're going to be talking about sequential stays today.

Let me just start by reminding everybody that some patients in the four different PAC settings -- that includes skilled nursing facilities, home health agencies, inpatient rehab facilities, and long-term care hospitals -- we think are quite similar. And given that overlap, the Commission has long promoted the idea of moving towards a unified payment system for Medicare to span the four different settings. And as required by the IMPACT Act, in 2016 we recommended the necessary features of a payment

system and considered the impacts of moving to such a system. And this session today focuses on issues related to accurate payments for sequential stays, that is, back-to-back post-acute care stays.

As a reminder for people mostly in the audience that might be new to this topic, the key design features that we recommended are listed on this slide. The unit of payment was a stay or, in the case of home health care, an episode of care. And each stay was considered an independent event.

Payments would be based on the average cost of stays, with a large adjustment for stays in home health agencies because of their much lower costs. Payments would be adjusted using beneficiary and stay characteristics. The design should include short-stay and high-cost outlier policies, and our assessment of the feasibility and evaluation of the impacts was based on 8.9 million PAC stays in 2013.

We have had a long track record over the last two years of what we've been examining, focusing on design issues and later on implementation issues. Using the 2013 stays, we concluded that a PAC PPS design was both feasible

and would accurately predict the costs of stays for most patient groups and establish unbiased payments, most notably increasing payments for medically complex care. The Commission recommended design features and outlined the likely impacts in 2016.

Because the design can use readily available data and would improve the equity of payments, the Commission concluded that the payment system could be implemented sooner than was contemplated in the IMPACT Act, and in 2017 the Commission recommended that implementation begin in 2021. That same year, after updating the costs and payments to 2017, we found that payments were high relative to the cost of care, and the Commission recommended lowering the level of payments by 5 percent when the payment system was implemented. And earlier this year, to increase the equity of payments before the PAC PPS is implemented, the Commission recommended that the Secretary blend the PAC PPS relative weights with each setting's current relative weights to begin to correct the biases in the current home health and SNF payment systems, and that would begin to redistribute payments towards beneficiaries who are medically complex.

So our initial work on the unified PAC PPS considered each stay as an independent event. But we know many PAC stays are part of sequences of care where patients transition from one setting to another or extend their care during a course of treatment. Sequential stays present two potential challenges to payment accuracy.

First, through the course of care, a beneficiary's care needs may change so that early stays may have different average costs compared with later stays. We examine whether payments under a PAC PPS would be aligned with the cost of care for each stay in a sequence. If they are not, providers would have a financial incentive to refer beneficiaries for unnecessary subsequent care or avoid referring beneficiaries who require continued care.

The second issue addresses how to pay for different phases of care for providers who opt to treat in place over a continuum of care instead of referring them to a different provider. How do we ensure these providers are accurately paid for each phase of care without making it so easy that the volume of subsequent care increases?

To analyze sequential stays, we defined one as a stay that begins within seven days of the previous post-

acute care use, and this is a rough proxy for clinical relatedness. We created sequences of stays and began with the same 8.9 million PAC stays we've used throughout this work. And we used admission and discharge dates to link the stays into sequences. This linking created 5.3 million sequences. Of these, 3.4 million (or 64 percent) were solo stays, just one stay, and 1.9 million were multi-stay sequences. This session focuses on that minority of sequences that are in multi-stay sequences.

Multi-stay sequences included stays in the same setting (such as back-to-back home health episodes) and stays in different settings (such as a SNF stay followed by a home health stay). We examined stays treated in the three institutional settings -- that is, in IRFs, SNFs, and LTCHs -- as a group and home health stays separately because this mirrors how the PAC PPS will pay for care. Separate payments would be made for each stay in a sequence.

Here's an example -- oops, the wrong slide got loaded here. The black lines are going to be hard to see, and I'm sorry about that.

This slide shows a couple of examples of

sequences. The first row is a solo stay, the second row is a two-stay sequence, and you can see these stays are separated by a three-day gap, and we'll calling that one sequence. The third row shows a solo stay and then two stays that are close enough together that they create a sequence. An early stay is likely to include beneficiaries recovering from acute events while a later stay may focus on strengthening beneficiaries and managing their chronic conditions, and those might require fewer resources, and they might, therefore, be lower cost. If payments don't track these lower costs, later stays will be more profitable, and providers could base referral decisions on financial considerations rather than on what's best for the beneficiary.

Oh, this one's hard to see, too. I'm sorry. Starting with a quick summary of patterns, there were over 5,700 different combinations of solo and sequential stays. This chart shows the top 15. Each sequence shows the type and order of stays. For example, the first and second bars are solo home health and solo SNF stays. The third bar shows a two-stay sequence of back-to-back home health stays. Of the 36 percent of sequences that include

multiple stays, the top 10 made up three-quarters of the combinations. Lateral stays, with beneficiaries having back-to-back stays in the same setting, were the most common and made up almost half of the multi-stay sequences. Back-to-back home health stays were the most frequent.

Sequences of decreasing intensity were three times more frequent than sequences of increasing intensity. The most frequent sequences of decreasing intensity were SNF and IRF stays followed by a home health stay. The most frequent sequence of increasing intensity was a home health stay followed by a SNF stay. Mixed sequences included stays of both increasing and decreasing intensity over the course of care, and these mostly were beneficiaries moving back and forth between SNFs and home health.

When I presented this work last fall, David Grabowski mentioned that he'd be interested in learning about the characteristics of solo versus multi-stay sequences, so we looked at that. This slide summarizes that information, and there is more detail in the paper. For home health stays compared with solo stays, stays in sequences were much more likely to be for beneficiaries who were dual eligible, disabled, admitted from the community,

and were less complex. The main reason for treatment didn't differ very much except multi-stays were less likely to be recovering from orthopedic surgery and more likely to be for a cardiovascular medical condition. Stays in a sequence were more likely to be provided by for-profit and freestanding home health agencies.

By contrast, institutional stays in a sequence were the opposite. Compared with solo stays, institutional stays in a sequence were less likely to be for beneficiaries who were dual eligible, disabled, and admitted from the community. The beneficiaries were more complex and more likely to be recovering from orthopedic surgery. But, otherwise, the clinical conditions were pretty similar. Providers of institutional stays in a sequence were more likely to be nonprofit and hospital based.

Turning to our analysis of the costs of stays over a sequence of care, this chart compares the costs of the first and last stays in sequences of different lengths, and here we show three-stay lengths, four, and five stays, with home health stays on the left and institutional stays on the right. We found that the average cost of stays

declined through a course of care. The differences in costs were larger for home health stays compared with institutional stays. For home health stays, later stays were between 16 and 26 percent lower than earlier stays, and the differences were larger for longer sequences. For institutional PAC stays, later stays had costs that were between 7 and 12 percent lower than the first stays.

Given the patterns of declining costs, if payments are not aligned, later stays will be increasingly profitable, and providers would have a financial incentive to furnish additional stays. These charts show the profitability of the first and last stays, again for sequences of different lengths. The measure of profitability we used here is the ratio of payments to costs, and higher bars mean that the stays were more profitable, and the horizontal line means where costs equaled payments.

On the left, we see that home health stays would be more profitable than earlier stays and the profitability increased for longer stays. This indicates the need for a payment adjustment so that providers would not have an incentive to furnish unnecessary home health stays.

On the right, we see the costs and payments for institutional stays would be much more closely aligned. The differences between payments and costs are smaller. The risk adjustment appears to capture differences in the cost over a sequence of care, indicating little need for a separate adjustment to payments.

I want to remind everyone that payments in general -- the PAC PPS would establish accurate payments for most stays, so what we're talking about here is a payment adjustment for later home health stays so that the profitability would be narrower across stays with different timing.

The second issue with sequential stays is how to define stays when an institutional provider opts to treat in place as the beneficiary's care needs change, instead of referring them on to a different provider, and I'm going to refer to this as "treating in place."

Under a PAC PPS, the regulatory requirements for institutional PAC settings would need to begin to be aligned. Otherwise, providers could face different costs associated with complying with their different regulatory requirements, yet they would be paid the same under a PAC

PPS. With the regulatory alignment, providers would have greater flexibility to offer a continuum of care and treat beneficiaries with evolving care needs.

Sequences that represent treating in place for beneficiaries with evolving care needs are best represented by sequential stays where the patient moves from one institutional setting to another, and those made up about 5 percent of multi-stay sequences.

Under current policy, when beneficiaries need a different level of care, they are discharged to a different setting, and that's the first row in that chart. Under a PAC PPS, providers opting to treat in place, Medicare will need to define when one stay or a phase of care ends and the next one begins, and that's the second row. Otherwise, with only one admission and one discharge, the provider will only get one payment, and this would be a financial disadvantage for those providers that opt to treat in place. So we need a way to trigger a payment for each phase of care without encouraging unnecessary volume.

One way to define the end of one phase of care and the beginning of another would be to define stays based on length of stay. A provider would receive a payment for

the initial stay, but if the stay reaches a certain length of stay, providers would conduct a new assessment and would receive a separate payment based on it. The advantage of this approach is that it is clear and would be relatively simple to define, administer, and monitor. The downside is that it would encourage providers to inappropriately extend stays beyond the definition to establish a subsequent stay and get an additional payment. In post-acute care, Medicare's experience with thresholds hasn't been good, and providers seem quite able to adjust their practices to take advantage of them.

There are several strategies that could counter the incentives to increase the volume of subsequent PAC. If a time-based definition was used to trigger a subsequent stay, the definition that is long would encompass most stays. Particularly if it is coupled with a short-stay policy, it would be harder for providers to extend stays beyond the threshold to get a second payment. A provider would have to extend the first stay beyond the definition plus the duration of the short-stay outlier cut off to establish a new payment. CMS could also require physicians to attest to the continued need for care, just as it does

now to recertify home health stays.

Implementing a value-based purchasing program that includes a measure of resource use, such as Medicare spending per beneficiary, would decrease the incentive to generate unnecessary stays because subsequent care would increase a provider's spending and count against its performance.

The Commission has underscored the importance of periodically evaluating the alignment of payments to the cost of care and making revisions as necessary. Otherwise, payments will not reflect current practice patterns.

And, finally, CMS will need to monitor provider behavior and audit those with aberrant lengths of stay and the use of subsequent PAC care.

We would like to get your feedback on the conclusions we reached regarding the need for a payment adjuster for later home health stays. We'd also like to hear about approaches to define stays when a beneficiary is treated in place. And, finally, we'd like to hear about other strategies to deter unnecessary post-acute care stays.

And with that, I look forward to your comments.

DR. CROSSON: Thank you, Carol.

So we'll take clarifying questions. I see David. We'll come up this way.

DR. NERENZ: Thanks, Carol. Great work, as always.

If you can go to Slide 10, please, I just wanted to clarify. Since one of the fundamental features of the model we're talking about is that the payments are adjusted to clinical characteristics, particularly on the left side of the slide, if over a course of multiple stays the patient is getting, say, healthy, less complex, that's already taken into account in this? Am I right?

DR. CARTER: Yes, those are all risk adjusted.

DR. NERENZ: Okay. So it's all risk adjusted.

DR. CARTER: Yeah, the payments are, yeah.

DR. NERENZ: And so the difference we're seeing here, the green bar's higher, that's with that taken into account.

DR. CARTER: Yes.

DR. NERENZ: I just wanted to clarify. I think the language is clear in the chapter. Okay.

DR. CROSSON: Thank you. Kathy.

MS. BUTO: Carol, I'm just curious why we chose seen days as the threshold for -- instead of, say, 10 or 14, because obviously you'd get more -- fewer, I guess -- or more -- is it more? Yeah, you'd have more multiple stays if you went to a longer threshold. I'm just curious.

DR. CARTER: Right. I think we wanted to make sure that they were kind of clinically related, and so we thought maybe we should have something that's more -- that's narrower. But we knew that sometimes home health can take a while to get in play, so we wanted somebody discharged say from a hospital towards the end of the week but you can't get home health right away, and so maybe it takes until the beginning of the next week. So we wanted something that was long enough to make arrangements particularly for home health, because I think a lot of institutional care is an immediate transfer from a hospital, but we wanted to account for maybe some delay in getting home health care and balancing our -- we wanted to have things clinically related. But you're right, the definition would definitely influence how many solo stays you had versus multiple stays.

MS. BUTO: What I was thinking was just looking

at -- if you look at a different threshold, are you seeing that the subsequent stay, say 10 days out or 14 days, is really related to the first stay? Or is it just that we have to come up with some way of developing a payment method that will hang together? I'm just curious, because it seems to me that if something happens within probably 10 or 14 days after the first stay, you're going to see some relationship.

DR. CARTER: Okay. We didn't actually look at alternative definitions. We sort of picked this one and ran with it. And I know that it would influence, you know, the mix of solo and multi-stay.

DR. CROSSON: David.

DR. GRABOWSKI: Great. Thanks, Carol. This is great work, as always.

When you did your original work modeling the unified PAC system, did you treat -- did you just model the original PAC stay? Did you look at all the stays? Did you roll them up together? I'm just curious how you treated in that original work where you had the 40 payment groups. Did you look at just that first stay? Did you have all the subsequent stays in there? Or did you roll them all up

together? Which I guess are three different approaches. Or maybe none of the above, too.

DR. CARTER: I was using shorthand because I think I said they were independent. We included all those stays, so subsequent stays were in there, and they were treated just like first stays. So the pool includes every -- all of those stays. And they're not bundled together. They're separate.

DR. CROSSON: Okay. Questions? Alice.

DR. COOMBS: So I had a question on Slide 8. When we compare the solo stays with HHS versus the institutional, I'm just kind of struck by the fact that you say it's more likely to be orthopedic on the institutional; whereas, I know that with CJR and most of the innovative programs with the hip and knees, they're actually going to HHS. And so I was interested to know what the private world looks like relative to Medicare in terms of this chart. Would this chart be reflective of commercial --

DR. CARTER: So this only is talking about Medicare beneficiaries, and for this time period it would probably predate some of the innovations that you're talking about. I would expect those innovations to

increase the use of home health care and for the SNF stays to be shorter. I think those have been sort of the two takeaways from at least the initial results of those innovations that CMMI is running.

DR. COOMBS: So my point is if the drivers now are for this streamlined process of less institutional care, how do we incorporate that with our -- how do we incorporate that ongoing with our, you know, pricing and timing of our stays going forward? Because that's a really important part of this, is we're modeling for something that's stationary -- I mean, it's right -- we're taking a snapshot, and maybe the video that we should be inculcating in this is one that says this is where we're going to be at that 2021 period.

DR. CARTER: Well, one reaction I have to that is if the risk adjustment model's decent, which we think in this case it is, if you think that more complicated cases that are currently in institutional settings, some of them will be moving to home health care, then our risk adjustment should pick that up. So the fact that practice patterns are changing we're hoping will be reflected by the risk adjustment and the clinical characteristics of the

patients.

DR. COOMBS: So if you will, I'm wondering if there's a way in which you can have an index of, say, health care reform would predict that this utilization of resource would go down 10 percent at this point, if that should be something that is kind of woven in this process across everything, whether it's the stay, the cost, or whether it's the proportion of patients that are going to be in the HHS versus proportion of patients that are going to be in institutional PACs, which we know are more costly. So I think that's something we should think about to be proactive in terms of if we're going to produce something going forward, this is not just stationary for today but going forward.

So I don't know if that's something we've thought about, but --

DR. CARTER: Well, we've been asked before if we have considered sort of behavioral responses, and we have said at least for our initial work, this is -- we've taken the current snapshot, if you will, and seen what that would look like. And some of what you're talking about, I think, is trying to anticipate how the world is changing and then

building that in. And we haven't done that work so far.

DR. CROSSON: Brian, then Jack.

DR. DeBUSK: This is a follow-up to David's question. Have you tried, if you bundle these serial stays together and refit the regression model, have you done that just to look at it and see?

DR. CARTER: No, but I knew you were going to ask that question.

[Laughter.]

DR. DeBUSK: It means I'm getting predictable. That's a problem.

DR. CARTER: No. It's good, it's good. We haven't done that work, and one of the things I guess I'd be interested in getting your reaction is, you know, you could define sequential stays as a time -- 30 days. Or you could say, you know what? For you institutional providers, we're going to bundle all that together and give you a payment. And we haven't done that work, but I'd be interested in hearing whether other folks are interested in that, because that would be a different approach that we could take.

DR. DeBUSK: Good. I'm ready for Round 2.

DR. CARTER: Okay.

DR. CROSSON: Jack.

DR. HOADLEY: So a couple things following up on what Kathy started. Have you thought about whether there's a non-day-based definition of these sequential stays? It seems like it's hard, but I wonder if you --

DR. CARTER: Well, we did, and I looked pretty carefully because SNF rules currently require patients to be reassessed when they have a significant change in condition or a change in therapy requirements. And so we're looking through those. The problem with whether they're a good model for this is they're trying to identify whether patients still require that same level of care; whereas, here we're trying to say it's okay you need a different level of care. We're now just going to pay for that evolution. And so trying to tease apart when somebody's just getting better or getting worse but doesn't require a new phase of care as opposed to, oh, I'm now treating in place and now what used to be an IRF/SNF is now one thing with two phases, we just thought that would be really hard.

DR. HOADLEY: Yeah.

DR. CARTER: And maybe game-able. So we did look at that pretty carefully, and we just wondered how you would monitor that. How would you set it up? It just seemed both -- even what the rules would look like would be hard to devise, and then trying to administer that and -- it just seemed like it was going to be complicated fast.

DR. HOADLEY: Yeah, that seems fair, and it's useful to hear that thinking.

With the treat-in-place cases, presumably in the data, they're one stay now. So when you talk about the counts of stays, anybody that's just in what you're envisioning as sort of treat in place today would look like a single stay. Is that right?

DR. CARTER: Well, right now they would -- so let's take an IRF stay that goes to SNF. Those would be two stays in our data, and they're linked, and they're a sequence. And so what we're talking about now in treating in place, that would now be -- either you use a definition somehow to say you're treating in place, but we're going to pay for both of those stays, even though the provider hasn't changed and the bene is probably still in the same bed; or you do something like what Brian suggested, which

is we're going to take those two stays, which we can identify, and set a payment for the combination. But right now we can see those stays separately.

DR. HOADLEY: And then I guess my other question is thinking about the change in the Budget Act to a 30-day, I mean, presumably at the very least that's just going to increase the number of multiple stays. If somebody today is 47 days, that's one stay. But if you change it to 30 days, that's two.

DR. CARTER: That's right.

DR. HOADLEY: Is there any other impact you think that might have, or is it just a matter of how often this kicks in?

DR. CARTER: Do you mean of the time definition or the other changes --

DR. HOADLEY: Yeah, if the 30-day -- if we go to 30 days, does it have any other substantive change beyond just sort of how often the --

DR. CARTER: Well, you will see more subsequent care, yeah.

DR. HOADLEY: But nothing that changes how we sort of think about the policy.

DR. CARTER: No, I do think -- I mean, that -- the huge change for that redesign, if you will, or change -- it's both the shorter stays and taking out the therapy thresholds.

DR. HOADLEY: Right, right.

DR. CARTER: And so those impacts are going to be more similar to a PAC PPS, right? Because you're going to be paying really based much more on clinical characteristics than the amount of therapy somebody got. So that's quite similar to this. So that's a different -- you know, that's sort of how is the money moving around under that compared to this, and it would be more similar.

DR. HOADLEY: Thank you.

DR. CROSSON: Yes, Bruce.

MR. PYENSON: Carol, a question to follow up on Alice's question of the impact of things like the bundled payments and ACOs. I think there is, as you said, good evidence on bundled payment, and perhaps I think some of the ACOs that have been successful have reduced PAC by quite a bit. My question is if you have insight or a guess on what that would do to the portion of PAC stays that are solitary, whether that might go up or go down. And from

the discussion standpoint of, you know, how important is this, is this going to be more important in the future, the multiple stays, or is it going to be less important in the future?

DR. CARTER: So I haven't thought about it. That's scary to answer. I think it would be -- there would be fewer multiple stays, just guessing. It's not just because there's pressure to be more frugal in your PAC use. But I think those entities tend to contract with higher-quality providers, so you see lower readmissions, and so there's a second -- the use of a second stay is going to be less because they're not triggering a second admission to the post-acute care, if you will.

MR. PYENSON: So a follow-up question. I know Brian has raised the issue of mean time to failure in the past, and, you know, because -- is that a measure of quality, the multiple stays? You know, can we think of this as a readmission?

DR. CARTER: I think having somebody in back-to-back same setting, maybe. And we didn't look at whether a rehospitalization explains why we're seeing back-to-back IRF stays or back-to-back SNF stays, but my guess is that's

what's going on -- mostly. I mean, sometimes it's beneficiaries choosing a different provider because they want to be closer to their family or something like that. But my guess is that's mostly hospital readmissions.

When beneficiaries are changing levels of care, that's probably appropriate care. They're in the wrong level, and they need to either go up or they're going down. So I wouldn't take that as a quality measure, unless -- and I don't know that this is a quality measure as much as a resource use measure. If a patient's going from one level of care to a lesser level of care, they might not have needed the higher level of care to begin with. But I don't know that. But in either case that's sort of an appropriateness question as opposed to an outcome quality -- I wouldn't say it is a trigger -- I wouldn't see it as a quality measure, narrowly speaking. Does that help?

MR. PYENSON: Yes. Thank you.

DR. CROSSON: Alice.

DR. COOMBS: On that, Carol, what he's saying -- the example you gave, if the patient's more critically ill, then they would be extracted out into our CCI category now. They'd be different, right? We would -- if the patient had

increased acuity of care, they would -- because of resource utilization, that's why this was designed in the first place.

DR. CARTER: Yes.

DR. COOMBS: They would be parlayed out into a different quarter altogether.

DR. CARTER: You mean -- are you talking about LTCH patients?

DR. COOMBS: Well, say, for instance -- you don't have that in your graph, but if a person was in a facility that could accommodate -- that rare facility that could accommodate everything from SNF to IRF and the LTCH, it's a big conglomerate, and say, for instance, you had a back-to-back stay where a patient came in with a simple problem, and all of a sudden developed this high-intensity CCI problem, that patient would be into a whole different world now, right? So we wouldn't include that patient in -

DR. CARTER: Well, you might include it, but hopefully with a reassessment you would pick up that their care needs have changed, right? We have several indicators of patient severity in the model, so I don't know that we would pick that up, but I'm hoping that we would.

DR. COOMBS: Yeah, so it would be a good thing that we would pay close attention to that because the patient may have come in for one thing, and you wouldn't want them to be trapped into this prescriptive model that dictates the second stay for the new problem is much less expensive when the resource utilization is actually higher.

DR. CARTER: Right, right. And, hopefully, since one of the things that's in the model is sort of the principal reason why the patient's there, and so if that changes, we're hoping that that will pick up sort of different levels of care needs.

DR. CROSSON: Okay. So now we'll proceed to a discussion. Carol has two proposals on the table: one to deal with sequential stays and the other one to deal with the issue of treating in place. And David is going to start the discussion.

DR. GRABOWSKI: Great. Thanks again, Carol.

So I think many readers of this chapter are going to go to the point that's already been raised in the discussion, and that is, why don't we just pay for an episode here, bundle the entire set of PAC services across all the stays into one kind of episode or bundle and pay

for that? There are obviously trade-offs, and so I'd like us to think a little bit in our discussion today about those trade-offs of paying for sequential stays versus paying for an overall bundle. And I believe, Carol, you're beginning to push towards a hybrid approach here where we would have a first stay and then have these kind of fixed day periods sequentially, and that's kind of a hybrid where you're paying an initial stay, and then these kind of bundles out over time. That's one way of approaching this. I wanted us to just think about the trade-offs quickly. When you pay for sequential stays -- and you already talked about this on Slide 13 -- I think the advantage there is pretty obvious. It's easy to define, administer, and monitor. The disadvantage is that if you pay for sequential stays, you're going to get more sequential stays. And we have a lot of experience with this in home health care. We've been paying by 60-day episodes. As you just suggested, sometimes that's very necessary and appropriate, multiple episodes. However, we have a lot of examples of low-value, multiple-episode home health care. And so I really worry about the flood gates opening here with this kind of sequential stay payment system.

Shifting over and thinking about an episode-based payment where we had a single convener that managed that overall episode of care, I think the advantage there is that you guard against this kind of gaming, if you will, of multiple stays. I think the disadvantage there or the potentials for stinting and all the problems we think about under bundled payment, you really have to make certain you have appropriate quality thresholds in that kind of system to kind of monitor performance.

So I would love in this chapter and in the discussion today for us to think about that trade-off a little bit more directly, and I think if we want to go down one of these two paths or this hybrid approach, that we at least raise kind of the trade-offs here in the discussion and think about, well, what are the advantages of having an overall convener versus paying for sequential stays?

And I'll raise another -- I talked about stinting. I think another challenge with a convener is how you think about payments and delivery and coordination across those different settings. That's an issue when you pay sequentially under the current system, but I think that's raised here of how that money's managed and how we

think about those hand-offs and divvying up the dollars across settings.

On Slide 14, you talked about some of the safeguards against multiple stays, and I'll note that in many respects we have these safeguards in place currently with home health care, and I don't know that all of them or some of them have worked all that well to date. And so I don't know that I have other candidates here, only to say that I think we should learn from that experience in home health care, that it's really hard to guard against this sequential stay issue, so I'm really worried about this kind of -- the flood gates opening and a lot of inappropriate use.

So I hope in our discussion today we're able to think about some of the trade-offs of maybe paying for a broader episode versus sequential stays because I do think potentially going down this path of an episode-based payment may be fruitful here. Thanks.

DR. CROSSON: David, I think we've discussed this once before that I remember, but could I ask you to explicate a little bit more? Obviously, if you're going to have a bundled payment when you've got different providers,

you know, there would be no easy way to adjudicate that. So you have this convener concept. Presumably the bundled payment would go to this entity. What sort of entity would that be?

DR. GRABOWSKI: That's a great question. Is it the hospital that's discharging? Is it the first PAC site? Or is it some other entity altogether that manages a health care plan? There are certainly plans out there right now that manage post-acute care risk, and I imagine they'd be happy to get into this market as well. Yeah, an ACO-type arrangement. So I do think there's different candidates there. I think there are trade-offs with all of those different players. I can imagine if I'm a home health agency I wouldn't love the idea of a skilled nursing facility controlling my payment and that bundle up front, and so having that third-party entity that's maybe not a provider would be really important here, I would think, to having like an ACO or a plan rather than having one of the providers control the bundle, at least one of the post-acute care providers.

DR. CROSSON: Okay. Thanks.

Kathy, on this?

MS. BUTO: Yeah, on this. I think also -- I like David's idea, but I think we'd also have to think about things like, you know, do you treat an orthopedic patient differently than a stroke patient? In other words, the kind of sequence of multiple stays might be very different, and beyond just risk adjustment, I think you'd have to think about the complexity of trying to get too large a bundle that encompasses all different conditions.

So I think it's a complicated issue. I like the direction, though, of more episode-based payment.

DR. CROSSON: Craig, did you --

DR. SAMITT: Are we going around or [off microphone]?

DR. CROSSON: Well, I'm marching now, I guess, marching down this way.

DR. SAMITT: So I have worries about the incentive model that we're designing here, and I guess it focuses on what's on this slide, which is how effective are we at putting in place countervailing forces against the gaming that will likely occur when we make this change. And while I recognize that we're trying to do what's right when subsequent stays are necessary, I just worry about the

resulting effects of what we're actually going to put in place here. And it goes back to questions that we always ask and answer, which is: What problem are we trying to solve? And is the solution here creating an even worse problem than the original problem that we're actually trying to design an answer for?

I do like the convener concept. I think we often come back to the fact that if we only had sort of a more prevalent, integrated, or ACO-like orientation to total cost of care, then the convener would likely be a clinician who is accountable for both quality and cost. And every time we don't have a sufficient effort or focus in that space, we start to dabble in fixes like this that I just think ultimately will not be as effective.

DR. CROSSON: David.

DR. NERENZ: Just a follow-up to the question about larger bundles and episodes. When we think about these long sequences of home health stays, particularly, Carol, some of the examples you showed in one of the charts, five, six in a row, and combine that with the idea that, if I'm following correctly, a lot of these are community admits, they're not truly post-acute in the sense

-- although they're in that setting, disabled, medically complex, it sounds like some of these are essentially unending, far as you can see in the future sort of thing. But presumably, then, if we thought about a bundle for those, assuming they could be identified, it would be like a per capita annual payment or something like that. I'm just curious, how many of these five-, six-episode-stays that we see now are essentially unending, last forever sort of situations? And it may be actually not bad. I mean, we think about incentives for providers doing too many of these, but maybe these are things that people need in order to avoid more expensive care. How do we pull this apart?

DR. CARTER: Well, I mean, this is really Evan's wheelhouse, but, you know, we've talked about how much of home health care is opposed to acute care and how much of it is something else, and maybe it's good sort of managing conditions to avoid hospitalizations, and maybe it's something else.

We haven't looked -- just, you know, the narrow question of did we look at is this, you know, never-ending home health care, and we didn't look at that. We had a year of stays and that's what we worked with. But, I mean,

I think you're raising the question of what, you know, and the program, I think, has -- we've certainly raised questions about what is this benefit and what are we purchasing.

DR. NERENZ: Yeah. I mean, theoretically, if you could clearly identify people in that care need situation you could just say what they get is not really payment for specific episodes but they just get some kind of annual payment, or it's structured in a different way. But the presumption would be that the need never ends. The need just continues as long as the patient is alive, or something else drastic happens.

DR. CROSSON: Jack.

DR. HOADLEY: Yeah. I mean, I'm interested in this last sequence of questions because, I mean, there is clearly some value, or can be value in that kind of a care pattern, where you have this extended -- and it is something that's pretty different than post-acute, if it's not being triggered by that event. So that may be something, you know, down the line to try to think about, is there something, and, you know, the fact that, you know, we've defined a lot of these services in that sort of post-

acute context, but there's reason to provide some of those services in other contexts, you know, we probably need to think about is there a way to sort of break those apart.

I guess the other thing I was thinking about, in connection with some of the comments that have been made, I mean, so we're worrying about some of the gaming opportunities if we make changes, but we've already got these situations, so, you know, you can get a second home health stay and a third home health stay, I mean, even if you just keep it in that sort of more clearly post-acute kind of context. And it sounds like some of what you're talking about for adjustments would be downward adjustments to those subsequent stays, where the level of acuity may be different. And I don't know how much of that sort of naturally would happen with the risk adjusters and sort of when the patient's characteristics would be changed.

But, you know, so changing it obviously creates new opportunities to game the system, but the set of rules in place now already has the opportunity, which is why, presumably, we got into this discussion.

DR. CARTER: I don't remember if I mentioned that I know, in the paper, the current home health system has an

adjuster for, you know, multiple stays --

DR. HOADLEY: Okay.

DR. CARTER: -- and in CMS' proposal to change -- make changes to the home health there's also adjusters for sequential home health stays. So this isn't a new idea. It's actually current policy, and it will continue to be policy. But, of course, we're still seeing the big differences in what -- right.

DR. CROSSON: Brian.

DR. DeBUSK: I'd like to echo some of David's comments and build on that. First of all, you know, the whole notion of a cross-venue PAC PPS is a bold idea, and when I saw, toward the end of the mailing materials, where we were talking about doing maybe a 30-day stay, my first thought was I really hope we don't blink at the last minute. So what I'd like to do is refer to page 12 of the mailing materials and just make a series of comments here. But the first is, you know, it looks like, of these 20 different permutations of stays, it looks really complex. But then you realize that, really, the number 4 permutation, the SNF to the home health, is really similar, or is really just an additional, or is a variant of the

number 14 and number 15 permutation there, the SHH and SSH. And then you look at the number 10 escalation. Well, that's really just -- I mean, number 10 permutation -- that's just an escalation from home health back to SNF.

And my point here, and this is -- you know, Jay was talking about all these different handoffs earlier -- it doesn't seem like there are really that many handoffs here, particularly on a weighted-volume basis. I mean, once you get past the SNF to home health handoff, and its variations, there just aren't that many.

So my first point would be, I don't think that we're going to have -- if we move to a prospective -- a truly prospective payment, or an episodic or bundled payment, I don't think there are quite as many -- there is quite as much money changing hands as we would think. But I do think that this is an ideal candidate for some type of episodic or bundled payment.

And I just want to point out, you know, when you look at our goals of things like care coordination, and wanting beneficiaries to go to the higher-quality PAC providers, this really solves a lot of those issues. I mean, a single prospective payment, even though it does

introduce the concept of a financially responsible party or a convener, it solves so many problems around, you know, for example, in-place care, sequential stays. I mean, it really solves a whole myriad of problems.

So to follow up on the Round 1 question, too, I really hope we do consolidate these stays and rerun the model, and look at the coefficients and look at how robust the model would be.

Really, the only other thing I want point out is if you wanted to argue against this, you know, you could argue that this would be very disruptive, because you really are talking about re-envisioning the way PAC is done. But I think that's sort of the whole point of impact and the PAC PPS is to move us to a very different place in post-acute care.

So the one other suggestion I would have is we could always phase this in by DRG. You know, we don't have to just go to everyone and say, on this date certain everyone gets a prospective payment. We could phase this in by some of the more PAC-intensive DRGS and have a transition program here that I think these providers could live with.

DR. CROSSON: Okay. Alice.

DR. COOMBS: This is such an excellent discussion. I really am enjoying this.

I was going to go straight to Slide 7, which is the slide you went to, that's upside down, and just mention the fact that what we are -- it's sideways. I think it's very similar. I was going to mention the fact that if we did an episode of care, just -- you mentioned the data that says that three-quarter -- 75 percent of them are in that first category, those three bars that we talked about. So the frequency of issues outside of that seems like it's not going to be, Brian has said, a big deal to do an episode of care.

My worry is the beneficiaries and how they navigate. Say they wind up with one home health agency. How do they get to maybe whatever reason they might be not well-treated or have some issues with choice in terms of being able to transfer from one home health agency to another, or that being said, if it's a SNF or it's any of the combinations that we have proposed here. So how does a beneficiary navigate? If we were to do what some have proposed, I think an episode of care sounds great, but we

have to understand if there's more than one provider under the episode of care, how do we reconcile that? How do we actually deal with the issue of two different providers within the episode?

And so one argument will be that maybe the potential for there to be multiple providers under the episode would drastically decrease, but the whole notion of what the Medicare program is predicated on is choice. How do we still maintain the patient, the beneficiary's choice and how do we educate the beneficiary with knowing what to expect with episode of care?

And every episode of care should have some other things that go with it, in terms of, you know, the quality parameters and also how do we look at risk adjustment and avoid selection, even in the process of episode of care. Because I can see -- I can foresee there might be some issues with selection. If I've got to bundle the episode of care, how long would we say the time would be? Are we talking about 60 days, 90 days? And someone feeling like that time period makes me really vulnerable with this type of patient.

I'm just telling you what happens in the real

world out there. So there might be some decision-making, based on the length of the episode, what that engages, the geography, where are you located. So I think those are the kinds of things that I would think about.

I think the episode of care is a good idea, but I like the notion of having a parallel track in the transition period, where this is a realistic possibility with people in the industry that are ready to kind of do this, kind of, and we can learn from that as well.

DR. CROSSON: So I think that's an interesting point, Alice, in the sense that, you know, depending upon the nature of the convener or the types of conveners and their incentives, it does appear that it would potentially interface with our next topic, in the next presentation, which has to do with beneficiary choice. So good point.

Okay. So where are we? Pat.

MS. WANG: This is just a -- to the extent that the direction of the conversation, I think, is a good one, and some of the concerns that have been raised about ensuring, you know, if there is some sort of prospective bundle or approach, with a convener or not, that what's going on underneath the bundle, given the variation in

providers who deliver these services, to ensure quality, et cetera, would be important.

To the extent that, on the home health side, the sequential stays are observed to be largely dual eligible, from the community, I guess the only other thing that I would note to possibly just keep in mind -- and this goes to David's question, is it like a continuing need -- at a certain point if it is a continuing need, Medicaid does pick up, you know, after the acute portion is finished. And so it's not always the case, I think, that it ends once the Medicare service ends. There may well be a Medicaid sort of LTSS-type of component. To the extent that -- so these are community duals, okay?

It's just something to keep in mind, because there are other ways to sort of -- if something shrinks on the Medicare side, sometimes it expands into the Medicaid side. Sometimes it's actually the same person in the home delivering the service. They're just wearing a different payment hat.

So when it comes to conveners, it is an important thing. I mean, a convener could be an MA plan, for example, that is kind of assessing the need for services

and figuring out what the appropriate next step. In a pure fee for service system you do kind of worry about the open-ended nature of it.

It's just a thought, given that these are duals.

DR. CROSSON: Sue.

MS. THOMPSON: Well, Carol, when I saw you were on the agenda again, when I got the packet, I thought what else can we talk about? But it's great to have you back.

And I must say that as I read the chapter I was almost kind of discouraged because I felt like we were trying to address what is really a historical path of bad actors, taking advantage of home care, and, at the same time, trying to be successful in a world of ACOs and trying to lead the way in value-based. We desperately, desperately depend upon home care.

And so I just want to end this discussion by going back to the comments David made, because I do believe we have some experience in a convener being accountable for, or a health plan being accountable for a group of patients and being responsible in taking a payment for that post-acute bundle. I think the opportunity there, while there is a lot of detail in the outliers, and there's all

sorts of issues yet to be worked through, I think the opportunities there are tremendous, and I just -- I think this conversation today has been really, really fruitful.

So thank you, and I'm glad you were back on the agenda, and I think this is a great, great topic.

DR. CROSSON: Terrific. Kathy.

MS. BUTO: Can I just ask a question? Don't MA plans not get extra payment for these subsequent stays?

DR. CARTER: I wouldn't think so.

MS. BUTO: Yeah. I'm just trying to figure out the convener part in an MA plan that, Sue, you were raising. I mean, I think it does sound good, but since they're not -- in fact, they're probably the laboratory to figure out what's going on right now with multiple stays in PAC.

DR. CROSSON: Well, I mean, in effect, they're getting a bundled payment. Right?

MS. BUTO: Yeah.

DR. CROSSON: Okay. So I think this has been a very good discussion, as some have said. I think we do have a bit of a consensus here, Carol, that while these two proposals have significant substance, I think there's a

sense that, particularly, you know, looking forward, in terms of the evolution of the delivery system and payment methodologies, it would be good for us to look at the pros and the cons of this other option, this, you know, option of bundling to the extent that it's possible, and the nature of a convener, and how that would work, and then the other ramifications of that, for example, on beneficiary choice.

So time to call up your twin, and get back to work together, and we'll see you again. Thank you.

DR. CARTER: Sounds like it, yep.

DR. CROSSON: Okay. As we said, we're going to continue our focus on PAC and we're going to talk about the issue of beneficiary choice of provider.

Evan, you have the floor.

* MR. CHRISTMAN: Good morning. Next we will examine options for encouraging the use of higher-quality PAC providers by Medicare beneficiaries.

This presentation has three parts and follows up on a discussion we last had at our September meeting. First, we will review Medicare's discharge planning policies. Next, we will review how beneficiaries select

PAC providers and the referral patterns that result. Finally, we will review options for modifying Medicare's discharge rules to encourage beneficiaries to use higher-quality PAC providers. A critical part of this will be defining the criteria Medicare follows to identify better PAC providers.

David, in our September 2017 conversation you raised a related issue about the adequacy of the publicly reported nursing home and home health quality data. Though we will not be discussing that today, improving this information is another option for addressing discharge planning.

Also, as a reminder, Medicare's discharge planning regulations apply to multiple settings, but we will focus on inpatient hospital discharges today as they are the most common site of discharge to PAC.

This slide is a reminder and is likely familiar to most of you. Post-acute care is delivered through four sites: skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term acute care hospital. About 40 percent of hospital discharges use one of these services, and the total spending in 2016 was

almost $60 billion. SNF and home health accounted for about 60 percent of this spending.

The main message of this slide is that PAC use is frequent and costly, and we need to ensure, for the sake of the program and its beneficiaries, that we maximize the value of the dollars we spend on these services.

Medicare statute and regulation assign responsibility for discharge planning to hospital. Hospital discharge planners are expected to assess the need for post-acute care, educate beneficiaries about their options, and facilitate transfer to PAC when necessary.

The BBA of 1997 requires hospital to provide beneficiaries with a list of SNFs and home health agencies nearby, but the list is not required to have quality information on it. Medicare statute provides beneficiaries with the freedom to choose their PAC provider and the laws states that hospital may not recommend providers.

The IMPACT Act created a new requirement that hospital use quality data during the discharge planning process and provide it to beneficiaries. But regulations implementing this new requirement have not been finalized.

The provider of beneficiary selects matter

because the quality of PAC providers varies widely, as we report in our annual assessment of payment adequacy. For example, the SNF at the 25th percentile had a rehospitalization rate of 12.8 percent, compared to 19.5 percent for the SNF at the 75th percentile. For home health agencies, the rate of hospitalization is almost double when comparing the provider at the 25th percentile to the provider at the 75th. This has real consequences for beneficiaries, as those served by low-quality providers will have more hospitalizations and likely have worse clinical outcomes.

For some conditions, it will also mean that hospital face steeper penalties under programs like the Hospital Readmissions Reduction Program. And, in addition, Medicare receives less value for the PAC care it buys, and spends more on rehospitalizations than it should have to.

Though Medicare has made quality data about nursing home and home health agencies available, reviews of the impact of this data have found that it did not have a significant impact on referral patterns, with some studies suggesting very small or no effects on provider choice.

In practice, beneficiaries report relying on

information from trusted sources like health care providers, families, or others that may have experience with PAC. These trusted intermediaries are often considered by beneficiaries to be more important sources of information than Medicare's publicly reported quality data. Factors such as distance from a beneficiary's home and community reputation are commonly cited by beneficiaries as important when selecting a provider.

Beneficiaries report that they would like to receive more advice from discharge planners, but as mentioned earlier, discharge planners cannot make recommendations.

Reviewing the quality of PAC providers used by beneficiaries is a way of assessing, in part, how often current practices result in beneficiaries using higher-performing providers. To assess this, we did an analysis that compared the quality of the provider a beneficiary actually used to the quality of providers that were nearby. We conducted this analysis for SNF and home health patients in 2014. For each patient, we determined how many providers with better performance on a compositive measure were operating with 15 miles of the beneficiary's

residence.

While this analysis will indicate how many higher-quality options were nearby, it does not capture other important dimensions of PAC access, such as whether providers had available capacity or could meet any specialized clinical needs a patient may have.

Our results indicate that most beneficiaries had a higher-quality alternative nearby. About 85 percent of SNF patients had at least one better option, and about 47 percent had five or more. About 94 percent of home health patients had at least one higher-quality option nearby, and about 70 percent of home health patients had five or more better agencies nearby. Beneficiaries in urban area generally had a greater number of better options nearby.

Higher-quality providers offered significantly better quality. For example, for beneficiaries residing in an area with one better SNF nearby, the better SNF's rehospitalization rate was, on average, 3 percentage points lower than the SNF the beneficiary received service from.

At our September meeting, we discussed several possible changes that could encourage beneficiaries to select higher-quality providers. One option that appeared

to have some interest was modifying Medicare's rules to permit discharge planners, under some circumstances, to recommend PAC providers. This would only be a recommendation and a beneficiary would not be obligated to select a recommended provider.

The goal of modified rules would be to assist beneficiaries in understanding that quality varies among PAC providers, and allow discharge planners to recommend higher-performing ones. Such a policy requires a definition of higher-quality PAC provides, and there are several approaches that could be followed. I am going to discuss a few options on the following slides. I would note that the options are intended to frame discussion and have several aspects that could be modified or removed, depending on policy preferences.

The first approach we refer to as the flexible approach. Under this approach, hospitals would have the authority to set the quality criteria, including selecting the measures, setting the benchmarks for performance, and considering other aspects of quality as they see fit. Hospitals would be responsible for collecting this data from PAC providers and other sources, and developing a

review process to select the PAC providers to be defined as "higher performing." Discharge planners would then provide this information to beneficiaries when they are selecting a PAC provider.

This approach would have advantages and disadvantages. The advantage of this approach is that it provides hospitals with the flexibility to set the standards they see as best for the patient and that reflects the availability and capabilities of the PAC services in their markets. The disadvantage of this approach relates to that flexibility. There would be multiple quality standards in a market, which could be confusing for beneficiaries and PAC providers. The designation of a PAC providers as higher quality could vary from hospital to hospital, and PAC providers would have to juggle multiple definitions.

Beneficiaries would likely find it confusing that the providers recommended would vary across hospital, and hospitals would have the obligation to conduct a review process, and CMS would have to establish some mechanism for ensuring hospitals were appropriately using the flexibility they have under this option.

We now turn to a second approach, what we refer to as the prescriptive approach. In this approach, Medicare would set standards that identify higher-performing providers. In one form, it could establish a single national standard that applies to all areas and PAC providers, including the quality measures and benchmarks. For example, it could be defined as only allowing providers in the top quartile of quality nationwide to qualify. Medicare would notify the public by releasing a ranking of providers on the criteria, indicating which providers qualified as higher-performing, and discharge planners would use this information when informing beneficiaries about their options.

A strength of this option is that it establishes uniform national standards, and it follows a consistent approach to designation that would be easier for beneficiaries and PAC providers to understand. This would also create less burden for hospitals as they are no longer responsible for vetting PAC providers.

This option would have the disadvantage that higher-performing providers are not evenly distributed across the country. For example, if we required that SNFs

be in the lowest third of the national distribution on rehospitalization, the number of SNFs designated as higher-performing would vary significantly among urban areas. 114 urban areas would have one or two SNFs that met the standard, while 39 urban areas would have 20 or more SNFs that met the standard. Beneficiaries in some areas would have few options while those in other areas could have many.

In one variant of the prescriptive approach, Medicare could have a uniform definition but set the standards in a way that allows for the variation in provider performance across areas. For example, CMS could establish a two-part test. The first test could require that a provider be in the top quartile nationwide, and the second test could expand the cohort of highly-qualified providers to also include those that are in the top quartile of performance relative to all providers in their local market.

This approach would treat providers who are top performers on a national basis consistently and would allow some flexibility to increase the supply of recommended providers in markets that did not have many in the top

quartile of the national distribution. Other formulations of a definition like this are possible, but the basic idea would be to have a combination of national and local benchmarks.

As an example of how this would work, let's consider the definition in the two sub-bullets in a market with eight providers. In the market, assume four of the providers are in the top quartile nationwide. These four, since they met the first test, would be defined as higher-performing. The second test would rank the eight providers relative to each other and take the top quarter of providers, two in this case. However, since they passed the first test they are already defined as higher-performing.

As a second example, assume none of the eight providers were in the top quartile nationwide. In this case, none of them would be classified as higher-performing on the basis of the first test, and the best two providers, 25 percent of the eight, would be classified as higher-performing on the basis of the market level test.

This approach has the advantage of maintaining uniformity and consistency in the designation of providers.

Beneficiaries and providers would have a single definition to work with. Though the performance levels might vary some from market to market, the recommended providers would not vary among hospitals within a market. This approach would help treat providers who were top performers on a national basis consistently and would allow some flexibility to increase the supply of recommended providers in markets that did not have many PAC providers in the top quartile of the national distribution.

This approach would be less burdensome for hospitals. Medicare would have some new responsibilities but this would not be as burdensome as the flexible option described earlier.

The presentation today focused on changing discharge planning to encourage beneficiaries to use higher-quality PAC providers. We are interested in Commissioner reaction to the different approaches to defining quality. Please let us know how you feel about the example provided or any other models you think should be considered.

This completes my presentation. I look forward to your questions.

DR. CROSSON: Thank you. Evan, let's start with questions. Jack.

DR. HOADLEY: So I had a couple of questions, and this is really a helpful presentation.

When you talked right at the beginning about the IMPACT Act, on Slide 4, and what that called for a change, that still didn't get into the area of recommendations. It was more just listing data about quality as part of the information that's provided?

MR. CHRISTMAN: That's exactly right. The IMPACT Act said provide quality data and did not change the freedom of choice provisions, and sort of expanded the requirement to provide a list and quality information to include IRFs and LTCHs.

DR. HOADLEY: And when CMS has not finalized this, have they indicated any reasons for that? Is it just some of the kinds of reasons we're talking about, that it's complicated, or was there pushback?

MR. CHRISTMAN: I have talked to many people about this, and it's kind of a parlor game as to what the concerns are. I don't think the industry -- I think they wanted some changes but I don't think they objected,

mortally, to this change. I think that there's a sense that it's somewhere in the shuffle there and it just hasn't been picked up by the system for completion.

DR. HOADLEY: Okay. In looking at these issues, have you, in any way, gotten input from beneficiary advocacy groups, or have they been engaged in some of these concerns on this particular point?

MR. CHRISTMAN: I guess we would say that we've looked at the -- we haven't specifically engaged with beneficiary advocacy groups on this point but what we have done is, to my surprise, there was a lot of literature that has been done looking at beneficiary experience in the transitions and PAC referrals, and some of it was done to support the nursing home compare and the home health compare, but others of it has been done to sort of support the development of transitional care type programs.

And, you know, I guess we would say that I think there is a sentiment out there that consumers find the current process confusing, that they would appreciate some more help. You know, if there's anybody specific you'd like us to engage with, you know, let us know.

DR. HOADLEY: Yeah, I'll think about that, and

I'm going to come back to that general theme on Round 2.

My other question, you know, as you talked about some of these options, you kept -- you know, you would talk about recommended providers, and it sometimes sounded like -- and I know you didn't mean this -- that the list of those recommended somehow then constrains the choice, because a beneficiary could still, in any of these situations say, "Well, I don't want any of the ones that you've sort of shown as the high quality, because they're not convenient," or they don't have to say why. They could still have their choice options.

So, I mean, I guess it's trying to think about the more limited list that might be put in front of somebody and sort of what does that symbolize in terms of constraining choice or not really -- not ultimately constraining choice but maybe symbolically or sort of in a practical way, constraining choice. I just think there's some nuances and we should think carefully about some of the language.

DR. MATHEWS: Yeah, Jack, maybe I could clarify what the intent here is. Allowing hospital to have greater leeway in terms of recommending specific providers to PAC

patients, under our construct, would in no way constrain th beneficiary's choice. As we point out in the materials, beneficiaries make the decisions as to where they end up, for all kinds of reasons, and what we are trying to do here is make quality information a factor that beneficiaries are better able to consider, and if the hospital is able to facilitate those -- the beneficiary's understanding of the quality of provider, that is so much better.

But you are correct. At the end of the day, the beneficiary could take the hospital's advice, or look at the list of providers, and bypass the higher-quality ones, bypass the recommended one, and for whatever reason choose another provider on that list.

DR. HOADLEY: Right. And I think that is clear, and I'll come back to that again in Round 2.

DR. CROSSON: Okay. Questions. Brian.

DR. DeBUSK: On Chart 8 of the presentation you talk about the fact that there's inconsistencies in availability of high-quality providers, and that it varies region by reason. Have you applied the peer grouping approach? Have you done, say, a sociodemographic stratification and tried to see if those numbers clear up?

MR. CHRISTMAN: I think -- I'm not sure I entirely follow your question, but I think when we have looked at this by some higher-level distributions, you know, we looked at for low-income beneficiaries, for beneficiaries of different race groups. We looked at the distribution of star providers among those different groups. And they weren't that -- they were pretty similar. You know, it didn't appear that, you know, the low-income were disproportionately in the two stars, or so forth.

DR. DeBUSK: Let me clarify the question. I was left with the impression that you were taking PAC providers, or, in this case, SNF providers, and aggregating them by geography, and then comparing how many high-quality providers would be available.

My question was within that geography, if you stratified them, say into deciles or into quintiles, where you were peer-grouping based on SSI percentage -- basically the same treatment that we've advocated for the Hospital Readmission Reduction Program, if you did that stratification and then looked at availability, would it clarify some of those numbers? I mean, would there be less variation? Are you -- and, I guess, I'll ask it in a

different way -- are you measuring variations in sociodemographic -- in the sociodemographic status of the beneficiaries by region when you say that some have, you know, five or more, and looking at that availability?

MR. CHRISTMAN: We haven't looked at it that way. I guess when I've just looked at it -- I'm not sure. We can go back and look at that. I don't think this directly answers your question. What I just did was look at the distribution of providers for individuals, for example, receiving the LIS Part D low-income subsidy, and I compared that -- how many got -- what percentage went to one-star providers, two-star providers, three-star, and so on. And I compared the distribution of that for home health patients, for the LIS, to the overall, to all patients, and they weren't that different.

But I think you're asking a little bit of a different question that might show something different, so we can take a look at that.

DR. CROSSON: Jon, on this or --

DR. CHRISTIANSON: [Off microphone.]

DR. CROSSON: Alice.

DR. COOMBS: Thank you so much, Evan. This is

another excellent chapter.

The question I have is, when we had this discussion how many years ago -- I think it was, well, prior to our current year, we had another discussion -- it wasn't so much the list. It was really who. And my concern is, have we looked at the process that actually occurs in the acute care hospital, because I know what happens. I've actually seen this, and actually just recently, and that some places will have a caseworker who is the discharge planner but it really depends on the relationship of the outlying industry to be on premises and readily available. So that you might have a list and then there's this whole notion of, oh, by the way, this person just happens to be here and will be available for you to discuss placement.

So the selection, because of early anchoring with certain facilities, and depending on whether or not they're available in the hospital to discuss with the family, when the family arrives, and so the question is a designated personnel relies on from whether it's a SNF or home health or LTCH or whatever. And so I've seen where that is a big persuader in the decision-making for beneficiaries, so that

you will have a list, but how that list gets promulgated and how the patient makes their decision is based on the availability of someone being assigned in the hospital.

And that question -- that we talked about before, I think, a few years back, when this discussion first came up. But I think we should look at that, because I think that's really important.

DR. CROSSON: Questions, here. Pat.

MS. WANG: I just want to clarify, on Slide 5, the SNF rate of hospitalization is just for the SNF stay and not if the patient extends their stay beyond into non-SNF, quasi custodial or stays longer than -- stays beyond the SNF stay. So this is just --

MR. CHRISTMAN: Right. So this is just -- actually, for an economy of words, this is actually just for the first 30 days of the SNF stay. So it's not capturing the full scope.

MS. WANG: Okay. And can you remind me, at least, what are the programs, if any, to incentivize SNFs to lower their bounce-back rate, if you want to call it that, or their admission rate?

MR. CHRISTMAN: I believe that a SNF value-based

purchasing program that includes some measure of readmission is just coming online in October of this year.

MS. WANG: Okay. Thank you.

DR. CROSSON: Questions this way. Sue.

MS. THOMPSON: Thank you, Evan. Do we know how big of a difference would be made if we could implement this policy? In other words, if hospitals could direct patients more clearly to high-quality providers, and, second assumption, if patients would go there, how much -- what kind of a difference would we be talking about in the overall total cost of care and improvement of quality? Can we think about that at all?

MR. CHRISTMAN: We can think about how to sort of give you some kind of an estimate of that. You can appreciate that, you know, there's a -- the last -- I think it was the last bullet on the previous slide, you know, we don't know how much room is out there in the better facilities, and other odd things such as special clinical needs. But we could think about a way to kind of bound and give people a sense that, you know, if the rehospitalizations went down X percent, what would it do, or something along those lines. We can think about that.

MS. THOMPSON: Thank you.

DR. CROSSON: I apologize. Jon was up next.

DR. CHRISTIANSON: Just a couple of quick questions, Evan. One is just to make sure I understand this. So if there were no post-acute providers that met this quality rating score, then, as a post-discharge planner, you would not be able to talk about any one of these facilities. Is that right?

MR. CHRISTMAN: That's the way we're thinking about it now. I guess the way I have thought about this is that a beneficiary would be given a list and the list would indicate these providers not recommended, not preferred, but this group of providers have been identified as the better, higher-performing providers in your area.

DR. CHRISTIANSON: Because they met the standards.

MR. CHRISTMAN: Because they met the standards. And then here are the rest of the providers in your area, and, you know, if you -- then, you know, it's up to sort of what the assistance of beneficiary asks for from that point. But hopefully a discharge planner would say, "Your odds are better at a preferred provider if you can get in,"

and sort of proceed from there.

DR. CHRISTIANSON: If there were no high-quality providers then it would go like it does today, here's the list of options available?

MR. CHRISTMAN: You know, for now I guess that's the way I've been thinking about it. I think, ideally, the list would eventually be IMPACT Act requirement to put the quality information on the list would show up, and that would give the beneficiary a little bit more of a sense of how to pick through this. You could also think about, you know, other options where if you had an ordinal rating -- ranking somehow of the facilities you could kind of give the beneficiary the list in that format, and it not be so, you know, here's the defined group and here's everybody else.

But I guess, obviously, if we want to give hospital this ability, or highlight certain providers, we're trying to come up with a way to ensure that that's used for the right purposes. And so the way we proceeded today is to offer these different definitions of a higher-quality provider.

DR. CHRISTIANSON: Let me follow that up a little

bit. So you're saying on the IMPACT list all of the providers would have some quality score associated with them? So this whole notion of national versus local and all of that would not really come into play?

MR. CHRISTMAN: Right. That's not contemplated in the IMPACT Act. I mean, if you're familiar at all with, you know, any quality scorecard, I think there would be, you know, the provider's name and sort of their performance on various benchmarks.

DR. CHRISTIANSON: All of that discussion in your chapter kind of is under the assumption that we won't have a quality score as proposed by the IMPACT Act. Is that --

MR. CHRISTMAN: No. I mean, I think the two -- maybe I've confused you, but I think the two go hand in hand in the sense that, you know, Medicare would have a definition of higher-quality PAC providers and we would use that to establish, you know, here are the providers that the discharge planner should highlight in the discharge planning process. And then, you know, the list could have the various providers and their performance under the various -- under the metrics that are available. I guess maybe I've miscommunicated something, but I see the two as

somewhat complementary.

DR. CROSSON: And is that notion of having this sort of blended as a regional or as a national score, that comes out of this concern that there won't be any high-quality providers in your region?

MR. CHRISTMAN: Right. I think it's two thing. That is the higher quality, and that -- I guess it's also -- we haven't looked at this specifically but it's also ensuring some consistency in the definition, that if you're in the top 10 percent nationwide, you know, maybe -- kind of like a gold card or something.

DR. CHRISTIANSON: So the merging of -- having the two options really, then, reduces the reward for a post-acute care provider to reach this national standard.

MR. CHRISTMAN: I guess it does, but, at the same time, obviously, I think we're trying to balance the fact that some areas would wind up with relatively few providers and the utility of being able to recommend, or whichever phrase we want to put on it, would be vastly diminished if there was nothing to recommend for them.

DR. CHRISTIANSON: Yeah. So that's a static analysis. That doesn't talk about a behavioral response on

the part of the PAC providers.

DR. CROSSON: So, actually, sorry, because I have had this rumbling around in my head here, and you kind of touched on it. So we've chosen to essentially approach quality in a categorical manner -- in other words, these are the high-quality providers, whether we do that nationally or locally -- as opposed to, I think what I heard you say was an ordinal, just basically just sort of saying, you know, like, arguably, like Medicare Advantage stars, you know, you've got your 4s, your 3s, your 2s, your 1s, and whatever, and then the beneficiary, whether they were in a market that had a lot of 4s and 3s, or 5s and 4s, or whatever, or they happened to be in a market that had mostly 3s and 2s, would see the relative valuation.

Now, in many ways, that, intuitively, seems to me like an easier way to go about this. Is your sense that either with respect to statute or the direction that's being taken in the regulatory process, that that's going more in the categorical direction and that's why we've chosen that, or do you just think it's a better way?

MR. CHRISTMAN: Well, I guess the way that -- part of what drew me to a more categorical approach is that

some people believe that the report cards and the standards have not succeeded because beneficiaries have had a hard time understanding them, and there will be less of a chance that they follow the recommended course of action if they don't understand why somebody has been pointed out.

And so I think that that was, at least for me, in the background, rumbling around, is one reason to do that. But it does force, you know, as you've seen in the presentation, a bunch of other conversations about how you deal with the limitations of having like a cutline.

DR. CROSSON: Thanks. Jack, on this?

DR. HOADLEY: Yeah. So do the current Home Health, Nursing Home Compare, those kinds of things, summarize measures into Stars comparable to MA and other --

MR. CHRISTMAN: They do put things into Stars, and I think, you know, we talk about that a little bit in the paper. From our perspective, there's a lot in there that's not post-acute care, and that's --

DR. HOADLEY: Right, so there's a problem with the measurement.

MR. CHRISTMAN: Right.

DR. HOADLEY: But it seems like, and to what

you're saying, Jay, in the MA world you get to see the relative number of stars, and if you want to, you can dig down to the subdomains and so forth. But there's also provisions that say for those that get five stars, they get some additional attention. They get extra enrollment periods or whatever. And it seems like there's a bit of a parallel here. So if you're in whatever the equivalent we're doing, five stars or four or whatever the line we draw, you get to be somehow highlighted in this. Is that a fair way to --

MR. CHRISTMAN: I think that that's, you know, one approach you could take on this, yeah.

DR. CROSSON: I saw that, between the two, yeah. I'm sorry. Kathy, finally.

MS. BUTO: My question, Evan, is really that as I think about the length of time it would take to sort of implement a system like this, won't we be at the more unified PAC by the time we get there in the sense that we won't be looking necessarily at SNF, IRF, home health agency, et cetera, will we? I'm just curious what your thinking is about how this would work in a situation where we've got more unified definitions and providers would be

treated more alike for the same kind of patient? So how do you do that comparison?

MR. CHRISTMAN: You know, we've talked a little bit about this internally, and I guess I would say that it might make some process for signaling to beneficiaries about quality even more important, because there won't be a name on the door anymore that this is an IRF and you're a rehab-intensive patient and you need -- and so you belong here. You know, obviously, the entity for which they are providing ratings for could change. And I think some of the basic problems will probably still remain. There's, you know, 12,000 home health agencies and 15,000 SNFs, so many beneficiaries, however we organize it, are probably going to have a multiple of providers in their neighborhood, and giving them a quality signal may become more important.

MS. BUTO: Yeah, I was actually thinking also of the fact that some facilities might specialize in ventilator dependent, for example, or other particular areas, and so the comparisons, if you're the hospital discharge planner, might have to look differently; in other words, you know, for this kind of patient we're looking at

these facilities. I'm just curious if we've thought about that, and it sounds like you've started to think about it.

MR. CHRISTMAN: Right, and I think that the concern you just mentioned, the importance of communicating to beneficiaries with specialized care needs is something people are starting to try and grapple with, too. For example, that's been an issue with Nursing Home Compare, and so I think -- but that's definitely something we could think a little bit more about in the chapter.

DR. CROSSON: Craig.

DR. SAMITT: This may be more relevant to the topic that we were just discussing before then, but on Slide 6, you talk about the fact that studies of referral patterns indicate that Medicare's publicly available quality measures don't significantly increase use of high quality. Do we have any evidence that this enhanced quality reporting done by the hospital will be any more effective in driving selection of high-quality PAC providers than the methodologies that exist today?

MR. CHRISTMAN: Well, I think the difference in what we're trying to do a little bit is provide the staff, who is supposed to be working directly with the beneficiary

in the hospital, a skosh more authority than they have now. Now it is my understanding it's characterized as a very heavy regulatory and enforcement requirement that nobody wants to be caught doing anything that looks like they're improperly steering a beneficiary. And the intent of this requirement -- excuse me. The intent of this policy is to say you, the discharge planner, are no longer at that risk, that you have this list of providers that gives you some signal about quality, and you, the discharge planner, are responsible for communicating that signal to the beneficiary.

Right now, the statutory required list of SNFs and home health don't -- they're required to provide a list or remind people they have a choice, but they're not required to put quality information on it. They're supposed to, but they haven't gotten there.

DR. SAMITT: So do you think there's sufficient incentive for the discharge planner to do more than just hand a list that says here's a list with the quality rankings for your information, as opposed to truly influencing steerage?

MR. CHRISTMAN: Well, I guess, you know, the hope

is that providing them -- one, providing them with a little bit more authority to identify higher-quality providers will reduce the reluctance they feel today. You know, we hear reports of beneficiaries asking and being turned away from discharge planners for the reasons that I listed. And the idea is to lift a little bit of that.

I think the second piece is that hopefully once discharge planners get through feeling this legal accountability to not steer, they will be more exposed to the various programs that the hospital is subject to for readmissions, ACOs, and understanding that this is part of addressing population health risk. You know, it was more in the paper we presented in September, but there is this sense among discharge planners that if they go too far in this area, you know, their compliance departments will be all over them, and they will be exposed.

DR. CROSSON: David, on this point.

DR. GRABOWSKI: Yeah, on this point I just wanted to amplify Evan's response to Craig's question. Will this information have a bigger effect than the existing Nursing Home Compare, Home Health Compare resources? All the focus groups that Evan mentioned earlier, a large number of

beneficiaries are not using the current resources. It's staggering just the numbers there. They were never made aware of these resources. They never went on and looked at the quality. Indeed, many of them choose based on other factors and they still continue to choose based on other factors like distance, whether their physician rounds at this particular hospital or nursing facility.

So there are definitely other factors that impact this decision, but I think it's safe to say that in the current model many beneficiaries aren't even touching these kinds of quality measures.

DR. CHRISTIANSON: Yeah, I would point out there's a pretty significant difference between asking a beneficiary to go online and finding a Nursing Home Compare as opposed to having an individual sitting across from you at a critical decision moment and saying, "Here's information that might be helpful to you." That requires no effort on your part to initiate the search process. So there's some possibility that it could work out differently, I think, Craig, than what we have. Who knows? You know, but there's some possibility that it could.

And particularly, I think, to the point of do

they have the incentive to actually use it -- "they" meaning the hospital or the discharge planner -- within an ACO I would say absolutely they have that incentive.

DR. CROSSON: Rita.

DR. REDBERG: To amplify what Jon said, I do think it will enhance the chance of getting quality information to beneficiaries, because they're often very eager for this kind of information, and as Evan said, discharge planners are now -- cannot, so they just get this list and they're totally confused on where to go, what's good. So I think being able to have hospital discharge planners give a list with quality ratings, it's already done, so it's kind of made it easier. They don't have to sift through the difficult kind of rating systems that are online. So I think that's a huge advantage for beneficiaries.

DR. CROSSON: Okay. Bruce.

MR. PYENSON: Thank you. Evan, on page 6 of the mailing material, you refer to the existence of preferred PAC providers currently, and I'm assuming that's a subset list that would earn a PAC provider the right to get on a list that's handed to the beneficiary. Is that how that

operates currently?

MR. CHRISTMAN: You mean Slide 6 of the paper?

MR. PYENSON: No, the mailings. Sorry.

MR. CHRISTMAN: Yeah.

MR. PYENSON: So the preferred -- network of preferred PAC providers, so a hospital may have --

MR. CHRISTMAN: Okay. I think that was a reference to the fact that providers -- some providers now, because of, you know, the existing population health programs, some hospitals now are going out and sort of developing what they refer to as "collaborative" or "preferred providers," and this is not unlike -- it's actually kind of somewhat like what we describe as a flexible approach here. They go out and they identify the PAC providers they exchange a lot of volume with and sort of seek to build a collaborative to better coordinate care and, you know, work on sort of quality improvement initiatives. And that's sort of being done to help their performance under, you know, things like the hospital readmissions penalty and the ACO. The difference between that and what we're talking about, some of the versions of what we're talking about here, is that, you know, they

technically don't have the ability to really tell -- they can politely mention that if you go with this provider, we have a closer relationship with them. But at least in practice, with the existing rules, they're not supposed to be leaning and saying we think this guy's the best. You know, that's what hospitals are doing now.

Does that answer your question?

MR. PYENSON: Partly. Just a follow-up question or two on that. It seems as though the preferred network does have some impact on --

MR. CHRISTMAN: Well, it has -- what a hospital does is, like I described, they'll put out a solicitation and say who wants to be in our network, and PAC providers submit their data and hospitals go through their vetting process, and quality is a part of that.

Another part of that to my understanding is that hospitals tend to pay a lot of attention in this process to the PAC providers they send the most patients to because they respect the fact that they don't have a lot of ability to move people around, change PAC referral patterns directly, so if they focus on the ones they send the most volume to, that's where they get the biggest bang for their

buck and quality improvement efforts and things like that.

So what we're proposing here would sort of shift that a little bit. It would be more quality focused and, you know, the volume issue wouldn't be there.

MR. PYENSON: Do you get any sense that ACOs or bundled payment awardees would be upset by this kind of an arrangement because it might change their referral patterns?

MR. CHRISTMAN: It would definitely be something that they would have to think about. I mean, you know, I think a lot -- some of those, the way they drive referral patterns now in some of those, what we've been told, is they sort of, you know, mention that this is the person that we're working with on this, and often what will be available are sort of either a transitional care nurse or some sort of supplementary service that sort of serves as a carrot to encourage the beneficiary down that path. You know, if the providers they're working with don't end up with a better ranking or in the better category in this process, it'll obviously be something they have to think about. But at the same time, I don't think they'll be defenseless to, you know, maintain the relationships

they've built.

MR. PYENSON: So do you envision there would be exemptions for bundled payment programs or ACOs? And I'm thinking some of the bundled payment conveners are doing things like giving patients an iPad or --

MR. CHRISTMAN: You know, we haven't thought about that, but we definitely could. I mean, I think that -- I can definitely see how there might be some disconnects. At the same time, I think we've also heard some noise that people in the ACO in those communities wish they had more authority here. So trying to figure out how to balance those two I guess is something we'll need to think about.

MR. PYENSON: Thank you.

DR. CROSSON: Pat.

MS. WANG: Evan, have hospitals developed preferred relationships with post-acute care providers when they are at risk, for example, the hospital readmissions penalty program for joints? They're going to have preferred post-acute care providers. How do they get their patients to them if they can't --

MR. CHRISTMAN: That's a good question. I mean,

I guess they -- what we understand is they do a couple of things. One is, like I said, they often will focus on -- the people they do a lot of volume with will be people they seek out, those preferred relationships with. They'll look for the SNF they send the most patients to, the home health agency they send the most patients to. That's one strategy.

A second strategy is, you know, carefully walking the line and just reminding people that, you know, my hospitals in a partnership with this hospital, we're working to improve quality together, and period, stop, letting that.

And then a third strategy is saying, you know, especially for something like hip and knee or ACOs, they say we have this transitional care nurse right here today with you that will travel with you to your next PAC site if you -- and they're available if you go to this preferred provider.

So that's kind of a fly-by of what they're doing now.

DR. CROSSON: Okay. I think we're ready for the discussion. So we have three options on the table here in

terms of how to do this, including one which is a variant of the second one. The notion here is the pros and cons of these different models, and as people talk, I'd like to see if we can't narrow down to see whether we all agree or to what degree there's disagreement, the goal being maybe to finish this off at this meeting. If we can't, fine, but that's the goal. David.

DR. GRABOWSKI: Thanks, Evan, for a great presentation and great chapter. This is an area, I believe, where Medicare's efforts to protect beneficiaries in one dimension has really harmed these same beneficiaries in another dimension. In order to protect freedom of patient choice, we have failed beneficiaries by not giving them really the tools to make good post-acute care choices. We've had such concern about hospitals steering patients to particular providers that we ended up having these beneficiaries make poor choices due to a lack of information.

I am very supportive of providing additional information to beneficiaries at the time of hospital discharge. Nobody wants to steer patients. This is about provision of additional information, not steering patients.

To Jay's question of which of these approaches I would advocate for, I'm not a big fan of the flexible approach. I think we're going to end up as business as usual here, with a lot of hospitals throwing up their hands. Evan, you did a really nice job of outlining all the disadvantages of that approach. I won't repeat what you said.

I would much prefer a more prescriptive approach, and I like what you're terming the "revised prescriptive approach," where you're trying to tailor this to particular markets.

I'll add that I think the information set here for patients could be a floor, not a ceiling, and that if particular areas or states or hospital systems want to provide additional information, I would be fine with that. I know there are hospitals in the Boston market that use the Massachusetts Department of Public Health information on skilled nursing facility ratings. They provide that at the time of discharge. There may be other regional measures that hospitals want to provide beneficiaries. I would be fine with that. I don't think we want to limit the information set here, but I really like tailoring this

set -- having a core set of measures and then tailoring that by market, I think that's the approach I would advocate for.

I wanted to make one other point, and it really comes back to a question Kathy asked during the last discussion. What does Medicare Advantage do? And there was a really important Health Affairs paper that came out over the last several months by David Meyers and colleagues at Brown University. They looked at -- and just to step back, obviously in Medicare Advantage the plans are allowed to explicitly steer patients to skilled nursing facilities. They're allowed to set up networks. What's the quality in terms of the star rating of those facilities where Medicare Advantage beneficiaries end up relative to traditional fee-for-service? My prayer would have been they would be higher in Medicare Advantage. It was actually the opposite. Quality was lower in Medicare Advantage. So there's something to think about along this continuum. Why is that and what's going on there? And maybe that's a topic for future meetings, Jay, but I do think as we look at this continuum, here we have an at-risk entity that should have every incentive to contract with the best

skilled nursing facilities in the market. That's not what ended up happening in this study. I know these authors are also looking at home health agencies and other kind of areas as well. I think that's a really fruitful area and one we should continue to think about as well.

Related to this, but to your point once again, I like the revised prescriptive approach. Thank you.

DR. CROSSON: And it's troubling as well. But just to get back, I just want to make sure that I understand the floor and ceiling reference. I think what I heard you saying was that if we went with the prescriptive approach, that hospitals -- this would not -- they would not be limited to just using that in terms of if they had access to other information, that could be provided as well. Is that it?

DR. GRABOWSKI: That's correct.

DR. CROSSON: Okay. Thanks. Commentary? David.

DR. NERENZ: Thanks. This is a very useful discussion, and I certainly support the idea of allowing hospitals more leeway and to give patients more information when they make this choice.

The missing piece I see in this is the explicit

recognition a beneficiary values and preferences. And I guess now that I am a beneficiary recently, I think about this a little more. Both of the approaches we talk about here I would characterize as very paternalistic. In one example, CMS says here's what quality means, here's how you should score quality, ultimately here's what's people on one side of the line, here on the other. In the second variation, we've moved that down to the hospital level, but in neither case have we said we should take explicitly into account the values and preferences of the beneficiaries, including their desire to make a decision based on other or different quality metrics.

Now, I know the hospital quality measure world better than I know this one, and maybe this is not a significant concern because perhaps say readmission rate really is the one thing that matters. But it seems to me that there's a third variant here where in the general framework of allowing more information to be provided, what we encourage is that there's the richest set of quality metrics available for SNFs or others, PAC providers who would be affected by this policy.

We then allow discharge planners and the hospital

to pick up a tablet, ask patients specifically what things they care about, what matters to them in their decision. You do the quick little calculation. There's examples of this all over the place where their preferences are formally linked into the metrics that exist and then out comes a ranked list. It's not the same for every patient. It's not the same for every hospital, not the same for every region. That's fine. That's okay.

It's very different from the two options being proposed here, and actually as a beneficiary, I'd prefer the third to either of the two that we're talking about. And I don't know why we couldn't also think along those lines.

DR. CROSSON: David, let me just -- I'm just curious. So, you know, other than -- and I think I know the answer, but I'd just like to hear what you say. Other than things like distance and, you know, familiarity, what would be some of those preferences that you would think of?

DR. NERENZ: Sure. And, actually, if time allows, I could give you a sort of anecdotal example. It's set in the hospital context, but I think it transfers here. You can tell me if you want that example or not. But, you

know, if we're talking about SNF, for example, that's a residential facility, and while you're there, you may care about the food, you may care about the lighting, you may care about how nice the lobby is, you may care about a bunch of things that have much more to do with sort of the daily minute-by-minute, hour-by-hour experience of living there than about the readmission rate. In fact, you may think that between your ability to manage problems and the family support and maybe the physician care you get alongside, you may feel that you're quite buffered against any potential readmission problem, but you really care about whether you like what you eat for lunch, maybe. I guess I'm a little reluctant to say that those preferences are invalid and that a set of preferences built by CMS or blessed by us are more valid.

Now, maybe, you know, I think this whole thing has been built on a different idea from mine, but I just think there are domains of quality that are not reflected in at least the examples that we've been giving here. And that was just off the top of my head.

DR. CROSSON: Okay. Just to be clear, I think you know this, we're just -- this proposal would be

additive to any of those other ideas that individuals might have about what they would prefer. And, of course, as we've mentioned several times, that individual could override this information that they're presented.

DR. NERENZ: I fully understand that, but, again, what we're talking about here is we've sort of started with the idea that these decisions are currently being made perhaps irrationally or not in a way that we think would be ideal. That's part of what the whole text is about people are choosing poor-quality facilities. So then what we're going to do is create a list and say based on this one specific formula in one particular weighting system, you know, these facilities in red font are the high-quality ones and then everything else on the list in black font are non-high-quality. And I think that would drive people's decisions, including in ways that I would not like to see driven for myself as a beneficiary.

So, again, I'm not saying that -- I mean, maybe in the end mix we have to be careful to say that, you know, this could be part of it and say, okay, by the CMS formula, with whatever its pros and cons are, these facilities are considered high quality. But now here's another set of

criteria, now here's what we could work out by using this tablet and incorporating your values and preferences.

I guess I'm a little concerned that just as presented to us it sounds like "the" way, not "a" way, or not part of a larger way.

DR. CROSSON: Yeah, Kathy.

MS. BUTO: I'm just thinking, just to pick up on Dave's point, it could be something, especially as we move into a unified PAC, where the beneficiary has a good support system at home and would rather be at home than prefer to go into a facility. So that's the kind of thing that if, again, under a unified PAC you might not weight that preference more highly, but given the circumstances of the individual, that might actually draw a different group of options for the beneficiary.

So I think there are, you know, if you will, medically or clinically related issues that have to do with a larger circumstance of a beneficiary that you could pick up with patient preferences if there was a way to bring those in.

DR. CROSSON: Right, and all I think I'm saying is -- and this goes back to David's floor versus ceiling.

All I think we're saying here is let's devise a way to provide beneficiaries at the moment of decisionmaking, you know, and in a facilitated way with a human being, additional information about quality; and as we had in the earlier discussion, this would in no way preclude at the level of an individual hospital that hospital taking into consideration other issues or providing additional information that that hospital happens to have.

MS. BUTO: Yeah, but I think, Jay, having been on the reg end of this, reg-writing end of this, unless you stress that patient preference is one of the issues, it will not get the attention, for instance. So it depends on whether we as a group think that's important. If we think it's more important that the actual regulatory requirements only touch on certain quality measures having to do with the facility itself or the provider, and not on patient preference, yes, it can always be added in. But it's an afterthought or it's at the discretion of the hospital.

So I'm just saying it's something that we have to think about and how important do we think it is.

DR. CROSSON: Well, again, I'm doing something I don't like to do, which is get into a dialogue here.

MS. BUTO: I'm sorry [off microphone].

DR. CROSSON: But I just need to understand. So you're saying, I think, something a little different from what I heard David saying. I think what you're suggesting now is that in the quality ranking process, that the preferences be included in some way, or that in the -- or in the promulgation of the regulation that would accompany this recommendation down the line, that there be an emphasis to say something like hospitals should also include patient preferences in this discussion or --

MS. BUTO: I don't think it should be part of the ranking process.

DR. CROSSON: Okay. I wasn't clear

MS. BUTO: Because patients are individual. But that as the discharge planner sits with the patients, that part of that ranking for that individual includes that individual's preferences. I think that's really the --

DR. CROSSON: And I think that's certainly something we could do, and a good suggestion. Okay. Thank you.

All right. Jon?

DR. CHRISTIANSON: I think part of this

discussion is prefaced on the notion of the stuff that Evan presented earlier on, that, oh, my gosh, there's five higher-quality facilities that they could have gone to, then they would have been better off. We don't know that. I mean, again, those quality measures are on very specific things. What does it mean to be better off? There are trade-offs these patients may make, but they're just assumptions, like, "What's wrong with you? You went past these five facilities." And I think that's an incorrect basis for the whole discussion.

DR. CROSSON: Okay. Now the hands have erupted. Pat?

MS. WANG: I think it's a good recommendation to allow discharge planners to have more robust conversations with patients they're trying to place. You know, David's description of the approach I think is good. I guess that I -- I don't think it's a huge proposal. I realize that it's in response to a directive. But I think that the issue of where patients go post discharge is really much more complicated than what the discharge planner may say or not say. I mean, providing the information is very, very important, but to the point, you know, rankings on a page,

even supplemented with additional information, may not really be the most important thing.

There are excellent SNFs in the market that have no capacity for additional people, so how bad will you make somebody feel to say these are the top three SNFs in the region or in the market, and everybody else is terrible, but they're all full so you can't go there? You know, you've got to be a little careful about stuff like that.

I think that the discharge planning process itself, at least in my market, is -- you know, they're working so hard just to get patients out of the hospital. I don't really know how much additional opportunity there is to sit and do a counseling session. I think, you know, you're kind of -- I don't want to say it the wrong way, but whether you're an MA plan or Medicare fee-for-service, you are kind of at the mercy of what goes on there. And there's very little opportunity to touch that honestly. The discharge planners are doing a job, which is to get people through and to get them out.

You know, I think on the issue of patient preference, it is very important. Transportation is important. There is sometimes a different mix of patients

in a SNF -- by age, by condition -- that, you know, a pure ranking might not reveal. That's all to say that I'm all for giving more information and allowing more conversation to occur, but I think at the end of the day, the important thing is to make sure that post-acute care providers are providing high-quality care. And there's a lot of variation in that right now. This issue -- I mean, the fact that there is a SNF, you know, quality readmission program that is coming on is very important from my perspective. I don't think that what happens to the discharge planning process is really going to solve the problem. So I would encourage us to continue to support efforts to improve the quality of care in all post-acute care providers.

There is a CMMI demo, for example, that I think focuses more on the custodial nursing home members and trying to prevent unnecessary admissions to the hospital. That is a really important program, and I'm familiar with some of the efforts there. The work is really hard because the slope is very steep. There's a huge amount of work that needs to be done in many different kinds of facilities. Some are much more sophisticated, some are

much less sophisticated. So I would just -- I would make that footnote.

DR. CROSSON: So a number of good points. I think one thing, just one practical thing, you know, in terms of writing this up, if we get there, is kind of a fundamental notion that you would not be presenting patients who were being discharged with a list that included facilities that were not available. That's something that a hospital could manage, right? No?

DR. COOMBS: No, no -- [off microphone].

MS. WANG: I think that's hard to do on a real-time basis because their work is going to be here's the list and then they have to call, you know, on a case-by-case, day-by-day, hour-by-hour --

DR. CROSSON: So what you're saying is it changes by hour, so it's not practical.

MS. WANG: Yeah, it's not practical.

DR. COOMBS: Can I comment on this? Because the other day, you look at -- you might give a counseling for a list, and you may not -- the caseworker may not actually go into details regarding quality. May or may not. But the bed becomes available -- the decision is made clinically

that this patient is -- it's time for this patient to go to a -- wherever, and that decision is made, and you have this list of potentials. You go down the list, and even with the list they say, "We don't have a bed today. We will in two days." The hospital is pressured to actually get that patient placed at that time. So you may have a list that is so fluid -- it's fluctuating dynamically that you don't know if that bed's going to be available.

So my point was going to be made that the reason why the low-quality places exist is because there's a demand for it, because of the changing availability of capacity in the community. So, you know, I couldn't agree more with what Pat has said. I agree to provide a prescriptive approach, but I just wanted to say that there are so many factors that come into play, and it's a dynamic change that is occurring throughout the day. You might have a bed in the morning and it's lost in the afternoon, depending on what happens at the SNF in terms of that -- what their bed situation looks like, if they're discharging people from the SNF to home. So I think that's the assumption that we're making, that it's fairly static, and it is not.

DR. CROSSON: Okay. All right. I'm going to stop interjecting myself. Brian. Oh, sorry, Paul. I didn't see your hand.

DR. DeBUSK: Sorry. Paul, go ahead.

DR. GINSBURG: Yeah, I wanted to get back to the issue that Jon raised, which is that whereas I'm not an expert on PAC quality measures, I know in every other area of health care our quality measurement is very primitive. It's better than nothing, but it leaves a lot to be desired. And the way this paper was written, it was as if this is perfect information, we should make sure it's used, we shouldn't allow any other information that might be less objective. And I'm really concerned about that.

There was a discussion about, well, business as usual. But I think that in these days there's clearly some alignment between hospitals and beneficiaries as to where they should go for post-acute care. And I don't want to rule out hospital judgments. Indeed, my interpretation of the prescriptive approach was it was almost like requiring hospitals -- making hospitals in Medicare's agents with Medicare saying just the data we collect is the only relevant information for choice of post-acute care

facilities, we're going to force you to use it, we're not going to let you augment it with anything else.

So that's just my perspective, and I'm really not comfortable with the prescriptive approach at all. I'd like to hear more about the problem with the flexible approach because I'd like to open up not only using drawing on these measurements for quality, but using other information such as, you know, we work well with this SNF, you know, we really feel it's been valuable in reducing readmissions.

I'll stop.

DR. CROSSON: Okay, let me -- I'm going to do it again. Sorry. And so correct me because I know you have a misapprehension here. But I thought that the difference between prescriptive and flexible in the context of the quality -- and you can argue about what you're doing to the quality mix -- was who develops that, the hospital or Medicare? But I didn't think -- and perhaps it's in the paper and I missed it -- that the prescriptive approach -- and I thought we had covered that earlier -- in addition said and the hospitals can't use anything else but that in their discussion with the patients. But that's your

perception, I think.

DR. GINSBURG: Yeah [off microphone].

DR. CROSSON: So, Evan, which are we saying?

MR. CHRISTMAN: I think we -- you know, the way the paper's written, it may leave you with the impression that we've said here's the quality measures that Medicare would set. I guess, you know, the notion of allowing hospitals to supplement that for the purposes of illustration, I don't think we went into that because it felt like we were doing enough variants already, and I was getting a little lost. But it's something you could definitely do. I guess adding supplemental information, you know, my first reaction is it starts to raise some of the issues we saw with the flexible approach, and, you know, it's what's supplemental information and what are they using it for, and it raises concerns of everything from, you know, will it be confusing to beneficiaries to have different hospitals doing different things, different hospitals is the preferred -- different PAC providers are preferred.

The other piece is, you know, avoiding situations where there's self-dealing going on, conflicts of interest,

those types of thing. And another concern was from Medicare's perspective, if hospitals are all doing something a little different, inevitably there's some concern about ensuring proper oversight of that, that hospitals are using the authority appropriately. So if everybody's doing something a little different, it's hard for Medicare to ensure that nothing inappropriate's going on.

Those were some of the concerns that came up.

DR. CROSSON: Okay. Paul.

DR. GINSBURG: This gets back to are we just requiring hospitals to be Medicare's agents, that only information from Medicare can be used. And, you know, I think I'd like to get into this issue. Given readmission penalties, ACOs, bundled payments, I see a fair amount of alignment. You're more concerned with self-dealing, kickbacks, and, you know, the question is: How big a problem is that? And we should take this head on before we come up with a recommendation to exclude all information beyond Medicare quality ratings.

DR. CROSSON: Okay. Brian.

DR. DeBUSK: I favor the idea, obviously, of

allowing discharge planners to engage beneficiaries with this kind of information. I do think that there's a lot more steerage, if you will, going on right now, particularly in some of the more advanced models.

You know, I've seen, for example, contracts in these bundled hip and knees where the patient actually enters into what looks sort of like a contract -- it's non-binding -- and they do it at the physician's office, so that by the time they go to the discharge planner, they're handing them this piece of paper that says, "This is where I want to go." I mean, they really take all the daylight out.

So I think there's more of this -- and to Paul's point with ACOs and readmissions penalties, I think there's more to this going on than we're probably acknowledging here. But I want to take a moment and say that I'm really not comfortable with the flexible approach. This idea that you're going to choose your own quality measures, it feels like the PQRS all over again. And I think we've already got one of those going, and one is sort of enough.

Back to the prescriptive approach, I really do like that approach. Knowing that these standards are going

to have to be harmonized across all four venues, which the IMPACT Act is going to require anyway, and knowing that those measures are going to evolve over time -- they aren't set in stone -- but this issue around having, you know, national standards and the fact that you're going to have some areas with more high-quality providers and some with others, what I would recommend here is that we measure these -- take these standardized measures, run them through our standardized peer grouping methodology. Let's go ahead and sort them by peer groups, whether you're going to use five peer groups or ten peer groups. But I think we've developed something for the HRRP that could transcend into other areas, because what you could end up with is a prescriptive approach where the results are then stratified based on socio-demographic status. Then we're using the same set of parameters to educate patients. We could use that for value-based purchasing, and we could use that for public reporting. So, ideally, we'd be working off the same platform using a standardized treatment that we've developed for other areas.

DR. CROSSON: Jack.

DR. HOADLEY: So there's a lot going on in this

discussion, and I think, you know, the narrow question -- I think where David started with the sort of revised prescriptive, you know, is sort of the right way to think of it, that it does make sense, you know, and just the way Brian was talking about it, that these will evolve and these are going to change, hopefully get better in various ways, but that we definitely don't want -- I think there's a fair consensus around we don't want to say that's the only information that should be brought into this discussion.

I guess what I think about is sort of this list of hospitals that might get sort of created as a document that's there, that, you know, has a certain life to it, but the reality is when you get down to the actual pickings, all this stuff about, okay, but who's got a bed today and all this other kind of stuff, that's where you're also getting -- trying to engage in the patient's preferences about, you know, the very practical things about convenience and location. Is this a ventilator patient where there's certain ones that are going to be better that isn't reflected in the overall ratings? Or just all these other things that Dave mentioned, you know, preferences for

kind of the style of institution or things you know about it.

I think what we ought to do, as part of this discussion, is be thinking about are there ways to study this process of the discharge planning. Maybe this has been done. Maybe there's some literature on this. Or maybe this is something where there's pilots, and I know you mentioned briefly at the end of the paper, you know, some pilot potential, because I kind of think about, you know, there's good steering and there's bad steering. There's the bad steering that's where there's these relationships, there's financial relationships, there's things we don't want to see happen. But kind of a good steering, you know, giving a list of quality is steering in some sort of lower case kind of way, less -- you know, not the way the term typically gets used. All of the principles of behavioral economics say that people, if you just give them, here's the 50 SNFs in the area, go pick one, you know, people are -- number one, with no information, they've got not basis to do it other than one they've heard of. If you give them a quality ranking and they see 50, they're just going to sort of start at the top

and go down, again, unless there's other criteria that they know about or have reason to be brought in. So we want to take advantage of some of the ways to help meet the people make sensible choices by, you know, lowering the number of options out there in some sensible ways to provide them ways to think about this, the way a SHIP counselor would sit down making your MA choice, okay, here's the thing that the plan finder kicked out, but let's look at some factors that are going on, let's look at the star ratings, let's look at these other kinds of things.

And so, you know, I think one of the principles we'd probably all have a fair amount of agreement on is getting out of this situation where the discharge planner is so afraid to even hint at a direction that they end up doing nothing. And so could we set up some situations where we try some things that allow varying amounts of flexibility, varying amounts of that kind of good steering to occur, and then look at what beneficiaries are doing? Are they just following the recommendations? Are they picking the highest rated? Are they finding it helpful? Are they wanting to look at other factors? Are they finding it frustrating? You know, all the kinds of things

that would let us see how it works. And it goes back to my point at the beginning about, you know, how do we get some input from the beneficiary perspective, whether it's, you know, some of the beneficiary groups that may have tried to engage some of these issue, you know, this hasn't necessarily been their highest priority. But maybe there are groups that are out there that have tried to think about this. Or if not, how could we go in with some analytic purpose, whether it's inspiring some research or calling for some pilots to try these things and really find out what it is that beneficiaries want to look at? Is it the quality factors? Is it the convenience? And we've mentioned, you know, locations, specialization, you know, the nature of the facility. We've mentioned a lot of these around the table. Let's figure out what people want to hear, what they want to pick on, how hard this is. You know, this isn't like MA where you've got potential for six weeks to sit down and shop and go back a second time. You know, this is a decision that's being made on the spot usually in that one day and you're being pressured to make it fast. So under those circumstances, how does that decisionmaking work? If somebody puts a list and there's

something in number one, does that just mean you're going to grab it? Or can we figure out a way to get people to express their preferences and then say, okay, in that case, number four here is really the one that's going to work better for you?

DR. CROSSON: Sue.

MS. THOMPSON: Again, Evan, thank you. This conversation causes me once again to ask myself, you know, what's the problem we're trying to solve? Because we've touched on many, and it feels a little bit like we have, you know, the fee-for-service world sort of battling up against this value-based world and are we really going to move to value, and population health, and then there's all of the other issues around patient choice that obviously many of us have very strong feelings about.

I would suggest, however, that within the document, I know it said that no formal studies have yet evaluated the effectiveness of the efforts in shifting beneficiaries to higher-quality providers. We do have a laboratory of experience, however, since 2011, you know, many organizations across the country have been involved in ACOs, and I believe in many, if not most, ACOs they've

operated under a waiver that has given discharge planners the opportunity to be very transparent with the beneficiaries about the quality of post-acute. And I think should we go and visit with many of those ACOs, we could learn a lot. And I think what we would learn would be very surprising. Anecdotally, you know, after reading this chapter, I visited with some folks and had some folks make comment on this very question that we've had some experience, and I think we'd be very surprised to learn how ingrained it is in our discharge planning staff to continue to give choice and to continue to want to honor that very value of choice to our Medicare beneficiaries -- despite the fact I think there's great anxiety that suddenly we would not -- or we would be limiting choice. But, again, I would want to have evidence to support that statement.

And I think the second piece is not only the availability of a high-quality post-acute facility being open when you need a bed, but the individual who wants to go back to that facility they came from, that they're familiar with, there's other reasons that drive beneficiary choice other than a star rating.

So to the question of what method I would prefer,

to me I think it's a blend. I think there needs to be some prescription, frankly, for just administration's sake, but there needs to also be some flexibility on the part of the hospital. And the example I would cite is post-acute care providers that engaged with us very early in our ACO work and invested in IT systems that we could talk to each other and they could have access to our records and we, theirs. And so those sorts of criteria I think are, again, hybrid but should be left to the discretion of the hospital.

So those would be my comments on this.

DR. CROSSON: Craig.

DR. SAMITT: So, just quickly, two things? I'm a bit surprised and confused by this discussion because I think over the tenure of at least those of us who are senior members now, we've concentrated on assuring that we provide beneficiaries with access to high-quality, accessible, affordable health care, and we haven't shied away from the notion of measuring quality and at least presenting information to beneficiaries about quality.

So with that intent in mind, I'm very much in favor of the revised prescriptive approach. I think right now, to Rita's point, you know, beneficiaries are hungry

for this information. We've provided no information. Now we actually provide some information. Is the information perfect for all the reasons that were described? Likely not. But I think we're -- you know, we shouldn't let perfect be the enemy of good in advancing what I think our mission is supposed to be.

That said, the second point that I would make is I am curious about the measurement of quality. David's comments about the study that suggested that Medicare Advantage plans were not necessarily directing their members to higher-quality PAC facilities. I think we should study that because perhaps MA plans are not using the same methodology that we would propose here in directing to certain PAC facilities. And let's not presume that our measurements here are flawed. Let's just really seek to understand what MA may be doing differently than what we would be proposing here. And if we have some recommended enhancements to what we would designate as high quality versus lower quality, then let's propose those changes, as opposed to, you know, backing away from the very notion that we should be sharing more information with beneficiaries about PAC quality.

DR. CROSSON: David.

DR. NERENZ: Thanks. I mentioned a couple things that underlie my particular view of this, which sounds like perhaps it's much like Paul's. And I'll talk a little bit about the hospital world, and I'll just raise the question, for those who know it better, how this relates to the SNF world or others that we're talking about.

In the hospital world, there are thousands and thousands and thousands of potential quality measures, some of which are explicitly measured, some are not, but they're specific to a clinical condition, they're specific to ICU versus -- thousands and thousands. Now, maybe the SNF world is simpler. I'm sure it probably is. But we may have hundreds and hundreds instead of thousands and thousands. We don't have billions and billions. It's not Carl Sagan.

[Laughter.]

DR. NERENZ: But we have a lot.

Now, inevitably, systems like star ratings take a subset. Every one I know of does that. They apply a single weighting system. They select some, they don't select others. And the second key thing -- and I know this

in hospital; I don't know it in SNF -- the measure are not correlated with each other. They are simply not. It's an empirical fact.

So any subset you take, no matter what you do with it -- score, star rating, whatever you want to do -- will have no predictive power to the rest of the measures that you haven't included in that subset. It's just math, I think.

So if you're a beneficiary and you care about things outside the scope of what's in the star rating or the score, that star rating is not useful to you. It might even be misleading. So that's the framework I bring into this, and I'll acknowledge it's driven largely by what I know about quality measurement in the hospital arena. Maybe it's really different in SNFs. Maybe the measures are correlated. Maybe readmission is all that matters. I don't know. But I want to raise the question because that's why I look at this and say I actually really don't like the prescriptive model because of these observations. But maybe they don't apply to the SNF world.

DR. CROSSON: Brian. I'm sorry. Bruce. There I go again.

MR. PYENSON: This has been a very interesting discussion. I wanted to pick up on Paul's comment on the incentives that are being built in the system to align post-acute with hospitals and whether they are strong enough. And I think a way I'm thinking about that is to say, well, suppose we just took off all the rules and, you know, the discharge planners could make an outright recommendation. I suspect in that circumstance we'd see investment by hospitals in nursing homes. And some of the issues around that are, you know, the ability to steer more profitable patients to own nursing homes and things like that. So there's good reasons why we probably don't have -- we have these rules in place, and that has resulted in empirically perhaps there's relatively few SNFs that are owned by hospitals and relatively few home health agencies that are owned by hospitals. And I know that's not on the table here. We're not saying, you know, take away all the rules. So I think the hybrid approach is a reasonable compromise along the lines of having some protections, because I'm not convinced that the current incentives for readmission avoidance are strong enough, for example.

I would ask that as part of the process we think

about easing the burden on audits and other phenomena associated with enforcement of the non-referral rules, currently the non-recommendation rules. So if as part of the hybrid approach or whatever approach we choose we can say we think that some of the rather onerous audit rules that discharge planners and hospitals face could get eased. If we could do those kinds of reviews perhaps on a claims data basis instead of an on-site basis, I think that would help make everybody's life easier here.

DR. CROSSON: Okay. Thank you, Bruce. Got that one. Did I see Rita first? Then Kathy. Then I think we're going to wrap up.

DR. REDBERG: So just briefly, because I think Craig expressed a lot of my sentiments, I just wanted to say I think the advantages of the revised prescriptive approach sort of give the best for what we're looking for in terms of information to beneficiaries and consistency.

DR. CROSSON: Kathy.

MS. BUTO: Okay, just a thought. Having listened really to Paul and others, and Pat, you know, generally I think it's a good idea, since we're going to be developing PAC unified standards of participation, that the quality

standards be built into those in some sense, and that every provider who's a quality -- who meets those standards can participate in Medicare, and those that don't can't participate in Medicare. Then at the point of discharge, discharge planners and others ought to be looking at a set of providers who meet Medicare standards the way hospitals do and so on. And they ought to be able to point to certain elements of those standards that are important and are uniform, but I'm a little troubled by the notion of layering another set of quality metrics on top of that that will be useful in measuring these providers for purposes of recommendations to beneficiaries.

So I'm not sure exactly, maybe they're the same, and Evan was already thinking about those being embodied into the new conditions when they are put together. But that seems to me the simplest way to avoid extra burden, duplication, and still get the result of being able to provide some information to beneficiaries that's useful.

DR. CROSSON: Okay. In summary, I think it's pretty clear that we've been successful at elaborating the complexities of a policy direction here. And I don't believe we have a consensus that would be necessary in my

mind to say we have decided on one approach or the other.

That said, I do believe -- and I think there's a general sense here -- that in the current situation, you know, beneficiaries have an inadequate amount of information or an inadequate quality of information about the quality of post-acute care providers; and that as Evan pointed out early in the presentation, one consequence of that, at least as we look at it based on how we're measuring quality -- and I think that -- I got that point. It may not be the right way. It may not be broad enough. But, nevertheless, that there's a significant number of -- on an observational basis, a significant number of beneficiaries who appear to have made choices that, arguably, if they had been given different or better information, they might have made a different choice. That's part of the problem.

The second part of the problem is I think that we have a sense -- and we've heard this repeatedly -- that maybe discharge planners are in a situation right now which is conflicted for them in the sense that they may know things about individual providers that they would like to be able to emphasize to patients, but they feel like

they're under a legal proscription to do that, and that's an uncomfortable result of the current regulatory environment. And if it's possible, we'd like to be able to find a way to relieve them of that pressure. At least to me, when we talk about what problem we're trying to solve, it seems like those are at least two parts of it. The solution, though, I think is still one on which we don't have a consensus.

So we are going to put together a chapter for June, and I think that, you know, rather than have a chapter that ends up saying, you know, we think we ought to do it this way, this prescriptive approach or this variant or whatever, I think what we're going to have to do -- and I think it's a positive in my mind, because I said -- I mean, people have brought up good issues here. These are important points, I think, that have added to the thought process already and need to be included in a chapter. So, Evan, you need to start looking for a twin, because my sense is what we want to do is expand within the final chapter that we write for June a number of the points that have come up here today. And I may not have listed all of them, but I think the issue of patient preferences and how

that gets incorporated into the final result here is important.

I think we have to resolve the question of whether or not we're making a recommendation or we think that -- or discuss the pros and cons of saying, on the one hand, we would develop this information and that would be the only information presented to patients, versus hospitals having the ability to provide additional information and what are the pros and cons, the benefits of that and the risks of that.

You know, I would like to see -- and maybe I'm the only one. I would like to see a notion in here at least to be considered of a simpler approach of just ordinal ranking, of just giving scores that would be one piece of information, without necessarily going to the classification or categorization. Just a little bit different from what you were saying, Kathy, so I think we need to present both of those notions.

And then the idea that maybe this is going to take more time, and before we resolve this, we need more information. Sue suggested that we look at what's been going on in the ACO world. I think this conundrum of what

criteria Medicare Advantage plans are using and why they're coming up with seemingly a ranking which is different from what we've had is an important point, because we could make a mistake if we don't under it.

Then also the nature of the -- however we decide to do the ranking, the nature of what we're calling "quality information" that we would be presenting, and is that -- you know, do we want that to be relatively narrow, or do we want it to be broader? And what are the pros and cons, practical pros and cons, particularly of doing it one way or the other?

So what we've done here is we've unearthed, I think, a much deeper set of issues than we thought we had when we went in. And I think virtually every one of these things that have been brought up are important, and it will take some time. In the June chapter, we will raise these issues without trying to resolve them. And then subsequently, as we put this into the work flow, we'll come back with a more complete discussion and try to work towards a conclusion.

Does that sound acceptable, reasonably? Okay.

At that point we'll conclude the discussion.

Thank you, Evan, for that. And now it's time for the public comment session. So if there are any members of our audience here who would like to make a public comment, now is the time to come to the microphone.

* [No response.]

DR. CROSSON: Okay. I'm seeing none, so we are adjourned until 1:30. Thank you.

[Whereupon, at 12:10 p.m., the meeting was recessed for lunch, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION

[1:31 p.m.]

DR. CROSSON: Okay. Let's see if we can sit down and we'll start the next session here.

We're now going to return to the set of issues involving the availability of emergency room services. We have draft recommendations. We'll be bringing this back at the April meeting for final recommendation, so we'll be focusing the discussion on the draft recommendations. Sydney, Jeff, and Zach are here, and who's going to start? Sydney.

* MS. McCLENDON: Good afternoon. Today we revisit our discussion on ways to improve efficiency and preserve access to emergency care in both rural and urban areas. Before we begin, I'd like to thank Brian O'Donnell for his work on this project.

For this presentation we'll be focusing on the growing phenomenon of stand-alone emergency departments. We have discussed stand-alone EDs on multiple occasions over the course of the last few cycles, including in the Commission's November 2017 meeting and our June 2016 and 2017 reports to the Congress. Today we'd like to continue

our discussion from November and provide some draft recommendations for your consideration.

To begin, I'll review the current use and payment of emergency departments, in addition to providing background information on stand-alone EDs. From there, Jeff will discuss rural ED access concerns, and Zach will cover issues regarding the use of urban stand-alone EDs. We'll then open it up to you to discuss the draft recommendations and how you would like us to proceed ahead of the April meeting.

The volume of overall ED cases in Medicare is growing rapidly. From 2010 to 2016, emergency department use in Medicare grew faster than ED use nationwide and Medicare physician visits.

In addition to overall ED visit growth, Medicare volume of the two highest-paying levels of ED visits, levels 4 and 5, represent a growing share of all ED visits.

Together, the higher volume of visits and the growing share of high-paying visits means that between 2010 and 2016 Medicare ED facility fees per beneficiary increased 72 percent. This increase, from $79 to $136 in facility fees, does not include payment for other services,

such as physician fees or ancillary services.

Furthermore, while the increase in the share of ED visits for the two-highest paying levels might indicate that lower-severity cases are being seen at other centers of care, Medicare physician visits are not increasing at a similarly high rate. This could suggest that the increased share of high-paying cases may be the result of coding practices.

Next we'll look at how Medicare pays for ED visits.

ED visits generate two claims: one for physician services and one for the facility. Physicians' claims are paid through the physician fee schedule, and facility claims are paid through the outpatient prospective payment system. On the slide is an example of total payment amounts for a patient that presents with a level 4 ED visit or a comparable level 4 physician visit.

The total payment amount varies by facility. In the example, Type A hospital EDs, which are open 24 hours a day, 7 days a week, receive the highest total payment of $476. Type A EDs can be on or off the main hospital campus and account for about 99 percent of all ED claims.

The less common hospital ED, Type B, is open less than 24/7 and would receive a total payment of $329. Type B ED rates are typically lower due to lower standby capacity. Finally, we have the payment amount for a similar visit at an urgent care center or physician office, which would be $167. We included the urgent care center for additional comparison, as urgent care centers' patient mix often overlaps with lower-severity patients seen in EDs.

Now, as you know, not all emergency departments are located on the main hospital campus, and in 2017, there were between 550 and 600 of these stand-alone facilities. Stand-alone EDs come in two forms: hospital-owned off-campus EDs, and independent freestanding emergency centers, which are not affiliated with a hospital. Of the two types, OCEDs account for about two-thirds of the nearly 600 facilities.

OCEDs can also bill Medicare if they are deemed off-campus provider-based departments, and in doing so, they receive the same payment rates as on-campus EDs.

Next we'll look at how Medicare payment differs for some stand-alone EDs.

So you may remember this slide from our November presentation, and today I'd like to again highlight how Medicare pays different facilities based on their location.

There are three facility types presented on the slide. You have off-campus hospital EDs, which are the small white circles; on-campus hospital EDs, which is the green circle; and hospital-affiliated urgent care centers, which are the yellow circles. Each facility's Medicare payment amount is presented within their respective circle. The slide also includes a 35-mile radius surrounding the main hospital campus, which is indicated by the large, white dashed circle.

So as you can see, the yellow urgent care centers are paid the same amount, regardless of whether they are inside or outside of the 35-mile range of the hospital. The white off-campus EDs, however, are paid different amounts based on their proximity to the main hospital campus. Off-campus EDs within the 35-mile radius are paid the full on-campus hospital ED payment amount, or $476, while an off-campus ED more than 35 miles from the main hospital campus would not receive an ED payment. This difference incentivizes hospitals to set up off-campus EDs

within 35 miles of their main campus.

I'll now turn it over to Jeff to discuss issues around ED access in rural areas.

DR. STENSLAND: Okay. The overriding objective in rural areas is to preserve access.

Medicare's strategy to help preserve access to hospital care has traditionally focused on inpatient payments, and there are currently Medicare programs that result in higher inpatient rates to rural PPS hospitals and cost-based rates to critical access hospitals.

There are two problems with these existing inpatient-centered policies.

First, these policies are increasingly inefficient. The volume of inpatient services are declining, and given the fixed costs of running an inpatient department, as volume declines the cost per discharge goes up. The result is inefficient inpatient acute and inefficient post-acute care.

Second, higher inpatient rates do not always result in a financially viable hospital. As we discussed in January and 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 from 624 per year to 335 per year. This is almost a 50 percent decline in 13 years.

The lower green line shows admissions for low-volume critical access hospitals at the 10th percentile of inpatient volume. This tells us that in 2003, 10 percent of critical access hospitals had 170 or fewer admissions per year. In 2016, 10 percent of critical access hospitals had 71 or fewer admissions per year. This is down to almost one per week.

Having one admission per week creates cost of inpatient care problems. It can also create quality concerns if clinicians do not have the advantage of gaining experience with large numbers of inpatient cases. You may ask why hospitals don't simply close these inpatient units. The problem is that if they closed these low-volume inpatient units, they could no longer bill as an emergency department under current rules.

A new policy may be needed so that the payment policy itself can catch up to the changes we have already

seen in the delivery of care in rural areas.

The idea we discussed in January is to set up a 24/7 outpatient-only hospital with an ED. A key is that it would focus on isolated providers. Right now, hospitals that close and are more than 35 miles from another hospital do not have the option of becoming an off-campus ED of a neighboring hospital. This program could target these isolated hospitals that currently don't have another option.

To help fund the facility, Medicare could do the following:

First, the outpatient-only hospital would get PPS rates for its outpatient services and emergency care.

Second, there could be an annual fixed payment amount. The additional funds could be use to help pay standby costs, maintain emergency services, such as your ambulances, or recruit physicians. The goal is to preserve access to emergency services in these communities.

In addition, we want to offset most of the cost of the program with savings from efficiency gains. The efficiency gains can be made by closing the inpatient operations and redirecting that money to the emergency

room.

One side effect is that acute inpatients would be shifted to other hospitals. This may help other hospitals struggling with low volumes and may improve quality by consolidating volume in higher facilities.

The cost of annual fixed subsidies would be largely offset by the savings that would come from reducing costly post-acute stays in critical access hospitals' swing beds.

So now this brings us to the Chairman's draft recommendation. It reads as follows: The Congress should:

Allow isolated rural stand-alone emergency departments (those located 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 costs.

There are three key implications to the Chairman's draft recommendation.

First, for providers, we want to reiterate this is an optional program. If the critical access hospital wants to continue with the status quo, it can.

Second, this is a way for providers to preserve the emergency services when inpatient volumes are so low that a traditional inpatient-focused hospital is no longer financially viable.

For beneficiaries, the main benefit will be preservation of emergency services. One drawback is patients will have to travel 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 the coinsurance at a critical access hospital.

Now, with respect to costs to the taxpayers, we do not have a formal CBO score yet for this recommendation, but we expect it would cost less than $50 million per year, and the reason is that most hospitals that would adopt this are currently critical access hospitals and so the savings we would gain by taking those subsidies that are currently used as critical access hospital subsidies and shifting those to the emergency department subsidies would cover most of the cost of the program.

Now I'll turn it to Zach.

MR. GAUMER: The Commission has discussed several concerns about urban stand-alone EDs in the past. Among the facts that we have discussed are that the number of stand-alone EDs in several urban markets has grown rapidly in the last few years. The growth in Texas is well-documented, but increases have also occurred in Florida, North Carolina, and Ohio.

Multiple studies -- in addition to our own analyses -- indicate that these facilities tend to locate in higher-income areas and where patients with higher rates of private insurance reside.

In November, several of you asked us to look at the proximity of these facilities from on-campus hospital EDs. We looked at five large markets and determined that roughly 75 percent of the 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, this 75 percent, averaged about ten or fewer minutes.

Studies of the diagnoses of the patients served at stand-alone EDs suggest that the severity of the stand-alone ED patient is somewhere between the patients treated

at on-campus hospital EDs and urgent care centers.

The information we have collected through interviews and site visits also suggests that the facilities have lower standby costs than on-campus EDs. While representatives of some stand-alone EDs assert that they do treat stroke and cardiac cases, the majority of these facilities do not maintain operating rooms, have trauma teams, or have specialists on call 24/7. In addition, representatives of ambulance companies and researchers in Maryland have found that when patients require trauma services or are suspected of needing subsequent inpatient care, ambulance drivers typically bypass stand-alone EDs in favor of the on-campus ED.

Despite their different resource needs, stand-alone EDs receive Medicare payments that are equal to on-campus hospital EDs. SEC filings indicate that this model has been embraced by three of the largest publicly traded hospital systems, suggesting that it is a financially attractive model.

Now we will shift gears to talking about policy options for setting payment rates for OCEDs that reflect the resources required of the provider.

For urban OCEDs in close proximity to on-campus hospital EDs, policymakers might consider two options for paying these facilities.

First, Medicare could pay these facilities a reduced Type A payment rate by using a fixed percentage across each of the five levels of ED services -- for example, a 30 percent reduction off of all Type A rates.

Another option we previously discussed for paying these facilities is Type B rates. We estimate this would lower ED payments, on average, by 28 percent across all five ED levels. However, an anomaly in the Type B rates is that the Type B level 1 visits -- that's the lowest acuity and lowest paying -- yield payments that are higher than Type B level 2 visits as well as Type A level 1 visits. The benefit of using Type B rates is that it would be a relatively straightforward administrative change to use a set of rates that already exist in the Medicare reimbursement structure. However, the benefit of using the reduced Type A option is that it is both administratively simple and it would reduce rates across all ED levels equally.

Next, for urban OCEDs that are relatively

isolated from on-campus hospital EDs, policymakers might consider permitting them to receive the higher-paying Type A rates as they do currently.

The rationale for these policy ideas is threefold:

They would align payments with the resource needs of the providers currently supplying the emergency services at a lower cost.

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

And they would preserve access to emergency services in urban communities that are truly isolated from other emergency care options.

For the Commission's consideration, the Chairman offers the following draft recommendation:

The Congress should reduce hospital outpatient payments for off-campus stand-alone emergency departments that are within six miles of an on-campus hospital ED, and this could be accomplished by either reducing current Type A ED payment rates by 30 percent or by paying Type B ED payment rates. And we expect the Commission to discuss which of these two options might be best for inclusion in

the recommendation.

So the implications of our draft recommendation for beneficiaries is that those treated at urban OCEDs near on-campus emergency departments would experience lower cost sharing, and overall, beneficiaries would experience a minimal decline in their access to ED services.

The implication for providers would depend upon the proximity that they are from the on-campus EDs. Those within six miles of an on-campus ED would have their payment rates lowered by either 28 or 30 percent using our examples. And, again, we estimate that this would apply to approximately 75 percent of the urban OCEDs.

Those that are six or more miles from an on-campus ED would not see a change in their payment rates because they can continue to bill Medicare using Type A rates without a reduction. Again, that is about 25 percent of urban OCEDs.

We do not yet have a CBO score on this recommendation in particular, but the other implication here that I'd mention is that, regardless of which option you choose, the Type B or the Type A reduction, you know, we estimate that we're looking at a small savings for the

Medicare program with either option. And to be clear, this is a policy that would reduce payments to hospitals which own an OECD, but it would be a small amount.

This brings us to the discussion topics.

The first policy recommendation we discussed involved preserving rural access to ED services. Here the key issues were the fixed subsidy and paying OPPS rates for services in outpatient hospitals.

The second policy recommendation involved urban OCEDs and aligning their payments with their resource needs. Here the key issue was which rates to recommend paying these facilities.

We welcome your questions and turn it back over to Jay.

DR. CROSSON: Thank you, all three of you, for very clear presentations.

I think what we'll do is we'll these together. We'll vote separately on the recommendations, but for the purpose of questions and answers and discussion, we'll take it as one.

Jeff, I'd ask you to do one thing. For the benefit of the audience, even though we've talked about

this before and it's in the paper, just to point out with respect to the rural ED conversion that there is a potential -- our recommendation would be that communities could reverse that based on need. Do you want to say I'm right?

DR. STENSLAND: Correct.

[Laughter.]

DR. STENSLAND: I always say Jay is right. This would be available for communities that have a hospital that can't make it and they want to convert to an ED. It could also conceivably be available to a community that's really isolated and doesn't have any sources of emergency care or that haven't had a hospital. And the idea is that this will be a difficult decision for a lot of these small communities that have had a hospital for a long time, and the idea is that then if circumstances change and their population grows or for whatever reason they think they need the hospital back, they would be able to convert back to critical access hospital status. And I think this is something Sue has discussed and Warner has discussed, but it would just make the decision easier having that option of converting back.

DR. CROSSON: Thank you.

Okay. Clarifying questions? We'll start with Sue.

MS. THOMPSON: Staying in the category rural, Jeff, I just want to make sure I understand the recommendation and the intent. It would allow isolated rural stand-alone emergency departments -- would they be critical access hospital only or is it any rural facility?

DR. STENSLAND: Any isolated rural facility that is willing to be an outpatient-only facility --

MS. THOMPSON: Okay, but they don't have to have had a critical access designation?

DR. STENSLAND: No. And so you could be an isolated PPS hospital --

MS. THOMPSON: Yeah, exactly.

DR. STENSLAND: -- and decide, "I can't make it anymore. I'm going to become an outpatient-only facility."

MS. THOMPSON: That was question number 1. Then more than 35 miles from another ED, is that any other ED, another critical access ED, or another PPS ED?

DR. STENSLAND: The idea there is it would be any other ED, whether it's a PPS hospital ED, a critical access

hospital ED, or another one of these stand-alone outpatient-only hospitals. You wouldn't want two of these next to each other five miles apart.

MS. THOMPSON: Thank you.

DR. CROSSON: David.

DR. GRABOWSKI: I want to shift over and ask a question about urban OCEDs. You came up with a very narrow range here, 28 percent if we use the Type B rates and 30 percent. Why are those the right numbers? Like why not 10 percent, why not 50 percent? Why is that the right -- and could you say a few more words about that?

MR. GAUMER: Okay. So when we talked about this the last time, the conversation was really revolving around using the Type B rates. And when we estimated or modeled essentially what the change would be across all the five levels, weighted by typical use, it came out to be about a 28 percent hit for any visit.

So the idea here with the 30 was to show you that we could do a similar amount and just pick a reduction, and just using the Type A rates. So are we stuck on 30? I don't believe so, but that's up to you to decide.

DR. GRABOWSKI: I'm less worried about the number. Is Type B -- can you say maybe a few more words about the rationale there? Why is that the right approach here?

MR. GAUMER: Okay. So when we started looking at current Type B use -- which is very small, I think it's only less than 1 percent of all ED visits occur in a Type B -- what we saw was that there's a different mix of ED levels being used, and so I'm just going to throw out an example. Let's say at a Type A -- for Type A claims, let's say 75 percent of cases are in the top three levels. It's kind of the opposite for the Type B's. It's much more of the 1's, 2's, and 3's than the 4's and 5's.

So then when we compared what we've learned from the Maryland, Texas, and Colorado studies and what we've learned anecdotally from interviews and site visits, it appeared as though the stand-alone EDs that we were able to talk with and learn about in those studies are more similar to what's going on with the Type B's in the Medicare data. And that's why it seemed like a good corollary.

So the caveat here is we don't have Medicare claims data yet, and that's a whole other recommendation

that you guys made a year or two ago. And if we had that data, we might be able to put a more specific number on it, but it seems comparable.

DR. GRABOWSKI: Thank you.

DR. CROSSON: Questions? Warner.

MR. THOMAS: I just had a question on the rural facilities. On Slide 8, where you talk about the 10 percentile, do you have an idea of the number of facilities in these different categories?

DR. STENSLAND: Yeah, so there would be about 130 CAHs that would have 71 or fewer admissions per year.

MR. THOMAS: Out of a total of?

DR. STENSLAND: 1,300. So there's about 1,300 CAHs, so about 650 have basically one or fewer admissions per day.

MR. THOMAS: And do you see -- I mean, obviously it's an incentive to be able to bill at the higher rate for the ER. Do you see -- are there any other things that we should be -- is there any information you looked at that could be helpful to help them in that transition as you're going through the data?

DR. STENSLAND: I think the transition actually

from a critical access hospital to an outpatient-only hospital would mostly be a psychological transition as opposed to really anything that changed that dramatically in the way the facility operated, and part of the reason for setting this up is currently they seem to not really have an option. Like some critical access hospitals that we have talked to have approached larger hospitals and said, "We'd like to become an outpatient department of your larger hospital and keep our ED." But the larger hospital would say, "Well, you're more than 35 miles away from us. We can't have you an as ED. We'd have to have like just a clinic with urgent care prices. That's not going to work."

MR. THOMAS: Right.

DR. STENSLAND: So we're trying to solve that problem.

MR. THOMAS: Okay. And then on the EDs in the urban environment, going back to David's point, the six miles, how did we land on six miles? I think depending upon the urban area, two miles could be a challenge.

MR. GAUMER: Right. This was a difficult task, and we looked at a wide range of distances for each of these hospitals -- these stand-alone EDs, excuse me, and we

settled on six miles because it captured 75 percent of the facilities, and there was just a natural grouping around that part.

DR. MATHEWS: And, Zach, if I could add a word or two here, Warner, you might recall when we first discussed this as a policy option, the unit of definition here was in minutes. It said 20 minutes. And there were some clear operational issues with executing a minute requirement.

MR. THOMAS: Right.

DR. MATHEWS: Time of day, traffic, road construction, you name it. And we had the staff use, you know, GIS mapping software to determine the distances, and as Zach said, 75 percent of the urban facilities are within six miles of another hospital-based ED.

MR. THOMAS: Yeah.

DR. MATHEWS: And that this translates into roughly a ten-minute drive, again, with all the caveats, traffic, time of day, that kind of thing.

MR. THOMAS: Okay. And then in the reading, you mentioned, you know, a few markets where this seems to be problematic. You mentioned Texas, Colorado. Do you get the sense of how many of these freestanding EDs are in

those markets where this is more of a challenge versus it being widespread? Do you have any sense of that?

MR. GAUMER: So this used to be a very Texas problem, and Colorado was a second. But in the last two or three or four years, it has changed, and we're seeing a lot more popping up in Charlotte and in Jacksonville and Cincinnati and Columbus. And it seems to me that we're seeing a lot more of the large hospital systems seeing this as a good strategy for their markets where they have hospitals set up currently. So it is a growing -- it's growing outside of Texas.

MR. THOMAS: And did you look at all at the wait times in those metropolitan areas that this is more of an issue? Was there any correlation there at all?

MR. GAUMER: So when we did our last work on this -- I guess it was last June, in the June report -- we had something in there on wait times. And, you know, some areas of Texas did have very big wait times and there seemed to be a rationale for why some of these were popping up where they were. But for this study we have not looked at wait times.

MR. THOMAS: Okay. Thank you.

MS. McCLENDON: I do think I would add one thing to that. There was a study that came out of Texas recently that did kind of compare wait times prior to the start of this phenomenon and wait times after, and wait times really didn't change even with this huge influx --

MR. THOMAS: At the major --

MS. McCLENDON: -- in different markets.

MR. THOMAS: -- centers?

MS. McCLENDON: Mm-hmm.

MR. THOMAS: Okay. Thank you.

DR. CROSSON: David.

DR. NERENZ: I wonder if you could just say a little more about this anomaly in the Type B payment rates down at Level 1. Presumably, that's a problem whether this discussion goes on or not, also, but it could be that there's a history buried deep in the arcane development process. Do we know what that is? And if it's seen as an anomaly by us, is there some chance it's going to be adjusted within that payment discussion, even if this wasn't going on?

MR. GAUMER: We've got a backup slide. There we go. How do you like that? So on this slide you can see on

the left slide there are the five levels of ED, and this is the 2018 OPPS payments, Type A ED payments there, starting with 69 and going down. And you can see in the next column over to the right, Type B payment rates, you can see that for Level 1 the Type B Level 1 at 102 is higher than the 69, and that is an anomaly because Type B's are typically lower.

To the best of our knowledge, what's happening here is that they're such a small group of entities that are billing for Type B payment rates, these are hospitals that for some reason have higher charges. And we haven't looked to see exactly which facilities these are, but they have higher charges and have for several years, which as the claims play out and you set the payment rates, they get baked into the payment amount.

DR. NERENZ: Also, just to press the point, also it seems an anomaly that 102 is bigger than 91.

MR. GAUMER: It is.

DR. NERENZ: And that's what made me wonder. Is this a problem that somehow might be addressed aside from any of our discussions? Because, otherwise, the Type B option's administratively clear, and you've given an

argument why it might be reasonable. This seems to be an impediment to going down that path, but maybe the impediment would be removed by others, not us. I'm just curious.

DR. STENSLAND: Yes, to all that.

DR. CROSSON: Okay. Questions? Jack.

DR. HOADLEY: Just a simple question. On Slide 3 where you talked about the growth rates, is your nationwide rate there Medicare and non-Medicare combined, the 7 percent in that first bullet?

MR. GAUMER: Yes, it is.

DR. HOADLEY: And do you know what the non-Medicare ED growth rate would be?

MR. GAUMER: No, we don't have that.

DR. HOADLEY: If that's calculable, it seems like that might help the comparison, even making it even clear. Thanks.

DR. CROSSON: Brian.

DR. DeBUSK: I had a question on Chart 14, where you talk about the lower patient severity and the lower standby costs of off-campus versus on-campus EDs. Couldn't I make the same argument that a community-based ED, and,

say, an ED attached to a Level 1 trauma center would have a similar differential in severity and in standby costs, yet we're paying them both Type A rates?

MR. GAUMER: Yeah, I think you could, absolutely. I think that the big difference here that we're trying to point out is that the standalone EDs are not going to have the operating rooms and the trauma capacity and the on-call capability for specialty physicians, whereas you might get more of that with the comparison that you're drawing.

With that said, there are probably big differences between, you know, your Level 1, Level 2 trauma centers.

DR. DeBUSK: Because I could make the same argument, say, for stroke. I could say, well, the ambulance operator is going to drive right past the community hospital and go straight to the stroke -- anyway.

The other thing, too, it is concerning that they appear to have lower levels of severity. I mean, I share that concern. But have we looked at how that issue is conflated with sort of the larger issue of appropriate ED use, in general? I mean, it seems like those two issues are mixed up. Have we tried to maybe sort that out? Would

off-campus EDs be an issue if we were using EDs appropriate across the board? Would they be? I don't know.

DR. STENSLAND: I think that's a big issue and it would be hard to address it. One problem that we have in Medicare is the Medicare beneficiaries really don't have an incentive to go to the urgent care center when it really is maybe the appropriate place to go if they have Medigap coverage that's covering all their co-insurance anyways. And if you have something, even if it's calling itself an ED, if it's closer to you and the wait time is shorter than the urgent care center, why wouldn't you just go there?

DR. DeBUSK: And then final question. If we did move them, say, to Type B rates, or did the 30 percent cut, what would keep them from then demonstrating Type B behavior, say cutting their hours back, lower their operating -- I mean, they could maintain that differential. Because I do understand, they probably do have a lower operating cost, but couldn't they maintain that differential by simply reverting to true Type B behavior and cutting their hours?

DR. STENSLAND: I think it depends on the state that's certifying them as an emergency department, but yes,

they could, you know, if they wanted to.

DR. CROSSON: Alice.

DR. COOMBS: So I was interested in the statistic that says off-campus EDs had X number of patients that go to the mothership. Do we have that information? Because one of the premises of that, the standby capacity and the fact that you have the resources in terms of the training of the individuals there have to be equivalent to the Type A environment, just in terms of their capacity to do certain things, the maintenance requirements for everything from the personnel involved, physicians, nursing, respiratory therapy, the whole works.

And so I'm just curious as to if you have any data on the frequency for which those off-campus EDs refer back to the mothership, to the main hospital.

MR. GAUMER: We don't have that for Medicare, unfortunately, and the only numbers that I can cite are from the Maryland study that happened on a very small number, two or three standalone EDs. And I think what they showed is that -- and we're talking admission rates. We're not even talking, like, people that went from the outpatient -- the OECD and got bounced to the mothership

ED.

But folks in comparison hospital, on-campus EDs were admitted 15 to 19 percent of the time, and the folks that were going to the standalone EDs in Maryland were admitted somewhere in the range of 5 percent of the time. And that probably speaks more to the acuity of the patient than maybe what you're trying to get at.

DR. COOMBS: Yes, because if you get the other number it tells you -- say, for instance, it's 1 percent or a fraction of a percentage -- then that tells you, indeed, they are behaving just like an independent, freestanding ED, versus some -- those off-campus EDs are like 20 percent of the patients who come through the door are having acute, time-sensitive illnesses that require major intervention right away.

DR. CROSSON: Paul.

DR. GINSBURG: I was wondering if the reasoning behind the off-campus EDs, urban, might apply a lot to micro-hospitals, and whether this might be a follow-on thing that we pursue.

DR. STENSLAND: I think there is similar reasoning, and part of, I think, the attraction of micro-

hospitals is that when you have a micro-hospital then you can also have these off-campus emergency departments around it. Another thing that's driving, I think, the micro-hospitals, to some degree, is you remember we had a recommendation for site-neutral payments for E&M services, and the way Congress didn't exactly do it the way we suggested, which was site-neutral based on the type of care you're receiving, E&M gets the same everywhere. They said you still get more if you're on a hospital campus. So that creates an incentive to create a hospital campus and a micro-hospital with eight beds or something. So these are all interrelated.

DR. GINSBURG: It sounds like that might be just a separate topic to be taking up, because the phenomenon seems to be growing and a lot of it is meant to just maximize reimbursement rather than to meet needs.

MR. GAUMER: And I just want to add one thing onto that, Paul. You know, we've taken a look at the micro-hospitals, a small amount. We have identified a handful. There are a couple of companies out there that are trying to develop these, but we haven't seen as big a swell in the micro-hospital industry, I guess if you'd call

it that, as we have the OCED industry. So it's kind of behind the OCED wave, is coming this micro-hospital wave that hasn't quite developed yet, but is a thing.

DR. CROSSON: Pat and then Jon.

MS. WANG: On Slide 15, when you summarized, you know, the options, I understand in the second bullet why there's this notion, for urban OCEDs that are relatively isolated, Type A payment rates. I guess the thing that I get concerned about -- and we had talked a lot about the, you know, time and distance before, and that's a very tricky thing, that at the end of the day it's somewhat arbitrary. Whatever one says, people will figure out, okay, so I'll go 6 ½ miles outside. But you could set up some strange phenomenon. I mean, you could have an urban OCED that is actually 4 miles from the on-campus ED and is getting a Type B payment rate, and then another OCED that is located 6 ½ miles and is getting a Type A payment rate but they are, in fact.

Is there -- did you think about creating another layer of a look at proximity of urban OCEDs to each other? I guess that's really what I'm asking. Because, you know, like mushrooms -- I mean, it's -- I think, you know, the

freestanding EDs are very important to provide access and capacity where it's needed, but since there is no real kind of need assessment process that makes that determination, I guess what I worry is setting up a new set of incentives of where you get the maximum payment, and especially after the legislative provision that basically says, you know, you can set up these freestanding EDs, surround them with clinics, and if you call it urgent or emergent, you know, you're getting OPPS rates. And it's a little concerning.

DR. STENSLAND: It certainly is a possible extension if you said you have to also be a certain number of miles away from the nearest off-campus OCED.

DR. CROSSON: Jon.

DR. CHRISTIANSON: This is for Jeff, I guess. In the rural section of the chapter, the graph that you showed as the declining admissions for critical access hospitals, do you have data -- I mean, since we're talking about emergency visits, do you have data on what's happening to visits to emergency departments in these hospitals? Has that been declining as well? And -- go ahead.

DR. STENSLAND: We haven’t looked at that.

DR. CHRISTIANSON: Yeah. That would be important

to me, because you also suggested that the reason you see declining admissions is that a large percentage of folks just drive by the closest hospital and are admitted to some other hospital, some larger hospital, presumably. It would be interesting to know if they're driving by those hospitals for emergency visits as well, and if they are, if you eliminate the beds, the existing beds in the critical access hospitals, will that make them even more likely to drive by? And the reason that's important is if you were to set up one of these, how much would the fixed-cost payment for Medicare actually have to be, and how concerned are we if the number of visits to that freestanding emergency department is very small? I mean, it kind of raises the issue of quality, and with respect to the hospital admissions, do we have similar concerns? You know, if we're getting really, really small numbers of visits because people will continue to maybe be even more likely to pass, how much is Medicare willing to subsidize the cost per visit, essentially, through that fixed cost?

So it would be good to see some actual data on emergency department visits over time, since that's what we're dealing with here.

DR. CROSSON: Yeah, I think that would be important to look at. I don't think, here, that we are trying to, you know, stop non-viability, right? In other words, you know, escalate the facility fee year after year, you know, so that nobody in any community goes down. I mean, I don't think we could afford to do that.

Correct me if I'm wrong. My assumption is there would be some number set for the facility fee, and that would be kind of it, and the issue of viability of a facility would then be as it is now, based on their community and preferences in that community, and their services. Essentially they'd still be open to the market pressure. Is that right?

DR. STENSLAND: That's correct. In the past we've talked about a fixed amount of, say, $500,000, which would be about 10 percent of the annual operating cost of one of these places, and if your patient volume is so low that you can't make it on that, then you have to do something else. And one option there would just be to have like just an FQHC or some other clinic in town, because you don't have the volume even for an outpatient-only hospital.

DR. CROSSON: So we could potentially get some

sense of that if we could get what Jon is asking for, which is sort of comparative ER use. You know, it might be useful, on a prognostic basis.

DR. CHRISTIANSON: I mean, the issue is kind of how much is Medicare willing to pay for a standby emergency department capacity, and I think that number depends, in part, on how people in rural areas value that. And if they're driving by now, they may not value it as much as we think they do.

DR. CROSSON: Okay. So are we still on questions? Kathy. Sorry.

MS. BUTO: Round 1?

DR. CROSSON: Round 1. Kathy.

MS. BUTO: I probably missed it, but how different are these OECDs and standalone EDs from urgent care centers in terms of patient acuity? Are they very different, or is it really just that they have the capability to handle more emergency services if they need to, even if they aren't, or they may vary? I'm just curious about patient acuity.

MR. GAUMER: So we've looked a little bit at this. The studies from Texas and Colorado give us a sense

of it. The acuity of the patient in the standalone ED appears to be a little bit higher than the acuity of the patient in the urgent care center. And in the Texas study, what they had done is look at the diagnoses, the top 20 diagnoses of patients in each one of these settings. And what they found was that there was overlap across those two setting, and, as well, there was overlap with the hospital ED.

But there were, I think, four services, four diagnoses that showed up in the most common list for the urgent care centers that didn't show up as common to the standalones. These were things like flu, and viral infection, and things that you would regard as more simplistic, I think -- not that they aren't complicated, but less acuity.

And in another study, from Colorado, what they did was they looked at the top 10 non-life-threatening conditions in each of these settings, and they showed the same pattern, essentially, that the standalone EDs had -- a smaller number of their top 10 was in a non-life-threatening condition, and the urgent care were doing most of these non-life-threatening conditions.

I hope that answers a little bit of your question.

MS. BUTO: It does. Thanks.

DR. SAMITT: Maybe you can help clarify, because I just have a tag onto that. My understanding of the Colorado study is that in standard EDs nearly 3 out of 10 patients or visits were non-life-threatening, but in freestanding EDs nearly 7 of 10 patients were non-life-threatening.

MR. GAUMER: That's right.

DR. SAMITT: So certainly while it's more complex than urgent care, it's far less complex than a standard ED.

MR. GAUMER: That's right, and in both of these I think the message is that the standalone ED falls somewhere in the middle and it's unclear how close to the hospital ED and how close to the urgent care, but somewhere in between.

DR. CROSSON: Okay. Craig, did that cover you?

Further questions? Bruce.

MR. PYENSON: A question for Sydney and I think for Jeff. The first question is, if a hospital were to set up a, say a freestanding amb-surg center off campus, what's that differential in reimbursement, and does that depend on

how far away it is?

DR. STENSLAND: I don't know. We'll have to get back to you. I think the same rules would apply, because they can have an off-campus, outpatient surgery facility.

MR. PYENSON: A new one?

DR. STENSLAND: Yeah.

MR. PYENSON: Okay. And on the rural area issue, do you see potential interest by current FQHCs in deciding to set up a freestanding ER if we change the policy?

DR. STENSLAND: I don't think so, unless they're at a place where the hospital closes, because FQHCs actually get a pretty big grant, annually, to operate, and I'm guess they would probably continue just to operate as a clinic.

DR. CROSSON: Okay. Seeing no further questions we'll move on to the discussion. So what I'd like to do here, this is the first round with recommendations on the table, put the recommendations up. And so the tenor of the discussion would be I support the first recommendation and the second recommendation, or I don't, and why, and potentially a solution, if you have one. So we'll go on that basis. Remember, we're not taking a vote. This is

just to inform the production of the final recommendations.

And I see Brian and Jack and Paul.

DR. DeBUSK: Regarding the first recommendation, I think the solution, or the proposed solution for rural EDs, I think it's well thought out, I think it makes a lot of sense, and I really like the work that you've done there, so I would support very much the rural solution.

On the urban side, I'm not quite there yet, and I want to get there, but I'm not there yet, because, you know, I'm not sure about, for example, you know, to I think it was David's question, what is the appropriate cut. You know, I'd like to see us determine that a little bit more carefully. And then the appropriate definition, to Warner's question, about should we consider wait times, take wait times into consideration. Should we also take the quality ratings of the hospital? I mean, for example, should a lower-quality hospital be more vulnerable to an OCED being able to spring up next door, than, say, a higher-quality hospital?

The other thing I'd like to understand a little bit more is the industry reaction. You know, do we think that they will start exhibiting Type B behavior. You know,

and if we're shifting payments downward, could they simply exhibit Type B behavior -- say it would be hours of operations -- and then enjoy the benefit of an even further reduced cost structure? So I'm wondering if it has a Whack-A-Mole feel to it, I guess is what I'm saying there.

And then also to Paul's comment, this issue of micro-hospitals. You know, between Type B behavior and micro-hospitals, I'd like to understand, or at least anticipate the industry reaction there.

So again, I do appreciate what you're trying to do and I want to get there. I just think that there's enough uncertainty there that I hope we get a chance to study it further.

DR. CROSSON: Jack.

DR. HOADLEY: So like Brian I think the rural recommendation makes a lot of sense. I think we've been building towards that over quite a while now, and it feels like a well designed solution. I guess I fundamentally am okay with the urban recommendation. I think there are a lot more open questions about sort of what incentives. In some ways I'm not as worried about what Brian said, you know, if you pay them Type B rates and they sort of shift

to more of a Type B type setting, I'm not sure that's necessarily a problem. But I do think the micro-hospital, the other ways they could game the system, I'm not sure there's a set of rules we could come up with that -- I mean, whatever you do, people find a way to respond and game to it. That's kind of a given, not just in Medicare but lots of places.

But I think the principle we're working at here is right, and so I would be comfortable with -- and in terms of the two options, it's kind of a wash. I think, like Dave was saying earlier, the B somehow feels more logical if we want to just not worry about that anomaly in the rates or assume that will get addressed in some other way. Maybe even having more volume in it helps address that. So I guess if I had to make a pick I would pick Option 2 of the Type B rates.

DR. CROSSON: Thank you. Paul.

DR. GINSBURG: Yeah, I think the rural option is a very creative one and I'm very enthusiastic about it. I think before we do a final vote it would be good to just, as Jon suggested, look at the trends and use of EDs in rural hospitals.

I'm comfortable with the urban one as well. I think I'd go for Option 1, because given that there's something wrong with Type B rates, I don't think we want to just assume it will be fixed. I think I'd rather, you know, know exactly what we're doing.

DR. CROSSON: Craig, Cathy, David, Rita. Craig.

DR. SAMITT: So I'm comfortable with the recommendations as well, for rural, most certainly. I think that it offers an alternative to freestanding hospitals that may wish to make a shift to freestanding ED instead. There is one caveat that I'll come back to.

And then in terms of recommendation number 2, I actually would prefer Option 1, regarding the fixed reduction in rates. And I think it stems mostly from the appendix that you showed, that, you know, given the high percentage of these visits in freestanding EDs that are more urgent care-like than they are ED-like, it looked as if the 30 percent or so reduction would more align reimbursement to lower-level coded visits, which would be more urgent care in nature. So for me -- and again, you flashed it up there and then took it down, but I would guess that Option 1 would be preferable over Option 2 in

that regard.

And then, you know, the only concern about both of the policies is, you know, I think it's also an imperative for us to assure that emergency rooms are used truly for emergency purposes, and not urgent care purposes. And I wonder if there's more that we could do to incent the proliferation and creation of more urgent care-like facilities as opposed to freestanding EDs. And so whether it's fixed subsidies for FQHCs to add urgent care capabilities where there may be need, as opposed to hospital EDs or freestanding EDs, is there a methodology that we could create to incent more urgent care-like settings as opposed to ED-like settings, especially it could be in either urban or rural environments. It feels like that part of the discussion is missing.

DR. GINSBURG: [Off microphone.]

DR. CROSSON: On that point.

DR. GINSBURG: Yeah, I was wondering, does Medicare even recognize an urgent care center, or are they treated as physician offices?

DR. COOMBS: Physician offices.

DR. GINSBURG: Yeah. So I think I really support

what Craig said about presumably an urgent care center is open longer hours, the cost of that is something that Medicare might want to accommodate, given the overuse of ED services and its interest in having more urgent care services available.

DR. CROSSON: Okay. I have Kathy, David, Rita, and Pat.

MS. BUTO: Craig, was --

DR. CROSSON: Sue. Sorry.

MS. BUTO: -- went pretty much where I was going to go.

DR. CROSSON: Peripheral --

MS. BUTO: What was that?

DR. CROSSON: I'm mumbling.

MS. BUTO: Oh, okay. All right.

So I support, wholeheartedly, the first recommendation on rural EDs. I actually was saying to myself I wish we weren't so far along with Option 2, because I would really like to have had us look at building out urgent care, maybe in the way ASCs are built out, with a facility fee or something that recognizes the greater degree of cost and some adjustment for acuity, that kind of

thing, partly because of the issue that Craig raised, certainly, of there is a continuum here between these OCEDs and urgent care, but also because I think it promotes the direction we want to go in, which is more primary care resources and entities that can manage primary care services with more complex services, rather than going in the direction of sort of trying to stretch the outpatient hospital entity beyond the hospital's footprint.

So, you know, I can live with Option 2, in which case I would -- or Bullet 2, in which case I would prefer Option 1, which is an across-the-board reduction, really for the reason that Paul mentioned. But I really wish we could build out the urgent care option, because I think that may be a direction we would ultimately rather go in as a -- sort of in keeping with our general concern about primary care.

DR. CROSSON: David.

DR. GRABOWSKI: Thanks. I'm supportive of both of the Chairman's draft recommendations. Similar to Craig and Paul and Kathy, I'm supportive of Option 1. I like the idea of basing it around the Type B rate cuts but doing that in a fixed way in which you avoid the idiosyncrasies

we've been talking about with the levels, and also some of the issues that Brian was just raising around if you're going to pay me Type B rates, I'm going to be behave like a Type B. And so I think doing this in a fixed way avoids both of those issues, as Craig and Paul suggested.

So I'm supportive of both recommendations but Option 1 in number 2.

DR. CROSSON: Thank you, and let me just say to Pat and Sue, I apologize but, you know, the person who is number one here is sort of in the far reaches of my peripheral vision.

[Laughter.]

DR. CROSSON: Sometimes a rather dramatic gesture would be helpful.

Rita.

DR. REDBERG: Thank you. I also am in support of the Chairman's draft recommendations and of Option 1, and, quite honestly, I don't understand how you could be an emergency room and not be open 24 hours a day. To me, if you're an emergency department then you are open for emergencies, which happen 24 hours a day.

But I did also -- you know, we're talking about

emergency departments and Kathy alluded to this already, but I think on a spectrum -- and it really gets back to what we talked about many times before, is that primary care is underdeveloped and under threat because most of these urgent care and standalone visits are things that really should be dealt with in a primary care office. And I think if there was more capacity and better payment for primary care, we would see that.

And, honestly, you know, a lot of this flu and upper respiratory infection visits, it's not even clear you have to go to any doctor at all. You know, they could get triaged over the phone. What happens when you see a medical facility is you get overuse of antibiotics for viral illnesses, which is another topic. But I think that -- I'm not sure we want to encourage. To me, the urgent care is really a response to the threat of primary care under-supply, and that we should fix the problem, which is not having enough primary care doctors to take care of patients and not be trying to have these other sort of retail clinics, which are really just -- you know, they don't know you. I mean, you can't get the same care at that kind of facility that you can get with a doctor that

knows you and takes care of you and has known you for years.

DR. CROSSON: Good point, Rita, and as you well know this is a topic we keep coming back to, struggling with. We're not giving up.

Pat.

MS. WANG: I agree completely with Rita, and my concern -- so on the first part, for rural, I think it's great, so no issues there. But for everybody else, you know, I think that the issue is even more, for me, more urgent -- no pun intended -- than Rita's great statement just now about the importance of primary care and the lack of incentives. If anything, the system is going in a different direction, which is to create incentives to stand up things like freestanding emergency departments, if only because that's how you get OPPS rates for physician services that otherwise are paid under the physician fee schedule. That's a really big deal.

And I am -- I think it's unfortunate. I don't think that was the intention, but I think that we have to be aware of the fact that it's -- there's now a strong financial incentive if you are a hospital and you want to

set up, you know, physician services. You know, you've got to set up a freestanding ED too. Otherwise, you're just going to get the physician fee schedule, and that's just a really unfortunate outcome.

So basic principle, I don't think that we should create more incentives to stand up more freestanding EDs. So Option 1 type approach, whether it's 30 percent or something that's more empirically derived, is probably a good approach.

On the second bullet I had asked the question about this location thing. I don't really know what the answer is, but I would ask that we try to think of a policy that is streamlined enough to be capable of implementation, that would discourage these things popping up like mushrooms. There's a lot of urgent care capacity today. They can't compete with the OPPS wraparound here. And even the Type B rate, as described here, is higher than an urgent care rate.

I think it's really a problem. I mean, there are markets were urgent care centers are now shifting their focus to try to do more intensive work, so you're getting even more into the Type B service and there may actually be

capacity in the system to do that. Many urgent care centers are developing relationships with hospitals where hospitals will decant, you know, their lower-level, lower-intensity patients who can't be seen in a timely way, and send them to urgent care, and then they have even electronic data exchange back and forth to ensure follow-up.

So I would just be -- you always want to use the capacity that's there before you build new capacity, and, to me, with the exception of areas where, really, like in a rural area, you absolutely need to have ED capacity, the emergency department is the last place in the world that you really want to create as a provider type. That's my view. It's like the worst place. You know, I don't think that the goal is to make sure that anybody who wants to walk into an ED, because it's convenient for them, should have an ED at the corner. I don't think that's the goal of this.

So I just -- you know, I feel like a need to sort of like hold onto those reins really tight, because this thing is going to run down the highway really fast. And so, as I said, you know, for the first half of this, the

Option 1 sort of approach for what gets paid, fine, but the second part, which is what you even recognize as a Type B OCED I think needs to be tighter.

DR. CROSSON: Sue.

MS. THOMPSON: Well, thank you to all of you for this important chapter. In spirit, I'm quite supportive of the recommendations around rural. I do have anxiety when I think about what the fixed subsidy is going to take -- or what it's going to take in terms of a fixed subsidy in order to convince a critical access hospital or a rural hospital to make a decision to make this conversion, even knowing they can go back. I mean, that's a big deal. So I think the devil is in the detail of what that subsidy will need to be.

I think about -- and I did a little work here. In the 118 hospitals in Iowa, 82 of them are critical access. There's not a hospital in Iowa that is 35 miles from another emergency department. So while there are some critical access hospitals who I believe financially are struggling, none of them would be eligible for this opportunity. So I think in the detail of you must be 35 miles from another, there might be an opportunity to

rethink that, because -- on the other hand, there's many, many of these critical access hospitals who have done a fabulous job building out their outpatient surgery, outpatient programs, physicians, clinics, providing great access to many Medicare beneficiaries across the state. And Iowa certainly has been the recipient of a lot of the benefits around the country's feelings towards making sure we keep access in rural America. But I think it's in those details that I do get -- I think there's a little more work to be done.

DR. CROSSON: So, Sue, let me just ask a little bit about that. So if, in fact, this policy in Recommendation 1 would really not be applicable to the whole State of Iowa, I mean, that's a pretty important issue, right? So do you think that we should consider a smaller circle? Or, you know, to what degree -- if there's more than one entity providing -- most CAH entities providing emergency services, to what degree is the closure of any one a problem for the members, for the beneficiaries?

MS. THOMPSON: I'm not sure -- I've got to think about that a little bit. I'm not sure it's a problem to

the beneficiaries, but to the economy of a community, it's enormous. And that's where the push will come.

DR. CROSSON: Because of jobs?

MS. THOMPSON: Absolutely. This represents -- in most of these communities, these small hospitals are the largest employer.

DR. CROSSON: So does that then -- does that also suggest to you that irrespective of the distance criteria, that for those economic reasons that would be a disincentive for many of these communities to make this change?

MS. THOMPSON: Absolutely. Now, I think many of these hospitals would -- you know, their average daily census is less than five in many cases. So to give up the inpatient designation would need to be matched with something else that's viewed as attractive. And it can be in the ambulatory side of business in today's world. I think the role these access points can play in providing high-quality post-acute care services is extraordinary. But to think they're going to get out of inpatient care simply to take some sort of a stipend and nothing else, I have concerns. In spirit, I love the fact we're having

this conversation, but in the details and in the practicality, as the rule would read today, nobody would be eligible -- in the State of Iowa.

DR. CROSSON: In the State of Iowa.

MS. THOMPSON: In the State of Iowa.

DR. CROSSON: I don't remember the map. There was a map, right, in the materials, and it was mostly the Northern Plains and Texas, as I remember. Can you bring that back?

DR. STENSLAND: Yeah, it's kind of the West. Iowa's kind of -- anything west of Iowa, basically.

[Laughter.]

MS. THOMPSON: West of the Missouri River.

DR. CHRISTIANSON: Well, the problem with Iowa for comparison is that when they drew up the county system in Iowa, they basically put a grid and plopped it down on the State. They have many, many counties. Every county has a county seat, and every county seat has a hospital. And that's why you end up with never being more than 35 miles away from something else. It's just Iowa history.

Can I comment?

DR. CROSSON: Yeah, please.

DR. CHRISTIANSON: So I'm in favor of the second recommendation. I don't have a strong preference about which payment option to go.

On the first one, I agree with Sue. The devil is in the detail. One detail I'd be interested in seeing is that some of these hospitals that we think would be candidates, how much are they -- is the ED right now being used as an urgent care center? In other words, are people who are really needing emergency care being driven to some other emergency department? So I think if we found something about that, then we could sort of think about do we think it's a good policy for Medicare to support urgent care centers if that's what it's being used for. And why would we think that, given some support, it would all of a sudden become a more highly used emergency department? I would think it would become less highly used if you actually eliminated the inpatient beds in the county.

So, again, I think the devil is in the details. I'm with Sue. I think the idea is great. We need to think of some way to help support a sort of option value or capacity that's out there in case of true emergency care. But we are making some assumptions about how these EDs are

being used right now.

DR. CROSSON: Warner.

MR. THOMAS: So the first recommendation, I think in spirit I can support it. The phenomenon in Iowa, I'm not aware of. I mean, I think that obviously needs to be vetted or thought about or if there are other issues in other states or communities that that's going to be an issue, because I think we don't want to pass something that then is not going to be applicable to a lot of hospitals that probably need this type of option or this type of flexibility. So I just think that ought to be considered before we look at a final recommendation.

On the second recommendation, I agree with the concept that, you know, we don't want to have overutilization of EDs. I think this would be a much better recommendation if it was coupled with a suggestion that Craig made where we enhanced the economic situation for urgent cares and made them a more attractive option for folks. Obviously, we are dealing with lower-acuity patients in freestanding EDs, so I think it would just be a much better recommendation.

I also wonder about the -- it seems like the

reductions are somewhat arbitrary. It would be nice to have a little bit more support behind that. And this is still a relatively new phenomenon, and it's -- you know, I think there's -- I think there are some cities that you mentioned, or some areas where this is problematic. You know, I don't think that it's necessarily that way everywhere. And I do get concerned where you have some urban areas that you do not have access in EDs.

Now, I think Sydney's point that it was a study that -- I'm not aware of it, and it would be interesting to know more about that, if it really didn't have an impact on access. But yet lower-acuity patients are going to get put at the end of the line in a big ED where there is a lot of serious things going on. That's just the reality of what's going to happen. I think we just need to be mindful of that. But I do think, going back to Craig's point, if we thought about a more comprehensive approach and looked at urgent care here -- because we made a comparison to urgent care in the analysis, but yet we don't really do anything to perhaps expand or enhance the urgent care option, which I think would make this a much more attractive situation.

DR. CROSSON: Okay. Sue, you were coming back?

No. Jack.

DR. HOADLEY: I wanted to come back on the point that Sue started. As I understood it, part of the reason that we put this particular option together is that that hospital that's within 35 miles does still have the option of aligning with that next closer hospital and creating the ED, so that there is another path there. Now, whether that's as good or whether that's as desirable we could talk further about. But part of the point is the ones that were further than 35 don't have that option. Have I got that right?

I also would observe that -- I mean, Jon's comment about the counties, I remember in Kansas it was a similar situation, and Kansas looks like another state with none of these, that small counties -- presumably every county has the county seat and the hospital, and so there are some circumstances.

And the last comment -- and, Jeff, you'll remember that site visit we did in Montana many years ago, to sort of Jon's point about what goes on, what I remember -- and I might not remember it right -- was that, you know, this very small hospital in Montana, the emergency room

ended up being used for traffic accidents, farm accidents and things, even if the patient ended up then getting taken down the bigger city, it was serving that function as the closest point for something that had that kind of urgency. And so that's part of that sort true ED function going on. I don't know if there's anything that would go beyond that one anecdote on a point like that.

DR. STENSLAND: On our site visits we did talk to some systems that had rural and urban, rural hospitals, rural freestanding EDs, urban freestanding EDs, and the general take there was the severity level at their rural critical access hospital and the rural OCEDs was a little higher than the urban OCEDs just because the driving past wasn't as easy. So at least if you're doing nothing else, you're going there to stabilize your heart attacks or whatever.

DR. CROSSON: Okay. This has been very helpful. He says.

[Laughter.]

DR. CROSSON: Here's what I think. I think we have a plurality of support for the recommendations and particularly for Option 1. But we've had a number of

requests for more information, some of which I think is possible to do within the time frame that we have. But the notion that Jon brought up about trying to us, you know, what's really going on in terms of people driving by entities, in terms of not just for hospitalization but for emergency room use, if that's possible, that would be very useful.

Sue brought up the question of the size of the subsidy. I think we have a ballpark figure, but maybe a little discussion about what we think about that number, you know, and the best you could do to say to what degree -- you know, and if you added on some of the other possibilities, the notion that some hospitals within the 35 miles could create a business plan to work with another hospital. And then, Sue, you brought up the other issue which we've talked about before, and that would be creation of post-acute care capabilities in those beds. And this all related to the job issue, to the extent that we can discuss that.

Now, the other two pieces I think which are critical also is the issue Craig started and others talked about, which is, you know, don't we have a more compelling

reason to think about the incentives that exist or don't exist for the creation of urgent care centers staffed by primary care physicians? I absolutely think that that's a piece of work that we need to do. It can't get done between now and the writing of the next paper in a couple of weeks. And the same thing, I think, Paul, with respect to micro hospitals, particularly if we think that this recommendation is going to goose that process along. We need to get on that issue relatively soon and not wait two or three years for this to become an extant problem, you know, that it has to be reversed. Again, I don't think we can do that work in the next two weeks either.

So I think what we're going to do is I'm going to recommend that we come back with Recommendation 1 and 2 with the Option 1, which seems to have most of the support, with the proviso that we get as much of the additional information together for you as we can in the time that we have; and, number two, that we make a commitment to working on the issue of urgent care centers and micro hospitals and fit those into our ongoing work stream.

Warner?

MR. THOMAS: I guess the only question I have, I

mean, would it be that difficult to expand the second recommendation to include something around urgent care. It wouldn't seem to me like that would be too difficult to enhance that a little bit, and I think it would make it a more palatable option. So I just put that out there for consideration.

DR. CROSSON: So let me -- expand on that a little bit.

MR. THOMAS: Well, I think it's what we talked about, what we were talking about earlier, you know, can we have a -- the whole idea that we -- why don't we see more of a proliferation of urgent care centers, at least see some? But I think we may actually see more freestanding EDs get converted to urgent care if that was a slightly more attractive option. And I think we ought to think about that. I know we've done it in certain cases. I think there are some places that have looked at that. But I just think that's something that could be considered as a way to mitigate this as well, because the differential is then, you know, much, much smaller.

DR. CROSSON: I don't disagree with you at all. Part of this is just a work flow process. You know, we

have one more meeting left this year. We're coming into the second stage of the recommendation process. So while I completely agree with you, I think normally what we would do is we'd come forward to you with an analysis of the issue. How many urgent care centers are there? What's the dynamic around urgent care center creation or dissolution? What would we have to do to encourage that? What kind of financial options would there be? How would it fit in the complex of payments that we already have? We certainly could not do that and then, you know, come back with a recommendation or just insert a recommendation unless we've gone through the normal analytic process that we have, unless I'm thinking this is more complicated than it is. But I think that the thoroughness with which we normally do things here might be a problem.

Kathy?

MS. BUTO: I agree with you, Jay. I think it's a whole topic. But I think what would be very useful -- so there were two thoughts I had. One was: Do we have to make a recommendation on urban EDs right now? That's one question. If the answer to that is, well, not necessarily, but we feel like we've made some progress and we ought to

do something, we could certainly go to the second option, but make it clear that this issue both of micro hospitals and building out of urgent care facilities are that option as a provider type, both of those -- those two are related. The micro hospital issue is greater if there's a big urban ED option out there that providers get to choose. I think urgent care is always going to lose in that calculation.

So I guess what I'm thinking is, is there some way either not to finalize the urban OECD option or if we do finalize what we've put forward so far, what the staff has developed, can we make it clear that we're looking at this other area? Because I do feel like it's going to ultimately be a choice. I don't think you can have both in the same urban area -- but, Pat, I think you know more about this issue of the mushrooms growing. If you give the emergency department option, that's the one that pays more, period. You know, full stop.

DR. CROSSON: Paul, Pat, and then Jack.

DR. GINSBURG: I like Kathy's idea of that announcing that we're going to be working on micro hospitals and urgent care, because to the degree that our urban ED recommendation should be accepted, just putting

information out there for investors of what MedPAC is getting to next year -- and you might want to be cautious about rushing in from some incentive that was just created.

DR. CROSSON: Pat.

MS. WANG: I think that it's a really good avenue, as Kathy suggested. I would ask in thinking about urgent care and kind of enhancing that, in order for it to be a better option for, let's say, a hospital, that OPPS wrap-around is a really big deal. I think that's very hard to compete with. And so I guess in that assessment, the question would be: Even if you had an urgent care rate from Medicare that was more generous -- and, by the way, at least from what I've seen, the lack of a Medicare rate has not stopped the unbelievable growth in investment and proliferation of urgent care centers. So this is one of those "don't fix it if it ain't broke" situations. If the intent is to try to come up with an economically attractive option to hospitals that might be affiliating with these independent emergency departments or setting up their own, I really think that the OPPS factor has to be baked in. You set up clinics, ancillary, even 340B pricing now extends -- even though it's been cut, it's a big pulling

along of reimbursement structure from the hospital campus that is difficult to compete with if you're a freestanding anything.

DR. CROSSON: So, Pat, I think that's a good example of the kind of information that we'd need to analyze and bring forward. If we're going to come forward with a robust recommendation about incenting urgent care centers, we'd need to understand those types of financial relationships. So, no, I -- and I'm sorry, I missed somebody. Jack? So I would amend what I said earlier, which is to say let's commit to put the micro hospital issue and the urgent care issue on our work agenda. We will do that. But also that in the final write-up and in the information we present to you before the vote in April, we'll do the best we can to indicate in what we write, and also in the presentation in April, that we're undertaking those considerations.

Jack?

DR. HOADLEY: Yeah, I'm supportive of where we're just going. I mean, I think it is premature to try to add it in as a recommendation, but we do need that additional analysis. But I think this notion of sort of flagging

these issues -- but also it's part of -- it seems like it's a natural part, we can say more of, in the implications of our recommendations or the rationale or wherever -- you know, whoever, in the text around the recommendation that we want to make sure this does not have these adverse consequences, and so we flag that, and, therefore, we're looking at these things -- or however we want to say it.

It might also be a good place to reflag our site of service recommendation, which obviously relate, and I don't know if it's explicitly -- I mean, I think it's at least referenced in here, but maybe this is a place to much more directly even reprint those recommendations, because it is part of that broader set of issues that this is about. I'll leave it to you to figure out the right way, but it seems like giving a little more attention to that in this context, acknowledging what's been done by now by the Congress, but, you know, what still sits on our recommendation --

DR. CROSSON: Yeah, because it does tie in.

DR. HOADLEY: Right.

DR. CROSSON: No question. Okay. That's what we'll do. Thank you very much.

[Laughter.]

[Pause.]

DR. CROSSON: Okay. Moving right along, Eric is here, and it looks like Carlos is riding shotgun on this presentation, which is a discussion of the status of the updates -- I'm sorry, an update on the status of the demonstrations for duals. Eric?

* MR. ROLLINS: Thank you. And I had to hold a shotgun to Carlos' head to get him to sit up here with me.

[Laughter.]

MR. ROLLINS: I'm here today to provide an update on the financial alignment demonstration for dual-eligible beneficiaries. The last time we presented on this topic was in April 2016, so it has been about 2 years since our last update. Today's presentation includes findings from site visits that we've made during that time to a number of participating states, and I'd like to thank Andy Johnson and Carlos Zarabozo for their help. We'll follow this session with another presentation at the April meeting that takes a broader look at using managed care to integrate Medicare and Medicaid for dual eligibles. The material from these two presentations will then appear as a chapter

in the Commission's June 2018 report.

I'll begin with some background. There are about 10.5 million individuals who qualify for both Medicare and Medicaid and are known as dual eligibles. Most dual eligibles -- about 7.5 million -- are eligible for the full range of Medicaid benefits covered in their state, and they're the focus of the demonstration. For this group, Medicaid covers long-term services and supports, wrap-around services, and Medicare premiums and cost sharing. The other 3 million dual eligibles only receive assistance with Medicare premiums and cost sharing and cannot participate in the demonstration.

Dual eligibles are generally in poorer health than other Medicare beneficiaries, and they account for a disproportionate share of spending in both programs. They are also vulnerable to receiving fragmented care because Medicare and Medicaid have relatively little incentive to coordinate care across the two programs. The demonstration aims to improve the quality of care and reduce spending for dual eligibles by better aligning Medicare and Medicaid.

Efforts to improve care and reduce costs for dual eligibles face a number of obstacles.

First, the dually eligible population is diverse and particular subgroups can have very different care needs. For example, there are dual eligibles in their 40s who live in the community with behavioral health conditions and dual eligibles in their 90s who live in nursing homes and have dementia.

Second, Medicare and Medicaid are both complex programs with separate benefits, payment rules, and administrative processes that have evolved over many years. There are simply many areas where the two programs can differ.

Third, the two programs can have conflicting financial incentives. In particular, states have the ability under Medicaid to provide greater care coordination to dual eligibles, but their incentives to do so are limited because they do not benefit financially from any Medicare savings that might result. For example, a state initiative that reduced readmission rates for dual eligibles would reduce Medicare spending since that program is the primary payer for inpatient care, but could potentially increase Medicaid spending due to the costs of providing the care coordination and higher spending in

nursing homes.

Policymakers have taken a variety of steps over the years to better integrate the two programs, such as the development of the Program of All-Inclusive Care for the Elderly and the creation of Medicare Advantage special needs plans. The financial alignment demonstration is one of the latest and most ambitious efforts to address this difficult issue.

Under the demonstration, CMS is working with states to test two new models of care for dual eligibles. The first is a capitated model that uses health plans to provide both Medicare and Medicaid benefits. The second is a managed fee-for-service model where states provide additional care coordination through Medicaid to dual eligibles who have fee-for-service coverage in both programs. A key element in both models is that states can benefit financially if a demonstration reduces Medicare spending. Our update today focuses primarily on the capitated model, which most of the states in the demonstration are testing, but we will touch briefly on the managed fee-for-service model as well.

There are a total of 14 demonstrations in 13

states under this initiative. As you can see, most of the participating states are testing the capitated model. Only two states, Colorado and Washington, have been testing the managed fee-for-service model, while another state, Minnesota, is testing an alternate model that integrates some administrative functions for Medicare Advantage special needs plans that serve dual eligibles. CMS is conducting the demonstrations using its CMMI authority, and they were originally going to last for 3 years. However, most have been extended by 2 years because the evaluations of the demonstrations are taking longer to complete than expected, and CMS does not have enough information yet to decide if they should become a permanent part of Medicare. CMS may provide additional extensions in the future. Colorado and Virginia turned down the two-year extension and ended their demonstrations last year. About 440,000 dual eligibles are enrolled in the demonstrations that are still active.

Over the next several slides, I'll touch on different elements of the capitated model, starting with the payment methodology for its health plans, which are known as Medicare-Medicaid Plans, or MMPs. MMPs receives

three separate capitation payments: one for Parts A and B, one for Part D, and one for Medicaid. These rates are set administratively by CMS and the state. MMPs do not submit bids like MA and Part D plans. The payment rates for Parts A and B and for Medicaid are reduced to reflect the savings that MMPs are expected to generate. The expected savings vary by state but are typically around 1 percent in the first year, 2 percent in the second year, and 3 to 5 percent in later years. On our initial site visits, some plans expressed concerns about the adequacy of the Part A and B rates. However, CMS increased those rates in 2016 by somewhere between 5 and 10 percent, and MMP payment rates now appear adequate based on the interviews that we have conducted with MMPs since the increase took effect.

The payment methodology for MMPs also has a feature known as a quality withhold. Under the withhold, CMS and the state deduct a certain amount from the payment rates for Parts A and B and for Medicaid that is later paid to plans if they perform well on certain quality measures. The amount of the withhold in most states is 1 percent in the first year, 2 percent in the second year, and 3 percent in later years. The withhold differs from the MA quality

bonus program in several respects: It is structured as a penalty rather than a bonus, it is smaller in magnitude (1 to 3 percent for MMPs versus 5 percent for MA plans), and plans can satisfy many measures based on improved performance. Finally, MMPs can receive part of the quality withhold if they perform well on only some measures, while the MA quality bonus is an all-or-nothing proposition.

Turning now to enrollment, states can passively enroll dual eligibles in MMPs, and every state has done this for at least some beneficiaries. However, enrollment has been lower than expected because many beneficiaries have chosen not to participate, either by opting out before passive enrollment takes effect or disenrolling from their MMP, often after a relatively short time.

One question about the demonstration has been whether the dual eligibles in MMPs differ in some way from the dual eligibles who opted out or disenrolled. Using enrollment transaction data, we found evidence of favorable selection for the MMPs, meaning that healthier beneficiaries have been more likely to enroll. We found that the beneficiaries who opted out had higher risk scores than those who enrolled, and that beneficiaries who quickly

disenrolled from MMPs had higher risk scores than those who were enrolled for longer periods. We also found that about 40 percent of the beneficiaries that states tried to passively enroll opted out, and that beneficiaries were more likely to opt out if they were over 65, female, or of Asian ancestry.

Overall, about 29 percent of eligible beneficiaries are currently enrolled in an MMP. The other 71 percent are a mix of beneficiaries who opted out, disenrolled, or were not part of passive enrollment and have not enrolled voluntarily. Participation rates vary widely across states, from 68 percent in Ohio to 3 percent in New York. Despite the lower-than-expected participation, overall MMP enrollment has been relatively stable since mid-2015 and now stands at about 380,000.

Looking now at plan participation, most MMPs are sponsored by companies that had prior experience with Medicare Advantage, Medicaid managed care, or both. There are currently 50 MMPs in the demonstration. The number of plans in each state varies, but most states have somewhere between two and seven plans. Another 18 MMPs have left the demonstration for a variety of reasons. Most of these

departures have been in New York, where beneficiary participation has been very low and many plans had very low enrollment.

Enrollment in the remaining MMPs varies widely, from fewer than 100 enrollees to more than 25,000. On some of our site visits, we asked MMPs if there is a minimum level of enrollment that they need to operate effectively. Some plans did not provide a figure, but those that did typically said that an MMP ideally needs at least 5,000 to 7,500 enrollees. Aside from the remaining plans in New York, most MMPs appear to have enough enrollment to adequately test the capitated model.

CMS is conducting a comprehensive evaluation of the demonstration that examines areas such as service use, quality, and cost. CMS plans to issue annual reports for each demonstration, but these are taking much longer to complete than anticipated because it has been difficult to obtain all of the Medicare and Medicaid data needed for the quantitative analyses. So far, CMS has only issued reports for the first year of three demonstrations, plus some qualitative reports on issues such as care coordination.

Although more evaluations will eventually be

completed, we think that the reports for the first year of each demonstration, and perhaps the second year as well, may provide little insight into the effects of the capitated model. In the states we have visited, there was broad agreement that the demonstrations were difficult to implement, and some MMPs said it took 18 to 24 months before they began to see changes in patterns of service use for their enrollees.

One of the central features of the capitated model is care coordination. The requirements for care coordination vary somewhat across states, but they all have three key elements: the completion of an initial health risk assessment shortly after enrolling, the development of individual care plans using interdisciplinary teams of providers, and ongoing help from care coordinators. Many plans initially had difficulty finishing these assessments on time, but completion rates have been rising. However, plans have also been unable to locate some enrollees because their contact information is out of date.

There is currently no data available on service use by MMP enrollees. However, the plans that we have interviewed on our site visits have grown more confident

about their ability to reduce the use of high-cost services as the demonstration has matured. Many plans have said that they are seeing reductions in inpatient and ED use, and a smaller number of plans have said that they are seeing some reductions in nursing home use.

With respect to quality, MMPs are required to submit much of the same quality data as MA and Part D plans. We analyzed two types of quality data for MMPs: the CAHPS survey, which looks at patient experience, and HEDIS, which measures clinical quality. We found that MMP performance on measures of patient experience either improved or remained stable between 2015 and 2017, with the share of enrollees giving their plan the highest rating rising from 51 percent to 63 percent. For clinical quality, we compared HEDIS data for MMP enrollees and for dual eligibles in MA plans and found mixed results. MA plans performed better on a third of the measures while MMPs performed better on 20 to 25 percent of the measures. The two types of plans performed similarly on the remaining measures. MA plans tended to perform better on measures that are used in the MA quality bonus program but not the MMP quality withhold, and vice versa. We also found that

MMP performance on HEDIS improved somewhat between 2015 and 2016.

I'd now like to touch briefly on the two managed fee-for-service demonstrations in Colorado and Washington. Under this model, the state assigns dual eligibles who have fee-for-service coverage in both programs to a Medicaid-funded entity that provides care coordination. Beneficiaries are not required to receive care coordination, and they remain enrolled in fee-for-service regardless.

CMS has estimated that the Washington demonstration reduced Medicare spending by $67 million during its first 2.5 years of operation, and the state will receive part of those savings as an incentive payment. That savings figure is based on an estimate of what Medicare would have otherwise spent on the roughly 20,000 dual eligibles enrolled in the demonstration. However, we believe that savings of that magnitude are too high given the relatively small number of dual eligibles (about 3,000) who actually received care coordination during this period of time. Saving a total of $67 million on 3,000 beneficiaries works out to savings of about $22,000 per

person, or roughly $9,000 per year when you spread those savings over a 2.5-year period. In contrast, CMS found that the Colorado demonstration increased Medicare spending.

That brings us to our last slide. The limited data that is available suggests that most of the demonstrations are now going reasonably well after a challenging start, but we plan to conduct more work in this area.

First, we plan to analyze MMP encounter data to see if it supports the claims that we have heard from plans about their success in reducing the use of high-cost services such as inpatient care and emergency department visits.

Second, we plan to continue our periodic site visits to the states because they have given us valuable insights into the demonstration's progress and challenges. We will also assess the CMS evaluations of the demonstration as they become available.

I'd like to close with two potential topics for discussion.

First, we'd like to know if there are other

issues related to the demonstration where you would like more information, including particular topics that you would like us to focus on in our future site visits.

Second, this relates to the MA program more than the demonstration, but this could be a good opportunity to discuss future work on the MA quality bonus program. When Scott, Carlos, and Andy gave their status report on the MA program at our December and January meetings, there was significant interest among the Commissioners in revisiting the structure of the quality bonus program. The MMP quality withhold differs from the MA quality bonus program in numerous ways and provides a useful straw man to identify particular issues that you would like us to focus on in our future work.

That concludes my presentation. I will now be happy to take your questions.

DR. CROSSON: Thank you, Eric.

Round 1 questions? David.

DR. GRABOWSKI: Great. Thanks, Eric, for really a nice presentation and a great chapter.

Has CMS given you any indication of when these results are forthcoming? It seems like a huge delay. I

realize there are data issues, but it's been years and years of programs that have ended already. What's going on there? And then I have a follow-up question.

MR. ROLLINS: So my latest sense -- and I think to some extent, you know, nothing is set in stone because these data issues I think have not been totally worked out yet. But I would expect sometime this year we would start to see some of the Round 1 evaluations for some of the -- so right now we just have Massachusetts, which was the first capitated model to start. The next ones that we would expect to see would be the year one reports for the demonstrations that started in 2014, so California, Ohio, Illinois, Virginia, and then probably a year two report for the Massachusetts demonstration would be sort of the next ones I would expect to see emerge.

DR. GRABOWSKI: And the second question, you mentioned in the chapter that the -- you didn't talk today about the managed fee-for-service results, but the initial reports that were released by CMS suggested really big savings estimates, too big to be believable, as I think you suggest in the chapter. Is there any reason to think that the next round of results are going to correct some of the

problems from the earlier evaluation of the managed fee-for-service programs? Or are we sort of stuck with the architecture here around these evaluations?

MR. ROLLINS: They used the same approach to analyze both the Washington and Colorado demonstrations, and I'm not aware of any plans that sort of change that methodology.

DR. CROSSON: David Nerenz, Kathy, Craig.

DR. NERENZ: Thanks. One of the themes that you've highlighted here is this sort of low enrollment. Particularly in New York, you mentioned there's a high opt-out rate, and then in a couple places in the chapter, you mentioned providers encouraging people to opt out. I'm curious on that last point. It seems to me there's two distinct classes of providers involved here, one on the Medicare side, one on the Medicaid side. You've got sort of doctors and nurses on one side, but then you've got sort of community support folks and other kinds of things.

Is there any evidence or do you know anything from site visits or data about which side of this has the greater provider resistance? Or is it perhaps equally both? Do we know anything at all about that?

MR. ROLLINS: I think it has varied by state. But I agree with you that we have seen evidence that sometimes it's the Medicare providers leading the push out of the demonstration, sometimes it's the Medicaid providers. Some of the states we have visited, as sort of in tandem with their demonstration, have moved to mandatory enrollment in managed care for the Medicaid benefits that dual eligibles receive. And one thing that was noticeable in those states, you don't get the opposition from the Medicaid providers that you do get in states where Medicaid fee-for-service is still an option, because even if they get beneficiaries to disenroll from the demonstration, they're still going to have to go into a managed care plan for their Medicaid benefits; whereas, in a state where Medicaid fee-for-service was still an option, you did hear stories of nursing homes calling up, "Can I disenroll 75 of my people with one phone call?"

DR. NERENZ: So in those states with Medicaid managed care, I'm used to thinking about that still on the medical care side as opposed to, say -- I don't know what acronym to use -- community services with the long-term support -- so in those states you gave, are those support

services included in the Medicaid managed care as exists in those states?

MR. ROLLINS: Yes, and this is something we'll talk about next month, but there's sort of a broad shift underway in a lot of states to take sort of the long-term care services, both nursing home and community-based, and put them into a managed care setting.

DR. CROSSON: Kathy.

MS. BUTO: Eric, thanks a lot for the chapter. I wondered if we have any data on -- I'm sure we do -- the number of beneficiaries and their characteristics as well as the payment rates and any differences in coverage among the MMP capitated population versus SNPs versus regular MA. Are they all getting the same coverage essentially? I know it differs in Medicaid by state, but regardless, if you're in a given state, whether you're in a SNP or an MMA or in regular MA, are you getting the same thing? And in terms of beneficiary characteristics, are we seeing a difference, say, for the under-65 disabled versus, say, residents of nursing homes?

MR. ROLLINS: So on your first question, in terms of the benefits, no matter what option you're in, of

course, you're getting the standard Part A and B benefit package, and you're getting Part D coverage, so that hasn't changed. There can be variation in terms of the additional benefits that might be offered by, for example, a D-SNP on the one hand versus an MMP on the other. And this is, again, an issue we'll get into a little bit more next month, but in some cases, the D-SNP gets paid more than an MMP and can offer richer extra benefits.

On your second question, have we compared sort of the beneficiaries that are in one type of plan versus another, we have not done that to date, but I agree that would be a worthwhile avenue to pursue.

MS. BUTO: Are you seeing the under-65 disabled who participate in any of these options more concentrated in one versus the other? Are you seeing anything like that in the distribution of --

MR. ROLLINS: It really varies by state. For example, to take an extreme case, in Massachusetts they didn't have sort of the managed care option for the under-65 disabled duals prior to the demonstration, so the demonstration is kind of it for them; whereas, you had states like California and Texas that had a lot of D-SNP

enrollment prior to the demonstration, and they still have a lot of enrollment in those plans now.

DR. CROSSON: Do you want to [off microphone], Craig?

DR. SAMITT: No [off microphone].

DR. CROSSON: Okay. Asked and answered. Rita, and then Jon.

DR. REDBERG: Thanks for an excellent chapter. I just had a very small point on actually the mailing materials on page 37 where we're talking about how we have outcomes measures for the MMPs, and one was medication in here, and I think it's a CMS measure, but I would just like to note it should be appropriate medication here or medication review and make sure that meds were appropriate. It's not always [off microphone].

DR. CROSSON: Jon.

DR. CHRISTIANSON: Just a quick question. Just remind me from the chapter, was the data availability problem primarily state Medicaid data?

MR. ROLLINS: There are a couple of problems, as I understand it. So the design of the evaluation is very comprehensive to look at both, what's going on on the

Medicare side of the equation for the duals and what's going on on the Medicaid side, so that's sort of issue number one, is you need data from both programs.

The second issue is what is your comparison group going to be, and prior to the demonstration, there was this widespread expectation that pretty much everybody who's going to be put in the demo is going to stay there, and so they didn't think they could get a comparison group from within the state. So in a lot of cases, their comparison of dual eligibles is sort of this matched population in sort of non-demonstration states. And so there's sort of two issues that have emerged with that. One is they need the Medicaid sort of claims and encounter data for that comparison group in the other states, but since they're not involved in the demonstration, there's a limit to how much sort of sway CMS has with them to get their data in in a timely fashion. That's problem number one.

The second problem is, as we understand it, it has been a challenge for the MMPs themselves to submit clean, usable Medicare and Medicaid encounter data.

DR. CROSSON: Pat, Paul, Alice.

MS. WANG: Notwithstanding that there have been

data issues to do a full sort of, I guess, economic analysis of the demos, are there any early findings or early indications around administrative wins from the demos? CMS did have to modify rules for enrollment. There is an existing FIDESNP program in Medicare Advantage that is administratively very difficult to manage. So I'm wondering, number one, you know, that the demos did succeed in kind of establishing some best practices around administering an integrated product. And then I have another question.

MR. ROLLINS: That's an issue that we have discussed with some of the plans we've interviewed, particularly plans that are offering both an MMP on the one hand and some sort of MA product, a D-SNP, on the other. And they have said that some of the administrative aspects of the demonstration are sort of one of the good things about it. The integrated enrollment process is one thing they point to. Right now you have separate enrollment processes for Medicare and Medicaid, and depending on the cycle in each state in terms of when eligibility files are prepared and sent to the plans, reconciling the two is very tricky. And so they've had to work out a standard process

for the demonstration, which seems to -- the plans have reported there's a plus. Also the demonstration plans have a lot more flexibility to no longer have to send you a Medicare provider directory and then a separate Medicaid provider directory. They can just come up with a combined product and just send you one, and that has been another thing that we've heard from a number of plans. It's been a feature that they think is good about the demonstration.

MS. WANG: The other question I have is whether similarly there are any lessons learned or best practices about the way that passive enrollment was conducted, and any observations about, you know, the lowest opt-out rates, like what did that look like? And the specific questions that I would have are: Was there any correlation to existing MAPD penetration in the area? Did that have any impact on people's decision to, you know, be enrolled into a plan and say, "Oh, I've never been in a plan before, this seems like okay," as opposed to maybe removed from a plan that they had voluntarily enrolled in and put into another plan they weren't familiar with, opt-out rate higher? Similarly, the passive enrollment algorithm in New York where the long-term care piece is a mandatory Medicaid

program, the state chose to use that as the driver for which MMP somebody would be passively enrolled in, which created a lot of friction with the physician community. So any observations there?

MR. ROLLINS: So a lot of it is very sort of state-specific. I'm trying to think where to begin on that topic. One of the things you were talking about was sort of the algorithm that was used to assign dual eligibles to a particular plan, and, yes, that was an issue in New York, they decided that your Medicaid plan trumped whatever your Medicare arrangement was, which caused problems for people losing access to their acute-care providers.

That being said, we also interviewed states where they had done it the other way, and the thing that really was the most important thing that determined which plan you got put in was your primary care provider, things like that. And we would hear, you know, for some beneficiaries, my primary care provider is not the most important, it might be my personal care attendant for my Medicaid services, or it might be a behavioral health counselor or something like that. So states have tried different things. I think neither approach has really worked

perfectly.

In terms of sort of how it's going generally, there has been -- you know, I don't have a great reason for it, but just the level of provider resistance does seem to vary a lot from state to state. As you know, in New York, a lot of it was driven by a care model that was deemed to be kind of unworkable. In California, there's a subset of providers out there who make their living off of fee-for-service dual eligibles and just are very reluctant to sort of having anything to do with managed care.

DR. CROSSON: Paul.

DR. GINSBURG: Yeah. Certainly the opt-out rate has been discouraging in this program, and I was wondering -- I would think provider payment rates must be, specifically physician payment rates must be -- so if a state has much lower Medicaid physician payment rates than Medicare, what rates do the physicians get as part of this demonstration?

MR. ROLLINS: You will not be surprised that my answer is, it varies. There are some plans teams say it's closer to using their Medicaid provider network and the rates were a little closer to Medicaid, but we have also

talked to plans where they do pay the Medicaid rate or close to it.

DR. GINSBURG: Is it up to the states, or up to the plans?

MR. ROLLINS: It's largely up to the plan. Some states can dictate it as part of the demonstration if they want to, but by and large it's a plan decision.

DR. GINSBURG: So, I mean, given that in California the Medicaid rates, which I think rank 49th lowest in the country, it would be hard to believe that if the physicians are getting Medicaid or close to Medicaid rates, that they would be urging their patients not to become involved. You're talking about these are physicians who are just out of every network.

MR. ROLLINS: The ones in California?

DR. GINSBURG: Yeah.

MR. ROLLINS: They call them Medi-Medis out there, the people who have Medicare and Medical, fee for service, and from what we understand that's by and large the only -- that's their practice, that they focus on that sliver of the patient population almost exclusively.

And just to be clear, I didn't mean to imply that

California was necessarily one of the states that's paying close to Medicare rates. I am not certain. We didn't get that impression.

DR. CROSSON: Oh, okay. All right.

MR. ROLLINS: In some other states it may have been closer to the reality.

DR. CROSSON: Alice.

DR. COOMBS: So, Eric, on page 31, the table has the results of the CAHPS survey, and I'm trying to understand, we do an analysis of timely visits, timely appointments. These are -- the results of this is kind of poor, and I was wondering how to reconcile this with what we see normally for the physicians, the update that we look at surveys by patients, and it would indicate that this is not reflected here. And I'm just wondering how you reconcile this with what we see in December, when we look at physician updates for fee for service.

MR. ROLLINS: Well, I can't speak too knowledgeably about the survey we use -- that we feel for looking a physician issues.

One issue that we do sort of mention in the paper is we have these CAHPS results for the MMPs, which is a

very specific population, the full-benefit dual eligible, and the data that we have available for CAHPS surveys for fee for service or for MA enrollees generally have much higher ratings for things like satisfaction with your plan --

DR. COOMBS: Right. Right.

MR. ROLLINS: -- and things like that. It's a little unclear how comparable the two are, because the full duals and the fee for service and MA sectors are a much smaller slice of the overall population, 10 to 20 percent, roughly. So it's a little unclear how much you can compare the two.

DR. COOMBS: But for patient experience, both on Table 7 as well as on the next page, for measures and HEDIS performance, and even in the MA plans it would suggest that it's not comparable in terms of either patient experience or quality within the demonstration thus far.

MR. ROLLINS: Well, again, for patient experience, I'm not sure that we have a perfect counterpoint from MA, because the data that's out there is for the entire MA population and not for the full duals. So to the extent if you could imagine perhaps full duals

and MA, potentially have lower responses on CAHPS than other beneficiaries, and you don't pick that up in the overall data that's available.

DR. COOMBS: And for Massachusetts demonstration, they used specifically a disabled population. Have we learned anything from that?

MR. ROLLINS: I think the plans would -- so the plans that are in the demonstration, I had prior experience in senior care options, which is the state's integrated program for the over-65 duals. And it was interesting talking to stakeholders there. I think they had it figured that since they had a lot of prior experience with that population that they'd be able to manage the disabled ones without, you know -- it would be something they could get their arms around, and they found it to be very challenging. And it was a couple of years before they felt that they had sort of found their footing in terms of how to care for the disabled population. Their service use was very different. Their population -- I mean the mix of providers they used was very different.

DR. COOMBS: And Massachusetts was one of the earliest, as a part of this demonstration.

MR. ROLLINS: They were the first.

DR. COOMBS: So we don't have data to anything -- there's nothing that's compelling in any of the information that we've gotten overall.

MR. ROLLINS: Compelling in the sense of --

DR. COOMBS: Lessons learned. How can we apply this going forward to the --

MR. ROLLINS: Well, I think the general lesson that we got from Massachusetts, and I think from a lot of the other states as well, is these programs are difficult to establish and they need time to mature. But if you -- you know, if you invest the time and stick with it, you can, generally speaking, develop these programs, but your time horizon for sort of when they're going to mature, when you're going to start seeing results, is probably, I think, longer than folks would like.

DR. COOMBS: So you would say, too, that there's a possibility that the physician providers may have certain stresses within working within the context of these programs as well.

MR. ROLLINS: It's possible.

DR. CROSSON: Jack.

DR. HOADLEY: So a question on the payment methodology. You said that the -- or the chapter says that the Part D payment is paid based on a national average bid for all Part D plans. So there's no geographic adjustment in that particular bidding?

MR. ROLLINS: As far as I understand, no.

DR. HOADLEY: It does seem like an issue, given that there's a pretty substantial variation in the Part D bids from state to state, so maybe that's a small piece to look at, at some point.

MR. ROLLINS: The one thing that they have modified is on the -- as you know, they get capitated payments for expected reinsurance and low-income cost-sharing that are then later reconciled to whatever the plan's actual experience is. And, in particular, in Massachusetts, where, again, it's an under-65 disabled population, where the use of prescription drugs is pretty significant, the plans there felt like they were really sort of having to front a lot of money, because the actual reinsurance they were going to get was much higher than what the national average would sort of suggest.

DR. HOADLEY: [Off microphone.]

MR. ROLLINS: Yeah, it's 12 to 18 months later, or whatever it is. And I believe CMS did sort of modify that in later years of the demonstration to say, you know, instead of making you wait 18 months for this money, we'll give you a higher up-front payment for the reinsurance piece.

DR. CROSSON: Dana.

DR. SAFRAN: Thanks. Just a couple of questions. The first one is, I understood you, Brian, and I think I do remember this from the chapter. There was a hard disenrollment rate among sicker beneficiaries. Is that right? So I was just curious what insight we have about that, and, specifically, whether it appears to be driven more by the beneficiary's experiences that are having them want to exit, or whether it's based on the advice of their providers, or kind of what's behind that.

MR. ROLLINS: I don't think we have great data on that. I think given how quickly some of the beneficiaries left the MMP, I suspect, in a lot of cases, it's not about their care experience per se. As part of passive enrollment, each beneficiary was supposed to get at least two notices that this was going to happen. But one thing

we heard in pretty much every state we visited is despite these notices there were a lot of beneficiaries that didn't realize they had been passively enrolled until, you know, the proverbial story of they go to the pharmacy counter and show their old insurance card, and that's how they'd find out they had been passively enrolled.

So I think for a lot of folks probably what happened is they, you know, realized they were in the plan, either they were totally unaware of it or they hadn't quite realized what it might have meant for their provider access, and then once they tried to go see their physician, or something like that, and said, "I have this new Medicare/Medicaid plan," and their provider would say, "I'm not in that network," then they would sort of fairly quickly disenroll. But that's sort of my impression. I can't say that there's firm data on that.

DR. SAFRAN: Thanks. My other two questions are kind of related and both under sort of the broad heading of best practices and learnings. So the first part of it is, have there been efforts, either ours or CMS' evaluation, to kind of identify, you know, are there states that seem like they're doing this particularly well, or even just shining

light, plans. And then the second part of that question is whether CMS has anything like what they've done in the ACO program, where they're doing convenings to try to share, among the plans, what's being learned and best practices?

MR. ROLLINS: There are efforts in some states where they will have periodic meetings between CMS and the state, and then representatives of the various plans discuss certain issues and sort of try and -- sort of, I guess, promulgate best practices through that mechanisms. So there are some efforts.

We have pretty consistently heard in the states we have visited that there is a recognition that there are -- the quality of the plans vary, and some are better than others.

DR. CROSSON: Rita.

DR. REDBERG: To follow up with the example you gave, Eric, it suggests that some of the disenrollments, just because they had trouble filling their prescription, where if there wasn't, like, that continuity in pharmacy, they might have stuck with the MMP.

MR. ROLLINS: I think -- I'm not so much -- I mean, the pharmacy was the example I gave in terms of just,

that's how they would just eventually realize their coverage had changed. The impression we have gotten is that the challenges with your access, moving from your old coverage to the MMP, are not really on the coverage of prescription drugs. It seems much more focused on your primary care physician or, for Medicaid, your personal care attendant, or something like that.

DR. REDBERG: Because you have to change primary care physicians --

MR. ROLLINS: Correct.

DR. REDBERG: -- in order to do that.

MR. ROLLINS: Right.

DR. REDBERG: Because not all PCPs were participating. Because they chose not to, or they weren't invited?

MR. ROLLINS: By and large they chose not to, is the impression we got. They didn't want to be part of the demonstration.

DR. NERENZ: Just on this point, also, to emphasize why I asked the question earlier, it's not just on the medical side and it's not just a PCP, and you mentioned this. It's on the community support side as

well. So somebody who is really tied into support providers, has been very tightly engage for years, you know, if that support provider says "I don't like this program," then there's going to be strong message to the beneficiary to not participate. It's not just on the medical side.

DR. CROSSON: Okay, good. Seeing no more questions we'll move on to the general discussion. Jack, I believe you're going to start.

DR. HOADLEY: Yeah, thank you, and I think it's really important that we're addressing this population and this particular issue, and great to have this update on what's going on with these demonstrations.

You know, when the plans -- when this demonstration was envisioned, you know, there was a lot of promise that this really gets to that core issue of how you bring the two streams of benefits of dollars together in one place, and just have to no longer have to worry about all those boundaries. And, you know, I think it just seems too early to know. And you say, you know, there's some settling in now after a few years, and maybe there are signs of progress. The concept still feels good but the

proof that it's working in this particular demonstration is still not there yet.

And obviously there's a frustration that I share with you, and with the plans, as you said, were frustrated because they're not getting the results back from the evaluations that they're interested in, and sort of knowing what the future of the program is. You know, it is a very strong point of frustration.

I did one site visit on this topic and it seems like now about Year 1 of Virginia, so that was 2015 or so, and even then we were sort of like, well, soon we'll know more, and soon things will develop, and now we're 2018.

I do think there is the potential for some interesting results in several areas, and a couple of them we are beginning, already, to learn. This last discussion about the passive enrollment issues, I think, is a really interesting one, and it's not just relevant to this demonstration but relevant to other settings where passive enrollment and things I remember from the Virginia case was, you know, they couldn't get, at that point, the CMS data on who your primary care provider was or who any of your fee for service providers were. And so those were

supposed to be part of the algorithm for assigning plans and they couldn't be, and I'm sure some of that has improved over time.

But it's all those questions of how do you improve that process and what can we learn as we go forward on whether passive enrollment is an effective methodology and is auto-assignment in the plans. That's the partner of it.

And you mentioned the example with the drugs. One of the issues I remember in Virginia was, okay, then the people disenrolled. Now they've got to be reassigned back into a Part D plan, where they suddenly have no drug coverage, and they had to do all kinds of sort of scrambling to figure out how to do that. So, you know, making sure that in any future program, or even future iterations of this, some of those issues are -- you know, we learn from some of those.

Another one that we haven't -- you just mentioned, really quickly, but I think under the context of the care coordination is the issues these plans have had in just locating the beneficiaries. And that, you know, every time I hear that -- and I heard it back in the Virginia

visit I did -- it's sort of like, "What? You can't figure out where this person is? You don't have the contact information?" It's kind of unthinkable and yet not surprising in another way that that happens.

And I think, you know, figuring out the solution to that, again, is not just within this demo that it's relevant, but in other places. I don't know whether these things have been issues in ACOs or other kinds of things where people want to reach out to beneficiaries. Maybe they're better there because you're working through the providers that they're seeing.

And then the care coordination, I think there's a number of interesting questions that you're only beginning to see some of the answers. Some of the things I remember coming up are the question of multiple coordinators. So this individual, who is a dual, who has got, you know, many encounters with the health care system, may be seeing a care coordinator through a clinic they're going to, through a nursing facility that they live in, through an aging services program, and, you know, there's always that question of who coordinates the coordinators, and when is just one more layer of coordination one too many.

And in a different project I was on, you know, one of the things we heard a lot about was the plan coordinators would come in and they would essentially get in the way of a well-established provider coordination process, at an FQHC or in some other kind of health care setting. And I hope that somewhere in the process of this, you know, some of the things you wrote about sound more optimistic, more positive than some of the things I remember hearing, and that may be just the maturing of these projects and they're learning how to do it better.

But I think thinking about are there cases where there's too many coordinators, you know, what's the right role for the plan, the provider. How prescriptive should the rules -- and I think something you mentioned in the paper was the demonstrations have been fairly prescriptive of what those initial care evaluations need to look like, and so forth. And, you know, are they too prescriptive? You know, do they not allow enough flexibility in terms of who does these coordinations?

You know, obviously we'll look forward to the service use data that will tell us someday whether the coordination is actually getting the things that you heard,

at least anecdotally or survey response, or interview response, rather, that there's some reduction in some of the categories of utilization, and we'll need to look more at that.

And then I guess the last thing to mention is some of the issue of the breadth of services that this involves, and these often include a lot of beneficiaries who have behavioral health issues, may have other kinds of transportation and housing issues, and to what extent are the plans? You know, again, I remember conversations in Virginia, but it was too early. They said, "We have this scheme of how we're going to deal with the behavioral health needs of these particular individuals," but it was too early that point to be able to say "and our scheme is actually making some sense." All they could do is, "We have a design. We're hoping it will work." So I hope we'll see, as the process goes on, whether, you know, they really provide -- these demonstrations provide a chance to address things like behavioral health needs, as well as some of the non-health services that are involved.

So it's promising to hear an update. It's frustrating that with this many years in we still don't

really know a lot. But hopefully in the next year or two, you know, we'll be able to know a lot more, and the next time you come with all these reports there will be more concrete information to produce. So thank you.

DR. CROSSON: It struck me, you know, maybe we need a lexicon here to describe a lump-shaped curve of uncoordinated, coordinated, and discoordinated.

[Laughter.]

DR. CROSSON: Okay. So further comments, feedback for Eric? Pat.

DR. REDBERG: [Off microphone.]

DR. CROSSON: I'm sorry. Did you want -- on this point?

DR. REDBERG: [Off microphone.]

DR. CROSSON: Go ahead, Rita.

DR. REDBERG: Just to your comment about the difficulty with content. I mean, I think it just points to something we've talked about before. This population is probably marginally housed, or homeless, and that, you know, we've talked that housing is sort of health care issue, and, you know, Medicare doesn't -- Medicaid doesn't cover housing but it's a big problem because when you're

not housed it's hard to reach people and it's hard for them to take their medicines.

DR. HOADLEY: Presumably one of the promises of these plans is that even if they can't provide housing services, the coordinations should be able to talk about housing issues and point them to resources in the community. And I think -- you know, I don't know whether you've seen any evidence of some of those kinds of things in the interviews you've done, that people have been able to wrap this into the process or not.

MR. ROLLINS: So two things. The first, just to expand a little bit on this issue of not being able to find beneficiaries, because one question we'll sometimes get is, "Well, they're using services. How can you not know where they are?" Medicaid LTSS, personal attendant care, something like that, those people are -- they know where those people are. So, I mean, the New York demonstration, for all of its problems, is focused on people who are using LTSS, and so they don't have the issue of "I can't find my enrollees." It's the people who are not using LTSS, that that's where the problem is sort of focused.

In terms of housing, we did -- you know, plans

are trying to figure out ways that they can at least sort of develop good relationships with local housing, nonprofits, or agencies to sort of at least have a relationship where sort of, you know, if they need to find some sort of short-term arrangement for one of their enrollees, you know, they have a place where they can start. But we heard from a lot of different plans that it's a real challenge for them.

DR. CROSSON: Pat.

MS. WANG: I think this is really important work, and, you know, there's some frustration around the table about the lack of a formal evaluation and all of the rest, which I am sure will come. But the issue is I think of paramount importance so I'm glad that we are looking at it and will continue to work on it.

The request that I would have, as you continue to monitor this, is to try to identify, notwithstanding, you know, again, not making the perfect the enemy of the good -- notwithstanding the problems with data, nevertheless to try to identify best practices, insights into two broad buckets. One is how do you get in, and, number two, what happens once you get in? And on the "how you get in" part,

the challenge of these demos was that, you know, it's the Big Bang theory, it's like anybody who is eligible, let's get them into a plan, wherever they are now. So that, in and of itself, is challenging.

The other approach, I think long-term for the program and for people, is something that is more gradual, where you age into these programs because wherever you are starting, you are seamlessly going into the next stage of the next stage, at least in states that have, you know, Medicaid managed care as the way that folks get, you know, their health care benefits if they're Medicaid.

As they age into dual status, you can imagine that they will seamlessly enroll into a Medicare plan -- perhaps this is part of, you know, I mean, this was part of the proposed rule -- but you can imagine a day where people could have the option of seamlessly enrolling, with an opt-out, into the plan that has the same provider network, the same care management structure, the same people in member services that they know how to use, et cetera, et cetera.

The same support services around housing, and everything like that, that is being worked while you're a Medicaid member, as they develop need for LTSS, you know,

bolt on the services that that plan also provides, so that there is as little disruption to the member, and that the services get built around the member, as opposed to moving the member around to all of these different programs that supposedly are set up for them.

You know, so I think notwithstanding the lack of data, there are, as you had started to allude to, Eric, there are some lessons learned that I would urge us to sort of call out, because maybe there's opportunities to improve the existing FIDESNP program. Maybe there's opportunities to engage in seamless enrollment and things like that.

In terms of the -- what's best practice once you are in, you already noted there are -- you know, some of the payment structure may or may not be good. What's the difference between the MMPs and the current FIDESNP program? If you're an MMP, you're getting the average Part D premium. There's no frailty factor. They did an artificial bump to the rates to compensate for the fact that, you know, if you're in a FIDESNP your members are eligible for the frailty factor, under the normal risk adjustment, so they had to sort of simulate something. It's like awkward.

And there are other differences as well -- as you had noted, some of the requirements around sort of these integrated care coordination meetings. Some of that is really good. Some of that was way over the top and kind of, you know, resulted in a lot of provider defection and anger. Sort of like where's the sweet spot in there that is actually affordable to an integrated plan?

And, you know, if we could -- oh, also, when you're in, what -- because I agree with you. The variation in benefits is more on the Medicaid side. So the normal sort of capitated Medicaid, long-term care benefit might be X. The MMPs, the states may have done X plus Y. They may have thrown in a much more robust behavioral health program. They may have thrown in, you know, home and community-based services under the waiver. You know, it would be great if we could just have one program for these people, as opposed to all of these different program, as Kathy noted before.

You know, in my shop we have four programs for really people with identical characteristics, and it would be really important, I think, to try to identify the characteristics of the best integrated care program and how

to get people into it so we could kind of start to try to move in that direction. So that's what I would ask us to focus on.

DR. CROSSON: Okay. David and then Craig.

DR. GRABOWSKI: Great. Thanks. Similar to others, I share the frustration here in the delay with the evaluation results, and I think this issue is magnified in that as you note in the chapter, there could be a program lag here. It doesn't seem like a lot was happening in Year 1. It took the plans time to kind of learn and get up to speed. And so as the Year 1 report comes out, we may not see a lot there, and it may not be until Year 2 or 3, and that's either going to be further out into the future. So anything we can do to push CMS and their contractor to move quickly with a result. I know it's sort of ironic having a researcher tell other researchers to move faster when I'm usually the one being pushed, so I'm enjoying this role.

Still, in spite of these delays, I really believe this model has amazing potential, and I think it really offers two innovations. Pat talked about some of the administrative complexities of some of the other models. The dual-eligible, special needs plans, for example. You

can still have three different cards with three different benefits -- Medicare, Part D, and Medicaid -- and, yes, for the fully integrated duals that may work. For the fully integrated dual SNPs that may work well. For other models it may not. Here you have one benefit, one plan. It's really designed to integrate services and really offer a better product for duals.

I think, you know, the other innovation here, beyond just the integration, is the passive enrollment, and I was really excited about this aspect of it. And I guess the good news is nearly a half million individuals have been moved into these plans, and there's a real opportunity to learn a lot and hopefully improve their care.

I think the downside is that the participation rates really vary by states, and you have a high, in Ohio, of 68 percent, a low, in New York, of 3 percent. So I think there's a real lesson there. Like everything else in Medicare, design matters, and Ohio is really smart about how they designed their passive enrollment. They first brought individuals into Medicaid, then did Medicare. New York maybe wasn't so smart with some of the issues we've already raised. Also, they required this care team meeting

up front, bringing in individuals from outside of -- from different areas, and there was a lot of resistance among providers in New York to the passive enrollment. So I think we can learn a lot going forward if we're going to use passive enrollment, in terms of design.

The other lesson here, and I think stepping back across all the states, given these low participation rates, I think we have to acknowledge, duals really like fee for service, and I hear that a lot in our research. "I want to go to the providers I want to go to." And you see that in your data with the highest acuity, sickest individuals, are the ones opting out here and disenrolling.

And so I think that's something we want to keep in mind in going forward in the design of these plans. Is there a way to balance some of that flexibility and choice that duals seem to really value here, and does that then impede your ability to actually achieve the kind of integration that these plans are trying to move towards?

I do think we have 14 really interesting experiments. I hope CMS will continue with these projects and that we're able to actually see this through and actually see the lessons at the end of the day, because I

do think this is a really important opportunity for the frailest, most vulnerable individuals in the Medicare program.

So this is a really important program. It's a really innovative program. I look forward to seeing the results, moving forward.

DR. CROSSON: Thank you. Craig.

DR. SAMITT: So I just want to briefly -- I think it's important to double down on both Pat and David's comments. As an organization that has a significant presence in this space, in duals, and our early experience being positive in the program and a desire to really expand upon it, I'm anxious to see the broader results with the program. And I, too, have great optimism about the potential of what this can do, if we get it right.

You know, beyond understanding what success has come from the program, I also do want to underscore what are the barriers to even greater success in the program? And I think they've been mentioned, to some degree, here. I think the enrollment mechanisms are something we need to take a look at, and if we believe that this program is highly effective and it's right for certain populations,

what can we do in terms of both enrollment and retention within the program, if we believe that, you know, better care at a lower cost is being offered here?

I think we also still struggle with alignment issues, whether it's reporting requirements or marketing material reviews or network adequacy standards. For those plans that are offering this service, have we truly created an environment of simplicity without duplication and extra effort, that really makes servicing this population more effective?

And then I don't think we talked much about the quality bonus program. I do think this is worth taking a good look at to determine the quality metrics that are appropriate for this patient population and assure that we get that right, as well as bonuses that would link to the plans that are doing this more effectively.

DR. CROSSON: You know, thank you, all three of you. And Craig, the thing that struck me is it would be interesting to know how much of this disenrollment or lack of retention is actually provider driven. I mean, you were getting at that a little bit before. It reminds me, sort of, of the 1980s, of the anti-managed care activities that

were going on, you know, among physicians, particularly who were really working hard to discourage their patients from being in a managed care environment. I don't know whether that's the mechanisms, but, you know, like others, when I saw those numbers of disenrollment it just seemed kind of intuitively hard to imagine that that many people would just spontaneously decide to drop a program that, by other measurements, seemed to be doing a good job.

DR. SAMITT: But it also speaks to the review of best practice. You know, where do we see fewer examples of retention-related issues –

DR. CROSSON: Yeah. Yeah.

DR. SAMITT: -- regardless of what the drivers are. And it's synonymous with kind of broader issues in the industry. Where is there a disconnect between what is right for the beneficiaries, what is right for the plans, what is right for the providers? And if they're working in opposition as opposed to working in a manner that sort of offers an alignment of goals and incentives, that's when we'll actually see the change happen. But if they're working in counter purposes, we're not going to see that.

DR. CROSSON: Which was a characteristic of the

1980s. Yeah, exactly.

Jack, did you want to comment on that?

DR. HOADLEY: Yeah. I mean, I think, you know, the impression I had in the places I went was it often was providers, and some of that was, you know, failure to reach out adequately to them early on. So if you don't explain to them what this is, it's like, well, this is going to screw things up, the nice way things are working. I'm not talking about the sort of fraudulent stuff. Just the working relationship. So, you know, let's just stay away from it and encourage our patients, if it's a nurse -- and many of them were nursing homes -- you know, fear of the unknown. And then, in some cases, when the state would reach out or they would set up forums where the plans could talk to the nursing homes, there are better. But, of course, if you did that too late, then they've already disenrolled and you may have lost your opportunity.

But the other thing -- and I know this as much from non-dual situations that involved Medicaid in a different project -- is that choice of providers. So, you know, somebody said it before. There's a real loyalty to the providers that you have, including the non-medical

providers, so their personal care representatives and those sorts of folks. And one of the things I heard in one case, in the dual demo, was plans that didn't really appreciate the importance of those particular providers to these Medicaid/Medicare dual beneficiaries. And again, it strikes me as something that's fixable.

So they were saying, "Well, we can have anybody play that role. They don't need to keep the person they've been working with." But yet these are people who they've got a long time, in many cases, you know, a person that helps them dress, helps them do all kinds of very personal, intimate kinds of things. And to say we're going to take that person away from you and substitute it, well, yeah, they're going to say, "I don't want this."

And so, again, that's -- I think there is a strong potential to have some lessons learned and to learn both from the negatives, see what failed, as well as the positives of where, you know, somebody figured out how to do that right, and got around that, and then, you know, had a happy ending to it.

DR. CROSSON: Yeah, Pat.

MS. WANG: You know, I think that the issue

around provider role in influencing the beneficiary's decision-making is very important. So just, you know, again, to reiterate, it's not applicable in all cases. It doesn't cover 100 percent of the population. But one of the reasons that I think it's important to work on seamless enrollment processes as people move into the system -- not the Big Bang, everybody goes in, but as they move through -- you have a greater chance, I think, of disruption in the provider network. I mean, so I have a Medicaid managed care plan. I have dual SNP. There's an 80 percent provider overlap. You know, it's not really going to be a big deal for the members as they move in, so that's one thing.

I think, also, in fairness to providers, at least in the experience that, you know, I had in my state, yes, there was some trauma around, like, the providers not in the network of the plan that the member just got moved to, and they didn't even know they were getting moved. The requirements of providers were not realistic and they were really burdensome and unfair on them, and I'm not surprised that they said, "I'm not doing this. You know, you're asking me to go to these meetings and these care

coordination things. I'm not getting paid a penny extra. You expect me to come in person, once a month to attend a meeting?" I mean, it's -- you know, stuff that was really burdensome. So I think, you know, that's an important, again, a lesson learned kind of thing.

And on the long-term care side, you know, Jack, I really agree with what you have said, and beneficiary choice is really incredibly important here.

I will tell you that in our experience, because we've had consolidation in our sort of MLTSS plan side, we've been surprised at the proportion of members who actually will move to stay with the plan, even if they have to change their aid. It's not everybody, but it's just -- the point is there's a lot of -- there are a lot of -- there's differences in the way that patients and beneficiaries choose.

The final thing that I'll say about the long-term care side is that personal care, which is really the primary service that's being delivered, on a constant basis, the personal care aide, is a very virtual business. Aides move from agency to agency. Agencies consolidate. It's not a fixed thing like you have to be with that agency

that has a contract with this plan in order to retain that aid. So I'm just saying that there's fluidity there too.

DR. HOADLEY: Yeah, I think, you know, one of the differences that you may be seeing in some of these instances is people who are moving from some kind of managed care relationship to a new one, and in certainly the cases in Virginia where mostly people moving from fee for service environments to managed care for the first time. So part of it is that transition in the unknown. And I think there was some effort, in some of the states -- I don't know, you know, Eric, how much you've seen this -- where the push to sort of get this going and begin to show results, you know, meant that they didn't take the time to sort of, you know, do, you know, the example of working with the nursing home operators but also with the beneficiaries, and say "here's what this is going to be about," is why you've got people with two notices and then suddenly they're surprised, because sending them two pieces of mail, you know, we all get lots of mail that we don't understand, and if people have any kind of deficits, then even more likely. And so how do you work it out?

And a lot of the states, I think, had good

programs for doing that, and hopefully there are some really positive lessons to be taken away.

MR. ROLLINS: Yeah, and I think in terms of sort of the initial start-up challenges, pretty consistently we heard from the states that we visited, if they had to do it again they would have gone more slowly. That sort of moving as fast as they did caused some problems.

DR. CROSSON: Okay. Thank you. Nice presentation. Good summary. Good discussion as well. A lot of support.

We'll move on to the last presentation of the day. Jeff is coming back to talk again about the effects of the Hospital Readmission Reduction Program. That mandate is when?

DR. MATHEWS: June.

DR. CROSSON: June. So hopefully we will have -- staff will have prepared answers to all the questions that came up at the last presentation.

Okay. Craig, are you starting off?

* MR. LISK: Yes. I'm going to start off here.

So good afternoon. This session is our second discussion of our congressionally mandated report on the

Hospital Readmission Reduction Program. The report is due in June of this year.

We want to remind you about the mandate for this study on the Hospital Readmission Reduction Program. In the 21st Century Cures Act, Congress required that MedPAC examine if reduced readmissions are related to changes in outpatient and emergency services furnished. And in this report we examine the relationship between the change in readmissions and three things: changes in observation stays, changes in ED visits, and changes in mortality during the stay and the 30-day period following discharge.

We have made some refinements to the report in response to the January meeting discussion. David Grabowski suggested we change the comparison groups in our graphics to conditions not covered by the program, and we have done that by updating the graphics, and we will show you many of those today.

David Nerenz suggested we test to see if the rates of readmission reductions actually changed after the program was enacted. They did, as we find readmission rates declined faster after program enactment, with differences statistically significant. We added some discussion to

this report on that.

We also looked at the most recent literature that has come out in the past two months and updated our citations to include some of this. But the most recent articles are largely consistent with prior work.

After including these refinements, the basic findings remain unchanged. The optics of the graphics, overall trends, and conclusions remain unchanged.

We will start by showing the overall trend in raw, unplanned readmission rates, shown here. CMS, in their analysis for readmission reduction programs and for reporting hospital quality metrics uses unplanned readmissions.

So if we look here we can see that in 2008, 16.7 percent of discharges from an acute care hospital resulted in an unplanned readmission. This was unchanged in 2010, but by 2016, it had fallen to 15 percent.

Now this next slide shows raw, meaning non-risk-adjusted, readmission rates for the five conditions initially covered by the readmission policy through 2016, plus the trend for conditions not covered by the program, the green line. What you notice is that readmission rates

covered by the policy fell faster than the readmission rates not covered by the Hospital Readmission Reduction Program. The difference in the rates of decline between covered and non-covered conditions are statistically significant and also fell faster by a statistically significant amount after the program passed for the covered conditions.

Next we look at the risk-adjusted rates. What we see is that the risk-adjusted rate changes were larger than the non-risk-adjusted changes, shown on the prior slide; the changes in readmission rates were also faster for conditions covered by the program than those not covered; and the rate of change in readmission rate reduction also fell somewhat faster after the program passed in 2010, for the conditions covered under the program.

One of the main focuses of the report is to examine how observation and ED use change as a result of the Hospital Readmission Reduction Program. In general, the growth in use of observation and ED visits was not driven by the Hospital Readmission Reduction Program. As the report explains, there were many factors at play increasing the use of observation and ED over this period,

when per capita admission rates were falling.

One of these was the RAC audits that were looking at the appropriateness of certain inpatient admissions, and second was the two midnight rule implemented by CMS to identify the appropriateness of short stay hospitals. What we see is that overall observations and ED visits increased for Medicare population, in general, not just those admitted to the hospital. From 2010 to 2016, we saw observation stays increase by 1.9 stays per 100 beneficiaries, and ED visits increase by 5.4 visits per 100 beneficiaries. In addition, this rapid growth in observation and ED visits began before the readmission reduction program passed.

Our analysis shows similar rapid growth in use of observation and ED for beneficiaries with and without an inpatient stay, suggesting that the Hospital Readmission Reduction Program did not drive the increase.

Here we show the change in readmission rates and growth in observation and ED following an inpatient admission for the five initial conditions covered by the readmission reduction program, the first group of bars on the left, and for conditions not covered by the program,

the second group of bars on the right. We have modified this slide to show the risk-adjusted change in the rates, rather than the raw rates, which we showed you last time.

But the story has not changed. The green bar shows that for conditions covered under the readmission program, readmission rates fell 3.1 percentage points from 2010 to 2016, which was larger than the 2.5 percentage point drop for conditions not covered by the program. But if we look at the change in use of observation, the orange bars, and ED, the red bars, we see that the change in use of these services was almost identical for conditions covered and not covered by the program. If we were to expect hospitals were using observation and ED settings to avoid readmission penalties, we would expect to see larger increases in use of observation and ED for conditions covered by the program, but we do not.

Now Jeff will go on and talk about mortality.

DR. STENSLAND: All right. Just to remind you about the mortality data that we discussed in January, when we examined mortality we look at mortality during the hospital stay and 30 days after discharge. The green line shows that on average for conditions covered by the

readmission policy -- not covered by the readmission policy, mortality was increasing. In contrast, for the three conditions covered by the readmission policy, mortality was decreasing for two and increasing for one.

The one that increased was heart failure. One reason we may see an increase in raw rates of readmission for heart failure is the decline in initial admissions. As we discussed in your mailing, initial admissions for heart failure declined by 14 percent from 2010 to 2016, including a particularly large decrease in one-day stays. Therefore, the increase in raw readmissions rates for some conditions, such as heart failure, may be due to the easier cases being treated on an outpatient basis.

And now we look at risk-adjusted rates. We see that all risk-adjusted rates are declining for the conditions covered by the readmissions policy. We also see rates declining for conditions not covered by the policy.

Some may look at this and ask whether the decline we show is due to a reduction in the true risk-adjusted readmission rate or is it simply due to coding. Given the totality of the data we have, it appears it may be some of both, and it is hard to say exactly how much is a true

reduction in readmission and how much of it is due to coding, but it does look like at least some of it is real.

And now we'll shift over to discussing a little bit about the readmission policy refinements. And while the incentives in the readmission policy appear to have generated some positive changes, as we've said in the past, the policy could be refined. As you mentioned in your report, the penalty formula could be refined by eliminating the multiplier and thus making the penalty more proportionate to the cost of a readmission. The policy could also be expanded to cover all conditions, and this expansion of the incentives in the program to all conditions would pay for the cost of removing the multiplier.

We have also discussed having a fixed target rather than a tournament model, so the hospital would know in advance which readmission rate it has to reach to avoid a penalty. Finally, we also suggested adjusting penalties for socioeconomic status of hospitals, Medicare patients, and Congress has already acted on that recommendation.

In summary, the readmission program was implemented to reduce the number of unnecessary

readmissions that beneficiaries must endure. While the design of the program is imperfect, the incentives were sufficient to change behavior. Readmission rates declined, with greater declines in conditions covered by the policy. While there was an increase in observation stays and emergency department visits following an admission, there was an almost equal increase for beneficiaries who were not admitted to the hospital. This suggested most of the increase in observation and ED visits were broad-based and not triggered by the readmission program.

In the end, the beneficiary's burden of being readmitted was reduced and the taxpayer's cost was also reduced.

We also examined whether fewer readmissions came at the cost of higher mortality, and after risk adjustment we see no evidence of this.

I will turn it over to Jay to lead the discussion.

DR. CROSSON: So thank you for the clarification.

I'm going to ask the first question here because I know I want to get -- I'll get annoying here, to get to one of the core questions. But if you put on number 9 --

and again, I'm not looking at numbers here. I'm just looking at these dots, and specifically the red line.

It looks to me like, just looking at this without the numbers behind it, necessarily, that almost, if not all of the increase in mortality for heart failure occurred actually before the penalties began.

DR. STENSLAND: Yes. Most of it would have been before the penalties began, but, you know, somewhat after the program was enacted.

DR. CROSSON: Again, I'm not -- I don't have numbers, you know. I'm looking at the points and where they are in relation to the lines. But it looks like, you know, the mortality rate at the beginning of the penalties, 2012 and 2016, are almost at an identical point. Is that not right?

MR. LISK: Actually, I mean, actually, when you look at it, if you talk about the number for mortality for heart failure in 2012, it's also -- in 2016 it was the same. So if you want to look at 2012 to 2016 aside of 2010 to 2016, you're correct, it's actually the same number.

DR. CROSSON: So that --

MR. LISK: It's a -- it's 11.9 percent in both

those years.

DR. CROSSON: And that may be unfair to kind of ignore the numbers in between. I understand that. But what struck me most was -- because I know this controversy around this issue, was that actually most of the increase occurred between 2008 and 2010. So it could lead you to say, well -- well, basically it's not any different from the non-HRP conditions, and/or in anticipation of the penalties policies were already being put in place, at least in that two-year period of time. And I think there's a -- you know, you could have an argument based on that.

But I just -- it just struck me that those, the two numbers, '12 and '16, appear -- apparently are virtually the same.

MR. LISK: Yes, they are. And, of course, this was -- when you talk about 2010 to 2012, that's when we had our actual act of -- with observation stays and use of ED, and a lot of these cases not being admitted -- a lot of the easier cases not being admitted because they were concerned whether they were going to be qualifying inpatient stays, and heart failure is one of those focuses of the RACs.

DR. CROSSON: Okay. Questions? Paul.

DR. GINSBURG: Yeah. If I'm correct, you were using the readmission rates for other conditions as your controls, and I would say, you know, that's a very impressive result because I would think that it's going to make it tougher to find one since there likely would be some spillover. Some things hospitals have done to reduce readmissions go beyond the three conditions.

DR. STENSLAND: Agree.

DR. CHRISTIANSON: So I think you're -- this is a really good paper the first time and I think it's better now. It's going to get a lot of attention when it comes out, and it's complicated, so we better get it right. Are there any sensitivity analyses that you contemplate doing that you weren't able to do for this presentation that would kind of even more tie up the loose ends for us?

DR. STENSLAND: Well, you know, there's other things that we did, you know, testing things this way or that way, looking at some really broad-based things such as, well, what's happened to mortality per capita, as opposed to just looking at mortality given an initial admission to kind of try to account for some of this change in initial admissions.

So there are some other things we did that, you know, added a little bit of value but not enough that we thought we should add it to the paper.

DR. CHRISTIANSON: So maybe it's appendix material or something? I mean, whatever, I think, you can do to assure people that you have really looked at this from a lot of different angles and tried -- basically tried what you could to make this result go away, and it didn't go away, would be good, I think.

Dana.

DR. SAFRAN: Yeah, so my two questions are kind of in that same vein. So one is that I'm curious whether you looked at variability across provider organizations over this continuum, because when we did that in our commercial world, what we saw was that there was much less variability before the enactment of readmissions mattering, which made some sense to us, because if there's no one really working on this, then the variability should be just kind of noise, whereas when folks really start to put effort into improvement you would expect to see more variability as some are succeeding and others are not.

So that's a question, and from your notes I'm

going to infer. Okay, you haven't looked at that, but that would be a good --

DR. STENSLAND: We looked at variability across providers, over time, but not before and after enactment.

DR. SAFRAN: Okay. So it may be worth doing, sort of in the vein that Jon was just suggesting.

And then, similarly, I was curious. I think in the mortality analyses, if I understand right, you've got in-hospital and 30-day combined, and maybe the numbers don't support separating them. But I think that those who are skeptical would want to really see the 30-day mortality and what happened with that.

DR. CHRISTIANSON: Other clarifying questions? Oh, I'm sorry, Jeff. Do you want to respond to that.

DR. STENSLAND: It would be a challenge for us to get that done before this is out. And we had some technical concerns about when they are separated as opposed to when they're together, because then the site of where you happen to die affects your mortality rate. Like if you're only looking at the post-30 days mortality, if all of a sudden you start to discharge some people to hospice, all of a sudden that counts as mortality getting worse,

whereas opposed to before, if you just would have kept them in the hospital and they would have died in the hospital -- and it's --

DR. SAFRAN: So maybe just spelling that out is a good idea.

DR. CHRISTIANSON: Others with questions? Yeah.

MR. PYENSON: Yeah, I think this was a terrific paper and still is. Thank you.

I think a reference point that might be interesting is the overall mortality rate in Medicare on a population basis, which I think is something around 4 percent annually, just as a reference point how much higher the mortality rates are for people who go to a hospital, you know, throughout this period, if that's not too hard to do.

DR. CHRISTIANSON: Anybody else?

Who is going to lead the discussion on this? Rita?

DR. REDBERG: Thanks, Jeff and Craig, for a really excellent chapter, and I agree, it was very well thought out and I think you've addressed the points in what is clearly a very difficult area. And I think, you know,

you've summarized the data on the really knotty issues, the raw and risk-adjusted readmission rates and mortality rates, and what are the interplay.

And, you know, I think what I concluded from this is that there clearly were some temporal trends, overall, although when you look at separating the HRRP conditions and the non-HRRP conditions there clearly seems to be a decline in readmissions that's greater for the HRRP conditions.

And, to me, as you said, the one -- the most difficult area is what's going on with the raw heart failure mortality. It's possible there's less admissions and maybe those are sicker patients now that are getting admitted. But it is -- I think it's probably not a big component but it's hard to rule out that, you know, people who have heart failure are not getting readmitted and then perhaps are not doing well.

And I think you've addressed it as well as you can from the data. Clearly, the risk-adjustment morality has gone down, and that's very reassuring, except as you mentioned there have been questions raised about upcoding and the risk adjustment. But clearly -- and as you showed,

also, the trend clearly goes down for the risk adjustment even greater, after the PPACA passes, and certainly after the penalties start, for all of the HRRP conditions, including heart failure.

So, you know, I think you really have summarized it really accurately. The overwhelming data suggests that readmission policy has been a benefit. You know, I think there's a tiny question remaining that's going to be hard to get rid of. And I'll just say, again, you know, population health and population measures are much more satisfying when we're dealing with a whole system instead of pulling out one piece, like readmissions. And, you know, we've talked about before, when we've talked about the readmission policy, that there are a lot of things that affect readmissions that are totally outside of the hospital and Medicare, like, housing, like, you know, follow-up, like all kinds of, you know, do you take your medicines, all kinds of other things that are really outside of the program currently. You know, we'd like to because we'd like to improve the health of all the beneficiaries.

So, you know, I think that you have really

accurately summarized the data here and that the conclusion is correct. So thank you.

DR. CROSSON: Commentary? Discussion further? David.

DR. GRABOWSKI: Yeah. I just wanted to echo others' thanks in terms of all the edits you made to the chapter. I think this is a big improvement.

Could you put up Slide 6? I just -- I know I was the one that -- I had suggested breaking out the other conditions from the HRRP conditions, and we are seeing a decline. This is the risk-adjusted readmission rates. We are seeing declines across all the conditions, including those other conditions not included. And I'm wondering, still, how much of this is due to coding and how much of this is due to the HRRP. You talked about, in the chapter, how the decline is faster for the HRRP conditions relative to those other conditions. However, you express everything on percentage point changes, and when you look at the other conditions it's lower at baseline.

And so is that the right comparison? I think you want to do this in percentage terms. I think that's going to be more convincing. And this really gets to Jon's

earlier comment. I think people are going to come at this result and so you really want to protect yourself here. Indeed, an even stronger test would be to find some conditions that have similar rates at baseline to the HRRP conditions and make certain there's not anything funny going on there with these trends, because it may be the case that the HRRP conditions are just more susceptible to coding.

So whatever it is there, I would want to find very similar conditions. I realize I was the one that got you down this path with the other conditions and I'm suggesting -- but I think just in the spirit of Jon's comment of wanting to protect ourselves, because I do think people are going to push on this and say is this -- what's due to coding here and what's due to the program.

MR. LISK: So on the coding front we do want to say, from the 2008 to 2010 period, coding is an issue. And this is one of the reasons why, actually, the raw rates versus the non -- and the risk-adjusted rates gets to be a problem here in terms of teasing this out. So in that period, we had the MS-DRGs were introduced, and there was substantial coding increases in that period, which is the

reason why we think there is a steeper slope, why we see the slope on that period in the pre-period, because of the coding -- potentially because of the coding effect.

And we mentioned -- have some of that in discussion in the paper, but that's one of the -- that is, actually, part concern there.

DR. GRABOWSKI: We're seeing the same thing in our data, and I do think there's something across the board in terms of coding here that increased, and that's why finding a set of conditions that were maybe coded similar in the pre-period is really important here, and that way they might be just as susceptible. I think it levels the playing field and sort of helps knock this issue out in terms of what's due to the program and what's due to coding.

DR. NERENZ: Jay, on this point, please.

DR. CROSSON: Yes.

DR. NERENZ: I'd also made a comment similar, although not in the context of coding, about simply the mathematical difference. You talk about absolute point decline or you talk about relative decline. And my point, I think, was simpler, and I mentioned this to the guys here

at our last meeting, just so everybody is on the frame, if you drop a rate from 20 to 18, it's a 2-point absolute drop, but it's a 10 percent relative drop. If you go from 10 to 9, it's only a 1-point absolute drop but it's also a 10 percent relative drop. So in one case one is twice as big as the other, and in the other case -- and it just simply depends on how you look at it. It's nothing but math.

And I did ask and suggest that this thing -- and, in fact, other comparisons be done on a relative basis, as well as absolute. Craig assured me offline that that had been done, and I said I didn't think I saw it in the chapter. I did it back of the envelope myself.

But I think my only point now, and this should be aligned with your point, that if all of the ways of doing this give the same fundamental message, it's a very powerful message then. It's kind of like a sensitivity analysis. You say if I do it adjusted or I do raw or if I do absolute, relative, if it all comes up the same way, no matter how I do it, then that's quite powerful, and I think readers would like to see that. Now it's a little tricky if the answers don't come up all the same, but, David, I

just -- I'm saying I had also made that point, but not so much about coding. It's just about the target conditions start at a higher rate. That's just the -- probably it's why they were chosen. So this issue of absolute relative matters, and if you get the same message either way it's good.

DR. CROSSON: Craig.

DR. SAMITT: The only other thing that I would ask is, are we sure that there aren't any other drivers of this trend? You know, we talked about the fact that it could be the program and it could be coding, but I also wonder, over the course of this period, are there other advances in hospital care that would drive down readmission rates that were unrelated.

Now the challenge is they may be closely intertwined with the program. So, for example, you know, we've seen a continued march toward enhancement of hospitalist services across the country, which likely, in and of itself, may reduce some readmission trends. So is -- and this may, you know, speak to Dana's question about, you know, variable results from system to system that gets more at what are the operational changes that had been made

that have resulted in a reduction in readmission.

So I just wonder whether someone could make an argument that, again, beyond the program there was something operationally done differently that could have changed these results.

DR. CROSSON: Bruce.

MR. PYENSON: I'm wondering, going back to the question period, if you could -- whether our emphasis here is that an unintended byproduct of the readmission reduction program was a reduced mortality. Is that we're trying to prove, or are we trying to -- is our charge something else?

MR. LISK: Charge is actually -- I'm looking at the observation and ED. So when we go to what happened here, where we're not seeing -- and we saw large increases in observation and ED going on at the same time, and even starting before the readmission reduction program started. And this is basically, if the hospitals are trying to get around the program by just having more ED visits and observation we would have seen it more on the conditions covered by the program than not, and we don't.

And so, really, for the report to the Congress,

this is more the bottom line answer for what they were wanting. The whole mortality is -- because that's come out in the literature, that's why we're covering that. But this more is the bottom line in terms of what Congress was wanting, in terms of the answer to the question they had.

MR. PYENSON: Thank you.

DR. CROSSON: Alice.

DR. COOMBS: So even though this is for Congress, a part of this is even bigger than this, because this is what we are actually proposing as a quality benchmark for population measure, and I think that answering the question, are there adverse events as a result of readmission reduction. And so that really is an important question and I think, as I reviewed the paper, one of the issues is we kind of waffled a little bit in terms of being able to say, okay, either this heart failure mortality is non-diagnostic or does not show as non-convincing or not persuasive that it would, in fact -- it would impact our readmission premise that readmission rate is very important in absence of increasing mortality.

So I recommended that either we say that or we say that the evidence is weak. We can it's strong or it's

weak or it does not prove that the mortality rate has changed as a result of a reduction in readmission rate. And I think it's bigger than that, only because we're going to use this as a benchmark going forward to say that these providers are performing in a way that is showing that the population health is improving. And even though it's a report to Congress, I think that's one of the things I think is very important.

And, Craig you brought up the issue of what else is at work here, in terms of looking at the graphs, and there have been studies to look at hospitalists versus family practice versus internal medicine, taking care of patients inside the hospital, and one of the greatest challenges is the communication that's supposed to occur when the patient is discharged, so that the readmissions might be increased from that sole program implementation by itself. So that's an important piece going forward. There's no way you could decipher that, I don't think, but I think it's one of the issues that you could have -- because there's been a transformation in hospital medicine, and if you ignore the transformation in hospital medicine, and that is, indeed, a piece of why the readmission rate

might be higher in some geographic regions or with some entities versus others, I think that's probably going to be another feature that we should look at. But I know that it's hard to decipher it.

MR. LISK: And I think that's -- I mean, that's right, and we mention the difficulty of teasing those things out. I know, Dana, you wanted something on ACOs and seeing what effect those are. I mean, that's just a whole other analysis. But to try to disentangle it, I mean, this is the main thing that was going on, and the literature was seeing that hospitals are responding, actually, to the program as other things are going on, and, actually, the participation ACOs may be one of the reasons why they're doing that too. So, you know, the readmission program may be driving -- helping to drive ACOs as well, so all that's going on.

And at least when we look on a risk-adjusted basis we don't see an ill effect of the readmission reduction program on mortality. We see a decrease. And so I guess it's up to you in terms of how that message is portrayed in the paper, in the report.

DR. COOMBS: You might say that this needs to be

continually observed, and we need to have ongoing investigation of that as an entity.

DR. STENSLAND: And I want to say, at least, I think, in the back we usually phrase this as the readmission reduction program is responsible for at least a share of this reduction we see, and I don't think we can do it and I don't think anybody could do it where they could precisely tease out and say how much of this reduction is due to ACOs, how much of the reduction is due to the readmission program, how much of the reduction is due to change in consumer preferences, or all those things. I think we have to be kind of a little bit more modest in what we can say.

DR. CROSSON: Okay. Good work. Thank you for the response. I think it was satisfying to the Commissioners. Commissioners will have one more look at this. If you want to see how the language comes out in the final report, check the blue box. Give it to Dana, the other Dana, and, you know, you'll have one more chance to look at it.

So thank you very much, Craig and Jeff. We're done with today's presentations. We now have time for a

public comment period. If there is anyone in the audience who wants to make a public comment, this is the time to do that. Step up to the microphone.

[Pause.]

DR. CROSSON: It looks like you may be by yourself. Just to let you know, this is one opportunity but not the only one to provide input to the MedPAC staff. We are quite open to receiving comments before the meetings.

I'd ask you to introduce yourself and any organization that you are representing, and then also confine your remarks, if you can, to two minutes. The light will go -- this light here will go back on and two minutes.

Thanks very much.

* DR. de MOOR: Hi. I am Dr. Carrie de Moor. I'm an emergency physician, the CEO of Code 3 Emergency Partners. We own and operate a freestanding, independent emergency room in Rockport, Texas, alongside with an urgent care facility also attached. You probably remember Rockport because of Hurricane Harvey coming ashore there.

I'm here today because I found out you were

talking about this yesterday and I booked my first flight out of Texas so I could let you know our story. I appreciate what you all have discussed today about the rural facilities. The critical access hospital 20 miles from us, in Aransas Pass, was destroyed during the storm, and that left us as the only facility, and we'd only been there for two weeks, to care for a 60-mile stretch of the Texas coast. And we continue to do this until this day, uncompensated for any care we're providing for any Medicare participants in our emergency room. We are caring for strokes every day, heart attacks, level 1 traumas. Anything they need, we are caring for it, and the beneficiaries in the Coastal Bend are not -- they're not covered, because they don't -- the Federal Government doesn't recognize us.

So I'm just basically here to ask you all today to please help, on behalf of my partners and on behalf of the Aransas County residents and those in the Coastal Bend. We need your help to tell Congress, and please recommend, sooner than later, that they need to authorize state-licensed, independent emergency facilities like mine, in rural areas of recently declared federal disaster areas, to

participate in Medicare to help maintain that access to care. It is a huge burden on my facility and my partners, and I cannot believe in the United States of America that we are providing the financing for the entire coast to receive emergency care. There has to be help and we need it now.

I just received word during this entire day I've been here that the phone service, internet service went down again, the second time in the last two weeks, into Aransas County. It's too far away from Corpus to get the maritime. When the President or the Vice President come, the Secret Service come to our facility, make sure we know because we're too far away from anywhere else that they would be bringing them there. As far as the governor of the state of Texas, the same thing. But our Medicare beneficiaries, I'm paid zero for.

So if you can please, again, make that recommendation as soon as possible, to Congress, to authorize state-licensed ER facilities like mine in rural areas of recently declared federal disaster areas to participate in Medicare, we would greatly appreciate it, and I would be happy to take any questions.

DR. CROSSON: Thank you for your remarks. Appreciate it.

Seeing none, no other ones at the microphone, we are adjourned until 8:30 -- is that right? -- tomorrow, 8:30 tomorrow morning.

[Whereupon, at 4:48 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, March 2, 2018.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, March 2, 2018
8:31 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
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

[8:31 a.m.]

DR. CROSSON: Okay. I think we can start. I want to congratulate everyone for the intrepidity, if that's a proper word. It's a custom here at MedPAC -- we've walked our way through blizzards to have meetings, and nothing seems to prevent us from working to save the Medicare program.

Warner remains ill and has gone home, so he will not be here.

I think Jim -- or I -- has talked to everyone that may be in the situation of having flights canceled, and just to remind anybody who gets a flight canceled, let Jim know, and your reservation, if you haven't already done it, at the hotel will be extended if you have to stay overnight. Otherwise, we're off and running.

So as Jim has reminded me, at some particular point in time at a previous meeting, it seems like I concluded a session by saying, "Let's take a look at cost-effectiveness." And so here we are, and we have a very nice paper that Nancy and Emma have put together, and they're going to take us through it.

* MS. RAY: Good morning. Recall that during the September 2017 meeting Commissioners discussed Medicare's coverage process for the Parts A and B programs. Fee-for-service Medicare covers services when adequate clinical evidence shows that these services improve beneficiaries' health outcomes. During the September meeting, several Commissioners requested additional information about cost-effectiveness. This presentation is in response to Commissioners' requests about how cost-effectiveness works and who uses it.

Your briefing paper and presentation is an update of our June 2005 chapter on cost-effectiveness that looked at many of the issues we are discussing today.

During today's session, Emma and I are going to review the objectives and design elements of cost-effectiveness analysis and Medicare's history in using such analysis in the coverage process. Then we will discuss the movement towards using cost-effectiveness analysis by some payers and purchasers and concerns by some stakeholders about its use.

Your briefing material and this presentation is informational only. We seek guidance from Commissioners

about including the material presented today in our upcoming June 2018 report chapter on coverage and low value.

Comparative clinical effectiveness 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. The central function of cost-effectiveness analysis is to assess the comparative value of alternative interventions for improving health. Researchers have used cost-effectiveness analysis to assess a wide range of interventions, including drugs, devices, and procedures. Although we are discussing its application to assess the value of medical interventions, cost-effectiveness analysis is used in other sectors and industries.

Researchers often use this grid with four quadrants to show the impact of a new intervention on net costs and net outcomes compared with its alternative. For example, a new intervention relative to the standard of care that decreases costs and increases health would fall into quadrant IV. By contrast, a new intervention that

increases costs and is less effective would fall into quadrant I. Thus, cost-effectiveness analysis shows the trade-offs involved in choosing among alternative interventions.

So let's discuss some of the design elements of cost-effectiveness analysis.

A key measure is the incremental cost-effectiveness ratio, which is the ratio of costs to health outcomes of two alternative interventions. Costs are measured in dollars and can include direct medical costs, direct non-medical costs such as transportation costs, and non-health care costs such as the costs due to productivity losses related to an illness.

There are two approaches for measuring outcomes. The first approach expresses outcomes by quantifying the quantity of health gained -- for example, the number of years of life gained. The second approach expresses outcomes by quantifying both the quantity and quality of health gained. For example, the quality-adjusted life-year combines changes in life-years and changes in quality of life into one metric.

Here are some other key design elements discussed

in your briefing paper.

The reference case is a set of methods and assumptions used for the analysis -- for example, how costs and outcomes are defined and the perspective of the study, which refers to the analysis viewpoint. A payer perspective includes costs and outcomes affecting that payer while a societal perspective includes costs and outcomes for everyone affected by the interventions.

Selecting the alternatives is important because an analysis can be affected if relevant alternatives are omitted. Regarding data, analyses often use cost and clinical data from multiple sources. The time horizon is the period of time that costs and outcomes are measured. For example, an analysis could follow patients over their lifetime or for a shorter time period.

Sensitivity analysis varies the assumptions of key variables.

So here is an illustrative example of a cost-effectiveness analysis that compares new intervention B and C to the standard of care - Intervention A.

For this example, the standard of care costs $100 and is associated with 20 life-years. Compared to the standard of

care, Intervention B costs an additional $400 and provides an additional three life-years. The incremental cost-effectiveness ratio of Intervention B relative to the standard of care is determined by first calculating the difference in costs between those two interventions -- $500 minus $100 -- and the difference in outcomes -- 23 minus 20 -- and then dividing net costs of $400 by net outcomes of 3. Thus, Intervention B costs $133 per additional life-year gained. Intervention C, compared to the standard of care, costs an additional $900 and provides an additional 3.5 life-years; thus, Intervention C costs $257 per additional life-year gained relative to the standard of care.

Now Emma will change gears and discuss the application of cost-effectiveness by Medicare and other entities.

MS. ACHOLA: Fee-for-service Medicare's coverage process generally does not consider cost-effectiveness evidence or cost in the coverage decision process.

CMS twice contemplated the use of cost-effectiveness analysis as a criterion in the coverage process, once in 1989 in a proposed rule and again in 2000

in a notice of intent. However, both the proposed rule and the notice of intent were not finalized.

In the past, fee-for-service Medicare has utilized cost-effectiveness evidence for coverage for some preventive services, including vaccinations and colorectal cancer screening tests. In these instances, legislative requests or directives initiated the program's consideration of cost-effectiveness evidence.

The role of cost-effectiveness analysis in the Medicare coverage process reemerged with the Patient Protection and Affordable Care Act of 2010. The use of cost-effectiveness analysis is constrained because statute prohibits the Secretary from using adjusted life-years or similar measures to determine coverage or payment.

In 1989, CMS released a proposed rule that would have established criteria and procedures used in the coverage process to determine whether a new item or service was "reasonable and necessary." Cost-effectiveness was introduced as a criterion for coverage, and this was deemed necessary given the increasing availability of new and costly technologies.

Cost-effectiveness would be one of many

components in coverage decisions and would not always be considered. For example, if there was a breakthrough technology that had no comparable alternative, there would be no comparative analysis to other available technologies since none existed. The sub-bullet points on the slide outline the new items or services that would be considered cost-effective. Additionally, CMS recognized the challenges to performing cost-effectiveness analysis for some services and technologies, including those that lack utilization and cost data.

The proposed rule was never finalized, and opponents argued that CMS could not use criteria for coverage that extended beyond clinical evidence and that the statute did not permit the agency to deny coverage based on cost-effectiveness. It was later withdrawn.

In 2000, CMS released a notice of intent that outlined criteria that would determine whether a service was reasonable and necessary under the national and local coverage process.

A new item or service would be considered reasonable and necessary if it demonstrated medical benefit and added value.

A service was said to have demonstrated medical benefit if it produced a health outcome better than the natural course of illness or disease with customary medical management. Additionally, a service would add value if it substantially improved health outcomes, provided access to a medically beneficial, different clinical modality, or could be substituted for an existing service and lower costs for Medicare beneficiaries.

Cost would only be considered in the instances where a new service or treatment was substantially equivalent to an existing covered service or treatment of a similar clinical modality.

As with the 1989 proposed rule, the notice of intent was never finalized and your mailing materials provide more detail.

Cost-effectiveness analysis has a role in the movement towards value-based health care. Some payers, including risk-bearing Medicare providers, have the flexibility to use cost-effectiveness data for medical and pharmacy management, and some private entities are currently using cost-effectiveness evidence, for example, in their formulary decisions and medical management and

negotiating pricing.

Drug and devices manufacturers are increasingly engaging with payers in value-based or outcomes-based arrangements. These arrangements incorporate both cost and clinical evidence.

The Institute for Clinical and Economic Review notably incorporates cost-effectiveness data in their assessments. Founded in 2005, the organization's goal is to provide independent analysis of evidence on the value and effectiveness of prescription drugs, medical devices, procedures, and delivery system innovations. ICER's assessments are used by payers, purchasers, and government agencies.

Cost-effectiveness analyses are widely used in countries outside of the United States. Cost-effectiveness evidence is used in these countries' decisions to cover drugs and in their negotiations with drug companies.

I will now turn it back to Nancy who will walk through concerns some stakeholders have with cost-effectiveness analysis.

MS. RAY: Despite the use of cost-effectiveness evidence by some entities, some stakeholders raise concerns

about its use. One issue is that the methods can vary from study to study, and evaluations of the same services and diseases can show different results. There is concern that some analyses are not transparent and that some analyses contain the biases of the sponsors who fund the studies and the researchers who conduct them.

The second concern relates to patients' access to care. Some argue that payers' use of cost-effectiveness information could result in not having access to all services, and that payers would not use the information to promote appropriate care. Some also argue that cost-effectiveness could interfere with the clinician-patient relationship.

Finally, some stakeholders contend that payers' use of cost-effectiveness information might slow innovation by creating a hurdle to launch medical services.

So this concludes our presentation. Commissioners should consider this information in the context of its inclusion in a June 2018 report chapter on coverage and low-value care. And we are happy to answer any questions that you might have.

DR. CROSSON: Thank you, Nancy and Emma, for an

excellent analysis and writeup and presentation as well.

We'll do clarifying questions right now. Rita?

DR. REDBERG: Thanks for an excellent overview of cost-effectiveness analysis. You mentioned in your talk and in the mailing material that it has been used very occasionally by CMS, for example, for colorectal cancer screening and cervical cancer screening. Can you say a little bit more about why there are those exceptions?

MS. ACHOLA: I guess in those instances the Congress legislatively directed there to be some sort of cost-effectiveness analysis done.

MS. RAY: Yeah, I guess I would like to come back to you with more detail about that, but in some instances, there was a direct request, and then in other instances CMS interpreted the legislative language to consider costs and cost-effectiveness.

DR. REDBERG: Okay. That would be great. I'm just trying to understand why it would be okay for some things but not for most other things.

DR. CROSSON: I think we have a couple of answers coming in here.

MS. BUTO: I was just going to say --

DR. CROSSON: Kathy, Craig, Bruce, and Dana all want to comment.

MS. BUTO: -- that for preventive services, there was a predisposition against covering prevention in Medicare, and so the way that extension of benefit was teed up was if it actually can save money and be cost-effective for the program, then it should be covered. And I think there is a whole realm of if the Preventive Services Task Force comes out with a new screening test and it appears it will be, again, cost saving to the program, then it could be covered. But, generally, the issue that I think folks were trying to get over was this lack of underlying statutory authority for covering prevention services.

DR. CROSSON: Craig, Bruce, and Dana, all on this point or separate?

DR. REDBERG: That, because, still, I think it's interesting, it's okay still for preventive services, but not for other things. What is the difference in the statute?

DR. CROSSON: Craig? No. Bruce? No. Dana.

DR. SAFRAN: I had a question [off microphone].

DR. CROSSON: Go ahead.

DR. SAFRAN: I may have asked this question when we were discussing Part D last time, but the question is whether -- because companies that have pharmaceuticals and maybe devices as well, I'm not sure, do have to provide cost-effectiveness information for their sale in other countries, as you point out in your chapter and in your presentation, I've wondered about the feasibility of just having those analyses be put forward for CMS' consideration in coverage. Has that ever been considered? It seems like the information has already been conducted, and conducted to a level of rigor to address some of the stakeholder concerns that other nations are willing to use it for their own coverage determination. So I just wonder if that has ever come up as a policy consideration.

MS. RAY: Outside of the attempts in 1989 and 2000 to try to consider an intervention's either cost-effectiveness or value or in the exception of the preventive services, no.

DR. CROSSON: Yeah, I think there's really two parts to what you're asking. One is: Could the information be made available or made public or whatever? The second part, which I think has historically been

problematic, is: And then what would Medicare do with it? And that's where I think the political difficulties have come in.

Jack?

DR. HOADLEY: Yeah, I was going to say part of the point with regard to Part D, it's not a government decision. I was going to come back to this in Round 2. But, I mean, plans can choose to make use of information. They certainly would take a look at that. But I'll talk more about that in Round 2.

DR. CROSSON: And that's a good clarification. We're really talking here about traditional fee-for-service Medicare. In fact, in Medicare Advantage and some other forms of Medicare where there's a different payment structure, organizations who are, you know, intermediaries, such as Medicare Advantage plans, do, in fact, use these techniques regularly.

Let me see where we are. So, Bruce, I think you had wanted to get in.

MR. PYENSON: Just on the point of other countries' studies, I recently had the opportunity to look at a NICE approval for a product dealing with maternity,

and the delivery of care in the U.K. is so dramatically different from that in the U.S. that it would have been just about impossible to translate to the U.S. context. So it kind of goes both ways. What might be cost-effective in another country or not may or may not here because of the different structures. So it's real interesting, some of the structural differences. For example, the cost savings relative to nurse-midwife care is not easy to translate into a context where you have global fees for delivery. Those sort of things.

DR. CROSSON: Bruce, just for our audience who may not be aware, could you just remind people what NICE is?

MR. PYENSON: The National Institute for Clinical Excellent I think is the acronym. It's a cost-effectiveness arm, agency in the U.K., and their decisions have influence on what the National Health Service in the U.K. -- Kathy's going to correct me, I think.

MS. BUTO: No. I was just going to say the other difficulty just related to your point of taking cost-effectiveness from another country is that a big component of that is the negotiated price. So it's hard to take a

negotiated price in Australia and say that's the price here and so, therefore, the same conclusion would be drawn. And, of course, in many cases the cost is much higher here. And the other thing to say is that many countries consider other factors, you know, beyond pure price, other social factors and ability to ambulate and stuff like that. So, again, it's just difficult just mainly because of the cost differences, and the fact that companies will go in and if they fail the test, may renegotiate the price. We don't have that in Medicare. So that's the mechanism for getting the eventual cost-effectiveness analysis done.

DR. CROSSON: Craig.

DR. SAMITT: I think Kathy's comment probably leads to my question, and Slide 8 is probably the best place to jump off of. The report, which is excellent, talks about using cost-effectiveness analysis for coverage determinations, and my question is: Have we ever thought about using it for pricing determinations? And drug is a whole other different ball game, but it's one thing to say if something appears to be low value, it wouldn't be covered. The other is, have we ever thought about developing algorithms or formulas -- you know, we are a

payment Commission -- formulas for payment that sort of reflect the incremental benefit that would come from any specific intervention?

DR. CROSSON: Kathy, do you want to --

MS. BUTO: The 1989 rule did do that. I think it raised the issue of least costly alternative, and using that analysis to inform whether LCA should be -- you could use that consideration to look at payment. But as you pointed out, it never got anywhere, and it was a little vague on how you would go about doing that. The intent was not use cost-effectiveness to decide something would never be covered. It was more about what's the appropriate reimbursement. At least that was the intent, and I don't know if that's what you picked up on, Nancy.

MS. RAY: Yes. And I think it might have been in the 1989 and we also think it was in the 2000 that they specifically mentioned least costly. And certainly Commissioners during Round 2 could discuss opportunities. Researchers and peer-review publications have raised the possibility -- you know, have discussed the option of using cost-effectiveness in the payment process, using cost-effectiveness to identify services for coverage with

evidence development, for example, using cost-effectiveness in terms of developing quality metrics.

So I guess the notion is it does not necessarily have to be used in the coverage process, and some have argued that using it in the coverage process -- it's sort of a blunt instrument and that maybe there's better opportunities.

DR. CROSSON: Jack.

DR. HOADLEY: Yeah, when we had our Part B drug discussion, some of the earlier rounds, it seems like that's part of what we looked at, least costly alternative as an option. We ended up with the common coding, which is sort of a different take and doesn't -- is not as explicit and really doesn't directly invoke that. But part of our discussion, it seems like, when we've gone through those options for Part B drug payment, was explicitly on that point. You know, pay based on the price of one, and if the alternative is more expensive, you know, figure out what to do with that extra cost.

DR. CROSSON: And we had quite a lot of difficulty coming to a consensus around that point, as I remember.

Okay. I'm not seeing other questions, so just to remind everybody, we're going to have this chapter in June on low-value care, and the notion here is that this material that's been prepared, which is excellent, again, would be summarized or reduced in size in some way to be part of that chapter. It's not going to be a chapter by itself per se. So I think the notion here and the discussion is: What are some of the major points that should remain, that should be emphasized for inclusion? That's kind of the notion. Or other points that I think you have to make, that you wish to make, and I think, Bruce, you're going to begin. Is that right?

MR. PYENSON: Yeah, thank you, Jay. And, Nancy, I want to thank you very much. This was a really well-balanced report and very informative, so thank you very much.

I've got two points I'd like to make to fellow Commissioners. I am emphatically, as you probably know, an enthusiast for cost-effective treatment and getting rid of the waste in the system that we've talked about many times. But I'd like to extend the concept and our discussion to things outside the academic realm of cost-effectiveness

analysis and quality and to point out that the private sector, including Medicare Advantage plans and ACOs to some extent, are using techniques every day to make cost-effectiveness decisions under the broad category of medical management, and there's extensive tools and processes and procedures that accomplish that goal, and, in fact, looking at some of the material we've produced, produced approximately a 15 percent reduction in medical spending, significant enough to cover the profits and the extra administrative expense of the Medicare Advantage plans.

There's a competing approach to getting to cost-effectiveness that's being widely used and has been used for decades and Medicare does not use outside of the 50 percent of beneficiaries that are covered by Medicare Advantage or ACOs. So I think that's a way to think about shifting patients away from dangerous and wasteful treatments. We've talked about back surgery for back pain, a whole host of issues like that that are worth tens of billions and are in front of us today.

So the use of that and those techniques are largely outside and barely footnote the academic literature, and part of the reason for that is that these

are what we might call low-hanging fruit, and the idea of using a scaler metric, a single number for complex cost analytics in the 21st century strikes me as very odd. So we have the -- quality as a measure might have been appropriate before we had the computing power that we do today, but we can actually look at particular conditions and the outcomes of those in a much, much more sophisticated way. But I think, unfortunately, when it comes to drugs, the private sector hasn't done the job, and part of that, as we've discussed, I think, is the structure of Part D where the catastrophic coverage, 80 percent of which is picked up by the federal government, is driving this high-price, high-rebate game. And I think to see the solution to that as what we've already proposed I think is the right way to go, shifting that.

So a couple of thoughts there. I think the cost-effectiveness discussion absolutely I'm enthusiastic about it, and I think this is a great start. But I really think we can move this in a direction to look at some of the low-hanging fruit that exists in the health care system today.

DR. CROSSON: Thank you, Bruce.

Rita and then Jack and Paul and Dana.

DR. REDBERG: Thanks. And, again, that was an excellent chapter.

I think it's interesting that we have the highest-cost health care system in the world, and we don't use any cost-effectiveness analysis, and perhaps there's some -- or any kind of consideration of cost, and perhaps there is some, because when people talk about markets and how we have to let markets operate in health care, most markets assume you know prices for things, and we don't know prices. You know, patients certainly don't know prices frequently in many parts of the system. So a lot of the elements for actual cost-effectiveness, you know, price transparency I think would be an improvement for our health care system, whether or not we were doing cost-effectiveness, I think there's the feeling that we don't want to put a price on things that could help people live better or live longer. And that's true. But, on the other hand, we have a system that many people cannot access because it's just too expensive, and so we have, you know, many millions of Americans that don't have any health insurance, thankfully not in Medicare, which is what we're talking about, but the rest of -- because of this problem.

But I just also wanted to note that even before we talk about cost-effectiveness, which clearly is a very loaded and, you know, has a long history as you went through, you have to -- in order for it to be effective, you have to have clinical effectiveness. And I think the example is helpful, but the numbers -- there's no interventions I know that give you 20 life-years gained. I mean, when we're talking about even very inexpensive and often it's almost nothing, like there's also nothing I can think of that's $100 that we do. We're talking thousands and tens of thousands, and now we're into hundreds of thousands. But we're talking weeks to months generally with these, you know, great new therapies that we have.

But we also spend easily billions of dollars in Medicare on things that have no clinical effectiveness, so then you're dividing by zero, and you have -- you know, you don't have to talk about cost-effectiveness. And I feel like there's a lot we could do on clinical effectiveness because we continue to pay for a lot of therapies -- Bruce mentioned back surgery. You know, we know there's never been studies showing that people do better with spinal surgery than they do with conservative therapy, but we

continue to pay for, you know, kyphoplasties, all kinds of spinal surgeries. Even for colorectal cancer screening, one of the examples where cost-effectiveness analysis was used, Medicare pays -- there's many ways to do colorectal cancer screening, and they're equally effective, according to the task force, but Medicare hasn't used cost-effectiveness analysis to say, okay, we're going to pay the cost of, say, fecal testing, which is equally effective for colorectal cancer screening as colonoscopy, which is a lot more expensive and has grown even more expensive because now it often involves anesthesia with propofol and all kinds of costs that are often not even covered by insurance. And, you know, other examples like treatment for prostate cancer, you know, Medicare pays for a lot of PSA testing that is not being done on people that it's recommended for, and then as a result of that, they go on to other treatments that we are then paying for, like proton beam therapy, all kinds of surgeries leading to negative effects.

So I'm suggesting that if we were able to look at low-value care without even looking at cost but just, you know, stop paying for things that are hurting people, our

beneficiaries, there was an opportunity to increase value without addressing cost-effectiveness. And I'm not saying we shouldn't address cost-effectiveness, but clearly there's a lot of political resistance to that idea. But I think we could really improve life for beneficiaries and save unnecessary costs for the program just by applying clinical effectiveness criteria, which we don't do now.

DR. CROSSON: Thank you. Jack.

DR. HOADLEY: Thank you. Like others, I thought this was a very well written overview and nicely balanced given the challenges of this topic. And like Bruce, I think it is important -- and others have said this already -- that some of these techniques are used a lot more in the private sector, but also including, you know, Medicare Part D plans as part of that sort of analysis and, interestingly, Medicaid plans on their drug treatments and the use of formularies.

I think one of the things that's interesting is how formulary analysis sort of thinks of cost-effectiveness analysis. Obviously, from the first point, Medicare does not, relative to Part D, say, you know, these drugs are eligible for coverage, these are not. They don't use sort

of the cost-effectiveness or any other basis to say -- you know, dictate to the private Part D plans what drugs -- other than certain categories that are statutorily excluded, what drugs, you know, may be covered. But private Part D plans are free to use whatever standards they may want to do to develop a formulary as long as, you know, there's no discrimination in that formulary, as long as there's a minimum amount of coverage per drug class. And, you know, what I've seen in looking at these, you know, the sort of classic situation is the P&T Committee, the Pharmacy and Therapeutics Committee, will evaluate the clinical evidence. They often do it in sort of a two-phase process. They'll sort of look first purely at the clinical evidence. Are these effective treatments? Are there alternative treatments for a particular condition equally effective? And if they're somewhere roughly an equivalence, then they'll look at cost. And so it's not quite the classic cost-effectiveness kind of analysis but cost comes in at that point.

Now, the other often difference in this is that cost then becomes a trigger for a negotiation process. Based on what we know about the relative cost of products

that we consider to be clinically efficient, can we negotiate with that manufacturer to get a lower price, with all the complexities of rebates and all the ways that's done, but also just to decide maybe that certain drugs, because we can't get a better price on them or because they're more expensive, you know, we're going to leave off the formulary?

So, you know, it is just, I think, interesting to think about the fact that for all the sort of animosity towards cost-effectiveness as a government decision, there has been a degree of comfort with allowing the private plans, private Part D plans, similarly with Medicare Advantage, to do this. And maybe that's an explicit political decision that that's the right way to do it. I'm not going to engage that here at the moment. But I think it may be worth, you know, including in this discussion sort of at least some observation about sort of what can go on with the private plans, Medicare Advantage Part D, and for that matter, drawing equivalencies to what's going on in the commercial sector to do this.

But I think it's also interesting -- and this sort of goes a little bit where Rita was going, you know,

there's that use of this as a starting point for negotiation, but even the Part D plans still are struggling because they don't necessarily have good evidence on effectiveness beyond the sort of basic FDA kinds of criteria, and they often don't have any good evidence on comparative effectiveness. They'll draw what's out there, and there is some evidence out there that they have to draw on, and probably the least amount of information on cost-effectiveness although the ICER analyses have tended to focus on drugs and provide something that a plan can choose to look at and say, you know, what's the relative gain, at least based on this one analysis? But, you know, the need for more studies in those areas to provide the basis to determine that drugs either are not valuable in some cases or among drugs that are sort of equivalently valuable, sort of where does the cost-effectiveness play out, more evidence in that direction would be valuable for the Medicare program even if Medicare as the government is not going to use it to make coverage decisions.

DR. CROSSON: Thank you, Jack. Paul.

DR. GINSBURG: Sitting here, going over ideas in my mind as to what could we do most useful in this report,

or if we can't get it done in time perhaps a future report, to foster better policy in this area. And I think just from Bruce's comments and some of Jack's, it seems as though some real description of how both commercial carriers and the private side of Medicare, Part D and Medicare Advantage, maybe even ACOs, how they have approached this, and then concluding with, well, if traditional Medicare wanted to do some work in this area, what might be the most feasible way to get into it? Or is this something like, you know, there would clearly be some activity, like utilization management, that Medicare Advantage does a lot, you know, and still Medicare doesn't do it. Medicare probably never will do it, probably, I could see why.

But in the sense to really focus on how these analyses are being used, and throughout private settings, and then, you know, conclusion with if traditional Medicare wanted to move in this direction, what might be feasible?

DR. CROSSON: Thank you. Dana, Kathy.

DR. SAFRAN: So I found the discussion really valuable and I think that where I'm coming from is feeling like I would like to see us take a fairly strong position

about the importance of reassessing the potential for including cost-effectiveness analysis and cost-effectiveness information. In particular, in payment, I feel less strongly about it with respect to coverage, but others who have looked at it through that lens may feel differently. But, you know, I think if we pull the lens back, as I think Rita was trying to do in her remarks, to the, you know, the broad policy issues that we have, and the challenges that we have around affordability, we have a large stream of work related to payment reform and that's going to help us a lot.

But, you know, as the great Uwe Reinhardt said, "it's the prices, stupid," and to tie our hands behind our back on that matter, just seems outrageous, for lack of a better word. And the fact that, you know -- and we could start with the places where the work of cost-effectiveness is done for market assessments and pricing in other countries.

I understand the caveats that have been mentioned, and they are important ones, about how that information can't be used directly, but the scaffolding is there, in these companies, to do that kind of work and

provide that kind of information, and for us to not take advantage of it, just when we have the challenges that we do around affordability, and when we have, you know, the tidal wave coming at us of specialty drugs and what they're going to cost, you know, just seems like a huge miss.

The last thing I'll mention is that why I would focus us first in, you know, drugs and the spaces where other nations are already doing this work is not just that the scaffolding is there but as part of the scaffolding that the measures are there, the patient report outcome measures that tell us whether an intervention works and how much to improve patients' functional status, their pain, their emotional well-being, whatever that intervention is trying to do, they are systematically in trials, evaluating that.

And that just brings me to the last piece, which is the absence of that information for most of the rest of what we do in health care is part of the problem. And there are some bright lights that -- of where patient report outcome measurement is now being systematically included beyond clinical trials, in frontline clinical practice, and helping organizations, some of which are

ACOs, to identify which treatments actually are most promising and for which patient subgroups in achieving good results, and which ones aren't.

So, you know, I'd be glad to follow up offline and share some of those. The work at the University of Rochester Medical Center is tremendous. We at Blue Cross have been motivating the adoption of patient report outcome measures in six clinical areas, and they are pretty far along in two of them, since 2013, and we're pretty far along in two of them.

So I would like to see us somehow get across the point that beginning to incorporate this area of measurement into clinical practice is what's needed for us to be able to not just do cost-effectiveness analysis but really to continue on the path of value-based payment. You know, we all agree we need outcomes-based measures, and these are really the ultimate measures of telling us whether what we're doing for patients in the name of trying to improve their health status is working.

So I think we can start with the places where they're already systematically collected and then move to their broader adoption in places where they're not.

DR. CROSSON: Thank you, Dana. It just reminded me, a good point to point out here, that with respect to drugs, as Jack has pointed out, some of these techniques, formularies, limited, although it is, is used in Part D, and our standing recommendation for Part B drugs, in fact, includes the notion of, you know, value-based decisions made by groups of physicians using formulary mechanisms and the like. Every chance I get to say that, I'm saying it.

Kathy.

MS. BUTO: So one of the things that Rita brought up, which I think is important, is this issue of paying for more clinical effectiveness studies, and I think the question I have is who would pay for that? You know, CMS tried to use coverage with evidence development, because the hook there is if you want to be covered you've got to actually produce additional clinical studies to show that coverage ought to be extended to whatever area.

So I think that is something that this issue of how do you get more clinical effectiveness studies done and can you leverage the Medicare program to do that is something we could raise.

And I agree with Paul that it's really helpful to

say something about how private payers are using cost-effectiveness analysis, because I don't think many of them are using it to deny coverage. I do think they are using it to establish payment or negotiating rates. And so the question of how do you sort of, you know, talk about that in the context of what Medicare can do is important, but I think it is very important to establish that, unlike other countries where they do actually deny coverage and say you're not going to be paid for by the national health service, we don't do that here. So what do we do and what are commercial payers doing?

The other thing is just back to Dana's point. If we're going to talk about other countries, there really are a whole variety of different ways that other countries deal with, say, new drugs, beyond cost-effectiveness analysis, and if there's going to be any kind of index -- and I -- you know, I balk at the idea because there are so many, but France, for instance, has a very different way of approaching new drugs. It's more analogous to what Peter Bach has suggested, which is kind of a trial period of a couple of years, until the data, in real world, are available, and then they can be reassessed. That kind of

thing is something that could also be mentioned here.

DR. CROSSON: We have David, Rita, John, Alice, Jack.

I'm sorry. Did I miss Craig?

DR. SAMITT: I'll go at the end.

DR. CROSSON: Okay. Sorry. I didn't see that. Now I lost track of what I'm doing here. David.

DR. GRABOWSKI: Great. Thanks.

One of the phrases we use a lot at these meetings is that we want to move the Medicare program from paying for volume to paying for value. And so what I really like about this chapter is it really gets at this explicit definition of what is value. I think we need to be very clear about that, that we're all speaking a common language. So this is a really nice contribution in that regard.

The other part here that I really like is that it broadens our thoughts around not just using at-risk payment to drive value but rather thinking about coverage decisions. I would even put cost-sharing as part of that, not just yes-no on coverage but can we think about value-based insurance design as well. There are a lot of tools

in our toolbox. I think we've been very limited in Medicare. I would encourage us to be broader and bolder in terms of how we think about cost-effectiveness. Thanks.

DR. CROSSON: Sorry. Rita, Jon, Jack, Craig. Did I miss someone? Okay, Rita.

DR. REDBERG: I just wanted to pick up on Kathy's point about coverage with evidence development, because I think that's a great suggestion, and I think that can work very well because it allows sort of studies that don't have clinical data. Like, you know, we're using here life years gained, but most things that are approved by the FDA don't have life years gained, and the FDA increasingly, certainly for drugs and devices, is approving on the basis of surrogate markers, and we don't get life years gained. You don't get anything close to it. I mean, even the U.S. Preventive Services Task Force doesn't use life years gain -- doesn't use all-cause mortality. It uses disease-specific mortality when it's evaluating, for example, cancer screening interventions.

But coverage with evidence development, which I think was used, to me, most successfully in the lung volume reduction surgery, where the NIH partnered with CMS because

there was this exciting, as it was described, new surgery that could help people with emphysema, it was thought. But the only way you could -- and the surgeon, I think, came to CMS and proposed this trial, because he was very confident that it would result in, you know, great results and coverage. And so the only way you could get the surgery was within Medicare's clinical trial, and Medicare actually collected the data.

And I mention that because there are other examples like for PFO occluders, where if you can get the same thing outside of the trial, it's very hard to get referrals because, as investigators or doctors have said, "Why should I refer to a trial when I can get paid for doing the same thing?" But the other part of it is that then it has to be sort of a conditional, or for a few years, as you were suggesting, with Peter Bach, which sounds like a CED for drugs kind of, because then you have go look at the data and actually go back and say, okay, this worked, and, you know, this is a good thing and we're going to cover, or it didn't work. Because we have a very long history of when something is out and used, PSA one example, but lots of them, it's very hard to pull it back.

So there has to be a clear sort of parameter set in understanding when we start that this is coverage with evidence development and this will be covered under this program, only under this program, we'll analyze the data, and then make the decision on what's best for the program and beneficiaries.

MS. BUTO: And not limited.

DR. REDBERG: And not limited, yeah.

DR. CROSSON: Thank you, Rita. Jon.

DR. CHRISTIANSON: Yeah, I really liked Dana and Paul's comments. So we could speculate about why this hasn't gone very far in the past, but I think we're now in a really tough environment for Medicare going forward, maybe more than we've ever seen in the past, with the growing expenditures and the growing enrollment in the program. And, frankly, our -- you know, the options Congress has to deal with that are not going to be that palatable. Are you going to increase cost-sharing by beneficiaries? Are you going to shift cost back to beneficiaries? Are they going to have lower payment increases for providers? Of course, everybody is in favor of reducing fraud, waste, and abuse, and we're getting

better at that with data-mining.

But I think it's incumbent on us, as a Commission, to lay out the options that Congress is going to have, or could have, as they try to address this problem, and to omit laying out options in this area would be a very serious omission on the part of the Commission. I think we need to be the ones that say, "Look, there is this other option that could be brought into play and here's how it might be brought into play."

So I'm really glad we're dealing with this but I think the key, as Paul was saying, is now what's the next step. This was a nice overview piece of what it's all about. What we have to deal with, as a Commission, is how do we want to lay out this to Congress in the context of you've got an enormous problem here, there are some levers that you have available, and here's one, and how might it be used to, you know, effectively, intelligently.

So this is a good topic. As I read the chapter -- I was telling Jay this -- I used to teach this course. I was like, okay, Cost Effectiveness 101. This is nice. But then the discussion has really been, I think, interesting, and started pushing us in another direction so that this

turns out not to be, I hope, just an educational chapter but a kickoff to a strategy that the Commission would have to sort of make sure the Congress sees all the options for controlling costs going ahead, and sees this as one thing that they should be considering.

DR. CROSSON: Okay. Jack.

DR. HOADLEY: Yeah. My just one comment is sort of triggered by Kathy's comment about, you know, denying coverage of something we tend not to do, but again, to use the sort of drug example, a Part D plan, like other commercial or Medicaid plans, you know, may, in fact, deny coverage when they leave a drug off formulary. You know, they do it in the context of there being other drugs for that same coverage. But if a plan thinks that the PCSK9 drugs for cholesterol are not a significant improvement over the much less expensive statins, they can choose not to cover those, and generally the way the Medicare Part D rules, you know, that's not a problem with the minimum coverage for a drug class because there's other cholesterol drugs covered.

But I think also the common approach to a lot of these things is coverage with prior authorization, which

becomes a sort of partial denial of coverage. So, again, a lot of plans, most plans, when they hepatitis C drugs came out, said, well, you know, they're expensive, we can't afford to make them available to everybody so we're going to cover them with prior authorization, in some cases a very strict prior authorization, and said only people that were, you know, at risk of a liver transplant or somewhere way down the clinical line. And you can debate, you know, the particulars of those decisions.

It's not necessarily an ideal way to do it, because it puts a burden back on a beneficiary, on the clinicians to push past that if they need coverage. But, you know, prior authorization does, and it's not just in the drug field, obviously. A lot of plans are using prior authorization for other kinds of things. But it's that's sort of part-way move, and I think to the extent that we think about where prior authorization fits in various parts of the system, whether it's Medicare itself doing it or whether it's only through Part D plans and MA plans, you know, I think, again, that's a big part of this story, how that plays out.

DR. CROSSON: Okay. Thank you. I've got -- hold

on a second. I've got Craig first, then Kathy, then Brian. Right? Did I see -- okay.

DR. SAMITT: So Dana's comments really resonated with me, and I would imagine that this has probably been one of our more uncomfortable discussions because we -- this was a want-to-know discussion as opposed to how do we push this further. And it feels to me that there are fewer more important topics that the Commission needs to discuss than something like this. And we've had several meetings where we talk about the need to be bolder, and if we really want to advance, on behalf of the beneficiaries, high-value care, this is not a topic that we need to, or should shy away from.

You know, from my point of view, what other industries advocate for paying excessive prices for things that don't work, or things that are of incrementally higher benefit than something of a lower price?

And so I understand the hesitancy about coverage, but I don't see why we wouldn't sort of tackle relative pricing appropriate to an incremental benefit for many of these services.

I also just -- I'd like the Commission to be

consistent. You know, we talk about, in other settings, comparative effectiveness. I mean, we spend nearly every meeting talking about PAC bundles, the reality being that we shouldn't be paying differential prices for comparable outcomes or comparable services. We concentrate in other areas on comparative effectiveness today. It feels like we need to be consistent in this regard as well.

So I agree. I think we need to be bolder and I don't think this should be just an FYI type overview, that we have to determine where we should go with this.

DR. CROSSON: On this point, Alice.

DR. COOMBS: So I really agree with Craig, and something you said earlier really resonated with me, the whole notion of a new entry into the market, whether it's from pharma or whether it's an intervention. And I was thinking, what can we do to actually help this chapter along, so that when some Congressman picks it up, or staffer picks it up, they can say, "Okay, there's something in here that I need to -- a knowledge base for when this new group comes in and advocates for something." And one of the things is to consider a framework for the notion of a new guide to the market and the magnitude of the pricing.

And so that, in and of itself, will -- even if it's cost-effective, even if we do the data and it says, okay, this is a cost-effective intervention, the magnitude of that will impact, by itself, whether or not the pricing comes out at X, Y, and Z. And I think that's really important for us. Just like we did a framework, we did principles for quality establishment, we should do principles and how cost-effectiveness can best be used. That might be something that you do at your retreat.

DR. CROSSON: Okay. Thank you. All right. I've Kathy, Brian, and Bruce. Is that what we've got? Okay. Kathy.

MS. BUTO: So I want to go back to something that Jack said because I know we can get really excited about doing this, but I think the most difficult part of doing this in Medicare is the notion that there will be a single body, CMS or its agent, that does this, and it will have, you know, NICE-like implications. I think the current success of cost-effectiveness use in Part D plans and Medicare Advantage is at least initially the most likely and probably the area where cost-effectiveness analysis should be promoted, because very few opponents of cost-

effectiveness analysis would disagree that at the level of individual plans, insurers, et cetera, that this information should not inform what they cover, their formularies, and how patient care is delivered.

I think the resistance has always been at the level of is the federal government going to establish a body that will in essence be, you know, the government telling you what you should or shouldn't get in medical care. And it's sort of analogous to the death panel discussion.

So I'm just saying this because I think that I've been in this area for a long time, since 1989, and that was always the resistance. In 1989, we got the only comment letter we have ever gotten signed by AARP, the AMA, the AHA, the device manufacturers, and PhRMA. It was, you know, uniformly concerned with rationing, the government getting into this area, et cetera.

So things have changed since 1989. A lot has changed. But I still think there is a greater degree of acceptance of this being done not at a national body level but by individual key components of the Medicare system, whether it's hospitals or et cetera.

Now, having said that, I really believe that -- and it's what Rita brought up earlier -- Medicare has an obligation to support and in some sense leverage the program to get some of these studies done, because no one else is going to do that. The NIH alliance around lung volume reduction was an unusual step. There are other things that could be done. It takes a long time to do these studies, but somebody has to do them, and no one has the incentive to support the study itself except Medicare if it's for the beneficiary.

So I don't know what the right combination is, and maybe we'll get to a national body, but I don't think that's the easiest path, if you will, to getting cost-effectiveness and comparative effectiveness adopted in Medicare. So I would just say as we think about this -- and I think it's definitely worth thinking about -- we need to think about what are the ways in which Medicare might do something like this, whether it's to influence payment policy or coverage policy.

DR. CROSSON: On that, Paul.

DR. GINSBURG: I think Kathy's ideas are very wise, and one follow-on is that we should be looking into

are there any restrictions on MA Part D ACO plans that could be loosened or remove to in a sense get a fuller -- at least a full, you know, decentralized approach to this, even if we can't at this time move the core traditional program.

DR. CROSSON: That's a good point, and I'll just take this moment to reemphasize that, in fact, our standing Part D recommendations do just that -- not perhaps as far as we might go, but we do have those changes, recommended changes in the restrictions on Part D plans if you remember.

Now, I'm getting confused here. On this same point? Jack and Rita on this point, and David, too, on this point? Okay.

DR. HOADLEY: Just very briefly. I think the other piece of that is the prior authorization exceptions process that is essential if you're going to start having these restrictions, but there are situations where individual people still need that, and we did talk about that, obviously, in the Part D context.

DR. CROSSON: Rita and David on this point.

DR. REDBERG: And just on Kathy's point, Medicare

is already paying for a lot of these and really investigational drugs and interventions, because there are so many things on the market that have little to no clinical data -- that have little to no clinical data and certainly no data on effectiveness but Medicare covers them. I just would note there also is this early feasibility program that the FDA has now been pushing in conjunction with CMS because CMS already pays for like -- if you're doing an investigational trial of a device, CMS doesn't pay for the device, but it pays for all your hospitalization care, which is quite expensive. It's already paying for those trials. And now the idea is to move it even earlier and to have CMS even pay for the investigational device costs. So CMS is really already footing a lot of trials, but we're not getting the data from them, and we're not making coverage decisions based on that data. So I think it would be a real improvement to have sort of an evidence-based system where we're covering things that actual help our beneficiaries.

DR. CROSSON: David.

DR. NERENZ: Thanks. Just to follow on Kathy's point, clearly it has been very difficult for CMS to go

down this path for at least 30 years, and there's a lot of reasons for that. There may be a little greater opportunity, though, if we change the framework a little bit. The chapter and our discussion have talked very appropriately about cost-effectiveness as a property of a treatment. But we could also think about cost-effectiveness as a property of a provider or a plan, and if so, there may be some elements where the doors are already somewhat open, where if beneficiaries could be encouraged to choose cost-effective plans or providers, what we're picking up is that dynamic that's much more local, much more decentralized, of making over and over again on a daily basis good cost-effectiveness choices. It's not CMS doing it. It's somebody else doing it. And the trick would be programmatically to link beneficiaries in a positive way and not a forced way to those plans and providers. So you may get it in a sideways way.

DR. CROSSON: Okay. I've got Brian and then Bruce.

DR. DeBUSK: First of all, thank you both for a very well written chapter. It was a great read.

I want to talk a little bit about what Craig

mentioned, which was that you could argue this is one of the most important things, if not the most important thing that we could do right now, considering the limitations and constraints of our current system. And I really liked where Jon was taking us, if I heard you correctly, this idea of going to the Congress with basically a menu, sort of a steady escalation of ideas all the way from, you know, Rita talking about just is it simply effective, a go/no-go decision, but then incorporating this escalating -- I hate to say aggressive, but increasingly aggressive things that we could do, you know, to Jack's point about prior authorizations or about some of the other utilization management tools along the way.

So I think it would be fantastic to have this menu of options with a steady escalation of effort, but I also think it's important that we go to the Congress with an implementation plan, because, you know, you think about how do you even -- let's say that we've identified our comfort level with what we were going to do. Well, what do we do? Do we go after new therapies first? Do we go after the most expensive spend areas? I think we would need to bring a predictable way of knowing, for lack of a better

term, whose ox gets gored first. And I think having a methodology there that we could also bring to the Congress hopefully would increase their comfort level that this can be implemented, because I can't imagine us just turning whatever methodology they want loose on every therapy simultaneously.

Then the other thing, Kathy made, I thought, a great point about some way to distribute this, again, this idea that one person would make this call or one body would make this call that would have these sweeping ramifications. I wonder if this is something that we could do at the MAC level through LCDs. Is this something that we could -- much like our coverage determinations have sort of a natural diversification to them, could we allow the system to sort of percolate up through local coverage determinations and incorporate that at the MAC level?

And then, finally, the last point I wanted to make, I know we're always looking for new tools for ACOs. You know, again, we're very invested in seeing ACOs be successful. Maybe some of these new tools or these new methodologies are things that, even if they're established at, say, a local or a regional level, maybe these are tools

that we allow ACOs to access just to increase their chances of success as well.

Thank you.

DR. CROSSON: Bruce.

MR. PYENSON: I was struck by Craig's characterization, correctly, of the work we've done on unified PAC as a form of comparative effectiveness, and perhaps we need new words for that or a new name for that, but I think that's exactly right. And it points out, I think, the value of using real-world evidence that that kind of work would have been very hard to do in a clinical trial, but we've got a wealth of real-world data to find answers and to come up with solutions. So I was particularly truck by that.

DR. CROSSON: Okay. I just want to see if I can bring this a little bit together for the benefit of the staff because, remember, what we're going to do here is this is a section of a chapter, not an entire chapter. However, after the discussion, I think it may be a longer section than we might have anticipated. But this is just a suggestion based on the discussion in terms of what we can do now and what we may need to do later, particularly, you

know, starting off, as you have, with a discussion of what comparative effectiveness analysis is.

Then I would think I would suggest, based on the discussion here, we go pretty rapidly in the paper to how this is used outside of the Medicare program per se, but also with respect to Medicare Advantage plans, accountable care organizations, and the like, what it's currently -- how it's currently being used for Medicare beneficiaries in these arrangements other than traditional Medicare.

Then I think what you might want to do is talk a little bit about -- and relatively short maybe, talk about the fact that it has been tried in traditional Medicare, as you have in the chapter, and that hasn't necessarily worked already so well. But then I would go I think more substantively, as we've heard here in the presentation, to elements of things that we've proposed already that are a solution to this problem in part, and I would say our recommendations on Part D, as Paul brought up, or our recommendations with respect to Part B, our commitment to delivery system and payment reform, you know, creating a ramp-up for more AAPMs or other organizations that have both the incentive and the ability to provide and use these

tools.

Where I think we can't go in this part of the chapter right now would be to propose a series of changes to traditional Medicare, some of which I think people have suggested and are good ideas, but we have not analyzed them nor discussed them nor to come to any consensus about what that would be. Brian, I think in your comment you said, you know, let's think about delivering to Congress a plan for the application of some of these principles to traditional Medicare. But we haven't done that yet. We don't have a plan. So we would have to put in our work flow that sort of work so that we can bring to the table all the theoretical and practical considerations in terms of what that would be. But I don't think we're ready to do that in this section of this chapter quite yet.

Yeah, Kathy?

MS. BUTO: So I also hope you can mention this issue of clinical effectiveness work, some of which the agency's already doing, as Rita pointed out, just to say that that's sort of a predicate and we're going to be looking at that as well, because it's not just for new stuff. It would be for existing covered -- not that we'd

want to say this necessarily in the chapter, but I think the issue that Rita's raising -- and I think it's really a path that we ought to be looking at as well -- is, you know, how do we get better clinical information about effectiveness on these therapies and treatments before they proliferate in Medicare and it's impossible to pull back? Which is what usually happens. So, you know, that whole area is necessary in order to do anything going forward on cost-effectiveness.

DR. CROSSON: Yeah, that would be a good -- Rita, is that what --

DR. REDBERG: Absolutely [off microphone].

DR. CROSSON: Okay. I think that's a good addition. Thanks.

DR. REDBERG: Because people always say, "Oh, it's expensive to do trials." Well, it's really expensive to keep paying for things that don't work and make people worse.

DR. CROSSON: Right, so an emphasis on the tools that already have been used. So is that helpful?

[Ms. Ray nods head in the affirmative.]

DR. CROSSON: So you think in 20 30 pages?

[Laughter.]

DR. CROSSON: All right. Thank you. Good discussion. Thank you very much, Nancy and Emma, for the presentation.

We are now at the last presentation for the March meeting, and we are going to talk about two potential new quality measure that we have been talking about a little bit already, for a while. And Ledia and David are going to take us through those two. And then I think at the end of the discussion we'd like to say, for each of them, what do people think and do we want to move forward with this particular measurement approach or not.

Ledia?

* MS. TABOR: Good morning. Today we'll continue discussions about quality measurement in the Medicare program, based on the Commission's premise that Medicare provider payments should not be indifferent to the quality of care delivered to beneficiaries.

In this session, we will review the Commission's principles for how to measure quality of care for beneficiaries in the Medicare program. We will then discuss our evaluation of using two population-based

measure concepts to measure quality in the Medicare program, potentially preventable admissions and home and community days.

The Commission has previously referred to this last measure as healthy days as home. Based on the Commission's feedback during a previous discussion, we are using the name "home and community days," which does not assume that beneficiaries are healthy.

The Commission has recently formalized a set of principles for measuring quality in the Medicare program that we can apply to measure development and modeling the design of value-based purchasing programs. Over recent years, the Commission has articulated elements of these principles in its policy development process, but we now present them in a complete framework.

The principles are as follows: quality measurement should be patient-oriented, encourage coordination across providers and time, and promote change in the delivery system. This quality measurement should not be burdensome for providers. And as we'll discuss today, Medicare quality programs should include population-based measures such as outcomes, patient experience, and

value. Providers can use their own more granular measures for their own improvement processes.

Also, Medicare should give rewards based on clear performance targets as opposed to "tournament models," where providers are scored relative to one another, rather than on their absolute performance. The Commission believes that Medicare payments should take into account differences in provider populations. Medicare should account for social risk factors by directly adjusting payment through peer grouping, as opposed to directly adjusting measure results.

Medicare should also target technical assistance resources to low-performing providers. And finally, Medicare should support research to reduce measurement bias, for example, about the effects of social risk factors.

The Commission has the principle that Medicare quality should be assessed using the same population-based measures such as potentially preventable admissions, readmissions, and patient experience. The population can be defined at different scalable levels, such as the fee for service population in a geographic area that represents

local health care markets, MA plans, ACOs, and providers such as hospitals and groups of clinicians.

The work we are presenting today tests the utility of using two outcome measures the Commission has previously been interested in -- to assess the quality of care fee for service beneficiaries receive as defined by different geographic areas, the MedPAC defined market areas, and Dartmouth-defined hospital service areas.

In this proof of concept work, we are investigating whether we can capture the quality of fee for service beneficiary care at a market level and whether there is variation so that we can compare that fee for service quality across markets.

I will now present information on the potentially preventable admissions measure concept.

Beneficiaries who are hospitalized can be exposed to health risks including hospital-associated infections, medication errors, device failures, and pressure ulcers. Some hospitalizations, such as those related to diabetes and pneumonia, can be potentially preventable if ambulatory care is provided in a timely and effective manner.

Rates of potentially preventable admissions can

reflect the quality of the care provided in a local market area.

To test our proof of concept of using population-based measures in fee for service, we applied an NCQA HEDIS measure to fee for service administrative data. This is a quality measure that MA plans calculate and report. In the past, the Commission has suggested that we look into the use of this measure.

We have previously used a 3M measure to capture potentially preventable admissions, but the Commission expressed concern that the measure was not available in the public domain and had complicated definitions of potentially preventable admissions.

Today we focused our analysis on observed rates of admissions because more development work is needed to incorporate risk adjustment in our fee for service data.

This measure represents the rate of potentially preventable admissions per 1,000 beneficiaries by chronic and acute conditions. The rates include admissions with the primary diagnosis of the following chronic conditions: diabetes, COPD, asthma, hypertension, and heart failure. The rates also include admissions tied to beneficiaries

with the following acute conditions: bacterial pneumonia, urinary tract infections, cellulitis, and pressure ulcers.

For 2016, there are about 22.5 million fee for service beneficiaries nationally include in our measure calculation.

This slide presents national observed rates of potentially preventable admissions calculated for different populations of fee for service beneficiaries. As shown at the bottom of the slide, there are nationally, on average, about 15.3 acute-related potentially preventable admissions per 1,000 beneficiaries, and 17.7 chronic condition-related potentially preventable admissions per 1,000 beneficiaries.

To test our proof of concept, we also analyzed potentially preventable results for different subgroups in the fee for service population. As shown at the top of the table, older Medicare beneficiaries have higher rates of both chronic and acute admissions. In the gender group, female beneficiaries have higher rates of acute admissions, and about the same rate as men for chronic admissions.

Finally, both fully and partially dual-eligible beneficiaries have higher rates of acute and chronic admissions compared to non-dual beneficiaries. These

patterns are consistent with our work with other measures. These patterns are also expected when comparing admission rates that are not risk-adjusted for population characteristics.

We are testing a proof of concept to assess fee for service quality across health care markets, so we calculated the rate of potentially preventable admissions for both acute and chronic related conditions in each of the over 1,200 local market areas that MedPAC recommends for MA payment and quality reporting. We then looked at the variation in measure results across market areas.

We found that these observed potentially preventable admission rate varied across market areas, with the lowest-performing market areas having a rate that was over two times that of the highest-performing market area. We found a similar pattern when calculating results for a more narrowly defined health care market called hospital service areas.

In summary, we found that in the fee for service population, observed rates of potentially preventable admissions showed some noticeable differences. By population groups -- age, gender, Medicaid eligibility --

and by market area and hospital service area. If the Commission would like, we could develop a risk-adjustment calculation for the fee for service population to derive observed to expected market rates.

I will now talk about the second population-based measure we are testing in our proof of concept, home and community days or HCDs.

The Commission has been discussing this measure over the past several years. The HCDs was designed to try to assess how well health care organizations that take responsibility for a population keep people out of health care institutions. It was also envisioned as a measure that beneficiaries could easily understand and that they could use to select their Medicare coverage.

Today we're going to discuss some continued analysis we have done on this measure concept. As I'll describe over the next couple of slides, we did not find much variation between HCDs and market areas, even when looking at a sicker population. This lack of variation makes us question the utility of the measure.

In HCDs, beneficiaries are followed for the entire calendar year. HCDs is calculated by subtracting

from 365 the days in which beneficiaries claims data identified days in the hospital, post-acute care, and mortality days.

The Commission has discussed whether or not to subtract home health from the measure, because home health visits may be more desirable than hospital or other post-acute care days. We did some analysis to understand the effect of excluding versus not excluding home health visits, which is included in your paper, and I'm happy to take on question. The values that I will present today subtract home health visits from HCDs.

Our measure analysis includes about 27.3 million fee for service beneficiaries 65 years and older.

The Commission has been working with a team from the Harvard School of Public Health to test our prototype HCD's quality measure. A critical step in the development of the measure is to develop a risk-adjustment model to make sure the measure reflects an organization's quality of care rather than underlying differences in patient severity.

As discussed during the November 2016 Commission meeting, we used a linear regression model with market

fixed effects that included age, sex, and disease burden, since those are common patient severity variables. We found that disease burden, age, and sex had the greatest impact on HCDs.

We also wanted to test the effects that social risk factors may have on the risk-adjustment model. When Medicaid status was added to the regression model, it did not change the explanatory power of the model. However, we did find some market-level Medicaid effects, meaning that markets with a higher percentage of Medicaid beneficiaries tended to have lower HCDs. Based on the Commission's quality measurement principles, in the future, if HCDs are used to adjust provider payments, Medicare should account for these social risk factors by directly adjusting payment through peer grouping,

To understand HCDs for different Medicare beneficiaries in different market areas over time, we calculated mean risk-adjusted HCDs in each market using three years of fee for service Medicare data for two populations, beneficiaries 65 years and older, and beneficiaries 65 years and older with at least two chronic conditions.

As expected, based on our previous work, we found that Medicare beneficiaries with greater chronic condition burden had fewer HCDs. In 2015, the adjusted HCDs' rate for beneficiaries 65 years and older was about 348 days, compared with 320 days for beneficiaries 65 years and older with two or more chronic conditions.

We also see that HCDs were relatively stable across the three years, which is what we would expect to see in the measure, since we know nationally that HCD components do not dramatically change from year to year.

As with the potentially preventable admissions, we calculated the distribution across both market areas and hospital service areas to understand the potential to compare quality across markets.

As shown in the first column, beneficiaries 65 years and older had a difference of 5 days between the 90th and 10th percentile market areas. As shown in the last column, the distribution for the beneficiaries 65 years and older with two or more chronic conditions was 16 days. The higher-performing market area's HCDs was about equal to that of lower-performing market areas for both populations, as shown by the ratios at the bottom of the table. We also

found that when home health is not subtracted from HCDs there was even less variation in HCD rates across the market areas.

The variation is limited, so a significant challenge in implementing the measure in Medicare is whether there will be meaningful differences between payment models and how best to communicate any differences to providers and beneficiaries.

In summary, we were able to capture risk-adjusted HCDs at the market and hospital service area level for two fee for service populations. We found that beneficiaries with chronic conditions have less HCDs and slightly more variation in market-level results. However, variation in HCDs for both populations is very small, which limits the ability for beneficiaries or providers to compare HCDs. HCDs for both populations were relatively stable across several years.

We tested the proof of concept using potentially preventable admissions and home and community days to evaluate the quality of care for fee for service beneficiaries in market areas. After answering any clarifying questions, we would like the Commission's

feedback on further work to use a small set of measures to assess quality for definable populations.

There may be limited utility of the HCDs measure.

Some potential next steps for the Commission's discussion includes calculating risk-adjusted fee for service and ACO potentially preventable admission rates.

Thank you, and look forward to the discussion.

DR. CHRISTIANSON: Okay. David has got a clarifying question.

DR. NERENZ: Yeah, thanks. Just if you can go to Slide 11, I just want to clarify. The differences you show here, these are unadjusted, right?

MS. TABOR: Correct.

DR. NERENZ: So they are not adjusted for what's in Slide 10?

MS. TABOR: They are not adjusted.

DR. CHRISTIANSON: I mean, theoretically you could, but they're not.

MS. TABOR: Yeah, exactly. That's one of the questions we have for the Commission, is do we want to do that.

DR. CHRISTIANSON: Okay. Dana, Jack, Brian.

Okay, let's start with Dana and move down.

DR. SAFRAN: On the HCD, I'm wondering whether it's possible or whether you have looked at differences for different types of health care organizations and, in particular, organizations that are functioning as an ACO, beneficiaries attributed to those versus not. The thinking behind this question is sort of like my comment yesterday around readmissions, where, you know, before anybody was really working it we found there wasn't a lot of difference. You know, the differences were noise. And so with this, the fact that you don't find market differences maybe isn't such a surprise, but who would be working on this would ACOs. So I just wonder whether you've explored that.

MS. TABOR: We've done some preliminary work on it, and are still not finding much variation between fee for service and ACOs, and when I say variation, we're kind of running into the same issue of perhaps ACOs and markets are 0.2 days lower than fee for service, but is that a meaningful difference? It's hard to tell.

MR. GLASS: Yeah, we did that with, what, the 20 percent sample.

MS. TABOR: We started it, yeah.

MR. GLASS: Yeah, so the question was should we extend that or not to the 100 percent.

DR. HOADLEY: Yeah, two questions. One is you reference, in the paper, a recommendation we made back in 2011 on QIO. Has there been anything -- have QIOs evolved in any direction relevant to what we talked about then?

MS. TABOR: I wouldn't say so. I think QIOs are still existing and still, you know, working in their communities.

I would say one thing that I think with MIPS and CMMI there's been kind of QIO extensions to work with hospitals, the HENs, the hospital engagement networks, and TCPI, which I believe is -- it's for primary care practices, really.

DR. HOADLEY: Okay.

MS. TABOR: So perhaps more resources have been devoted to things to improve community-level quality improvement, but not much change in the QIO structure, the results.

DR. HOADLEY: Okay. And my other question, on the potentially preventable admissions measures you said that the sample is age 67 and up. Why that particular --

MS. TABOR: That was because we really wanted to follow the HEDIS specification.

DR. HOADLEY: Okay.

MS. TABOR: I think their rule of thumb is MA plans should kind of have accountability for a population for a year or two before they can be held accountable.

DR. HOADLEY: Okay. And have you done anything to look at the under-65 population and any reason to suspect that would be -- there would be interesting differences there?

MS. TABOR: We haven't. I would say that, again, since we've used the 3M measure before, and that did use 65, there wasn't much of a difference, but we could look into that.

DR. HOADLEY: Okay.

DR. DeBUSK: Do you guys want to guess my question?

[Laughter.]

DR. DeBUSK: No, first of all, thank you for the work. It's fantastic work and I'm very supportive of what you guys are trying to do.

But as a clarifying question, on Slide 17,

please, if you look at the lowest decile of the most medically complex patients you get 311 HCDs. In the 90th percentile, highest-performing, the least medically complex patients, you get 351 HCDs. Is it fair to say that measure is topped out? It's basically 10 percent of the range from best to worst.

MR. GLASS: That's what we're concerned with.

MS. TABOR: Yeah.

DR. DeBUSK: It is a topped-out measure.

Have you looked at mean time between failure as opposed to -- and again, and not to get into a Round 2 issue, but, you know, I think if, say, a frequent flyer to the emergency department, who is there like a clock every two weeks, versus, say, someone who has one LTCH stay, well, they may both produce 26 facility base days per year, but those are very different experiences, you know, frequent flyer versus someone who just had a spell of illness that qualified for LTCH.

So could you speak to maybe the difference in MTBF versus HCDs?

MS. TABOR: So I will say that we didn't look at the mean time between failures because kind of the general

thinking behind this measure, the healthy days at home measure or home and community days measure that we've been working on is the idea of it should be easy for beneficiaries to understand. It's like 365 days in a calendar year, so --

DR. DeBUSK: So if an ACO says, "Choose us because we can keep you out of the hospital on an average of 400 days at a time," that's pretty to understand, isn't it?

MS. TABOR: Yeah --

DR. DeBUSK: To say as a beneficiary, "We'll keep you out of the hospital roughly 400 days or so."

MS. TABOR: Yeah, I mean, we could talk to beneficiaries about that if the Commission wants us to proceed with that.

DR. NERENZ: On that point, wasn't -- I couldn't bring it up fast enough on my computer. Wasn't there a table in the full written chapter that said that of the little variation we have here, death is actually the major driver of the variation you see?

MS. TABOR: Mortality is the highest component.

DR. NERENZ: Mortality. There aren't that many

time between failures. You only fail once.

[Laughter.]

DR. DeBUSK: Well, that's what an engineer would call a "catastrophic failure." But in healthy days at home, I mean, here's a great example of your problem. A beneficiary who dies on January 2nd has a very different healthy days at home score than a beneficiary that dies on December 30th.

DR. NERENZ: That's the point [off microphone].

MR. GLASS: Right, and so you would include mortality in mean time between --

DR. DeBUSK: Mortality would be a catastrophic failure. So what you would do -- and, again, I don't want to go Round 2. I don't want to break my streak, staying out of Round 2 this meeting. But what you would do is basically look at mean time between facility-based care, and that would be the key metric that you would report, is this is how often we will keep you out of our facilities.

MR. GLASS: So you would not include mortality.

DR. DeBUSK: Mortality would be a catastrophic event that would basically end the -- yes, you would not incorporate that into the calculation.

DR. CROSSON: It looks like we're coming up this way. Alice.

DR. COOMBS: Thank you very much, Ledia and David. Is it fair to say that plus or minus home health does not make a difference in the variation in terms of the instrument, your estimate is that this is not of high utility for us? There's a comment that says it's feasible, but because it's feasible doesn't mean it has a utility for us.

MR. GLASS: Well, as Dana has pointed out, the more interesting question, would it work between ACOs and the general population or between --

DR. COOMBS: For the general fee-for-service population, would it be fair to say that the utility of this is --

MS. TABOR: We questioned it, because there -- although it's feasible to calculate this, you know, how much meaning it would actually have to drive quality improvement, we questioned.

DR. COOMBS: And have you considered -- or elements of this don't seem as much patient-centered as it does other regards. Have you considered other patient-

centered type of population measures? Can you have patient-centeredness with a population measure?

MS. TABOR: We've considered patient experience so -- within the chapter's work in the March report, we compared fee-for-service --

DR. COOMBS: Right, right.

MS. TABOR: -- MA CAHPS.

DR. COOMBS: Other than the CAHPS survey.

MS. TABOR: We haven't looked into any others but, you know, would welcome thoughts on whether we should proceed and what measures to use.

DR. CROSSON: Pat.

MS. WANG: As you think about potential future analysis for the potentially preventable admissions, what are your thoughts as risk adjustment for fee-for-service and ACOs, how it would differ from what's in the HEDIS specification?

MS. TABOR: So we would like to use the same, you know, kind of characteristics, so HEDIS for MA plans uses HCCs and age and sex and comorbidities related -- calculated for HCCs to risk-adjust. And if the Commission would like, one thought we've had is we could take that

kind of same methodology but calculate risk weights based on fee-for-service an ACO data, so kind of risk-adjusting for each separate population.

MR. GLASS: Yeah, I mean, the concern being that coding is different in the MA plans.

MS. WANG: I see. Okay. But you --

MS. TABOR: And population characteristics, too.

MR. GLASS: Right. So if you use those weights, you'd end up with maybe not --

MS. WANG: Preventable admissions is a very interesting measure. I can guarantee you that people who live in an apartment building over the Cross Bronx Expressway are going to have more of these for asthma and that that is not captured by the HEDIS specification for risk adjustment. Do you see any opportunity to incorporate those factors? I believe that the Massachusetts Medicaid program has incorporated into their risk adjustment algorithms factors like homelessness, and they have found ways to identify markers of poverty and environmental factors that are very, very influential on some of these measurements.

MR. GLASS: Well, again, probably wouldn't put it

in the risk adjustment model but would later in a peer group or something to bring that into the payment adjustments, if there were any.

MS. TABOR: And work that I've looked at, you know, Medicare is kind of at an advantage -- or Medicaid and States is kind of at an advantage because they have different data than we have for a national fee-for-service population for Medicare to be able to kind of do different analysis. So that's why we have, I think, traditionally stuck with the dual-eligible as a way to assign peer groups to providers.

DR. CROSSON: Okay. Questions over here? Bruce.

MR. PYENSON: Thank you. On page 14 there's a formula for the HCDs. A question on post-acute care, how that was handled. So for home health care, did you count the days of service or the days of the 60-day episode?

MR. GLASS: The number of visits.

DR. CROSSON: Okay. Seeing -- Alice, then Jon.

DR. COOMBS: So the slide that describes the acute versus chronic condition, I just wanted to make a comment. I know this is probably Round 2, but pressure ulcers is really not an acute condition. Usually it means

you've been in a position long enough that you get a pressure ulcer. So just in general, the majority of the patients that we're going to -- the beneficiaries that we see in this age group, you might reconsider that category.

DR. CROSSON: Jon.

DR. CHRISTIANSON: So if you do drop out home health days, which I'm totally in favor of, as you know, and dealing with the sort of mortality issues, would it be fair to call this measure the days not in institutional care?

MS. TABOR: That would be -- that sort of makes sense.

DR. CHRISTIANSON: So the notion is then that it's bad to be in institutional care more than the norm risk-adjusted, so forth and so on. Okay.

MS. TABOR: Makes sense to me.

DR. CROSSON: Bruce.

MR. PYENSON: A follow-up question on that. So I take it in the current definition things like events of ambulatory surgery or dialysis on an outpatient basis are not subtracted from --

MS. TABOR: That's correct.

DR. CROSSON: Okay. Seeing no more questions, we'll go on to the discussion, Round 2. The endpoint here would be -- and I'd ask you to kind of focus your comments on the two measures under consideration. Do you support moving ahead with this measure? Not necessarily exactly the way it is, if you have some thoughts about how it could be improved, that's fine. But, fundamentally, with respect to potentially preventable admissions, I think we should go forward with this notion. And with respect to -- what is it now? -- home and community days, we should go forward with this or we should not? If so, why not?

Craig was going to start off, and unfortunately, he has been called away, so we'll just begin the discussion in the open. I see Alice and Brian first, and David.

DR. COOMBS: So I'll start by saying there are some things to be gained by the preventable admissions, but one of the questions is in terms of risk adjustment and what that looks like for specific communities and specific populations. And also the acute and chronic sensitive conditions, and as mentioned earlier, just the notion of the social-economic impact of some of the diagnoses for which people are admitted, and I know we don't have control

over this piece, but specifically I was going to point out asthma as well. Asthma is such a socially mediated arrangement in terms of people having dust and cockroach antigen and anything, you name it, so that if you were going to take this population measure and apply that to a provider or provider group, it would really be important to know that there's this indigent -- not indigent, but there's like the housing complex project dwelling that's going to make that patient population more likely to be readmitted -- or to be admitted in general. And so this is where it's really important in terms of getting the social, economic, and social impact adjustment right because providers who take care of vulnerable populations will be disproportionately impacted. If you're living in Wellesley or Newton, it's a different story if you're living in Roxbury or you're living on, you know, Benning Road. So I think we cannot ignore that fact.

In terms of the HCDs, I think my gestalt is because of the variation limit. What's a patient going to learn from reading that? Who's going to base a decision on someone's quality measure on such little variation within the groups? And so I think that that measure doesn't have

the utility that we would like to see, and in terms of the value of that, will a patient actually look at that and make choices based on being at home ten extra days a year? I don't believe that that's going to trickle down to patient decisionmaking and impact patient decisionmaking.

And the harsh reality is: Does the patient actually have a choice between a population measure from 328 days to 348 days? You know, so if we were to classify or put those days in groups, it would be the same thing of the patient choosing what he might think is a worse alternative because he really doesn't have a choice. If indeed they have the -- if they have the understanding that this is an important piece in terms of a grade for a population measure. So in terms of the strength of that population measure, I question it.

One thing that Jay may not have wanted from us, but I would like for us to begin to explore other population measures that might be a little bit less impactful on socioeconomic status and also on communities and how this measure's going to trickle down. Will it be ZIP code? Will it be MSAs? How is it actually going to be implemented? And Gary Puckrein has done a lot of work with

ZIP code analysis of diabetes. You can go from one ZIP code to the other ZIP code, and your diabetes goes up from, you know, 8 percent to 25, 26 percent. So that if this was going to be used as a population measure under the VVP, then that physician really would be in a ZIP code that they may not know all the dynamics of that ZIP code, and yet they're basing these two -- they're being evaluated by these two measures.

Lastly, about the granular measures, I do think there's a role where the granular measures do connect to the population measures, and that's a sweet spot for us to find. How can we really negotiate between the things that matter to the level of a specialist or the level of the primary care doctors? And how do we connect that to the population measures? And ACOs have been able to do that in many regards, and I think when you have this notion of the volunteer value program, there needs to be this oversight as to what are the important pieces of that. How do we connect these granular measures, the things that matter for, you know, me as an anesthesiologist, an ICU doctor, in terms of me being able to discharge a patient and not have that patient come back, or how does that connect to the

community in many other ways. So I think that's where the sweet spot is. How do we connect the granular measures to population measures? And I think that's an important piece of this that we're really not connecting.

DR. CROSSON: Thank you, Alice.

Just to be clear, you know, we are talking about these two measures, but maybe I didn't say this right, but, you know, if in your own mind you either like or you don't like these but you think that there's a way to do this differently to get to the same end on a -- that's certainly on the table. If I said it in a way that suggested that's not, I apologize.

Brian?

DR. DeBUSK: First of all, thank you for a very well written chapter. I think your potentially preventable admission measure is there. It shows nice sensitivity across the deciles. It would be nice to see a peer group now just to make sure the world works the way we think it does.

And then, obviously, back to the HCDs, I really hope you don't give up on that measure. In the reading materials, it was clear to me that that thing was topped

out. And I appreciate and I think we all appreciate what you're trying to get at, because, again, if I'm trying to choose even an MA plan or an ACO, what I really want to know is: Of the potentially preventable facility-based care, how good are you at keeping me out of your facilities for conditions that are potentially preventable? And what I'm hoping is that we could look at potentially preventable ED visits, admissions, LTCH, anything facilities-based, and I would consider SNF facility-based. Home health, obviously not, because I do share the concern that I think we overreached a little bit when we went to home health days. Again, great effort. A little overreach. But I would love to be able to look at those intervals because I think what you're going to get is a good feel for how effective a given system, plan, program, whatever is at keeping you out of facilities. And that way you're far less sensitive. You know, I think of things like LTCHs. You can have an LTCH stay that's 20 days. You can have an LTCH stay that's 60 days. And, you know, so much of that isn't necessarily the quality of -- you know, I think of some of these chronic wounds, for example. I mean, you can be there forever. And that really doesn't speak to the

quality of the care that's provided. I mean, there's just certain patients' wounds are only going to heal at a certain rate.

So, again, it would be nice to look at those intervals, and I really, really hope you don't give up on this principle of HCDs or healthy days at home. And, David, I know you're just wincing over there, but, you know, engineer to engineer, let's try this MTBF thing. For what it's worth -- and this is my last plug -- the principle of MTBF predates Medicare, okay? So people have been working on this thing for a while.

DR. CROSSON: Okay. I've got Brian, David, now Dana and Bruce.

DR. GRABOWSKI: Great. Thanks. I really enjoyed this chapter as well, and I very much agree with Brian that I think we're there with potentially preventable admissions. I like that measure a lot. The home and community days, as Brian said, I just think it's topped out, and we're just not seeing the variation we would like to see from a statistical perspective to make this a valid measure.

However, similar to Brian, I'm very excited still

about this construct. I've been studying institutional post-acute care for 20 years. I'm still waiting to meet the person that wants to go into one of those facilities. It's just not there. And so how do we think about community-based measures?

Jay, I liked your charge of thinking about alternative measures here, and I'll give several candidates. The first, one that's reported on Nursing Home Compare is just successful community discharge, and I don't know if we've ever as a Commission looked at that measure or similar measures to that, but anchoring on a particular service and then looking at whether individuals are successfully discharged is one way of doing this.

Another example is from a paper we did in the new England Journal of Medicine where we defined a measure called "home-to-home time," which made this point, that it's not just your time in inpatient stay but also institutional post-acute care and adding that up and looking at, you know, how long is it from the day I leave my home or community to the day that I return.

The third measure -- and it really is spurred by this mean time between failures, and with all due respect,

I don't find like X number of days between failures intuitive to a beneficiary as a measure, but there's this great work by Joan Teno where she's looked at end-of-life care and the number of burdensome transitions, and I think it sort of gets at the same construct that you're pushing at. And I really find that intuitive, that, you know, in the last six months of life, this beneficiary had, you know, five burdensome transitions, and she's got a particular definition, and she's published this in high-profile places. So I think that very much gets at anchoring on a specific time and thinking about the number of inappropriate or burdensome transitions. I really like that construct, and I think there's something there. I don't know if the number of days is the right way of framing it.

DR. DeBUSK: [off microphone] sickness.

DR. GRABOWSKI: That's exactly right. So, anyway, thanks again for this great work, and I look forward to further work in this area. Thanks.

DR. CROSSON: Thank you, David. Dana.

DR. SAFRAN: So very similar points of view. O on potentially preventable, I think this is a good measure

to move ahead. My one comment about it is that I wonder about the name. In my experience, having the term "potentially" in a high-stakes measure can create a whole world of challenges, and when you're asking an organization to take accountability for something that's potentially preventable. So I think, you know, the fact that these are ambulatory-sensitive admissions, I think that's kind of what we're talking about, is one way to look at it. But just words matter on this.

On the healthy days at home, I really agree with the point that Brian and David have put out there. You know, it's clear that the measures as its currently configured isn't workable, but I'd hate to see us give up on this. And as I've been sitting here thinking about, you know, what would a beneficiary want to know, I was going to a place that I think is similar to what David was just describing, which is for a patient who has had an institutional event, how good is this provider organization or this provider at helping to restore you to good enough health that you can now be in the community? So I don't know how you get to "successful discharge to the community," which I think was the phrase that David used,

but I think the concept is there, and it certainly applies with end-of-life care and wanting to avoid bouncing, you know, between institutions.

So I just wonder if we want to focus this measure rather than on the full population or, you know, people with a couple of chronic conditions, focus it on those who've had a hospital stay and how successfully are we able to kind of restore them a health status that allows them to be in and stay in the community.

DR. CROSSON: Thank you.

David, a clarification?

DR. GRABOWSKI: I was just going to give you the definition that CMS uses on Nursing Home Compare for a successful discharge, and maybe, Carol, you can correct me if I say this wrong. But less than 100 days in the SNF, no readmission to the hospital, and then 30 consecutive days in the community. And so that's their definition. I don't know if that's the definition we would want to use. It's a definition. But it obviously doesn't follow the beneficiary out further over time. But that's what they report on Nursing Home Compare.

DR. CROSSON: Okay. Bruce, then Kathy.

MR. PYENSON: I do support the potentially preventable admission metrics, but I would have supported total admissions more. The fact that the two are correlated heavily gives me some comfort, but I think perhaps along Dana's point of trying to parse out too finely what is potentially preventable, what is ambulatory surgery and so forth, the fact that the two are strongly correlated suggests something else is going on with a lot of the admissions that are not potentially preventable.

I also support moving to Brian's concept of mean time to failure, and I know we've tried to steer away from process measures, but this is a meaningful measure that's easily calculated based on available data that characterizes a process. It's not the process of did you talk to a patient about X or did you copy into the medical record Y. It's not a clinical administrative doing something, but it's a characterization of a system on a holistic basis. So I think health care has been incredibly primitive at adopting such metrics from other industries, and I think it's time that we start to look at those sort of metrics.

Another example of that which has been adopted in

the pharmaceutical industry metrics is PDC, portion of days covered, or medication possession ratio. Those are analogies of a day-by-day kind of accounting of care on an administrative claims basis that's probably meaningful.

And along the lines -- I really do like HCD like some of the other Commissioners, but I'd ask for a second version of that which counts any interaction with the health care system as a negative. And the reason for that, that's -- sorry, that's a process measure. We have a system that cycles people through and through and through, you know, different sites of care, different physician offices getting called back, not having things done efficiently all on the same day when they could have been. And so I think that's a measure of -- a utilization measure on a grand scale.

So maybe we don't exclude preventive care, but anything else in my mind is an indication of on a population basis that would correlate with the systematic processing of patient care and how efficient that is.

DR. CROSSON: Okay. I've got Kathy, Paul, and David.

MS. BUTO: So I support continuing to pursue

preventable admissions or ambulatory-sensitive conditions as population-based measure.

What I liked about HCDs – and I agree that you made a good case that we -- they're not meaningful in the kind of analysis we'd like them to be -- but what I liked about them is they were a positive measure, not a measure that indicated failure. And so I'm struggling with, if we're talking about population health, are there -- and I guess I would focus on something like a chronic condition, like diabetes is a root cause condition, something like that, where we feel that the physician group or the ACO or whatever had made a difference, vis-à-vis fee for service, because of something they did to manage a chronic condition, which, by the way, Bruce, if they were doing a good job it might mean encounters with the health care system, so I'm not sure I would see that as a negative.

But I'm just struggling because population health to me is more than just avoiding bad things, and we -- it strikes me if there's some chronic condition measure that hasn't already been picked up, that we can think of, that would be useful in evaluating these different delivery system options, I think that would be a terrific thing to

add.

DR. CROSSON: Paul.

DR. GINSBURG: Yeah. I'm comfortable with the fact that the home and community days is an amalgam of things that are implicitly weighted equally. So, in a sense, implicitly, we're giving a day when -- I'm going to look at the opposite of the good things -- a day where a patient is deceased is equivalent to a day when the patient is in a nursing home, and equivalent to a day where the patient is at home getting home health care.

So I think the measure is going to be dominated by mortality, and the fact that you don't see much variation maybe is another way of seeing that the margin health care doesn't contribute that much to longevity.

So, you know, maybe there's a possibility to focus. And, you know, I think the home health is particularly problematic, because we don't know whether a day at home with home health is a good thing because you're home, or a bad thing because you need help. So what we might do is just look at the -- since we have, I think, good measures for preventable hospital admissions, maybe we just go to do a companion measure of days in institutional

care or days not in institutional care, and that might bring us something useful. Maybe we get some variation with that, given that it wouldn't be dominated by the mortality.

DR. CROSSON: Okay. Let's see. I've got David, Jack, Pat, Jon, Sue, Rita.

DR. NERENZ: Thanks. I just want to check with Brian and David, when you use the word "there" on the preventable admissions. I just want to know what you mean. You know, it strikes me we're one step down a long road. Okay, I'm seeing nodding. That's good.

You know, as we know, what we're looking at has no risk adjustment in it. I tried to check the technical specs as far as I could to determine whether the measure, if you apply it an area level, is actually adjusted for the disease prevalence in that area. I just couldn't tell. I mean, you'd know. You know, you're going to have more preventable admissions if you just have more disease in the background, even if the quality of care is equivalent to your area.

So I just want to check, because I assume we're kind of on the same page. I would have said this is one

step down a very long road, you know, if we think about the information required for a process like NQF endorsement. I just want to make sure you didn't mean, like you were at the end of the road.

DR. DeBUSK: [Off microphone.]

DR. NERENZ: Well, I'd say it needs a ton of work, but, no, I'm happy to see the front end, but are we kind of on the same page?

DR. GRABOWSKI: Yeah, I would say we're there -- sorry, to move forward to the next step.

DR. NERENZ: Yeah, yeah.

DR. GRABOWSKI: That's how I framed it. I don't think it's ready for prime time.

DR. NERENZ: Okay. I just wanted to check.

DR. DeBUSK: I was just trying to be responsive to Jay's request earlier.

DR. CROSSON: Okay. Jack.

DR. HOADLEY: Yeah. This is partly picking up on what I asked in Round 1, and obviously the particular question about the age 67. I totally understand. But I think, you know, doing -- sort of extending this proof of concept of the under-65 disabled seems like a useful -- you

know, if there's some reason this measure works very differently in a population that is fundamentally in Medicare because of their disability, that would be useful.

And then, you know, I suppose this is in the category of that "down the road" that David was just talking about, but, you know, thinking about within categories of patients, some patients with a behavioral health problem or patients with certain other chronic conditions, and then doing the other comparisons, and that would be partly, presumably, variously tied into how you would look at risk adjustment. But I think it's good.

And I would concur with the comments people have made on home and community days. It seems like we're hearing some interesting new ideas, and I think some of those will be worth pursuing.

DR. CROSSON: Thank you, Jack. Pat.

MS. WANG: I think that the potentially preventable, ambulatory care-sensitive, whatever you want to call that, admission measure is very important, but I do want to reiterate what I asked about during the question period and what Alice touched on, and something that Kathy said. This is a negative measure. Providers help,

whatever, you know, get sort of painted with you're doing a bad job.

And this is one example of the type of measures that I think is the poster child for the fact that the health care system is only a very small component of people's health. Their environment, it goes beyond ambulatory care-sensitive. It's like where do you live? What is the disease burden? You know, is gun violence your major health care concern? The delivery system, I don't care how great the ambulatory care system is, do you live in an apartment building in the most polluted area of America, you know? Those factors are nowhere reflected in any of the risk adjustment for this type of measure.

And I understand the challenge of doing that but I would urge that in the further on this that we don't just adopt the existing risk adjustment methods, which is better than nothing, but that we perhaps do literature surveys, or other things that, at least -- even if, you know, to your point, you don't have access to state-level data, there is a desperate need, in my view, to really kind of delve into this more and get better risk-adjustment factors. You can report the raw scores, but if the purpose of this is to

evaluate the effectiveness of a delivery system, it has got to be better risk-adjusted to tease those factors out.

And dual status, you know, it's good to use dual status. Dual eligibles, in one place, are not the same as dual eligibles in the other. It's better than nothing, but, you know, dual eligibles in Tennessee, I think face different challenges than dual eligibles in the South Bronx. There may be some similarities with income but environmental issues are going to be different, and those very much affect things like the ambulatories care-sensitive, whatever you want to call that measure.

So I would really ask us to continue work there.

DR. CROSSON: Thank you, Pat. Jon.

DR. CHRISTIANSON: Yeah, on the first measure I'm kind of where everybody else is, I think. On the second measure, I think I'm -- I have real concerns about that, like other people have expressed.

I guess I would go back to, you know, what we're doing here. We want to come up with population-based measures that allow us to compare MA plans, ACO, and fee for service Medicare. So we give a fixed dollar payment to the ACO and we say we've got the incentives lined up. Now

we want you to improve the health of this population. And I think the first measure gets -- even though it's negative, it's appropriate.

The second measure includes what economists would call inputs to production. They're not intrinsically bad things, right? I mean, I know people don't want to go in a nursing home. Sometimes that's what is needed. That's the level of care that's needed.

So when you start using home health as the example, penalizing an ACO, second-guessing the ACO, in a sense, for using a lot of home health care, right, that doesn't make a lot of sense to me. That's sort of antithetical to what we say we're about when we're transferring risk to these organizations and then trying to measure health outcomes. These are not health outcomes per se.

Paul's concern about weighting is absolutely dead on. Just because there's no attached weights here doesn't mean there aren't weights. So are they weighting all these things as if they're equal? I think that's a terrible idea. But if we don't do that then we're into the quality world, or something like it. So I think that's a real

stumbling block in terms of doing a measure like this.

I like the suggestions that Dana had and Kathy had, in terms of, you know, let's parse this out a little bit. Let's get things that are really comfortable about -- as being bad, per se. How well do we integrate people in the community? Maybe we could turn that into a positive measure.

Now a lot of my concerns would be diminished if I thought risk-adjustments solved all problems. It doesn't. We talk like it does all the time. "Oh, we're going to risk-adjust it." That leaves an enormous amount of variation not explained. So, yeah, the risk-adjustment model is about as good as we can do here, but I think this whole approach, this aggregate approach, days in the community approaches, has a lot of problems attached to it and I think it would be much more productive to go along the lines that Kathy and Dana and others have suggested, and not necessarily continue to work on how you aggregate institutional days and the community together and subtract it from one. I mean, that's just -- okay, now it's positive news. If we didn't subtract it from one it's a negative measure.

I'm not sure that we don't get mired down in the weighting issues and the question of this care. This is not negative stuff. This is just care, different kinds of care.

DR. CROSSON: Do you want to comment on that, Bruce?

MR. PYENSON: I'm not sure we, with healthy days at home, or HCDs, we're measuring exogenous factors, inputs, because in the health care system, services beget services. And the more services you have, and the less efficient they are, it cascades.

So I think that's one of the phenomenon that we're measuring. So if you think of it as from a production line standpoint, like how efficiently can we produce the output of health care, is the question. And, of course, there's always going to be balances of, you know, too little care or too much care, but, frankly, the dynamic in fee for service Medicare is not too little care. It's how care begets more care.

DR. CHRISTIANSON: Yeah, like I said, I think if you could risk-adjust for all of this adequately then I would sort of agree with you, but I don't believe that the

risk-adjustment process will accomplish all of that.

DR. CROSSON: Okay. Sue.

MS. THOMPSON: Actually, Jon made the point that I was wanting to make, about using home care, and is that a good thing or is that a bad thing? I think that's probably a question that's, you know, floating around here.

And just -- I wanted to call out, in our work in home care, we're actually moving into a model of hospital at home, where we're going to be providing acute care services for patients who, you know, for cellulitis, for, you know, IV infusion therapy that can be delivered in the home and doesn't require the patient have to be in the four walls of a hospital. So that then causes me to wonder, is that a good thing or is that a bad thing?

So it just caused me to wonder about our definitions, and what are we trying to -- what problem are we trying to solve? And if the problem is we're truly trying to develop measures that help us understand our work and our success in population health, that's, you know, a lofty and wonderful goal. What we don't need is more measures that confuse us. I mean, we have more metrics and more measures than we know what to do with. So I just

think we need to be really thoughtful, as we are. But I just want to underscore the importance of that.

DR. CROSSON: Thank you, Sue. Rita.

DR. REDBERG: I would just add, I support, or I think potentially preventable admissions is a excellent measure, and I take Dana's point that potentially it is very difficult to define, so we think about that. And I really commend you for the work on home and community days. I mean, I think it's really important to check it out. It sounds like 20 percent sample is probably big enough to say that this isn't really showing us the differences we thought it would. It's interesting, I think, why it isn't, but it seems pretty convincing.

You know, to me, if our home -- of course, it always depends what your alternative is, but if the alternative is being in an institution or a hospital, I think there's no question that people prefer to be at home. And then, of course, they would prefer to be at home without needing to have a home health aide. But, generally, people don't get home health forced on them. They have an agreement about it. So I would take that as a good thing because the alternative is usually being in an

institution.

Then I guess you got me starting to think about, well, if it's iatrogenic and you only -- you know, you were fine before you went in but now you've had complications from your hospitalization -- but that's really complicated for us to start to get into and I don't think we can. So I think it's good, you know, if you're at home I think most people would agree that's a good thing, with or without home health.

DR. CROSSON: David.

DR. NERENZ: Thanks. Jon said something very important. Jon, if you could clarify it. You said the purpose of doing this was to come up with measures that could be used to compare MA and fee for service and ACOs in a region. But in December and January we were talking about this in a very different context. We were talking about comparing physician groups. So this is for one purpose or the other, or both? Because I think it's important to declare what purpose are these measures to be used in?

DR. CHRISTIANSON: Well, the chapter started out by saying they would be used to compare these three.

DR. CHRISTIANSON: And I just -- I think it's very important to make that clear, because when this phrase of, you know, the population -- what did we call it? -- you know, it was in a very different context two months ago. So just --

DR. CROSSON: Well, my own sense here is that, you know, this work of developing population-based measures is very much tied to the notion that we have had for a long time, which is we should move the health care system into accountability for populations. So if you're going to be accountable for the health and cost of a population you have to have measures which reflect that.

Now, you know, the nature of the entity that is accepting, or is given risk for population I think is in flux, and some -- you know, we don't know where that's going to end up. But the fundamental concept, I think, is still the same.

Brian?

DR. DeBUSK: To that point, you know, I think we do need to be conscientious of developing standards that sturdy, or measures that are sturdy enough that say we could use them in a voluntary value problem and then turn

around and use them to compare, say, an ACO to an MA plan.

And I just want to build on something that Pat had said earlier about the risk adjustment too. You know, I go back to one example of standards that the staff uses routinely, that I'm very impressed with, and I noticed it even slipped into this documentation, this concept of MedPAC units. You know, it's a geographic unit where you split the CBSAs by state, and then you group in the HSAs. You guys use that all the time. And you think about how useful it is, just to have that in your back pocket and know -- like we're all trained now. When we see MedPAC units come through, even if the reading material doesn't say MedPAC units, we know what you're doing.

Now look at what's happened with the peer grouping. You know, it looks like we're standardizing around this idea of SSI percentage and stratifying the groups into deciles. I mean, we've got a fairly sturdy, reusable measure there that we can apply to different situations and different venues. I would encourage us to do that with risk adjustment as well, if it's possible, and that may be overly ambitious.

But then on top of that is we develop a measure,

whether it's potentially preventable admissions or HCDs or whatever. Let's try to build things that can transcend venues and programs, so that we aren't constantly reading the footnotes and trying to figure out, you know, is this a 90-day readmission, or is this a potentially preventable readmission, or is this a 30-day readmission, just so that we've got reusability of some of these metrics.

DR. CROSSON: Okay. So I think, you know, what we've got here is the general support for the potentially preventable or ambulatory-sensitive admissions, with, I think, a strong indication from a number of Commissioners that, that said, there are issues around risk adjustment or adjustment for population-based biases or issues that need to be worked on, to the extent that we can do that, and there are limitations, as many have said.

With respect to the home and community days, I think there's a general consensus that the concept, as currently constructed, is not something that we want to pursue. However, I also hear at least a plurality of interest in doing something in that direction, something that is more positive rather than negative. Where I think I'm having trouble is, you know, like what that direction

is. You know, I thought for a while we were basically coming along to say something like, in different ways -- Brian has one way of doing it, others had others -- essentially saying something like we would hold organizations who are responsible for based-based care accountable for keeping people out of facilities.

And then we had various versions of that. Maybe it's just let's keep people out of hospitals, because, you know, maybe people who are in nursing homes need to be in nursing homes, and certainly home health. But I'm not sure -- we also had some others, I think, who were saying something like, well, even that, you know, maybe we want something that is more positive or more something, different than that.

And then the other strain I think I heard was, you know, maybe we want to be thinking about this in terms of subpopulations. Because you can even go back to that chart on home and community days. There was a rather significant difference between the analysis of all beneficiaries 65 years and older and those with two or more chronic conditions. I think one was a difference of 5 and the other was a difference of 16 days. I think Jack

brought up the notion of maybe looking at subpopulations, for example, people with mental health conditions, and somebody else said, you know, maybe Dana said why don't we start with people who have already been in the hospital and see, subsequently, what goes on there.

Then I began to think, well, I mean, if we're looking at, you know, some sort of measure that is a positive measure but it's basically let's keep people out of hospitals, that's beginning to sound pretty close to the first measure, right, which potentially preventable hospitalizations.

So the best I can do here is to say that -- which is sort of where I started with this, which was that the current consideration probably is not what we want to continue, but there is interest in trying to find something in this area. And I guess I'd ask you, David and Ledia, to take the discussion here and, you know, when the workflow allows that, to come back with the potentially preventable or ambulatory-sensitive admissions, with your best attempt at taking into consider the risk adjustment ideas here.

And then maybe to get a little creative, more creative than I apparently am at the moment, in terms of

where we might go to capture this. And is it something that we should look at with respect to subpopulations? But I don't think we want to come back with just another way of looking at keeping people out of the hospital, because I don't think we need to do that.

Yeah, Kathy.

MS. BUTO: Is there a way to sort of get at this issue of low-value care, you know, the reduction, and we could be selective and try to figure it out? But this notion of trying to see, because we're looking at delivery system approaches of that area of reducing the use of low-value care. And maybe it's just too complicated.

DR. CROSSON: No, no. I mean, I think --

MS. BUTO: Something like that feels more positive and aimed at population health than finding another way to say let's keep people out of the hospital.

DR. CROSSON: Look at that. Rita agrees with you.

DR. REDBERG: [Off microphone.]

[Laughter.]

DR. CROSSON: Right. So, again, I mean, that's another way of, you know, of looking at the same sort of

thing. In other words, let's see if we can find some positive way of expressing the fact that we don't want -- whether it's facility-based or not, we don't want people to be engaged in, through the health care system, in activities which don't produce anything of value to start with and may, in fact, injure people.

So, you know, that's another way of cutting it. So I hope, Ledia and David, that those are a few little darkly visible arrows pointing in a new direction.

Thank you so much for the presentation and for the work that you have done. I think this stimulated a very thoughtful and constructive discussion.

We will conclude the meeting at this point, and now there is time for public comment period. If we have any members of our audience who would like to make a public comment, now is the time to come to the microphone so we can see who you are.

DR. GINSBURG: Excuse me, Jay. While we're waiting, you know, I was thinking about the whole term, low-value care, encompasses a lot of things we've been talking about today, and maybe we should just pursue that as an umbrella for a lot of the things we do, as a label.

* [No response.]

DR. CROSSON: Right. Okay, see no one at the microphone, the meeting is adjourned. We will reconvene for the April meeting.

Safe travels, everybody, or travels just in general.

[Laughter.]

DR. CROSSON: Or we could all party here in Washington if we end up here.

[Whereupon, at 11:00 a.m. the meeting was adjourned.]