MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, September 6, 2018
9:23 a.m.

COMMISSIONERS PRESENT:

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

AGENDA PAGE

P R O C E E D I N G S

[9:23 a.m.]

DR. CROSSON: Let's see if we can reconvene.

I'd like to welcome our guests. This is the beginning of the 2018-2019 MedPAC cycle. Many of you have been our guests before; some of you have not. So what we do to start off the year is to have a discussion about the context, the context of the Medicare program, particularly from a financial perspective, which is helpful to indicate the size and intensity of the problems that we are trying to address in the work that we do during the year.

We have got Jennifer and Olivia here, and they are going to take us through a context chapter, following which we'll have a discussion.

MS. PODULKA: Thank you, Jay. Good morning.

Part of the Commission's mandate in law is to consider the budgetary impacts of its recommendations and to understand Medicare in the context of the broader health care system.

One of the ways we meet these elements of the mandate is to include in the March report to the Congress an introductory chapter that places the Commission's

recommendations for Medicare payment policy within the context of the current and projected federal budget picture and within the broader health care delivery landscape.

These recommendations appear in other chapters of past reports. The Context chapter is intended to summarize these recommendations at a high level and frame the Commission's upcoming discussions regarding payment updates and policy recommendations in other chapters.

So while there are no new recommendations in this chapter, we seek your comments today on its scope, substance, and tone. Please note that as usual some of the numbers that we'll present today are preliminary and will be updated as data are published over the next several months.

In today's presentation Olivia and I will discuss the main topics of the chapter, which include: health care spending growth, Medicare spending trends in detail, Medicare spending projections, Medicare's effect on the federal budget, the burden of Medicare and health care spending on households, and evidence of inefficient spending in the health care delivery system and challenges faced by Medicare to increase its efficiency.

For decades, health care spending has risen as a share of GDP. From 1974 to 2009, total health care spending -- which is shown in the top line in the graph -- more than doubled, while private health insurance and Medicare spending -- the yellow and green lines -- both more than tripled.

But from 2009 to 2013, health care spending as a share of GDP remained relatively constant, as shown by the narrow shaded section on the graph.

Then in 2014, spending began to modestly grow, driven in part by health insurance expansions under the Patient Protection and Affordable Care Act, or PPACA, as well as growth in both the use of and prices for medical goods and services, including increases in prescription drug spending mainly on new treatments for hepatitis C.

Government actuaries project that over the next decade, health care spending will continue to gradually increase.

Taking a closer look at Medicare during the slowdown period, the year-to-year change in spending per beneficiary slowed in traditional fee-for-service, Medicare Advantage, and Part D. These lines look a bit noisy, but

keep in mind that they're showing year-to-year changes. The lower growth rates were generally due to both decreased use of health care services and restrained payment rate increases. Beginning in 2012, PPACA reduced annual payment rate updates for many types of fee-for-service providers, and in 2011 began lowering payments to MA plans to bring payments more in line with fee-for-service spending.

Beginning in 2014, growth is more mixed. Both fee-for-service and MA growth began to modestly increase following the slowdown period. Part D was quite high in both 2014 and '15 and then fell in '16, in part due to hitting a temporary peak in spending for hepatitis C drugs. Note that the recent decrease in growth rates doesn't mean that the Part D spending problem has been solved. Growth is projected to pick back up.

Taking a closer look at fee-for-service, even before the slowdown, per beneficiary spending was not uniform across settings. For example, from 2008 to 2009, outpatient, SNF, home health, hospice, and labs had high growth. Then the slowdown from 2009 to 2013 affected settings differently. Outpatient remained pretty high, while SNF, home health, hospice, and labs dropped a lot.

Following the slowdown, inpatient, physician, SNF, hospice, and DME continued to stay low or fall even more, while outpatient, home health, and labs rebounded. Note that home health and DME experienced negative change. These are two settings where Medicare has implemented specific policies to improve efficiency. The results demonstrate that it is possible for the program to affect spending trends and yield savings.

Comparing across the decades on the left side of the graph, the upper blue portion of the bars indicate that per beneficiary spending growth has fallen to average annual rates of about 1.5 percent so far this decade.

Looking ahead to the next decade, the Medicare Trustees and CBO both project that per beneficiary spending growth will pick back up to an average annual growth rate of almost 5 percent.

In addition, as shown in the bottom yellow portion of the bars, the aging of the baby-boom generation is causing an increase in enrollment growth of almost 3 percent so far this decade. Higher than usual enrollment growth is projected to continue throughout the next decade.

Hence, the Trustees and CBO project growth in

total spending -- shown in the numbers above the bars -- to average about 7.5 percent annually over the next decade, which will exceed the projected average annual GDP growth of about 4 percent.

This means that the size of the Medicare program will nearly double over the next 10 years, rising from about $700 billion in total spending in 2017 to $1.3 trillion by 2016. And while spending is growing, Medicare's financing is growing more strained. Workers pay for Medicare spending through payroll taxes and taxes that are deposited into the general fund of the treasury.

As Medicare enrollment rises, the number of workers per beneficiary continues to decline. As you can see by the steep curves of both lines, this is happening in real time. The number of workers per Medicare beneficiary has already declined from nearly 4.5 around the program's inception to about 3 today. The Trustees project there will be just about 2.5 workers for every baby-boomer by 2027, and these demographics create a financing challenge for the Medicare program.

As you may have heard, the Trustees project that the Hospital Insurance trust fund will become insolvent by

2026, which is three years sooner than projected in last year's report, but that date doesn't tell the whole financial story.

The HI trust fund covers just over 40 percent of Medicare spending. It includes Part A services. It is financed by a dedicated payroll tax, and it is projected to become insolvent in eight years as payroll tax revenues are not growing as fast as Part A spending.

The Supplementary Medical Insurance trust fund accounts for the remaining about 58 percent of total Medicare spending. It includes services under Parts B and D and is financed by general tax revenues, which includes deficit spending, that covers about three-quarters of its spending Plus it is also financed by beneficiary premiums that cover the remaining one-quarter. Premiums are reset each year to match expected Parts B and D spending. And since by design SMI income grows at the same rate as its spending, its trust fund is never expected to go insolvent. This doesn't mean that it doesn't also face major financing challenges. It does, which the next slide shows.

The line at the top of this graph depicts total Medicare spending as a share of GDP. The layers below the

line represent sources of Medicare funding.

Working up from the bottom, all the layers up to the very skinny purple layer represent dedicated funds collected specifically to finance Medicare spending such as payroll taxes and beneficiary premiums.

At the top, the pink area represents the Part A deficit created when payroll taxes fall short of Part A spending.

The big orange layer represents the large and growing share of Medicare spending funded through general revenue transfers. This share is over 40 percent today. And keep in mind here that general revenue includes both general tax revenue as well as federal borrowing.

And, of course, these same dollars and deficit spending could be used to fund other federal programs, and there's great competition for these tax and borrowed dollars.

The black line at the top of this graph represents total federal spending as a percentage of GDP. The layers below the top line depict federal spending by program. And the dashed line represents total federal revenues.

Working up from the bottom, Medicare spending is projected to rise from about 3 percent of our economy today to about 6 percent by 2048.

In fact, by 2041 -- shown by the vertical line -- spending on Medicare, Medicaid, the other major health programs, Social Security, and net interest will reach about 20 percent of our economy and by themselves exceed total federal revenues.

I'd like you to note the shape of the total federal revenues line, which reflects CBO projections based on the Tax Cuts and Jobs Act of 2017. Federal revenues will be roughly flat relative to GDP over the next several years. Revenues are projected to tick up briefly in 2026 following the expiration of most of the provisions of the Act directly affecting the individual income tax rate.

And a final note, these later revenue projections may be optimistic in assuming that federal revenues will increase above 19 percent of GDP, which is greater than their historical share of about 17 percent. If, on the other hand, federal revenues continue closer to their historical spending, spending on major programs and net interest could exceed total federal revenues even sooner

than 2041.

And now I'll pass to Olivia for a look at the impact of these costs on individuals and households.

MS. BERCI: Many Medicare beneficiaries are not exempt from the financial challenges of the program's ever-growing cost-sharing liabilities. In 2018, SMI premiums and cost sharing will consume 24 percent of the average Social Security benefit, up from 7 percent in 1980 -- of course, excluding the yet to be created drug benefit.

The Medicare Trustees estimate that those costs will consume 30 percent of the average Social Security benefit by 2035.

On average, Social Security benefits account for more than 60 percent of income for seniors. For more than one-fifth of seniors, Social Security benefits account for 100 percent of income.

The burden of out-of-pocket costs falls on those with private insurance, too. In the last decade, per capita health care spending and premiums have grown much more rapidly than median household incomes. Starting at the top of the figure, from 2006 to 2016 premiums for individuals and families grew 52 and 58 percent,

respectively. And per capita personal health care spending grew 45 percent, but the median household income grew just 22 percent. Thus, in 2016, out-of-pocket costs among the commercials insured made up a greater share of household income. Note that the dollar amounts on the slide are current year unadjusted dollars.

On average, since 2007, the cost of commercial insurance -- shown on the graph by the pink line for HMO premiums and the blue line for PPO premiums -- has grown more than twice as fast as Medicare costs -- shown by the bottom yellow line.

One key driver of the private sector's higher prices was provider market power. Hospitals and physician groups have increasingly consolidated, in part to gain leverage over insurers in negotiating higher payment rates.

Medicare's slower cost growth is partly attributable to restrained increases in Medicare's payment rates. While commercial insurers usually negotiate prices with providers, Medicare sets prices for many services.

Over the same time period, combined Medicare per capita costs, represented by the yellow line, grew by 20 percent. If fee-for-service Medicare had followed growth

in commercial pricing, Medicare costs would have grown substantially more.

Despite Medicare's lower price trend, there are opportunities for further savings in the Medicare program. There is strong evidence that a sizable share of current health care spending in Medicare is inefficient, providing an opportunity for policymakers to reduce spending, extend the life of the program, and reduce pressure on the federal budget.

For example, services that have been widely recognized as low value and even harmful continue to be provided. Also, the U.S. spends significantly more on health care, both per capita and as a share of GDP, than any other country in the world. However, despite higher spending, studies consistently show that the U.S. ranks below average on indicators of efficiency and outcomes. Notably, Medicare beneficiaries' gains in longevity are outpaced by their peers in other industrialized countries. And note that not all Medicare beneficiaries are experiencing gains in life expectancy.

To sum up, the Medicare program as well as the health care system more generally face a number of

challenges in achieving savings. For example, Medicare has a fragmented payment system across multiple health care settings, reducing incentives to provide patient-centered, coordinated care. And Medicare's benefit design consists of multiple parts, each covering different services and requiring different levels of cost sharing.

The Commission works to address these challenges with the tools available to the Medicare program, and there is a detailed inventory of Commission recommendations in your paper.

So with that I'll conclude. The presentation only covered a portion of the information included in the mailing materials. We welcome your questions and comments on any of the issues discussed in the presentation or mailing materials and look forward to your discussion.

DR. CROSSON: Thank you, Olivia and Jennifer.

So we'll now start Round 1, clarifying questions for either the presentation or the more extensive chapter that you reviewed. Questions? Kathy.

MS. BUTO: Thanks a lot for the presentation. I really always enjoy this chapter.

I have a couple questions. One is about the SMI

spending growth and whether it is -- whether we have a sense of how the proportions are changing between SMI and HI in terms of the share. I know it's more than 50 percent now for SMI spending as compared to the whole, but if you could just tell us, has that been increasing rapidly? And the reason I ask is really about, as you think about solutions, whether we're talking about the HI trust fund or we're talking about general revenues. So that would be Question 1.

And Question 2 is really do we have any sense of what the cost of the ACA premiums are in terms of growth compared to Medicare per capita costs and overall commercial? Because I know it is buried in the commercial, but if you've got some way of giving us a sense of where the ACA premiums are in relation to the overall.

MS. PODULKA: Great. I'll answer in reverse. I don't have with me data on the ACA premiums comparison to Medicare costs, so we'll have to get back to you about that one.

The first part of the question about the difference in HI and SMI, there has actually been a rapid shift, so as recently as 2010, HI accounted for about half

of Medicare spending, and now it's down to just 40 -- like a little bit over 40 percent. So that is a pretty big change in a short period of time.

It's projected to decrease a bit more, but be roughly flat, like somewhere around 39, 40-ish or so percent for the coming decade or so. So definitely within Medicare, spending has shifted recently from HI to SMI. It's projected to be somewhat similar as now in the future.

MS. BUTO: Thank you.

DR. CROSSON: Okay. I have Jon and Dana and Pat -- I don't know whose hand was up first -- Marge and then Warner.

DR. PERLIN: Let me add my thanks for a terrific presentation.

DR. CROSSON: Sue.

DR. PERLIN: Again, my thanks for a terrific presentation. A tremendous amount of information.

In looking at the per beneficiary spending growth across some settings, your Slide 5, I'm just curious to what extent volume is a factor in the increase in the outpatient, hospital, and lab services, in part a result of CMS' own policies. If one looks at the period of time,

certainly there was a shift of services, surgical, ambulatory surgical activity out of the hospital, joints, that sort of thing, two midnight rule, et cetera, changing perhaps how care is delivered. And I wonder if you have data on how that might be related to the very modest growth in inpatient hospital, only 0.2 percent. I assume there's a sort of hydraulic there.

MS. PODULKA: Absolutely. I don't have specific numbers to share with you on the shift, but definitely in other chapters and as well in the context chapter, we discuss the shift in site of service from inpatient to outpatient. So while you see the inpatient bar is dropping, the same facilities typically operate outpatient. So it's somewhat a shift within the same player.

DR. CROSSON: Let me just be clear. Did I get this right? Pat, Dana, Marge, Warner, and Sue. Did I miss somebody? Is that correct? Okay. Pat.

MS. WANG: We've done a lot of work at the Commission about integrated care for dual eligibles. I'm just wondering in the slides -- and I'm starting at Slide 11 now -- whether there is an additional story in these layers about not just the growth in, you know, the number

of beneficiaries as a result of baby-boomers, but what portion of those are expected to be duals and whether there's sort of a second part of the story here about the costs that Medicaid will incur. Even though it's coming from the states, it's kind of part of the story of the total cost of care for Medicare beneficiaries who are duals. Is there anything to tease out in here? Because the slope lines are -- kind of they say what they say, but to the extent that Medicaid and Medicare are often joined to provide health care to the same person whose primary coverage is Medicare, is there more to this story about the growth in that trend line?

DR. MATHEWS: So, Pat, if I could just ask a clarifying question to your clarifying question, is what you are asking -- so here we've got a trend that shows growth for Medicare. We've got a trend that shows growth for Medicaid, CHIP. Are you asking what is the growth rate specific to the dual-eligible population that would include both Medicare and Medicaid spending?

MS. WANG: Yeah, I am, sort of, I guess, within that yellow line. I mean, it's too big, the scale is too big. But is there a separate story that we should be aware

of that is connected to other policies that we have talked about here about integrating care, because it's -- they're part of the trend line. Duals are going to be part of the trend line in --

DR. MATHEWS: Yeah, I now understand the question. I'm not sure I can commit to an answer right now, but we can come back in the revised version of the material, and to the extent we can answer it, we will do so there.

DR. CROSSON: Dana.

DR. SAFRAN: Thank you. Great chapter. Really great information. I have two questions.

One is on Slide 14 you're doing something that I think is really important, which is trying to contrast the rate of growth that we're seeing in the commercial insurance versus Medicare. But I think the way that you're doing it here might not be ideal because if I understand right, you're contrasting premium growth on the commercial side with historic -- like the past years' spending growth on the Medicare side. And I wonder if we might do it differently, like per capita spending trends, both for commercial and for Medicare, because the issue with premium

trends is premiums are -- you know, I'll call them a guess, but they're a projection about what's going to happen to spending. And so, for example, you know, in our own data at Blue Cross of Mass., our actual spending trends when you look at the last 12 months are very often lower than what premium trends look like because you're anticipating, you know, increases in all kinds of things, right now specialty drugs and the things that we're worried about.

So I worry that this might not be the most accurate way to do the comparison that you're trying to do and wonder if you could do it with per capita spending growth for commercial versus per capita spending growth for Medicare.

MS. PODULKA: I understand what you're saying. We do have definitely a bit of an apples-and-oranges comparison going on here. In part, that's driven by our available data. But we'll go back and take a look and see about the possibility of doing per capita on the commercial insurance line.

DR. PAUL GINSBURG: Yeah, if I could add to this point, I think it would be very difficult for them to get the spending data from private insurers. But, you know, I

think the phenomenon of the underwriting cycle where the premium trends for a couple of years would diverge from the spending trends, I think the consensus is that the underwriting cycle is much less pronounced than it used to be. So, in a sense, you know, year by year there might be a difference. But if you go for a period of two, three, four years, I think it would be very close. So I think the premium data is a useful proxy to compare to Medicare spending data per capita.

DR. CROSSON: On that point?

MR. PYENSON: I think an issue Dana might be also asking about is the deflation in premiums due to shift to lower benefit richness.

DR. PAUL GINSBURG: Yes.

MR. PYENSON: And I think there are ways of getting at that. But that would tend to make the blue and red lines higher.

DR. SAFRAN: I'm more optimistic that we could get the per capita spending. I think you even have data in the chapter that say for the commercial book, you know, for people who are commercially insured what has spending been, and we know how many people are covered by that. So I

think it might be, unless I'm missing something, easier to do that than we might think.

But I'll just go to my second question so I don't gobble up too much time. My second question really had to do with what the assumptions are in terms of the payroll taxes and the kind of revenue coming from the working population. I'm curious how much that builds in assumptions about the changing nature of work, and the, you know, so-called gig economy, where I assume a lot of payroll taxes just aren't even a thing, right?

DR. PAUL GINSBURG: They are supposed to be.

DR. SAFRAN: They are supposed to be. Yeah, legally they're supposed to be. So just that question about how much, if at all, it sort of factors in the changing nature of work, and, you know, a whole generation that's trying to be self-employed, for example. So I'm just curious about that.

MS. PODULKA: I can't really delve into the underlying mechanics of the projections for payroll taxes. They are calculated by the Office of the Actuary, so in a sense we are sharing a book report with you. They do attempt to make projections on the nature of the workforce

going forward. I can't speak to how much a gig economy aspect plays into that.

DR. CROSSON: Marge.

MS. MARJORIE GINSBURG: My comment may fall under the category of scope, in terms of the content here. I realize this is a very broad topic area, but what stands out for me, particularly as we look at the issues around inefficiency of services, and that is a comparison between traditional Medicare and Medicare Advantage, and how those -- and I know that statistically Medicare pays for more Medicare Advantage, which is, I think, a separate issue, but the real issue is how are the services delivered and the differences in efficiency and use of particular services among these two populations. And I know Medicare Advantage may not be used highly in certain states where there are very few, if any, and a lot of others.

So it seems to me if we ultimately really want to get to this incredible problem we have of we spend far more than we're going to have the money for, then one place to start may be a more in-depth comparison between original Medicare and Medicare Advantage. I'm a newbie so forgive me if this has already been covered many times before.

Thank you.

MS. PODULKA: No, it's a very good point to observe. We have to balance, in the context chapter, highlighting policy approaches and solutions that we've addressed in other chapters. We've definitely addressed the issue of relative efficiency on the two sides of the Medicare program, and we didn't get a chance to go through it, but Jay referred to outstanding recommendations. There is a very extensive appendix at the end of the chapter that lays out the past several years of recommendations and attempts to organize them into the different categories that we consider our approaches to dealing with Medicare challenges.

We can also seek some additional opportunities to add some text to the chapter, calling out past discussions about MA versus fee-for-service.

DR. MATHEWS: And Jennifer, if I could --

MS. PODULKA: Sure.

DR. MATHEWS: -- add one thing to this. Marge, you were not here for this but over the last cycle we did report out on our initial evaluation of MA encounter data that we've received from CMS, and one of the questions that

we were hoping to use that data for was to compare, you know, the provision of services between MA and fee-for-service, and this gets at your question about efficiency, I believe. And our bottom line, with respect to the current state of encounter data, is that it is not complete enough to allow us to definitively make those kinds of comparisons, but we over, this cycle, will be talking about some policy options to improve the quality of encounter data with this objective being very much front and center with respect to the utility of the encounter data.

DR. CROSSON: Warner.

MR. THOMAS: Just a couple of questions, maybe building on Jonathan's comments and question. On Slide 5, the outpatient hospital and lab services. Do we have any more specificity on this that may help us understand this transition from inpatient to outpatient, like ambulatory surgery or what's in imaging versus lab? Do we have any more specificity there, or not?

MS. PODULKA: We don't include specificity along with this graphic. This is trying to capture the sort of high-level comparison and it got kind of noisy even doing that. But we can look within the chapter and see about

adding a little bit more discussion about what's happening underneath the outpatient lab.

MR. THOMAS: And obviously --

MS. PODULKA: Oh, we had a really detailed answer.

[Simultaneous speaking off microphone.]

DR. ZABINSKI: I'm not sure if this is specific enough but to add some. We know that, okay, number one, as you said, there is a shift from inpatient to outpatient. Then there is obviously the issue of physicians becoming hospital employees, so things are moving from the office setting to the OPD.

MR. THOMAS: Right.

DR. ZABINSKI: Drugs are having a huge impact here, and there also seems to be unprecedented uptick in observation care, and I'm not sure what exactly underlies that, but that's, you know, driving things as well.

MR. THOMAS: It may just be helpful in the chapter to provide some additional colors, drivers there. You know, I'm not surprised by the observation care comment and/or the transition of, you know, folks that have been short stays, inpatient, outpatient. It may just be helpful

for context.

The second question is, a clarifying question, is on page 6. The 2010 and 2017 spending for beneficiaries, 1.5 percent, and then the projection for '18 to '26 has both going to 4.9 and 4.8 percent. Do know what's driving the differential there, because the relatively material change in history versus projection in spending beneficiaries.

MS. PODULKA: Absolutely. So basically the answer is it's a mix of everything. So it's prices ticking back up again, it's use of medical goods and services ticking back up. Specifically drugs play a role but they're not the only aspect of service. And remember that part of the historically low growth of 1.5 percent is when there are some PPACA tools going into effect that lower rates, as well as, you know, observers can note and argue about other causes, like the recession might have reduced utilization, other things. So the 1.5 is not expected to turn back up again any time soon.

MR. THOMAS: Okay. Thank you.

DR. CROSSON: Okay. So I've got Sue and then Paul on this point? Okay.

DR. PAUL GINSBURG: I didn't want to say anything but I really wanted to turn to Bruce to see if he could characterize for us what happens with actuaries have a few years of a trend lower than they expected, when they still have to project the future, and that might have something to do with this.

MR. PYENSON: Well, I think the expectations of actuaries and others are that the relentless trends that we've seen for decades will continue, and that's an underlying assumption that seems to be built in, explicitly or implicitly, into not only what actuaries do but business plans and other implementations of health care planning. So when an actuary is looking at that for purpose of a risk-bearing entity, it's very important to think about the solvency of that enterprise and to have the margins that can sustain adverse fluctuations.

So people had seen an example of that perhaps as in the Part D experience, when there was the missed increase in cost associated with hepatitis C treatments, and that was, in reality, followed by, as we saw on a chart, a decline in spending, because the backlog of patients got pushed through the system and spending on

hepatitis C went down dramatically. However, many organizations projected an increase in trend. So the initial shock was missed and the subsequent decline was missed. So, on average, it's probably just about right.

DR. CROSSON: I could make a joke there but I think I'm -- Sue and then Jaewon. I saw Sue.

MS. THOMPSON: Jennifer and Olivia, thank you for your work on this chapter. Nicely done. It's always kind of an overwhelming orientation to the year, but thank you for your work. It's very grounding, very grounding.

On page 57, this is in the category of fraud and abuse, just a clarifying question about the reference to fiscal year 2014, when 12.7 percent of payments to fee-for-service Medicare were inaccurate and something like 9 percent in Part C.

First question, do we have any more updated information in fiscal year '14? When do we think we would get updated information? And then the third part is, it's a reference from the GAO from 2013, so was it a projection as they looked ahead, or just help create a little more clarity around that reference.

MS. PODULKA: That's a very good catch. I'll

have to confirm about the date of the GAO report, and if it's '15 rather than '13, because that happens sometimes.

We will check for even more recent information, because I realize, you know, things can peak in a certain year if it doesn't necessarily carry of every single year. And part of the issue, though, is that GAO and OIG don't necessarily release reports on this topic every single year, but we'll check and see if we can find something more recent.

DR. CROSSON: Thank you. Jaewon.

DR. RYU: Yeah. I just had a question around, this gets to the shift discussion that we had earlier between the outpatient and inpatient, and it would be helpful to understand how much of that shift, you know, are we seeing intensity versus volume, and just being able to parse that out a little bit more I think would be helpful.

The second question is getting back to Marge's comparison between Medicare Advantage and traditional Medicare. I think it was Figure 5, at least from the reading -- I forget what slide it was -- but, and, Jim, you had a comment around the encounter data. And I don't know if the encounter data it ripe to do some sort of risk

adjustment around the spending and the spending trend, but I think that would also be helpful to understand how much is a selection bias between who is entering each program and how is that feeding the trend.

MS. PODULKA: I'll have to go back and talk with my MA colleagues to see what we can do about the risk adjustment aspect. I can definitely look and see what we can add on breaking out volume and intensity as a proportion of that inpatient to outpatient shift.

DR. CROSSON: Okay. Seeing no more hands for questions we'll move on to the discussion, and I think Bruce is going to lead off.

MR. PYENSON: Thank you very much, Jennifer and Olivia, for a terrific presentation. Personally I found this chapter to be the most important work that MedPAC does, because it's so general and so broad and guides everything we do.

My personal view is that we can use this work as a framework for expectations of success in a couple of ways, and if we go to Slide 3, I think that success would look like those curves, upward curves would tilt downward, that health care, like other mature industries, should be

becoming a lower and lower portion of health care spending over time, and that that would be certainly a good thing for the U.S. economy and a good thing for the health care of the population.

But we have a trend that goes back decades and decades, certainly the entire course of my career, and it's part of the expectations that we all have that I think are implicit in a lot of ways that affect our work. And I'd like to talk about one of them in particular, that we have a long-term vision here and a long-term evidence, but so much of the health care system is tied up in very, very short-term increments, in particular in annual cycle. The way that fees are set, contracts are negotiated, bids for Medicare Advantage or bids for Part D are set are all on this very short-term, one-year cycle, as though we don't have the confidence to go beyond one year, or the ability to manage that. And I think that actually supports this relentless inflationary system that we have.

So as we go through our work, I am hoping that we can think about longer-term impacts in processes that would set expectations on a somewhat longer-term basis, perhaps bids that are every two to three years, or fees that get

set for two to three years in advance, without the opportunity to make so many adjustments in the next year.

Another point I'd like to make about these charts is I think I see evidence for the important role that Medicare has on the rest of the system, and there have been pieces that have come out of MedPAC work about how, when MedPAC makes a policy, that affects the rest of health care spending in a good way, and I think that's probably a more important issue than the generally recognize. So I think the success that Medicare has had in constraining spending has had a beneficial effect on the rest of health care spending, but we should take advantage of that as we go ahead.

So, again, thank you very much.

DR. CROSSON: Thank you, Bruce. Further comments on the context chapter? Jon.

DR. CHRISTIANSON: So just three suggestions, I guess. One is when you discuss the trust fund solvency issue in Part A, I think you need to have a sentence or two there defining what you mean by solvency and insolvency. And what I'd like to see there is basically some acknowledgment for readers that aren't aware of this that

being insolvent doesn't mean there's no money coming into the trust fund. In fact, it looks like you'd have about 86 percent of the money needed, something around there, to pay hospital bills. So just a sentence or two to clarify when you say insolvency, that's what's meant.

Second, I think there's kind of a gap in your discussion around sort of Medicare performance. I think there's nothing in here that I can see that's really much about the quality of services received and patient experience. You've got lots of stuff on the Medicare financing. You've got some stuff on kind of a population health life expectancy sort of thing. Not really much or anything about quality of care in the sense of are beneficiaries getting the services they should be getting, the screening they should be getting, what's the trend or what's the evidence around percentage of beneficiaries that have hemoglobin A1c levels and are diabetic and have those levels, those sorts of measures. Especially since we focus a lot of our discussion on value-based purchasing, we need to focus our discussion on context here, around both the costs and also what we're getting for the cost from the delivery system. So I think the chapter is very light on

that.

Subsequent chapter, where we talk about clinician payment, we have descriptions around access to care for Medicare beneficiaries versus people covered by other kinds of insurance. That would seem to be a logical thing to have in this chapter, because it contains context and it also contains important information about the beneficiary experience in the program.

And then sort of a very general comment. I think you have a challenge in terms of balancing sort of two things going on in this chapter. One is it reads more right now like a status report on the Medicare program than a context chapter in a broader sense. A context chapter in a broader sense would talk about what's going on in the health care system as a whole and how that affects the way Medicare can do business, and vice versa.

So we talk about this in our discussions month by month, and we've talked about how there's lots of things going on in the drug environment, that Medicare has no impact on, that we can't affect through our recommendation, but to have an impact on what our recommendations can do. And I think the consolidation issue, which you kind of

brought up in passing, is one of those other things that's going on in the general environment, it provides context.

So you're kind of balancing those two, how much of that to put in here, in this chapter, versus how much to make this a status report on Medicare. I think it's come down fairly heavily on the status report on the Medicare program. And as you go through the next draft I think you might want to sort of ponder whether that's the right balance or whether there are areas where you need to provide sort of more information on context and less on what Medicare numbers look like right now.

DR. CROSSON: Let me be clear. I've got Kathy, David, Karen, and Warner. Did I miss -- okay. So we've got everybody.

MS. BUTO: Okay. So --

DR. CROSSON: Not really everybody, but we'll go this way for those who want to talk, and then I'll start over here.

MS. BUTO: I'm picking up a little bit on Jon's comment, but something Warner said earlier, too, which is I wonder if we can -- and we may not be able to do it in this go-round, but if there could be some follow-on to the

context of -- that goes more to the issue of some of the recommendations that we've made over time, number one; and, number two, areas we're looking at that have promise, both aimed at changing the cost curve for Medicare. So, in other words, trying to get more at -- I know we have this very comprehensive list of recommendations over the years. There are some in there that have a much bigger impact than others in terms of maintaining quality but changing the cost curve.

So since so much of what we do in this chapter is to point out how Medicare and Medicaid to some extent are eating the federal budget, I think it would be good to remind people that the Commission has actually looked at some of the big targets for making that cost curve change.

So some of those are, in my mind anyway, the PAC PPS work that has been done. The work that we did early on to look at what are the most efficient systems by area, fee-for-service, ACO, MA, and how we can move more toward beneficiary contribution or contribution by the program to promote more of that efficiency. So there are some big ideas that we've touched on before that it would be nice to be able to at least talk about those and some of the other

areas that we're pursuing, and not just leave the context as this is the picture, it's pretty bleak, you know, and, by the way, here are a lot of the recommendations that we've made over the years.

I just think bring that back home to the big ideas that could make a really big difference.

DR. CROSSON: Thank you for that, Kathy. I agree.

Let me just point out there's a significant imbalance between the number of hands I saw and the amount of time that we have allocated for this. So I would ask people to be succinct. I think we can extend this until 10:30, but after that, that's pretty much it.

Okay. So David and then Karen.

DR. GRABOWSKI: Great. Thanks, Jay, and I'll be brief. Could you put up Slide 16, please? I just wanted to make a quick observation.

When I look at Medicare's challenges, I think MedPAC is doing a lot of work on some of these challenges, but there's at least two of them, maybe more, that we can't do anything about -- for example, Challenge No. 3, coverage of services delivered by any willing provider. Well,

that's a Medicare statute. Challenge No. 4, benefit design. Well, we know a lot of beneficiaries in traditional Medicare have supplemental coverage.

So we keep coming back to value-based payment as a major tool in our toolkit, and I think there's a reason for that. It's something we can -- it's a lever we actually have access to, and it's something we can do to actually move the needle.

So I just want to make that observation that I really think we spend a lot of time in this Commission criticizing a lot of the flaws with value-based payment, but there's a reason we go to it time and time again and that there's some real challenges with addressing some of these other issues. Thanks.

DR. CROSSON: Thank you. Karen.

DR. DeSALVO: Thank you. I want to just begin with the comments that Jon made because that was certainly raised for me, this idea of having a more balanced perspective in the chapter to really understand the impact on the beneficiaries to their health and to access to services. So I think it would be wonderful to include more of a balanced perspective, not just on the fiscal issues

but also on the impact on the beneficiaries.

My second comment has to do with general environment, and I suspect that you all have a sense of the material impact that some of these trends will have on the Medicare program and perhaps they're too small to really acknowledge. But since they're topical and since, to Bruce's point, what Medicare decides and does influences the rest of the market and vice-versa, I'd just raise a couple.

One might be a trend towards more consumer-oriented services that may or may not change the definition of "any willing provider" as the Medicare program gets more interested in and perhaps liberal in allowing telehealth or other kinds of service delivery that's virtual as an example.

The second has to do with probably some more in the drug portfolio, so perhaps it's already included there, and it's about precision medicine and the potential impact of that world on creating really high-cost drugs and service delivery.

And the final is probably the one I'm most interested in, which is about the social determinants of

health. It's embedded in the chapter and some of the work that you've written that we have a the baby-boomers coming into the program seem to be more impacted negatively by social determinants of health, things like economic opportunity, education, et cetera, and it's manifesting in their health. I think it would be interesting and probably important to understand what that might mean from a cost standpoint since there is some literature and data to show that people who have a higher burden of social complexity, of social determinants of health, have higher cost, and by impacting those, the program might be able to lower costs over time.

Thank you.

DR. CROSSON: Thank you. Now, I had Warner. I didn't see anybody else -- Sue, and then Warner.

MS. THOMPSON: Well, I just want to build on what I just heard Karen say, because it strikes me that there's some freedom in moving to a value-based platform that relieves us of a lot of complexity, and I just want to underscore that and I'll be succinct about that.

The second piece, I will be succinct, but the entire description around rural health and the fact that we

have studies that suggest we have a 20-year difference in life expectancy just screams out the need for us to continue to work around answering the disparities, not only between rural and urban but male and female, and that's well illustrated. But I think there's work we have done in rural that would be nice to be included here, and maybe even calls us to broaden that work beyond just thinking about how do we either save or cross-walk small rural hospitals that are failing and think more broadly from a community, from a Medicare standpoint across the continuum.

So I just wanted to call out that piece of your work in this chapter. Thank you.

DR. CROSSON: Thank you, Sue. Warner.

MR. THOMAS: So I thought the chapter was well done. It's certainly sobering. A couple of comments that I wanted to bring up. Especially given the fact you have outlined where we have a flat trend that -- a relatively flat trend, you know, 1.5 percent, and we don't anticipate continuing escalation and, you know, more baby-boomers going into the program escalating drug costs and the solvency. And I understand, I think, Jon's point, which I think is helpful, that solvency just means that essentially

there's more general revenue that will essentially cover the cost versus coming out of the trust fund. I guess it is 42 percent today, and it is declining.

But the one comment that I wonder if we should add into the chapter -- and we talk about what we have to do to raise payroll taxes or reduce expenses by 16 percent. There's really no discussion about eligibility age. And I just wonder if there should be a comment around eligibility age and the impact that could have on the program. I think we all know when the program was started, life expectancy was approximately 65, and essentially eligibility age was 65. And so today with life expectancy, depending on what you look at, is 73, 75, or higher, I think it begs the question as to whether that's something that should be looked at or at least sized as to what the impact could be for the program.

Then if we can keep tweaking the payment mechanisms, and I agree with the comments around value-based reimbursement and if we could move to a different trend for cost, that would certainly have a major impact. But I really would encourage us, if we're mentioning payroll taxes, mentioning reduction in cost, you know, a

comment or a section around eligibility age and the impact, given the alarming change in that we've dropped three years on the solvency number, you know, just in the past year, and if that escalates, that certainly creates what could be a crisis even sooner.

DR. CROSSON: Thank you, Warner.

Can I see hands here? Okay. So Dana.

DR. SAFRAN: Just very briefly picking up on two things. One, starting with points that I think Jon was the first to mention is I really think that it would be important to have additional focus in this chapter on quality and the quality landscape, because we say very little -- there's three pages on the relationship of cost and quality, and really that's the relationship of cost and life expectancy. But particularly in the context of value-based payment over the last years -- and I'm not assuming the data will be that encouraging, but at least we should put the data out there of, you know, some of the major metrics. What do we know and see to be happening on some of the important quality and outcome measures? So what's happening with hospital-acquired infections? What's happening with readmission rates? We've been investing in

those things. Are we moving the needle? And also the HCAHPS data and other, you know, ambulatory patient experience data would be important as well.

Then to the point that Warner was just raising, a couple others have raised about value-based payment, I just wonder whether it's worthwhile for us in a context of a kind of gloomy forecast about the finances. Is it worthwhile to do some positing of what could be possible if value-based payment really expanded and was highly successful? You know, what could that mean for the program both in terms of cost trends but also in terms of the improved quality and outcomes that you'd expect by putting incentives there?

DR. CROSSON: Thank you, Dana. Pat.

MS. WANG: I think that notwithstanding the important clarifications on the definition of solvency and what that actually means, the two sort of facts in here or projections that to me I just can't get out of my head -- and they're not new -- is the decline and the projected decline in the number of workers per Medicare beneficiary. You can put as much federal revenue in to make the trust fund solvent, but, man, you are going to be pulling money

out of people's paychecks like there's no tomorrow. And the percentage of retirees' Social Security checks that are going to be consumed by premiums Part B, D, and cost sharing. I mean, it's gigantic.

So there's a huge ripple impact to, you know, the technical definition of solvency, you know, assuming that that -- it's just going to have a huge impact on the economy. I think that those are two statistics that are hard to kind of pencil out.

I would like us to see -- and echoing some of the comments that have been made here, suggestions from the chapter, perhaps on page 59 when there's a recitation of the different sort of things that the Commission has been interested in that we say more on the bullet of "encouraging care coordination and quality." I believe that in my time on the Commission there has been a consistent theme throughout in promoting, pushing -- you know, pulling, pushing the development of more accountable forms of delivery in health care from a payment as well as a deliver perspective, whether it's ACOs, MA, integrated care for duals. There is now seamless enrollment. CMS reopened the door for seamless enrollment of duals,

Medicaid aging into Medicare. Those have a consistent underlying trend, which is not just to develop the health care system to be more coordinated, and I think we should point out some of these things, but also to encourage enrollment in what we believe will be more efficient, higher-quality systems of care, because it is a very sobering chapter, and the federal fisc is not bottomless. So I think, you know, it's important to kind of put a marker down.

DR. CROSSON: Great. Thank you.

Jonathan?

DR. JAFFERY: Thank you. So maybe this is a bit out of scope for this particular report, but on page 21, you refer to Commission work aligning the health care workforce, and then the appendix references a number of recommendations that are generally somewhat dated. I think they're all from 2010. And so in light of a lot of the changes that have happened in the last eight years or so and a lot of the increased focus on population health efforts and a recognition that there's an increased need for primary care and the reality that people are feeling in terms of primary care, the difficulties in hiring primary

care, I wonder if there's an opportunity in the future to provide some information on workforce trends and how that might impact access, and even thinking about, to follow up on Pat's comments, the -- you know, as we push towards these goals for more care coordination, are there trends in training? Because it's very different -- the requirements are very -- don't really work towards those, and, of course, the needs may be very different from the way most of us in the room were trained.

MS. PODULKA: We do have an upcoming presentation, not this session but one of the ones in the fall, specifically on workforce, NPs and PAs and physicians at least. It's not encompassing everything. And once that material is shared with the Commission, we can refer to that here in the context chapter as well.

DR. CROSSON: Okay. Yeah, I wasn't clear, Jon, whether you were putting your hand up or not.

DR. PERLIN: Honestly, I was debating. I realize the overall thing here is the continuation of the solvency of Medicare and its effectiveness. But I can't help but comment -- if we go to Slide 14, we note that the impact of the premium increases, as Dana pointed out, among

commercial insurers exerts an upward pricing pressure for Medicare in terms of assuring beneficiary access. But it's just interesting to me that there's a reciprocal as well, which is that there's a pressure for increased premium support by virtue of cross-subsidization, particularly as we note with the negative margins that, you know, many hospitals face, particularly in terms of Medicare services. My best understanding is that 66 percent of hospitals have negative Medicare margins, and even we note that there's pressure on those providers that we'd call very efficient, a quarter of hospitals with total negative margins, and 31 percent with negative operating margins.

So in that context, it's not surprising that they're exerting an upward pressure in terms of the pricing on the commercial to sort of cross-subsidize and retain, and so I completely endorse all of the different mechanisms to extract better value from the dollars spent. But I think we have to be bidirectional in terms of understanding the dynamics in this particular slide.

Thanks.

DR. CROSSON: Thank you.

Brian, for the last comment.

DR. DeBUSK: Actually, Jon, you took me exactly to the slide and exactly the point that I wanted to make.

On Chart 14, the one thing I would want to add to that, when you look at those two curves, the employer-sponsored curves, you know, if anything, those are understated because you have employers that have robust enrollment mechanisms and utilization management tools and the ability to narrow networks and the ability to pare back benefits.

So if you really look at that spread, it's probably somewhat understated, and if you notice our failure so far, at least in the fee-for-service side, to meaningfully address service use -- and I'm sure there's some isolated examples that we have. But if you look at where we've really failed in a wholesale way to address service use and you look at the way those curves are still spreading, to Bruce's point earlier about Medicare controlling costs, it has to be in the rates right now, which means that I hope that we're keeping a close eye on the spread on those rates, because I think once we do finally break, once we have a break in that gap -- and I'd make the analogy it's almost like psychiatrists. I think

about 50 percent of them even participate in Medicare. What I'm afraid of is that once the spread gets great enough and this issue becomes obvious, it may be more difficult to fix than we realize.

DR. CROSSON: Okay. A lot of wisdom there. Thank you very much. The chapter will be undergoing some hip transplants --

[Laughter.]

DR. CROSSON: -- and other sorts of adjustments, surgical and chiropractic, and we'll come up with a good product based on the discussion. So we'll move on to the second presentation of the morning.

Okay. So this work, particularly for our guest, is a continuation of work the Commission has done over the last few years on a unified payment system for post-acute care, and is addressing the question about what regulations, federal, state, and otherwise, might need to change in order to see that outcome. Evan is here to present and lead the discussion.

MR. CHRISTMAN: Thank you. Good morning. This morning I will be presenting some analysis on how to align Medicare requirements for PAC providers under a unified

payment system. I would also note that Stephanie Cameron, Dana Kelley, and Carol Carter also contributed to this presentation.

My presentation today has three parts. First I will briefly review Medicare's current PAC systems and our recent recommendations for a more unified payment system. Second, I will review Medicare's current system of setting specific statutory and regulatory requirements for PAC providers. And finally, I will provide some analysis that considers how to set common requirements for all PAC providers that would be aligned with the goals of a more unified payment system.

This slide provides a brief overview of Medicare's current PAC silos. SNF and home health account for the majority of PAC expenditures. IRF and LTCH have lower total spending, and this reflects the smaller patient volume of these more specialized settings.

Analysis by MedPAC and others has frequently found that there are overlaps in the types and severity of patients seen in these four settings. This overlap is particularly striking because each setting has its own payment system, and as a result payments for similar

patients vary based on the setting a patient is served in.

The Commission has made a number of recommendations to move towards a more unified system of paying for post-acute care. In 2016, we found that it was feasible to establish a unified PAC PPS that was accurate and equitable across many patient categories. This system would replace the current four PPSs with a single system for all PAC providers. In 2017, we recommended, that a unified system be implemented in 2021. We also recommended that a unified system lower aggregate payments for PAC, as current margins are much higher than cost in most settings.

Finally, we also recommended that Medicare revise its statutory and regulatory requirements for PAC providers to align with the goals of a unified system. How Medicare could develop common requirements for PAC providers is our focus for today.

This need for better alignment is a result of the very problem that led the Commission to recommend a unified system. Similar to the separate payment systems for each of the PAC settings, Medicare also has a siloed system of statutory and regulatory requirements that create distinct requirements for each of the four settings. Adding even

more complexity is that sometimes these requirements are very different across the settings while in other cases the requirements for each sector are actually relatively similar.

The purpose of the unified PAC PPS would be to make payments based solely on patient characteristics and minimize the role of site of care in setting payments. Establishing a patient-focused set of common requirements for all PAC providers would be better aligned with the goals of a unified PAC payment than the current siloed set of requirements.

Medicare PAC providers have setting-specific program requirements, referred to as the Conditions of Participation. The CoPs establish the clinician responsibilities and services required for each setting. The COPs are extensive and there is more detail in the mailing materials that explains their purpose and content.

Our examination of the COPs found that there were areas that that PAC settings had requirements that were relatively similar in the purpose or in the responsibility they place on providers. They are listed here on the slide. I am not going to go through each of these but

these broadly include the basic activities expected of a health care provider, such as management responsibilities, compliance, quality assurance, and the other areas listed here.

There were also some areas that the institutional settings had relatively similar requirements, such as fiscal plan, pharmacy, and dietary services. I would note that these services are not provided by home health agencies.

There were also areas that the setting-specific requirements differed, with the great differences occurring in the physician supervision and nursing requirements. As noted on the first line of the table, the IRF and LTCH required daily or relatively frequent physician visits. In contrast, SNF patients are supposed to have a visit with a physician in the first 30 days, and there is no requirement for a physician visit during home health. The institutional settings also required some form of a medical director, while home health does not.

Nursing requirements also varied. IRFs and LTCHs, which are governed by the inpatient hospital COPs, have to have around-the-clock coverage by a registered

nurse. SNFs are only required to have a registered nurse on premises eight hours a day. In home health care, registered nurses or patients can initiate care and provide or supervise the delivery of services.

Medicare does not set specific staff-to-patient ratios in any of the PAC settings. Providers are expected to have the appropriate staff for the number of patients and severity of patients that they serve.

Finally, we also examined the coverage and payment requirements for each sector. For example, admission to skilled nursing, or SNF care, requires a three-day prior hospital stay and that the patient have a skilled need, that is a need for nursing or rehabilitation services. Home health care requires that a patient be homebound, and also that they require nursing or rehabilitation.

And the program requirements for IRF and LTCH are more complex. For IRFs, at least 60 percent of a facility's patients must have 1 of 13 conditions determined by CMS to be rehab intensive to be paid under the PPS. In addition, there are IRF coverage criteria that patients must meet. The patient must require intensive rehab and

need at least two different types of rehab.

For the LTCH setting, the program also has unique payment and facility criteria. To be eligible for payment under the LTCH PPS, a facility must maintain a 25-day average length of stay for certain Medicare fee-for-service patients. In addition, for a specific case to qualify for a payment under the LTCH PPS, the patient must have had a prior stay in a hospital ICU or received at least four days of mechanical ventilation services during the LTCH stay.

A revised set of requirements under a new system would seek to move toward a more patient-centered definition of coverage and eligibility by minimizing or eliminating silo-specific criteria.

A new set of requirements for PAC providers could take several forms, but could adhere to a few principles. The requirements should be defined by patient needs and should reflect the range of clinical severity experienced by Medicare PAC patients. Consistent with the goals of PAC reform, the new requirements should generally be the same regardless of site of care.

A limited exception could be the need to reflect the difference between the responsibilities of

institutional PAC providers and home health care. The new requirements could establish separate categories to acknowledge that delivering care in the institution has some responsibilities that care in the home does not have, such as room and board and other ancillary services.

There are several possible approaches, and I will walk through an illustrative example in the next few slides. In this example we will split requirements into two tiers. The first tier setting general requirements for the services needed to serve the majority of Medicare PAC patients, and the second tier setting requirements for patients that require more specialized care.

The first tier requirements would establish the basic competencies expected for all institutional and home health PAC providers. These requirements should include services and responsibilities that are sufficient to meet clinical needs for the majority of PAC patients. These requirements could begin by establishing common requirements where the purposes or responsibilities of existing standards are generally similar, for example, those I mentioned earlier, such as management, compliance with laws, licensure, and other basic responsibilities,

like emergency preparedness and quality improvement.

This tier could also include the basic requirements for services for institutional providers, such as facilities, dietary services, and so on. This would ensure that all beneficiaries served at institutional providers receive the same comprehensive services.

A key decision for policymakers will be the level and intensity of physician and clinical services available in the first tier. For nursing, policymakers will need to consider how much nursing to have at these facilities. IRFs and LTCHs are required to have nurses on premises 24 hours a day. While some analysts have suggested a similar standard for SNFs, CMS only requires 8 hours a day of coverage with a registered nurse. Medicare could consider establishing a 24-hour requirement but would need to weigh the cost of this with the value. A 24-hour nursing requirement would increase costs but it would also improve care for beneficiaries.

The first issue for physician services is the presence of a physician medical director. Medicare would likely want to continue the medical director requirement for institutional PAC settings, and could also require home

health agencies to have a physician medical director.

The second issue is how often a patient is examined or treated by a physician during their PAC stay. The frequency of these visits varies among the three institutional settings in the current requirements, with LTCHs requiring daily visits, SNFs having a visit every 30 days or even longer, and home health does not have any requirement for a visit during an episode. Given the range and the frequency of physician services under the current requirements, determining the appropriate frequency would be an important decision for policymakers.

The second tier of requirements would identify conditions needing specialized treatments or staffing that exceed the services required by the first tier. These rules would set requirements for PAC providers that seek to treat certain categories of patients. These conditions could be identified such as by reviewing current patterns of care or using experts to identify high-risk or high-need conditions for PAC patients. Each condition would have its own set of requirements and providers would have to meet these requirements in addition to the first tier. These categories could be revised over time to reflect changes in

practice or patient needs.

This slide gives some examples of categories of patients that may require specialized care. For example, these could include patients requiring ventilator or respiratory care, patients with a prior ICU stay, patients with conditions requiring intensive rehabilitation, or complex medical patients, such as those with serious infectious diseases, cancer, or requiring dialysis. For each of these clinical categories, Medicare could establish requirements for providers that indicate the staffing or ancillary services it must have to treat patients with these conditions.

A final consideration would be aligning coverage requirements for PAC patients. For home health, the homebound requirement is critical to ensuring that the benefit only serves patients who have difficulty accessing ambulatory care, and Medicare would likely want to continue with this requirement. Medicare currently requires SNF patients to have a prior hospital stay of at least three days, and the program may want to consider extending this requirement to all stays under a unified PAC unified PPS, as it would set a minimum standard for patient acuity that

would come at all settings.

However, a new requirement may want to provide some flexibility, as under current utilization many home health, IRF, and LTCH patients do not have a prior hospital stay, and if a unified system required such a stay they would not be able to access the care they get now.

Medicare could implement some flexibilities to protect access for some patients, such as adopting the Commission's recommendations to count hospital outpatient days towards the three-day stay requirement, or allowing ACOs or other entities at financial risk for Medicare services to waive the requirement when they deem it necessary.

A final issue would be the timing of the implementation of the new requirements. One approach would be to phase in the new requirements in two sets. The first could begin relatively soon and be focused on areas that current requirements are aligned. Ideally, these should be easier to develop and simpler for providers to implement. The second phase would be areas making more substantive changes, and could be implemented concurrently with the unified PAC PPS. These areas are more complex, but would

align Medicare requirements with the goals of a unified payment system.

New requirements for PAC could take several forms, and this discussion is intended to identify the major issues for aligning PAC requirements. The analysis today focused on how to structure the new requirements. We offered an example of a two-tiered structure, a patient-centered, general, and more specialized requirements. We are interested in hearing your reactions to this approach as well as to the contents of the two tiers provided as an example.

We also reviewed how Medicare could restructure its existing coverage and eligibility requirements, and finally, we also presented an example of a phased implementation of these changes. We are interested in hearing Commissioner feedback on the issues identified in this analysis and any additional areas you believe Medicare should consider.

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

DR. CHRISTIANSON: Thank you, Evan. So the first round of questions are clarification and then David will

take over at that point. So let's start with you.

DR. DeBUSK: First of all, thank you for an excellent chapter. I thought it was a really good read.

I have a question specifically on Chart 16, where you're asking about insuring appropriate use and the application of the three-day stay requirement. Considering the conversation we had earlier in the context discussion about this shift from inpatient to outpatient, have you contemplated procedures that are moving, say, a knee replacement? Let's say you're doing an outpatient knee. You clearly don't have an inpatient stay anymore so you don't have the three-day requirement. How would you address those types of procedures, because someone may still need SNF or some form of PAC, even though they're doing outpatient work now?

MR. CHRISTMAN: I think, you know, we haven't looked specifically at that. A few years ago we were asked to look at whether there was an increased pipeline of outpatient patients, from the outpatient setting to home health, which doesn't currently have this requirement, and we haven't observed -- we didn't see any at that time. You know, I think the -- it's sort of a policy decision of what

level of acuity, what you want to insure, is sort of the floor, and we haven't looked at how that would affect outpatient users of PAC, which really would be maybe home health, and then, in theory, IRF and LTCH. But the sliver -- the slice of people that go there is relatively small.

DR. CHRISTIANSON: Let's go down this side. Jon.

DR. PERLIN: This time Brian asked my question. To follow on on that, would entities operating in bundles be considered entities at financial risk under this proposal?

MR. CHRISTMAN: To be honest, I haven't thought specifically about that. I mean, I think the ACO example is the easiest one to cite because they're sort of at risk for everything, right? I think what we were thinking of as the example is, as you're probably aware, in the current ACO program, CMS lets -- in some situations lets ACOs waive the three-day stay requirement for SNF care. I don't recall if they've extended the waiver to the bundling, but, you know, that would be one -- they have? Okay. Yeah. I mean, that's certainly a possibility.

DR. PERLIN: I'd encourage it in terms of the efficient use of resources, particularly under the both the

advanced and some of the more sophisticated paradigms. Thanks.

DR. CHRISTIANSON: Amy or Paul, any clarifying questions?

MS. BUTO: Evan, I'm not sure if this is for you or Carol but I was trying to remember if we made any assumptions about the level of either nursing care or physician involvement in developing the payment model. No. Okay. Thank you.

DR. CHRISTIANSON: David.

DR. GRABOWSKI: Thanks, Evan. This was a great chapter.

At the very end of the chapter you raised state certificate of need laws, and that being a potential barrier towards implementing these rules. You introduced it, you showed us some different rules in the appendix across states. I'm wondering if you have any thoughts of how we're going to overcome that barrier, because you raised it but it made my head hurt just thinking about how to circumvent these certificate of need rules.

MR. CHRISTMAN: I think, you know, it is important to keep in mind that these are -- this is kind of

a needle that providers have to thread in the current environment, anyways, where Medicare makes one set of rules and the states have another set of rules.

I think as CMS goes down this path and begins to develop new rules, you know, softening the path for people who will have to come to grips with their own state requirements may be something to think about. But given that they're able to sort of satisfy both the state requirements and the ever-changing current Medicare rules, I think that it's -- you know, in practice, I think it would be surmountable obstacle. It seems like in practice we've been able to avoid situations where the rules may be different, but they don't, you know, directly contradict each other in a way that they're unexecutable.

DR. PAUL GINSBURG: I was wondering whether in a sense having a unified PAC PPS would actually be a useful flexibility so that in states where it's -- you know, so you can't have an LTCH. This in a sense is supportive of that since, you know, more flexibility where patients' needs can be met by other post-acute care.

DR. GRABOWSKI: My sense, though, Paul, would be if there was a shift from one post-acute care setting to

another under the unified PAC payment system, can those states meet that demand if there's a certificate of need law in place and we can only have so many home health agencies or so many skilled nursing facilities?

So I totally agree with you, this will -- the existing market conditions will help shape utilization, but I worry about our ability to kind of shift with the new PAC payment system.

DR. CHRISTIANSON: Karen, did you have any clarification questions? No? I'll go to Bruce then.

MR. PYENSON: Thank you very much, Evan. I really like the tier structure, and it seems like in Tier 2 there is a set of potential more detailed specifications for qualifications. My question is whether you can envision using that such at the time of patient discharge where the discharge planner would essentially assign Tier 1 to this patient or would assign Tier 2 with this list of specialties to a particular patient. Is that perhaps coverage determination -- I'm not sure what the right words are.

MR. CHRISTMAN: Well, right, I think the point -- in this example, I think what we've envisioned is that the

second tier categories would have relatively clearly defined clinical or condition-specific guideposts, if you will, and it would be clear to a discharge planner that, you know, this patient is, a clear example, a mechanical ventilation patient, and this is the tier of provider I should be aiming for with this person. They will have the specific capabilities that pertain to that condition.

MR. PYENSON: So the structure would, in effect, be a coding on the patient as well as the providers?

MR. CHRISTMAN: Right.

DR. CROSSON: Marge.

MS. MARJORIE GINSBURG: I also have a question about these two tiers of types of patients. The second tier are the more intensive patients, the vent-dependent and all. You reference level of staffing, but I don't -- you talk about types of staff required for the regular people.

MR. CHRISTMAN: Right.

MS. MARJORIE GINSBURG: But there's no reference to staffing ratios or anything that suggests how many are needed for how many patients. And it seems to me that that would need to be included here. Maybe it is and I didn't

see it. But I'd be curious on the issue of staffing ratios for the higher tier.

MR. CHRISTMAN: It's something you could, you know, definitely do. I think there's clearly some literature out there that shows that it's something that matters for quality and outcomes. I think part of the reason we're sort of walking a line there is, to my understanding, Medicare, at least in its conditions of participation and other regulatory guidance that I've seen, has never set a staffing ratio. And it's certainly something you could do, but, you know, I guess if -- we could definitely talk a little bit more about that in the paper, but given that we were sort of pivoting a little bit off of what Medicare has today, you know, we talked a little bit more about just whether you have a nurse present.

I do appreciate that there's a lot of literature on staffing ratios being important. To date, the onus Medicare has placed that I've seen is just this language about having an appropriate level of staffing given the needs and volume of your facility. So I would have to think about if Medicare wanted to go down this path, you

know, what you would think about basing a ratio on.

MS. MARJORIE GINSBURG: Do individual states to your knowledge have those kinds of ratios that Medicare --

MR. CHRISTMAN: They do. I believe California is the most commonly cited example, and I know they have it on the inpatient side. I'm not close enough to recall whether they have in the nursing side? They do. And, you know, we're obviously, at least in this context, thinking about it almost on a more granular basis, obviously, like a specific type or kind of patient. So that's definitely something we could talk a little bit more about in the paper.

DR. MATHEWS: And, Marge, if I can also inject here, just a reminder that this is the first time we've presented this information to the Commission in any detail whatsoever. While we could go down to any granular level of detail that you collectively want us to, what we would find most helpful at this point would be the reaction to the general notion of a two-tiered structure, and in addition to the kinds of groups of patients that we have set up as examples of patients who might need a higher standard of care, are there other types of patients who

might similarly need higher standards? And if so, in a more general sense, what kinds of things would we consider with respect to provider requirements? Staff certification requirements, things like that. So we haven't, you know, as Evan mentioned, gotten into the level of being very prescriptive with respect to staffing ratios for vent patients versus complex infection patients, but it's at a level or two higher than that that we're looking for guidance from the Commission.

DR. CHRISTIANSON: Presumably, it will all happen during the next round as we're still on clarification round here.

DR. CROSSON: Okay. Sue.

MS. THOMPSON: Two quick questions. Thank you, Evan, for this chapter.

First of all, in Appendix A, when you identified the six states that were selected, were they selected at random, or was there some theme here with those six states?

MR. CHRISTMAN: I think we were looking for states that represented a mix of big and small, and I think there was also a little bit of sort of knowing that there were certain states that had been more active in this area

than others and trying to include, you know, some states that had really leaned out more on this.

MS. THOMPSON: Okay. And then the second question I have goes back to your opening paragraph, that 43 percent of Medicare fee-for-service patients go into post-acute. Do we know what percent of MA patients go into post-acute, what percent of ACO patients go into post-acute? And then the second part of that question is, of the $60 billion that is spent, what percent of that is in the fee-for-service arena versus MA versus ACO?

MR. CHRISTMAN: Okay. So the second question is easier, so I'll take that one first.

[Laughter.]

MR. CHRISTMAN: The $60 billion is all fee-for-service dollars.

MS. THOMPSON: Only fee-for-service?

MR. CHRISTMAN: Only fee-for-service.

MS. THOMPSON: Okay.

MR. CHRISTMAN: And so do the -- you asked what it looks like in MA and ACOs, and I am unaware of anybody who's looked at this on the MA side, and I would be -- I would appreciate the value of any work they did, but, you

know, given the issues that have been identified with the encounter data, I think that anything we look at would have to be viewed carefully.

And then in terms of you asked about the impact on ACOs -- and I appreciate you asking the question. This is something we're actually looking at. But there was a paper prepared by McWilliams that looked at the changes, and I don't believe they found that the incidence of PAC after discharge changed by very much, but the mix did. And, in general, it was less skilled nursing and more post-hospital home health. What we refer to as the -- in their work, they found that what we refer to as the community-admitted home health actually went down a lot. But that was based on the first -- I think it was the first two years of MSSP, and we're doing a project that will look, you know, at more recent data to see what's going on.

MS. THOMPSON: Thank you.

DR. CROSSON: Okay. Amy?

MS. BRICKER: I don't know if that -- maybe I missed it. Is it implicit that the recommendation around tiering, that there be some stepdown, so specifically, you know, the patient with the serious infection, once that

infection is resolved or once they are no longer receiving IV therapy, they're stepped down or -- I think we'd have to consider sort of the parameters, not just that they started as a Tier 2, but that there's some triggering event.

MR. CHRISTMAN: I think that's something we could think about. I think the other thing is the idea that these clinical categories capture patients, you know, in the normal course of their disease. You know, a good example is a mechanical ventilator patient. You know, once they are weaned, you know, weaning them and then, you know, recuperating them perhaps for some period after that would be an expected part of the benefit, but certainly allowing some room for people to step down would be a consideration.

DR. CROSSON: Warner.

MR. THOMAS: Just one quick comment. I think from a quality perspective, you know, one of the things that -- I think there's a wide variety of performance probably across all health care but certainly in post-acute providers that we've seen, some sort of thought around penalties, not dissimilar to the readmission penalties we see in inpatient, you know, how do we get post-acute providers aligned on readmissions like the stays? I just

think it's something that should be -- as we think about key policy issues, we may want to think about some sort of reference around that area as well.

MR. CHRISTMAN: I think, you know, we've definitely recommended readmission penalties for SNF and home health. I don't think we've made -- you know, I think we've always envisioned that in the unified PPS there would be similar incentives. I don't think we've gone as far as to make a recommendation on that. Even better, we're talking about it next month.

[Laughter.]

MR. THOMAS: I knew that. That's why I brought it up.

MR. CHRISTMAN: Which is what I should have started with.

DR. CROSSON: Pat.

MS. WANG: You may have covered this, and so I apologize if I didn't -- if I missed it and didn't understand. Is this going to have implications for systems of coding patient characteristics? Because right now, you know, people go into settings based on these kind of big -- like you have to have a three-day prior stay; you have to

have some characteristics; you have to have a 25-day length of stay, 60 percent of your -- you know, this strikes me -- it kind of, I think, got triggered by Amy's question -- more fluid and so payment will match sort of the complexity or the needs of the patient. How is that going to be determined or monitored? Do you expect there to be a need for changes in coding or new assessment instruments to properly classify people?

MR. CHRISTMAN: I guess I'm -- I think I hear two questions, which is, yes, it's absolutely true that we do see, you know -- we do suspect that there are different coding practices across the four settings today that reflect the peculiarities of their operation or their existing payment systems. And so to some extent, you would see -- you'll probably see that change.

I guess the broader question is, you know, trying to -- just worrying about whether people are going to the right setting I think is the core of your question, if I hear it, and we'll -- and I think part of that would be, you know, making sure that we pay attention to the outcomes, because certainly now we've tied the payment to the patient and not the setting anymore, and just making

sure that we're, you know, holding the line or improving on things like readmission and things like that.

Part of what gets us into this issue in the first place is, you know, the patterns of utilization today often reflect these kind of existing standards that were developed often for other purposes than just getting the right patient to the right setting. You know, the IRF and LTCH definitions were created to differentiate them from inpatient hospitals.

And so I think part of my difficulty in answering your question is, you know, we've always had questions about the appropriateness of the patterns of utilization we see today, and sort of going forward, what I would think everybody would be doing is sort of paying attention to the outcomes of the new system and making sure, you know, they're in line with what we want to accomplish.

DR. CROSSON: Okay. Thank you for the questions, and the answers, Evan.

We'll proceed to the discussion now. I direct your attention to Slide 16, which I think is still up there. These are at least the starting point for questions that the staff would like to have answered, and I think

we're going to begin with David.

DR. GRABOWSKI: Great. Oh, did you

MS. BUTO: Go ahead. No.

DR. GRABOWSKI: So, first, thanks again, Evan, for a great chapter. This chapter has a really important question. The site-neutral PAC payment requires site-neutral PAC rules, and I think the answer we're moving towards is yes and no. And the yes and no is in the two tiers here. So in Tier 1, this would consist of all those basic competencies that would apply across all PAC settings to those moderate or less severe patients. And I like this foundation we could think about as is up on the slide, kind of levels of nursing and physician involvement for those kind of Tier 1 patients.

And then for those kind of more -- higher acuity, more specialized patients, we would establish this Tier 2 and establish more stringent requirements for patients meeting these criteria, regardless of which PAC setting they end up being treated at.

So I'll start by saying I really like this basic framework. Obviously, we need to work out kind of what's in the first and second tier in terms of conditions. I'll

leave it to the clinicians to really think about those kind of Tier 2 conditions. But I did want to raise a couple of points.

First, I always worry about overuse with post-acute care, and I really like the idea of retaining the three-day rule and the homebound rule for home health care. I think both of these make sense under site-neutral payment. I like the idea Evan had in the chapter of actually applying the three-day rule to both LTCHs and inpatient rehab, but potentially exempting those Tier 2 conditions.

I also like the idea of including any observation days towards counting towards the three-day stay that would qualify for PAC. So I'm positive about that.

The final point I wanted to make was around ACOs. I like the idea you raise of exempting ACOs and other risk-bearing models from these rules. Jon, you raised the point about our bundled payments models, are those risk-bearing models? Should they be exempt? And we need to work those kinds of issues out. But these incentives are already baked into an ACO's incentives. We want these ACOs and other risk-bearing models to be innovators. We want to

encourage entry into that model. And so I am all for relaxing these kinds of rules around the three-day stay, around the homebound rule for home health, for value-based payment models.

So, overall, I really like the direction this is going. It's not a one-size-fits-all but, rather, this two-tiered approach, I think that's a really great start. And I look forward to seeing our further work on this topic.

Thanks.

DR. CROSSON: Thank you, David.

We'll start with other comments. I have Kathy first, then Bruce, Jaewon --

MS. BUTO: I really like the way David set this up, and I want to agree with everything he said. I think coverage, which is like three-day stay and homebound, criteria are different, so I think they could still be applied differently than the standards.

I was struck by two things, I guess. The first was home health doesn't really fit very well. I think we discovered this in the payment model as well. It doesn't fit well because even for Tier 1, level of nursing and physician involvement are not major functions or factors in

home health. It's much more therapy-based, and so I struggle with that. And I think we -- I don't know that we want to take home health out. I guess I almost think of home health as being a fraction or a reduction in payment for whatever we come up with for Tier 1 services that apply in home health, something like that. But I would not want to apply the nursing standards or the physician involvement standards to home health. So I just put that on the table.

The other thing that struck me was, even though we're moving toward common requirements, I feel like there needs even more than there is now, or maybe as much as there is now, a need for a common assessment tool. So, you know, I've forgotten who asked the question of how do you even know where you're going to go. Maybe it was Jon or Jonathan. But how does a patient assess the options that are available given that it's more fluid and there's more overlap among the providers?

So I don't know if we've looked at that, but I think we probably need to consider that, and I recognize that might mean an extra service, which is always more money, but it just strikes me that we don't want this to be a little of this, a little of that, very serendipity where

people end up, or driven by providers.

DR. CROSSON: So, Kathy, my mind was going one way and then shifted. So in terms of a common assessment tool, when you said that, I was starting to think about, you know, for the purposes of CMS oversight, for the purposes of payment changes and things like that. But then I think what you were saying or thinking was, you know, this would be something that beneficiaries or proxies for beneficiaries, caregivers, could use prospectively in making the determination with discharge planners as to where the person was going. Is that where you were going or what?

MS. BUTO: I was thinking discharge planners, but I recognize not all of these are going to be driven by a hospital stay. So I don't have an answer to the question: What about those that are more community-driven? I guess I would have the ACO have more of a role in that, or obviously, the MA plan. But for those fee-for-service beneficiaries who are not in a hospital, I guess the OPD, if they have an OPD encounter?

DR. CROSSON: Right.

MS. BUTO: So I haven't thought about that.

DR. CROSSON: But the major thrust of -- that notwithstanding -- the major thrust was more from the perspective of where beneficiaries, to the extent that they can, choose to go, right, as opposed to assessment from the perspective of the regulator or the payer. Right?

MS. BUTO: Right. I think the -- yeah, the issue was the beneficiary should know where the appropriate providers are that can provide a service --

DR. CROSSON: Got it.

MS. BUTO: -- they need.

DR. CROSSON: Got it. I just want to be clear. Thanks.

Okay. So let's see. I went down this side again, I apologize. Bruce?

MR. PYENSON: Yeah, thank you very much. I like the overall structure of it. To pick up on a point I think Warner and others raised, wondering if there is a common element in addition to level of nursing and physician involvement that has something to do with accountability. And that might be, as Warner suggested, readmissions or other complications but, more fundamentally, who's in charge and what are they accountable for. So I'm not quite

sure how to detail that, but I think that would be a useful element that perhaps doesn't exist today across the different settings.

DR. CROSSON: I had Jaewon first, and Sue, I think I saw your hand there.

DR. RYU: Yeah, I like the framework as well, and thank you, Evan. I'm drawn to this three-day stay requirement, and I think it makes sense on a variety of levels. You mentioned a few statistics that I think are pretty --- I found surprising. Eighty-five percent or more of IRFs and LTCH patients come from that discharge from an acute care hospital, and then I think the 43 percent or whatever of acute care hospital discharges that land in some post-acute. It starts feeling like the three-day requirement makes sense, but then it pushes us, or it seems like it pushes us, towards maybe the bundles should be just a universal approach, where you're lumping the in-patient hospital stay, the acute care and the post-acute care together. And I'm curious if we could evaluate, you know, the pros and cons of something along those lines.

The hospital serving such a --- I mean, they're often the ones dispositioning patients to that environment.

It seems like there are some incentives that you'd get out of that kind of framework where, you know, there might be investments in one setting that may prevent the need for going into the other setting, and net-net, maybe that's a more efficient way of delivering the care. But some evaluation along those lines feels like it might be helpful.

DR. MATHEWS: Yeah, just to react to that. About 10 years ago, the Commission churned on this very issue for about two or three years running, and the payment policy and the analytics are very, very easy to get bogged down in. So we could contemplate this again. Given the schedule that we've laid out for the year, it's not going to be this cycle, but we'll go back and kick around the idea and see if we have any appetite for resurrecting this concept. So we have some history here.

DR. CROSSON: Karen, do you have a further comment?

DR. DeSALVO: [Off microphone.] No.

DR. CROSSON: On this point

DR. DeSALVO: [Inaudible.]

DR. CROSSON: Okay. But you wanted to get in the

queue. I'm sorry. Okay.

DR. DeSALVO: [Off microphone.] Maybe not [inaudible.].

DR. CROSSON: Sue.

DR. DeSALVO: [Inaudible.].

MS. THOMPSON: My comments: I, too, I think this is a good start in terms of how we think about the clinical aspects of the tiering of the patients and obviously a platform for more discussion.

Additionally, as I read this chapter, it just really struck me that it's grounded in a set of assumptions about fee-for-service Medicare that I think it's important for us to recognize, and as well evidenced by the conversation just leading up to my comments, that we have an environment that is quite innovative and are taking an opportunity in alternative payment models, that I think we just have to pay attention to as we further advance this set of work. It's -- I mean, it's a bifurcated discussion, but I think it's important that we not --- because it feels like we're really weighted down by an old set of assumptions that may or may not be the payment model for the future in terms of sustaining the Medicare program. So

I just call that out.

And to Kathy's comment about home care, I really do think --- I think we do need to have more discussion about where does home care fit here because, and then coming full circle, we have hospital-at-home models that are happening. So then we come all the way back to the complexity of patients that we're caring for in the home now based upon a home-care chassis. So it adds complexity to the discussion, but I think we've got to be aware this is going on in our environment, this is very much where the industry is headed. So in terms of advising and recommending policy, I think we need to understand the pacing at which the environment is moving.

DR. CROSSON: Warner.

MR. THOMAS: Yeah, I'd just dovetail on Sue's comment, and I think I would --- this idea of level of nursing or thinking about staffing ratios. I mean, I would rather us look at outcomes because I think we're going to just have a lot of different technology ways that we address this, and it may not all just be about staffing ratios. So I would encourage us to stay away from that model but really focus on outcomes-based information. I

think virtual care is going to play a big role in this area going forward.

DR. CROSSON: Okay. I'm going to get a little wild and crazy here because Dana has been waiting. So I'm going to go Dana and then Karen and then Paul and go down that way.

DR. SAFRAN: I'll make it brief because Warner just said exactly what I was about to say ... was, you know, I do like this tiering model, but I'm concerned about assuming that we know the right staffing models and that -- and so I'd love to see -- this seems absolutely the area of care where an outcomes-based set of criteria could really be applied and be effective. So I'd love to see us do that.

DR. CROSSON: Okay, Karen.

DR. DeSALVO: We're in vehement agreement. And including patient-reported outcome measures would be valuable in this space.

And putting on my clinician hat, just as you're thinking about -- oh, first of all, let me just also say that I agree that we shouldn't be assumptive about staffing because the world is changing pretty rapidly in terms of

our ability to use technology to support people and even keep them out of the hospital in the first place.

But wearing my clinician hat, Evan, a lot of times what keeps people from going home isn't a medical condition; it's a behavioral condition. So let's -- you know, we should think about even mild cognitive impairment, but it's also the home situation. Do they have family that can administer IV antibiotics, or do they have a safe place to live? So this adds to it's not just medical complexity but behavioral health and social complexity.

One issue I just -- that I also want to underscore is this move-to-value piece which is related to technology, and this could be also an opportunity to not only encourage through the value-based models, more seamless opportunity to be not in the acute setting, the in-patient setting, but more importantly, to improve coordination of care because the number of hand-offs could get difficult, is difficult for a patient. Data doesn't move with them, et cetera.

So I'm not really describing this well, but ... instead of thinking about it as different silos, is there a way to use this as an opportunity to just again center on

the patient, including their data, including their care teams, and the address where that happens is less important than the outcomes that we're able to achieve for them?

And I agree about home health being an outlier. I have so many things to say, I'm sorry, but I think it is a little bit of an outlier.

DR. CROSSON: Thank you.

Paul.

DR. PAUL GINSBURG: I just wanted to also say that I like the tier structure. I think that's a great way to proceed. David explained it very well.

And I also, you know, want to be very careful with ACOs, that they not only not be inhibited by three-day stay and homebound, but also to protect them and to support them. I don't know if existing policy deals with patients or beneficiaries who have leaked out of the ACO, in a sense, whose care is being -- they may have been attributed to an ACO based on their primary care physician, but if they're being cared for by another physician who's not in the ACO, then I think the ACO needs those requirements to protect it. And that's what I wanted to say.

DR. CROSSON: Sorry, I couldn't quite follow the

end of that. So the ACO --

DR. PAUL GINSBURG: Yeah, the end of that is that --

DR. CROSSON: -- needs what requirements?

DR. PAUL GINSBURG: In a sense, you know, if the beneficiary is being, say, managed by an ACO physician --

DR. CROSSON: Yes.

DR. PAUL GINSBURG: -- then, you know, the waiver of the three-day and homebound is fine. But if the beneficiary has leaked out of the ACO, meaning they've gone to a physician outside of the ACO --

DR. CROSSON: In the hospital setting or?

DR. PAUL GINSBURG: Well, maybe not even in --

DR. CROSSON: They're not --

DR. PAUL GINSBURG: -- yes, in the hospital setting.

DR. CROSSON: Okay.

DR. PAUL GINSBURG: Then the sense the requirement shouldn't be waived because the ACO is not having an influence.

DR. CROSSON: And they are at risk for the cost.

DR. PAUL GINSBURG: And they are risk

financially. So to support them, you know, I think we want this waiver to be very specific about patients being managed by the ACO.

DR. CROSSON: Got it. Thank you.

Next, Jon.

DR. PERLIN: Well, thanks. Let me just add to appreciation for the really thoughtful work, Evan.

I want to address your point three of your ensuring appropriate use. I'll share the observations of a large nameless health system with insight into, say, 42 markets...the trajectory of patients. I think you need to ensure this work is in conjunction with other policy and mechanisms. The notion of discharge criteria that are absolute or very specific will be extremely helpful in assuring the right level of care.

As you might imagine, a lot of patients, as you indicated in your presentation, end up at higher levels of care that are not only necessary but probably from a clinical basis advisable in terms of any number of outcomes. In, you know, looking at our own system in preparation for BPCI Advanced, note that, you know, in a continuum from LTCH to IRF to SNF to home health, 20 to 40

percent of patients probably could have been discharged to a lower level of care. It's the freedoms offered by the bundles that allow the reconciliation to the appropriate level of care because in an environment where, say, 90 percent of the physicians are not employed, the determinations about discharge site are made for any number of other possible factors. But the results are not inconsistent with the results you showed, that patients systematically end up at higher levels of care.

So with that in mind, I think we need to talk -- think about the way this would interact in terms of those discharge criteria, allowing really institutional discretion in terms of choosing not only the level of care through criteria but the best providers of care at a particular level, as that's highly correlated with all sorts of additional impairments to quality, additional expenditures related to quality readmission, et cetera.

And then finally, with that in mind, whether or not it's encompassed under the payment scale, I would argue strongly that home health has to be part of that continuum so that those patients end up in home health when that is in fact the most appropriate setting and it doesn't become

parsed out as unnecessarily complex, leaving the default a higher and more expensive level of service. Thanks.

DR. CROSSON: Thank you.

Brian.

DR. DeBUSK: Thanks again on a really well-written chapter. As others have said, I really do like the tiered structure. When I was reading the chapter, I thought that's a very novel approach.

I also like hearing what the fellow commissioners have said about being less prescriptive on the staffing requirement. I think that's really promising because, as others have mentioned, I think technology is going to be very, very disruptive.

Sue, your hospital-at-home model ... I mean, what happens in a world where you can effectively move an LTCH or an IRF into a patient's home? I mean, is that home health anymore? Is that -- I think you've created something entirely new, and I think we need to give the participants in this new space a lot of running room and a lot of leeway in being able to innovative.

I also want to bring up this issue, this outpatient shift, again. This isn't specific to the PAC

PPS. I think this was something we were going to have to address with PAC anyway. But, I mean, who would have thought that people were going to get their aortic valves replaced on an out-patient basis? I mean, it really makes you rethink what is PAC and the three-day stay requirement.

I completely understand the need to have the three-day requirement, but what I would hate to happen is something like this stand in the way of this shift from in-patient to out-patient services because I think that shift is happening. I think it has excellent momentum, and I think it's -- you know, we opened today's meeting with this discussion of context of Medicare, and I think those are the kinds of shifts, wholesale shifts say, from an in-patient to an out-patient environment that will give us the kinds of savings and cost structures that we need to keep the program going.

So you didn't -- this is not a problem that, or challenge that, is specific to the PAC PPS. But, congratulations, I think you inherited it.

And then the final point, and others have mentioned this, I do think that we need to relax the requirements even further when you're dealing with an APM

with downside risk. I think this is back to the idea of putting your thumb on the scale when it comes to accountable care organizations that have downside risk.

Or, you know, to Jon's point earlier, you know, he mentioned bundles. Obviously, I still like episodic payments, but Sue, before you throw anything, only in the context of serving under an APM with downside risk. Bundles should be wholly subservient to population health models that govern them. We good? Good. Thank you.

DR. CROSSON: Thank you. Brian, good points --

DR. CHRISTIANSON: [Off microphone.] Did you get Jonathan?

DR. CROSSON: Yeah, I saw it.

Appreciate that. Jonathan.

DR. JAFFERY: Yeah, thank you. So I'm not going to spend time going -- essentially repeating what many people have said that I'm generally in favor of as well, but I just want to emphasize one thing that actually is a little bit redundant, but it's something Karen talked about in terms of question two, I guess, to think about specialized criteria and just really to emphasize that because you speak -- you have this bullet point about

medically complex patients. But behavioral health does impact the ability to efficiently and effectively care for people with medical disease in so many situations, and so I think you really want to try and capture that.

DR. CROSSON: Okay. Thank you. Good discussion again.

Evan, congratulations on this work. You've got a lot of support here from the Commission. So you should feel good about that, and thank you for the discussion.

We will now move on to the public comment period. If there are any of our guests who wish to make a comment, please step to the microphone so we can see if there are any who would like to do that.

[Pause.]

DR. CROSSON: Seeing none, we are adjourned until 1:00.

[Whereupon, at 11:28 a.m., the meeting was recessed for lunch, to reconvene at 1:00 p.m., this same day.]

AFTERNOON SESSION

[1:00 p.m.]

DR. CROSSON: Okay. It is 1 o'clock on the nose. Thank you, everybody, for getting back on time.

We're now going to take on a topic which is not exactly new but kind of new, certainly to me in my time on the Commission, and that has to do with the process of beneficiary enrollment and particularly as it has been impacted in the last, I don't know what, Scott, eight or nine years with changes in the eligibility for Social Security. So we're going to take it from the top.

DR. HARRISON: Okay. Before I start, I would like to thank Carolyn San Soucie for all her work on this project.

I'm about to present an introduction to the process of beneficiary enrollment into Medicare and identify an information gap that could complicate the process for beneficiaries. As Jay said, this is sort of a new topic, but it's an outgrowth of Commissioner interest in Medicare enrollment patterns over the past few years.

First I will touch on the different roles of government agencies in the Medicare enrollment process,

namely the Social Security Administration, or SSA, and CMS. I will provide some background on how Medicare enrollment is linked to Social Security benefits.

Next I will talk about how some beneficiaries have an information gap, which may cause them to be exposed to late enrollment penalties.

And, finally, we can discuss how the information gap might be closed.

The SSA runs the Social Security program as established in Title 2 of the Social Security Act. As part of that role, the SSA collects information on work and wage histories and the payroll taxes to fund the program. Also established under Title 2 is Part A of Medicare, including the entitlement criteria. So SSA determines when an individual is entitled to Medicare.

SSA is also responsible for the collection of Part B and Part D premiums, as most are paid through monthly deductions in Social Security benefits.

Now, when an individual applies for Social Security benefits and becomes entitled to Part A, SSA will send information on the beneficiary to CMS so that it can notify the beneficiary. Once CMS receives information for

a beneficiary, it notifies the beneficiary of their entitlement to Part A and their eligibility to enroll in Part B through a Welcome to Medicare packet. The packet will include benefit information as well as information on the Medicare Advantage and Part D drug plan options available to the beneficiary in their specific geographic location.

I should note here that Part B and Part D were established in Title 18 of the Social Security Act, commonly known as "the Medicare statute," and CMS is responsible for the administration of those parts of Medicare.

Individuals become eligible to enroll in Medicare by age, disease, or disability. Certain individuals under age 65 may be eligible for Medicare if they have qualifying disability or disease. However, for today, we will focus on eligibility based on age.

All individuals who are 65 years of age or older are eligible to receive Medicare benefits. At age 65 individuals are entitled to Part A as long as their work history or their spouse's work history would make them eligible for Social Security benefits. Typically, if an

individual paid Social Security payroll taxes for 40 calendar quarters, she would be eligible for Social Security benefits. And at age 65, individuals are eligible to enroll in Parts B and D. For the 65-year-olds who are already receiving Social Security benefits, the Medicare enrollment process is relatively smooth because they receive a notification a few months in advance of their birthday that they will be auto-enrolled in Parts A and B and the Part B premium will be automatically deducted from their Social Security benefits. Now, if they so choose, the beneficiary can decline or opt out of Part B.

Historically, individuals became eligible for Medicare at the same time when they would receive full retirement benefits from Social Security, age 65. However, the full retirement age is rising gradually to 67 by the year 2027.

The current age for full retirement benefits is 66, although individuals can retire early and collect reduced benefits starting at age 62. In 2002, only 10 percent of eligible 65-year-olds were not receiving Social Security benefits. Because of the increase in the full retirement age, 40 percent of 65-year-olds were not

receiving Social Security in 2016.

Remember that the SSA only sends information to CMS once a beneficiary has applied for Social Security. This means that 40 percent of those Medicare-eligible at age 65 are not auto-enrolled and may not receive government notification of their eligibility for Medicare. They may also be unaware of the need to enroll within three months of their 65th birthday to avoid any potential penalties for late enrollment into Part B or Part D.

I will say more about the timing of enrollment into Parts B and D and late enrollment penalties later, but for now I just want to make two points.

First, although 40 percent of beneficiaries may be at risk for paying a late enrollment penalty, the vast majority of these individuals do not pay any penalty. In 2016, approximately 700,000 individuals were paying a penalty on their Part B premium, which amounts to about 1.5 percent of the total Medicare population.

And, second, Part A entitlement is not affected because, even if a beneficiary has not enrolled in Part A, she can retroactively enroll once she needs the benefit and there would not be a late enrollment penalty. Generally,

there are not late enrollment penalties for Part A. However, because Parts B and D are voluntary enrollment benefits that require premiums, the lack of eligibility notification can be a problem for beneficiaries.

An eligible beneficiary has three different opportunities to enroll in Parts B and D.

First, there is the seven-month Initial Enrollment Period, or IEP, around the beneficiary's 65th birthday. The IEP includes the birthday month, the three months before, and the three months after. This is the period when auto-enrollment would occur if the beneficiary were receiving Social Security benefits.

Next are Special Enrollment Periods, or SEPs. These are time periods when individuals are allowed to enroll in Medicare without penalty due to a major life event such as a change in employment status or a loss of employer insurance coverage.

Individuals who do not enroll in Part B during their IEP and who are not eligible to enroll during a SEP can enroll in Part B before the end of March each year. This period is known as the General Enrollment Period. Coverage for these individuals who enroll during general

enrollment begins July 1st of the year they sign up. And these individuals may face late enrollment penalties for not enrolling when they were first eligible.

Let's look at a few specific examples of Part B enrollment in these three periods.

In this example of enrollment during the IEP, the beneficiary has been receiving Social Security benefits at least four months before their 65th birthday. SSA informs CMS of the beneficiary's entitlement for Part A. CMS mails a Welcome to Medicare package to the beneficiary and informs her that she will be auto-enrolled into both Part A and Part B and has the option to enroll in Part D. Unless the beneficiary actively declines Part B, the premium will be deducted from her Social Security benefits. And if Part B is accepted, there would be no late enrollment penalty.

A beneficiary could also enroll during their IEP by applying directly for Medicare benefits. In that case there is no need for auto-enrollment. We think that between 60 and 70 percent of beneficiaries are auto-enrolled, and maybe another 15 percent or so enroll in Part B on their own during the IEP.

The most common example of a beneficiary

enrolling during a SEP is a beneficiary that remains an active worker with employer coverage past age 65, who declines Part B at age 65, and then retires and enrolls in Part B within eight months of losing her employer coverage. As long as she enroll within those eight months, she will not have a gap in coverage or a late enrollment penalty. And I think somewhere in the neighborhood of 20 percent of beneficiaries sign up during a SEP.

So that leaves the General Enrollment Period. Beneficiaries who enroll in Part B during general enrollment did not enroll during their IEP and were not eligible for a SEP at the time of their enrollment. The beneficiaries in this group may have a break in coverage because they must enroll in March, but do not receive coverage until July. All the beneficiaries paying late enrollment penalties would be in this group, but not all beneficiaries in this group have to pay a penalty. Dual-eligible beneficiaries do not pay a penalty because their state pays their premiums. And beneficiaries who enroll within a year of the end of their IEP would not have to pay a penalty, as I will explain shortly. We think about 2 percent of beneficiaries enroll during general enrollment.

Let me give you some details on the late enrollment penalties.

For Part B, the late enrollment penalty is 10 percent of the basic Part B premium for each full year coverage was delayed after the IEP or SEP. If the delay was less than a full year, then there would be no penalty. The basic premium is currently $134 per month, so the penalty would be $13.40 a month for each full-year delay.

For Part D, the penalty is 1 percent of the average monthly premium per for each month delayed. If the coverage delay was a year, or 12 months, the penalty would be 12 percent of the average premium. Currently, the average premium is about $35, so, pardon my math, but the penalty would be $4.20 a month for each year's delay.

There are no caps or time limits on the penalties so if a beneficiary waited 20 years to enroll in Part B, She would pay a penalty of $268 per month for the rest of her life.

The increase in full retirement age has led to a much larger portion of Medicare beneficiaries needing to begin the Medicare enrollment process on their own.

For those not auto-enrolled, the process can be

confusing. Although they can seek out information from government-sponsored phone and online assistance programs, beneficiaries are often unaware of them and instead rely on information sent to them by private insurance plans, financial advisers, and insurance brokers.

In beneficiary focus groups the Commission held this summer, most of the beneficiaries said they were unaware of delayed enrollment penalties. We also spoke with brokers and counselors in several cities who told us that beneficiaries not automatically enrolled into Medicare found the enrollment rules challenging and generally did not know about the penalties before seeking help. All involved thought there should be an official notification just before the beneficiaries turn 65.

So we plan to do more research on enrollment and late enrollment trends and learn more about how SSA and CMS interact and exchange data relevant to the enrollment process. But it seems clear that the lack of a notification process ensuring that individuals are aware of their eligibility for and their need to enroll in Medicare as they turn 65 should be addressed.

Current law does not seem to require that either

SSA or CMS notify individuals who have not begun receiving Social Security payments. If the Commission would like to see a change in notification, staff could explore options. Bear in mind that the current notification process is tied to Part A entitlement under Title 2 of the Social Security Act and is administered by SSA. Thus, any change in the notification and enrollment processes would likely involve SSA to some extent. And, of course, we're not typically conversant with SSA.

Perhaps the general approach would be to urge the Secretary to work with SSA to facilitate better information flow and more timely notification of Part B eligibility to beneficiaries who could subsequently be liable for late enrollment penalties.

Now I look forward to your questions and discussion.

DR. CROSSON: Thank you, Scott.

So we'll take clarifying questions for Scott. I see Paul, Karen.

DR. PAUL GINSBURG: Scott, could you discuss how this interacts with ACA? For example, if someone inadvertently did not enroll in Part B for many years and

faced a big penalty, would they have an option to enroll in ACA and get a subsidy?

DR. HARRISON: So in talking with the SHIPs this summer -- those are the state health insurance assistance program counselors, volunteer counselors that help Medicare beneficiaries, and they also help ACA beneficiaries -- we found that this was a group they were particularly concerned about. People who are in ACA at age 65 think they're covered, so they don't want to pay the Part B premium, and so they just stay in their ACA plan. But it turns out that by law they're supposed to not be in the ACA plan, and so if they do switch to Medicare later, they are subject to the coverage gap and late enrollment penalties. So they're not -- this is a particular problem group, we believe.

MS. BUTO: Scott, are they liable for having to pay back subsidies if they were getting subsidies under ACA?

DR. HARRISON: I don't know that.

DR. CROSSON: Okay.

MS. MARJORIE GINSBURG: Just related to that --

DR. CROSSON: On this point, Marge.

MS. MARJORIE GINSBURG: I was under the impression that, at least in California, the ACAs know that when you hit 65, you know, you got to get out. I don't know how much you've talked to other states. How much do they push that? You know, they're not interested in subsidizing anybody that they don't have to.

DR. HARRISON: I think different states are different, and the insurance companies in the different states may differ as to -- you know, I think they're happy to keep their ACA folks.

DR. CROSSON: But this is a good point because in terms of things we could do, you know, purview -- well, I take that back. Over plans that do both Medicare and ACA, we might be able to do something.

Anyway, I don't want to get into it. I'm getting a little confused here. We've got Karen. Bruce, did I see your hand? Karen, Bruce, Dana, Pat. Is that it? Yeah, thanks. Dana, Pat, and David.

DR. DeSALVO: Scott, thank you for the presentation and the work. I think it's an interesting and important area. I had a question about the 700,000. You mentioned that those who were very low income, dual

eligibles, perhaps don't fall into that pool. But I wondered what we knew so far about the characteristics of those 700,000 individuals to help us think about strategies to be able to reach them and mitigate the impact on them.

DR. HARRISON: So that number came from the Social Security actuaries, but it was just a number, but they did also give me the distribution of what the penalties were, and about 40 percent of the penalties were just the 10 percent, and they went up from there. But we don't know anything about the characteristics of the people. But these are people that are actually paying the penalty, not just liable for it.

DR. DeSALVO: Do you think there's a way that we can understand more about their geography or where they are in age, maybe income, maybe literacy challenges?

DR. HARRISON: So unless we could get data from Social Security, you would have to rely on me being able to simulate something with some of the data that I have, and it's possible we might be able to simulate who these people are. And we'll see how that works. I plan to try to do that over the next period of time.

DR. CROSSON: Bruce.

MR. PYENSON: Well, thank you very much, Scott. I've got two questions. One is sort of a process question. I think SSA also supplies CMS with the death indicators for termination of benefits. Is that --

DR. HARRISON: I believe that is correct, yes.

MR. PYENSON: So there's a couple of interactions that go on at the front end and at the back end.

My other question is: Did MedPAC do some work on the adequacy of the -- or the development of the penalties? I seem to recall reading something. Maybe it wasn't --

DR. HARRISON: Certainly not on B, no.

MR. PYENSON: Do you have an opinion on whether CMS is making or losing money on the penalties?

DR. HARRISON: I think that's an interesting question and, again, something we could try to get through. I don't know whether changing this would be a coster or a saver, for instance, so we can check that out.

DR. CROSSON: Dana.

DR. SAFRAN: So as you think ahead to possible solutions, does SSA have the information about people who are turning 65 regardless of whether they're getting SSA benefits?

DR. HARRISON: So, generally, yes, because they have their work histories and they have their age.

DR. SAFRAN: And they know based on that work history if they're eligible for Medicare?

DR. HARRISON: Yes.

DR. SAFRAN: Okay. Thank you.

DR. CROSSON: Pat.

MS. WANG: I was curious whether we know more or whether we should know more about how effective SSA is in transmitting information on people who are eligible for Part A and the other programs but have not enrolled. And I'm thinking about state Medicaid programs in particular. Just from my own experience, there's a lot of noise in the pull-down of that data and the accuracy of that data, which has implications, you know, for state budgets, but -- and certainly for clients who may be eligible for Medicare, should sign up for Medicare, are eligible for seamless enrollment into a Medicare Advantage plan, while there are a lot of people, including me, who think that that's a really good thing, who are kind of not -- that's not happening because there seem to be data flow issues. I just wondered if you could -- maybe it's just the state

that I'm familiar with, but I wondered if you could comment on that, whether you observed any noise in the system.

DR. HARRISON: So if you are not applying for -- if you haven't applied for Social Security benefits, then that means somebody has to -- either you or the state have to apply for Social Security benefits, or even if you were going to just apply for Medicare, you actually apply to the Social Security Administration. So on some of these other programs, I don't know that there's -- I don't know what the outreach situation is ahead of time. I think generally there's not a lot of outreach if you haven't applied for Social Security. You do get statements occasionally on your Social Security account, so you might see something that would tell you that you should sign up when you're 65 if you read everything very carefully.

DR. CROSSON: David.

DR. GRABOWSKI: I wanted to ask about the enrollment issues for non-auto-enrolled beneficiaries. You had this point, I guess it was on Slide 11, the last point there. Most beneficiaries are unaware of late enrollment penalties, and you said you learned that from a focus group. I'm just curious. It helps me get at the why here.

Maybe the people aren't enrolling that aren't auto-enrolled. Did the focus group --

DR. HARRISON: So for the most part, they are enrolling.

DR. GRABOWSKI: Right.

DR. HARRISON: But they just didn't know --

DR. GRABOWSKI: For those that --

DR. HARRISON: Right, they just didn't know about the penalties. They were going to enroll anyway.

DR. GRABOWSKI: So these are enrollers who didn't know about the penalty but had enrolled. These weren't individuals who didn't enroll and --

DR. HARRISON: So in our focus groups, we did have one person who --

DR. GRABOWSKI: Yes, I read that one --

DR. HARRISON: -- who had slipped through the cracks and didn't enroll and then needed to --

DR. GRABOWSKI: And you said it was one out of 97 of the focus group --

DR. HARRISON: Yeah, which isn't far from a point and a half, so, you know --

DR. GRABOWSKI: And I wonder about convening a

focus group of non-enrollers and seeing kind of -- learning a little bit more about the why here, and that might be helpful.

DR. HARRISON: Now, they're harder to find.

[Laughter.]

DR. GRABOWSKI: What's your problem, Scott? I just suggest these things. Thanks.

DR. HARRISON: We'll talk to our focus group contractor.

DR. CROSSON: Seeing no further questions, I think we'll proceed to the discussion, and I believe, Paul, you're going to start us off.

DR. PAUL GINSBURG: Well, Scott, you've done a really good job of bringing up this issue, and I'm glad that we're pursuing this because I think there are people falling through the cracks.

And I wanted to think along the lines of whether we could broaden out besides process of notification.

And two things I was thinking about is: One, I'm aware from anecdotes from friends about how tedious and difficult it is for those who have worked after age 65, and thus, you know, did not enroll until they were finished

working, to document the fact that they had employer-based coverage and whether -- you know, the people that told me about that, they just, you know, were annoyed at how hard they had to work, but they did it. I wonder about people that just couldn't do it and have lost out because of that.

And the second issue is whether -- you know, these penalties of 10 percent a year, going on for the rest of your life, strike me as extremely severe. And particularly, you know, given the debate we have on the individual mandate in the ACA and some of the proposed alternatives to it, which were much, much milder than this, whether we should actually opine about -- you know, given that many of those who are being penalized may be penalized because of an accident or because of something else -- whether the magnitude of the penalty should be reconsidered and perhaps differentiate between people who first enrolled in Part B after age 65 versus those that dropped out of Part B and then want to re-enroll, which I would support higher penalties for those people just to deter them from gaming the system.

DR. CROSSON: So, well, that raises a question for me then. Is there a process by which a beneficiary can

appeal the penalty?

DR. HARRISON: Yes, there is a process, but I think what you have to prove is that you were told something wrong by a government official.

DR. CROSSON: Well, I think I'll leave that unaddressed. Okay.

DR. PAUL GINSBURG: I'll say one more thing about the severe nature of the penalties. You know, when Medicare began, the life expectancy of a 65-year-old was probably a lot shorter than it is today.

DR. CROSSON: Right.

DR. PAUL GINSBURG: So in a sense, you know, we're talking about penalizing people for many more years because they may have missed enrollment then in the original design.

DR. CROSSON: But it also raises the question of whether or not the penalties are -- you know, were kind of plucked out of the air or do they have an actuarial soundness to them that we -- you know, knowing that, we could maybe make a judgment as to whether we want to change the stakes for the Medicare program. Is that -- Jon, it looked like you were going to say the same thing. Is that

-- sort of somebody had the same --

DR. PERLIN: Can I ask that as a question?

DR. CROSSON: Yes.

DR. PERLIN: I mean, is there an actuarial basis? And this number seems -- 10 percent seems very arbitrary. And if there is an actuarial basis, actually, is this percentage -- you know, particularly for someone who may have had employer-sponsored insurance or other coverage until later in life and then for whatever reason would end. What do we know about what those deferred or premiums that didn't go paid would have contributed to them adversely or positively to the overall insurance rate setting?

DR. CROSSON: Right. So how many variables have we got moving on this? Is this analysis you could do, Scott?

DR. MATHEWS: Scott?

DR. HARRISON: [Off microphone] We can probably find information on risk scores ---

COURT REPORTER: Turn your microphone, please.

DR. HARRISON: We can find information on risk, the average risk scores for people of different ages and average spending for people of different ages. I think we

could at least do something like that.

DR. PYENSON: How do get a risk score if someone is not enrolled in Medicare?

DR. HARRISON: Oh, everybody has risk scores.

DR. PYENSON: Well --

DR. HARRISON: Yeah. So, no, no.

[Simultaneous discussion.]

DR. HARRISON: They're calculated. No, they are calculated for fee-for-service people as well.

DR. PYENSON: But it's the default because you don't have the diagnosis --

DR. HARRISON: No, no, no. You have a diagnosis in fee-for-service.

DR. PYENSON: Yeah, but if someone didn't enroll.

DR. HARRISON: Oh, you're saying the MA people.

DR. PYENSON: No, no, no. For the non-enrollees.

MULTIPLE SPEAKERS: The non-enrollees.

DR. HARRISON: Oh, the people who have not enrolled. Yes, sorry.

[Simultaneous discussion.]

DR. PYENSON: Yeah. I mean, there's -- yeah, there's default risk scores for them. I wonder how those

were calculated.

DR. PAUL GINSBURG: I guess you have Part A data for those non-enrollees.

DR. CROSSON: I didn't mean to introduce something we can't adjudicate right here, but I think the question is a good one. You know. Rather than make a recommendation at random for changing the 10 percent or the monthly penalty for Part D, we might want to do that, but it would be informed, if possible, by the question of what the implications would be for the Medicare finances. Anyway.

So on this point, Pat?

MS. WANG: So I agree with your comment about rushing to the penalties before -- I mean, the penalties seem unfair because of this mismatch now between Social Security and eligible for Medicare. Is it feasible for the Social Security Administration simply to enroll everybody with sufficient work orders at age 65, whether they're taking social security or not? What if they just created another category on enrollment into Part A, whether you were taking your benefits or not? They have all the information about who's eligible.

DR. CROSSON: But it's not in A.

MS. WANG: Wouldn't that address a big part of the problem now?

DR. CROSSON: It could be, but it's a B problem, and B is voluntary.

MS. WANG: It's true except to the extent that people are not enrolling in A because they're not notified or what have you. The B, I think, is a caboose onto that problem. I think you have a more -- I think the issue is coming up now because of the disconnect in the ages of eligibility for the two programs prior to that divergence. I'm not sure that the penalties and who was subject to the penalties was as large an issue. Maybe it was, but I would kind of bucket that separately.

DR. CROSSON: Okay. Perhaps I'm missing something. Scott, did you want to reply?

DR. HARRISON: So it's -- certainly CMS -- I mean, excuse me, SSA sends a packet of information over to CMS when someone applies for social security, but it seems like maybe they could do it just on the -- you know, three months before the 65th birthday.

MS. BUTO: Well, they used to do it.

DR. HARRISON: They did used to do it.

MS. BUTO: When the age was 65.

DR. HARRISON: Oh, sure, sure.

MS. BUTO: So they clearly can do it. And, by the way, they also do Part B. We went through we sat down and did this with my husband, and it's -- they also, you know, will enroll and make a...

DR. HARRISON: Yes.

MS. BUTO: Now, you might have to pay out of pocket if you're not receiving benefits yet. So I think one question is: What does it cost Social Security to do it?

DR. HARRISON: A-ha!

DR. SAFRAN: But wouldn't they end up auto-enrolling people who are still employed, or would they know that you're still employed and therefore not auto-enroll you?

MS. WANG: As I understand it, for Part A, that's not an issue because a lot of people who are still employed enroll in Part A.

DR. SAFRAN: Yes.

MS. WANG: There's no premium associated with it.

To me, the enrollment in Part A is the trigger for paying attention to B and D and making a conscious decision that is informed. I'm not enrolling now because I'm still employed, or I'm choosing not to and there's a penalty down the road, or what have you.

It sounds like the source of the problem is the disconnect because SSA now is not really acting on anybody until they become social security-eligible, which is later than their Medicare eligibility age.

DR. CROSSON: Okay.

DR. MATHEWS: Can I just get in with one comment here?

DR. CROSSON: Go ahead.

DR. MATHEWS: So we can obviously come back to you with such information as we can find regarding the actuarial basis for the calculation of the premiums and -- penalties, I'm sorry -- and then, you know, the duration of the effective penalties, you know, at a point in time, say a decade ago, two decades ago, relative to the duration of those penalties now given the change in lifespan. So we can do what we can and come back to you.

But I would also just raise the point, not to

seem anti-beneficiary by any stretch of the imagination, but the rationale for the penalties is to try and incentivize, you know, people to enroll when they are eligible and not to defer enrollment until the point in time that they think they are going to need benefits. And to the extent a prospective Part B enrollee is facing, say, an income-related Part B premium, that could be a strong disincentive not to enroll. And if you, you know, took out the penalty, that delayed enrollment might be even more attractive. So there could still be a need for a penalty. And the question is, you know: What's the right level? What's the right duration?

DR. CROSSON: Okay. I have to admit I'm a little lost here. So I see Marge, Bruce.

MS. MARJORIE GINSBURG: Actually, I had a number of things. I have to keep track of them. One point of clarification, someone turns 65, they're still working... or, let's say they're not working, but they haven't gotten their social security, they haven't gotten their notice. They're hit by a car. They're lying on the sidewalk. They go to the hospital. They notice they're 65. They haven't received their card yet. That doesn't matter, does it?

They still --

DR. HARRISON: Now the hospital will get you signed up.

MS. MARJORIE GINSBURG: Right. So they get -- Part A is theirs, whether they have the card or not, whether they're --

DR. HARRISON: Right. It's an entitlement, not a voluntary enrollment.

MS. MARJORIE GINSBURG: Okay. So I just wanted to get that settled.

I think it was in this report where there was discussion about because the government subsidizes Part B to such a high extent, higher than I realized. Seventy-five percent of Part B costs are actually borne by the government. There was a question of: Aren't we better off having people not sign up for Part B, which saves the government more money because they're not spending it?

So then we have to ask ourselves: Well, wait a second. What was the purpose of setting up Medicare in the first place? It's to get people covered. And doing this as a way of saving money doesn't exactly follow the intent of the program.

So my last comment was about the penalty. Perhaps one compromise solution is to apply a penalty that lasts two years and then disappears. So it's enough of an incentive at the beginning to encourage people to sign up for Part B even though they "never go to the doctor," knowing that this will then forego a higher cost later on, but not to make this penalty endless.

DR. CROSSON: Okay. So we have -- we've got -- I got you in a second, Bruce.

I just want to be clear. We got kind of two things on the agenda, on the table here now. One has to do with the penalties itself and whether we want to move towards a solution space there and a potential analysis, which I understand is going to be quite complex to do, and then the other one has to do with the notification issue and how we can suggest that CMS leverage the Social Security Administration to do that. So just I just want to be clear; we've got two string going on here.

I saw Bruce and then Jonathan.

MR. PYENSON: At the risk of introducing a third and fourth string. It strikes me that what we're talking about is changing entry into the fee-for-service system.

And if we're going to embark on a fix of that, there's a couple of other issues to tag along with that, which is to -- one of them is to integrate Part C into A, B and D. And I think an interesting paradigm for that is the process of enrollment into ACA plans through the marketplace, through the federally-run or state-run exchanges as an administrative system. That seems to accomplish a lot of things all at once.

DR. CROSSON: Sorry, Bruce. Are you talking about auto-enrollment into Medicare Advantage? I may have not...

MR. PYENSON: Perhaps not auto-enrollment but...

DR. CROSSON: No. Using that as an example. But the point you're making is what about Medicare Part C?

MR. PYENSON: Oh, is that when that's -- when the options are presented, currently, the enrollment into Part A or Part B are the options that we've been talking about, and Part C is a -- comes after that. So if we're going to redesign the system, and I'm not sure if we want to, but if we're going to, we have an opportunity to say let's present the options all at once.

DR. CROSSON: You're not talking about auto-

enrollment. You're talking about some sort of equivalency of information flow to the prospective beneficiary.

MR. PYENSON: Correct.

DR. CROSSON: Got it.

MS. MARJORIE GINSBURG: You need Part D to get Part C anyway. So that's just the first step towards getting into C is getting both A and B.

DR. CROSSON: Right now.

MR. PYENSON: So it's a very incremental process now, fragmented process as it's being described

DR. CROSSON: You're proposing something different from the current situation, which would be more simultaneous or something, I think.

MR. PYENSON: Correct. And the example I think might be useful to look at is the enrollment in ACA --

DR. CROSSON: Yeah, I got that.

MR. PYENSON: -- plans through that, where you've got low income subsidy issues, you've got all sorts of things going on at the same time, as well as which metallic plan and so forth. So that's one issue, and I'll back off if there -- you know, if there's not interest in doing that, I'll understand that.

The second issue I wanted to raise, which seems to have similarities to many of the things we're talking about with the penalties, is an issue that MedPAC has raised in the past, which is the potential of Medigap to induce utilization in the fee-for-service side. And because if we're talking about, in effect, penalties, there probably should be a penalty on Medigap to -- as almost a tax on the Medigap policy to pay for the induced utilization on A and B. So all of that -- and that could -- potentially, that could flow through the same structure and the same system.

So I think we have -- all of these are enrollment issues, and at the same time someone enrolls in A and B and D, or A and B, or C, they could enroll in a Medigap plan.

DR. CROSSON: So I need some help on the last point because I know we've discussed this, I know we've talked about it. I don't know that it has risen to a recommendation.

DR. MATHEWS: No.

DR. CROSSON: It has not, but it has been on the table before as a reasonable idea.

Jonathan.

DR. HARRISON: Could I just get some clarification on that? You would have a penalty on Medigap at what point?

MR. PYENSON: Well, it would be potentially a premium tax.

DR. HARRISON: But is it related to the late enrollment?

MR. PYENSON: No. It would be upon enrollment, but...

DR. HARRISON: Okay.

DR. CROSSON: But we're not talking about a tax on the beneficiary. We're talking about a tax on the plan, the Medigap plan. At least that's the idea we've had before.

UNIDENTIFIED SPEAKER: [Off microphone/inaudible.]

DR. CROSSON: Well, okay. All right, all right.

MR. PYENSON: But all of these are enrollment-related issues. So why not address them through the same system?

DR. CROSSON: Right. Well, okay. I got it.

Jonathan. And I think I saw Pat and Karen.

Jonathan?

DR. JAFFERY: Yes. So first of all, I really appreciate this conversation. This is a topic I knew very little about, and I feel like I'm understanding a little bit less as we discuss it.

But I'm curious, and maybe you answered this already. So I apologize if you did, but... that 1.5 percent of folks who are paying penalties in 2016, has that percentage gone up historically?

DR. HARRISON: We don't know it right yet. I only have a one-point-in-time estimate. I'm going to try to figure that out.

DR. JAFFERY: Okay. Because it begs the question: Is this -- is the issue we're talking about late enrollment fees, and this is separate from the first topic that you had mentioned, which is, is 10 percent arbitrary or is it the right and what not?

The issue related to what happens because of the gap between social security and entitlement and Medicare entitlement may not be a new issue, or that may not be the issue. And maybe that speaks to us simply being able to suggest that SSA actually notify people when they're 65.

DR. HARRISON: Right.

DR. JAFFERY: Okay. Yeah, yeah.

DR. CROSSON: Just to be clear, within our purview is the Medicare program and CMS, and so as the sort of suggestion suggests, we would be talking to CMS and asking them to work it out with SSA, just technically.

Okay, Pat.

MS. WANG: I just wanted to clarify in case it wasn't clear. I actually -- I know that there's a lot of concern and there's discussion around the penalties. I don't know if they're at the right level or not, but I actually think that whether you call them "penalties" or "disincentives" to screw up the risk pool, so that you wait to get coverage until you actually need it. You wait to sign up for Part D until you need some really high-cost specialty drug. Like I don't think we want to encourage that. That's what the penalties are there to discourage, is to get everybody into the risk pool. So I'm not as concerned about the penalties.

My thing is I really think that it's fair if people know when they turn to the age of eligibility for Medicare, that they know that they should sign up, that the

information is clear, and if they don't sign up then they're going to accept the consequence of that because there are consequences that are financial.

And that's why I keep going back to I would prefer to see whether there's a simple solution where SSA, which has this information and used to send it to CMS when eligible people turned 65, can just do that and that people, whether they're working or what have you, not -- they're not receiving their social security benefits yet, are getting the welcome packet from Medicare. It should be a separate process.

And then I think it's fair for people when they get that information to know what's ahead of them. Then I think it's fair to talk about penalties. The concern over penalties I think is heightened now because a lot of people have a knowledge gap.

DR. CROSSON: Okay. Thank you. Karen.

DR. DeSALVO: I'm concerned about the penalties inasmuch as -- because I don't know who's getting penalized. So my worry is that it's low-income people who are, because of their own personal budgets, not opting into Part B and then they're getting further penalized later in

life if they need to get Part B, certainly my experience clinically working at places like Charity Hospital where a lot of our patients didn't have Part B because they couldn't afford it.

Now, if it turns out that because it's people who don't need to draw down their Medicare because they have lots and lots of money and penalizing them makes sense because you want to incent them to join the program -- that's why I was asking the question about what we might know about the 700,000 because it would help me understand whether we need to press harder on the penalties or lighten up on the penalties. And maybe it's nuanced.

I also just am worried about the communication piece and think that the Secretary and SSA probably do have a lot of avenues to reach individuals that we should consider beyond even -- I completely agree that you're going to get a packet, but there's the federally qualified health center networks, there's probably some SAMHSA grantees for people that are uninsured and maybe fall outside the usual bucket.

So as you're thinking about this, maybe go broad, and there are things you can get in the mail. But if you

don't have a permanent address or have other challenges, you may not get it in the mail. So there are other ways that we could reach those particularly high-risk people that we might want to. I know that you'll be thinking of other solutions, but I'd encourage you to think broadly.

DR. CROSSON: Thank you. Good points. Okay -- Paul, and did I see anybody else? Bruce.

DR. PAUL GINSBURG: Yeah, I want to say I think some of the biggest problem, which is the hardest to get at, is not so much the 700,000 people that are paying the penalty, but the people that were uninsured because the penalty is beyond what they could afford. And what's so hard is that of the people who are over 65 and not enrolled in Part B, you don't know how many of them have other coverage and how many of them just are going uncovered.

DR. CROSSON: Bruce, last word.

MR. PYENSON: Just another thought on the comprehensive enrollment issue. In the last session, we had some discussion on whether or not Medicare eligibles should be able to, quote-unquote, enroll in an ACO. And I think a comprehensive enrollment program would open the door to that. So as we think about the future, that might

be an attractive infrastructure to have if we go down the road of letting beneficiaries enroll in an ACO.

DR. CROSSON: So some of the newer ACO payment models come close to that already.

Okay. Very good discussion. Scott, your backpack's a little heavier than it was when you sat down, but you're the man for the job. Thanks very much. We'll move on to the next presentation.

Okay. Our second presentation this afternoon is discussion of our mandated report on long-term care hospitals. Stephanie, you have the microphone.

MS. CAMERON: Good afternoon. Before I begin, I would like to thank Emma Achola for her work on this project.

Today we are here to discuss long-term care hospitals in a first of several presentations in response to a congressional mandate due in June of 2019.

Today's presentation will primarily provide background and context for our work to meet the requirements of the congressional mandate. First we will discuss the statutory changes to LTCH payment policy and the specifics of the mandate. Next we will step back and

provide an overview of LTCHs, LTCH payment policy, and a brief regulatory and statutory history. Next we will discuss the value of care provided in LTCHs and efforts to define an LTCH-appropriate patient, including the most recent MedPAC recommendations. Lastly, we will review our work plan to address the mandated report.

In future meetings we plan to present our findings as they pertain to changes in LTCH admissions and spending, use of other PAC providers, and the quality of care in LTCHs.

We are talking about this today because in the Pathway for SGR Reform Act of 2013, the Congress required that LTCH cases need to have an immediate preceding acute-care hospital stay and that stay either includes three or more days in an intensive care unit or subsequently receives prolonged mechanical ventilation in the LTCH to qualify for the full payment. Discharges that don't meet these criteria receive a lower site-neutral payment. The legislation specified a two-year phase-in at 50 percent of the site-neutral rate and 50 percent of the standard LTCH payment rate for the cases not meeting the criteria. The Congress subsequently delayed the phase-in to continue for

an additional two years. We expect the policy to be fully implemented across all LTCHs by the end of fiscal year 2020.

As part of this legislation, the Congress mandated that MedPAC examine the effect of this dual-payment policy on the following issues: the quality of care provided in long-term care hospitals, the use of hospice care and post-acute-care settings, the effect on different types of long-term care hospitals, and the growth in Medicare spending for services in LTCHs. In addition, the Commission was asked to consider the need to continue to apply the 25 percent threshold rule, which I will discuss momentarily.

Taking a step back, I'd like to provide an overview of LTCHs. As discussed in your mailing materials, to qualify as an LTCH under Medicare, a facility must meet Medicare's conditions of participation for acute-care hospitals and have an average length of stay for certain Medicare cases of greater than 25 days. Care provided in LTCHs is expensive. The average Medicare payment in 2016 was over $41,000 across all cases. In 2016 Medicare spending totaled just over $5.1 billion for about 126,000

cases. Medicare fee-for-service beneficiaries account for approximately two-thirds of LTCH discharges.

Medicare's special payment policies for LTCHs began when the inpatient prospective payment system -- the IPPS -- for acute-care hospitals was implemented in 1983. Because their patient costs could not accurately be predicted by the IPPS patient classification system, CMS continued to pay this group of hospitals on the basis of cost. These hospitals with average lengths of stay greater than 25 days predominantly began as tuberculosis and chronic disease hospitals.

Since October of 2002, Medicare has paid LTCHs prospective per discharge rates based primarily on the patient's diagnosis, the same groupings used in acute-care hospitals paid under the IPPS but with a base rate and relative weights specific to LTCH patients. The LTCH PPS has outlier payments for patients who are extraordinarily costly and in 2005 began to pay a reduced rate for patients with shorter than average lengths of stay.

The Commission has been concerned about the growth of LTCH spending and use for close to two decades for several reasons. First, LTCHs are often clustered with

multiple facilities in a single market. Many new LTCHs located in markets where LTCHs already existed. However, some areas of the country have no LTCHs. This dynamic underscores the fact that medically complex patients can be treated appropriately in other settings.

This leads us to our second concern. Historically, there has been overlap in the type of patients, especially those lower-acuity patients, who receive care in LTCHs and in other less expensive post-acute-care settings, while at the same time, research has been unable to show a clear advantage in terms of outcomes or episode spending for LTCH users compared to users of other PAC provider types. Because care provided in LTCHs is typically far more expensive than care provided in other settings, and there has been no clear advantage for many LTCH users, the Commission has contended that as a prudent payer Medicare should define the type of patient most appropriate for LTCH care.

Here we show one reason the Commission has been concerned about the growth of LTCHs. As displayed on the graph, Medicare spending for LTCH services was growing at an average annual rate of about 18 percent between 2001 and

2003, before the LTCH PPS was implemented. Given the inflationary incentives of cost-based payment methodology, the establishment of budget-neutral prospective payment rates resulted in overly generous payments under the PPS. Spending growth accelerated in the years following the implementation of the LTCH PPS, averaging 27 percent annually from 2003 through 2005. After 2005, Medicare spending for LTCH services continued to increase until it peaked at $5.5 billion in 2012. After 2012, spending began to decrease and in 2016 totaled $5.1 billion.

As you saw, the growth in spending did begin to slow in 2005. This is primarily after Congress and CMS implemented a number of payment changes in an effort to reduce spending growth. CMS established the 25 percent threshold rule to set a limit on the share of cases that can be admitted to an LTCH from a single referring acute-care hospital in an attempt to prevent LTCHs from functioning as de facto step-down units of the acute-care hospital. This policy was never fully implemented, and CMS eliminated this policy in its fiscal year 2019 final payment rules.

The Congress implemented two separate moratoria

in an attempt to slow the growth of new LTCHs and new beds in existing LTCHs. Although many hospitals were certified as LTCHs through the exceptions process during the first moratorium, the growth in the number of new facilities slowed as the moratorium continued. A year and a half after the expiration of the first moratorium, Congress enacted a second moratorium. That moratorium expired at the end of fiscal year 2017.

CMS implemented a policy that reduced payment for cases with relatively short lengths of stay. This policy was intended to ensure decisions about treatment and discharge were made for clinical rather than financial reasons. This policy continues to apply to LTCHs today. So although these regulations combined reduced the growth in spending, the Commission remained concerned about defining the patients most appropriate to receive LTCH care.

Researchers and policymakers have struggled with how to define the patients most appropriate for LTCH care for over the past several decades. The literature describes the chronically critically ill as patients having multiple body system failures, requiring heavy ICU use,

being ventilator dependent with major comorbidities, multiple organ failures, or septicemia and other complex infections. LTCH medical staff, administrators, and case managers have had difficulty describing the patients most appropriate for LTCH care during conversations the Commission. However, a measure of ICU days has been found to be an indicator of case complexity.

So with that in mind, in 2014 the Commission recommended that standard LTCH payment rates be paid only for LTCH patients who meet certain criteria at the point of transfer from an acute-care hospital. Such cases should be those that spent eight or more days in an ICU or received mechanical ventilation for 96 hours or longer. The Commission recommended that Medicare pay for all other cases admitted to LTCHs using an IPPS-based payment rate.

The Commission chose ICU days a threshold to define the most medically complex cases since ICU days are positively associated with case complexity and a measure of ICU days is readily available in administrative data. The Commission also wanted to ensure that beneficiaries who required prolonged mechanical ventilation but did not have an ICU stay of eight days or longer continue to have

appropriate access to specialty weaning services offered by many LTCHs.

The Congress adopted a variant of this policy in the Pathway for SGR Reform Act of 2013 which, as we previously discussed, uses a three-day ICU stay requirement, as opposed to the Commissions eight-day requirement. This was the legislation that also asked the Commission to report on this new dual payment policy, and as you will see in future meetings, even the looser criteria has, in fact, had an effect on the LTCH industry.

Now I will walk you through our approach to meeting the Commission's mandate that I described earlier in this presentation. Because the dual payment rate is being phased in over a four-year period, the policy is still only 50 percent implemented. At best, our analyses will reflect this partial policy phase-in. I would also like to note that the phase-in was based on LTCH cost reporting year, meaning that hospitals began the policy at different points throughout fiscal year 2016. This means that the 2017 data will be the first and only data we will analyze for this report that reflects a full year of the phase-in across all LTCHs.

Given this limitation, we will augment the administrative data with information gleaned from site visits and telephone calls with LTCHs, referring acute-care hospitals, and skilled nursing facilities. We are conducting site visits in six states. Each market represents a varying degree of managed care penetration, ACO penetration, physician employment structure, state regulations, acute-care hospital occupancy rates and bed availability, and LTCH and other PAC bed availability. These facilities all vary in size, ownership, Medicare payer share, and degree of integration with other health care providers. Finally, we are also conducting telephone interviews with acute-care hospital representatives in three additional markets.

We plan to present preliminary findings from our analyses in response to the Commission's Congressional mandate at future meetings. Today I plan to walk you through each of the topic areas specified by the mandate and some concerns as we proceed with our analysis.

Let's start with our approach to the analysis of quality. As you'll recall, LTCHs were one of the last PAC sectors to adopt a Medicare quality reporting program and

to report assessment data to CMS. The Commission has historically relied upon changes in non risk-adjusted measures of mortality and readmissions to report on LTCH quality. As you can imagine, mortality in this sector is generally high given the degree of illness across some of the LTCH population. Hospital readmissions are fairly low during an LTCH stay, which is expected given that these facilities are certified as hospitals, thus having clinical capabilities to handle a broader range of issues that may result in a readmission from a different PAC sector. While our measures are unadjusted, we are able to isolate the analysis for Medicare beneficiaries who met or would have met the criteria to receive the full payment amount for comparisons across this population over time. We plan to again report on these measures later this fall.

Next we consider changes in the use of hospice and other post-acute-care settings in response to the LTCH dual payment system. Gross changes in LTCH use will be difficult to assess on an overarching system basis given the relatively low volume of LTCH discharges compared to the volume of users in other PAC settings. In this context we plan to analyze certain diagnoses that are more likely

to use LTCH care and consider patterns in PAC use across markets with the highest and lowest historical LTCH use on a per beneficiary basis.

Moving now to changes in use and spending, we will continue to analyze use and spending data as it becomes available across different types of long-term care hospitals. We will consider changes in the availability of facilities and beds across different markets, and cases and spending in total, and by different LTCH characteristics. This includes by type of ownership and size. We will also consider changes in urban and rural facilities but caution that only about 5 percent of facilities that reflect only about 4 percent of LTCH discharges are located in rural areas. This means that one facility change or closure in a rural area could have affect the pattern of use across this entire category of providers.

It's also important to again keep in mind that this analysis will reflect the partial implementation of the policy. The Commission will expect additional changes to occur as the policy is fully implemented over time.

Lastly, even though CMS eliminated the 25 percent threshold policy in its 2019 final rule, we plan to discuss

our concerns regarding the elimination. As you'll recall, the Commission historically viewed the 25 percent threshold policy as a blunt but necessary tool to reduce the incentive for LTCHs to function as step-down units from a referring acute-care hospital. Under a dual-payment structure, incentives remain for acute-care hospitals to unbundle care, discharging the most expensive patients to an LTCH. This is especially true given that under the current policy about 20 percent of acute-care hospital patients could qualify to receive the full LTCH payment, if discharged to an LTCH.

The expiration of the moratorium in addition to the elimination of the 25 percent threshold policy could result in growth in the number of new LTCHs especially in markets with high-occupancy tertiary and other high-acuity hospitals.

So with that I will conclude today's presentation. We look forward to your questions and feedback on the information we presented today, our overall approach to fulfilling the mandate, and any additional areas of interest you have in this sector. And with that, I turn it back to Jay.

DR. CROSSON: Thank you, Stephanie.

We'll take clarifying questions for Stephanie. Amy, Jonathan.

MS. BRICKER: The point you made around the clustering of the facilities and given that there's a portion of the population that doesn't have access and, therefore, is managed without, do we know more about -- I know we've spent years on this, so I think the answer is likely yes. But what do we know about those people that don't have availability to an LTCH and their quality or the management of their care versus those that are managed through an LTCH, even if you looked at those that are vented per se, like one population? So we have much insight there?

MS. CAMERON: So there have been numerous studies that have looked at varying populations kind of that we would consider to be more likely or high probability to go into an LTCH. And there has been a lot of variation in what the literature has found, and it also depends on how long a time period the literature is looking and the research has looked.

So, you know, for example, there have been

studies that have shown that for the most acute high vent population there are benefits to being in an LTCH. The costs of treating that patient over, I believe, 180-day period -- so a six-month period -- may be lower, but the Medicare payments are actually higher. So that's one example.

Other literature has shown that on an episode basis, the lower-acuity patients are, in fact, much more expensive without any increase in quality, whether that's a readmissions or a mortality estimate.

Most recently, there was an article that was published by NBER, and that looked at what happens to an area, a hospital service area, when an LTCH enters the market. And so the study basically looked over 1998 to 2014 and found just over 180 areas that LTCHs had entered, and it looked kind of before -- look at that, the high probability LTCH population before the LTCH entered and looked after the LTCH entered. And what it found was that there was an increase in LTCH use. There was a decrease in SNF use. There was an increase in spending, and they did not find any changes in I think what we would consider outcomes measures or notable outcomes measures. So that's

kind of the most recent literature. But like I said, there hasn't been any truly definitive, you know, answers found in the literature at this point.

DR. CROSSON: I would just add a question to Amy's sort of along the same line. You mentioned earlier, I think, in the presentation a distinguishing element was the use of weaning protocols in LTCHs. Now, as a clinician, that doesn't seem like rocket science that LTCHs should have a weaning protocol but acute-care hospitals not. Do you know anything about that?

MS. CAMERON: There has been literature showing that there is a volume outcome relationship with weaning, and so the more frequent weaning is conducted in a health care facility, the better the outcomes likely are. Weaning is often a long, very involved process, and LTCHs have created -- some LTCHs and, frankly, most LTCHs do have a niche for weaning. They have a lot of patients with respiratory failure. They take a lot of patients on vents. And over the past decade and a half, that population has actually grown in LTCHs. So over time, I think more of those patients have been -- LTCHs have seen more and more of those patients and have dedicated more and more time to

something like weaning.

DR. CROSSON: So the answer is it is rocket science, at least in its implementation.

MS. BRICKER: So on that point, though, even that population, knowing that they have then the experience around the weaning protocol, we don't see that as an outcome that's more positively correlated to those patients in the reference that you mentioned, the recent --

MS. CAMERON: So the recent study did not specifically look at weaning patients as a group. It looked at high probability -- patients with a higher probability of going to an LTCH. So it didn't isolate those patients, and so that is probably -- and it didn't look at an outcome related specific to those patients. So that may be why that finding wasn't shown in that literature.

DR. CROSSON: Thank you. Okay. I have Jonathan, then David and Dana, and then Brian. Go.

DR. JAFFERY: So thank you for this report. It's starting to have an additional analytic framework for this. It's clearly an important topic. I have two questions.

Do you have any information about or hoping to

find information about the financial impact to beneficiaries and families if they enter an LTCH versus if they don't? And if you want to tie that to outcomes, clearly. But specific not only just to Medicare costs but also to beneficiaries.

And then also related to beneficiaries, when you are discussing the different focus groups as you go out, are you planning to talk to beneficiaries or families? And one of the things that I think would be particularly interesting or important to hear about is potential burden for them to go to multiple facilities, especially if they're transferring back and forth. We've seen that in clinical practice a bit, that that can be a burden.

DR. CROSSON: On that?

DR. GRABOWSKI: Yeah, in that NBER study that Stephanie mentioned, they do look at out-of-pocket spending, and it did go up when individuals entered an LTCH. So that's another outcome that they did examine in that study.

DR. CROSSON: David.

DR. GRABOWSKI: So I was originally going to ask you about the NBER study, but Amy already sort of got at

that. That got a lot of attention. It was written up in the New York Times and elsewhere, and so I think that's something we'll want to kind of think about as we proceed because I thought it was a really well done analysis.

I wanted to kind of ask you about quality, and I think that's kind of the omitted variable in that study. They have some measures like time in an institution, mortality, but there's not a lot of other quality measures, and I wonder kind of in our steps here, what other quality data are out there that we could look at? Obviously, your focus groups are going to be really important, but are there other sort of quality measures like functioning that we could think about? I know this gets back to common assessment instruments across PAC sectors, but what can we learn there?

MS. CAMERON: So the LTCHs were recently required to start reporting assessment data from the care data set, and they have been reporting that. Functional data just began to be reported, so we're hoping to have something about that in the next year or so where we can look at function.

It's unclear, though, I think -- and, you know, I

think some clinicians in the room might be able to help answer this. What are some of the more important outcomes and functional assessments that are needed for an LTCH type of patient? You know, the typical functional assessments include things like walking and, you know, all the other pieces. But for a vent patient, is that really an appropriate measure? And I look to some of the clinicians here to help understand that.

DR. CROSSON: Okay. You know, maybe, Stephanie, that input we wouldn't be giving you right now, but there are other ways to get that.

Okay. Dana?

DR. SAFRAN: I could have missed it, Stephanie, in your list of the things that you were going to cover, but I wondered if you were planning to look at data that would indicate how often LTCHs are keeping patients, you know, pretty close to exactly 25 days. From personal experience, I can tell you that I think that gets gamed really badly. And it would be good if the work that we do could shed some light on that. Even if we're planning to propose something that does away with it, it may be some data to support why to do away with that kind of --

MS. CAMERON: Sure. So, if I may just jump in for a moment, the average LTCH length of stay is 25.1 days.

[Laughter.].

MS. CAMERON: And that has gone down over time, and that's the Medicare length of stay. You know, there is variation across different conditions on kind of what the average length of stay is. Some are much longer, and some are shorter.

There was a recent rule change that started in fiscal year 2018, and taking a step back and kind of diving into the weeds for a quick moment, the short stay outlier policy I referenced used to use a threshold, and that threshold was set such that if a patient stayed less or shorter than the threshold, then the LTCH would get paid the lesser of a series of four different equations, and it was like lesser of, you know, 120 percent of cost, the IPPS comparable rate, the LTCH rate. It was quite low. And then if the patient stayed beyond that threshold, the LTCH would be eligible for the full payment rate. And over the past five to ten years, the Commission has shown that when that threshold is met, wouldn't you know, discharges go up and in order to get the full LTCH payment.

In 2018 CMS amended the policy such that it was no longer this strict kind of very kind of harsh drop-off or this cliff, if you will. And, instead, it's now a blend that kind of comes up to I think about 80 percent of the payment, five-sixths of the payment, somewhere around there. And so there's much less of an incentive now for an LTCH to discharge a patient -- to wait to discharge. The incentive has gone down.

Now, unfortunately, that policy started in fiscal year '18 and the latest and greatest data we will have in '17. So in two years, I look forward to coming back to you with that information to see how things have changed and if that cliff is, in fact, reduced and it's much more of a smooth curve.

DR. CROSSON: Good to know the Commission has ongoing business.

[Laughter.]

DR. CROSSON: Brian.

DR. DeBUSK: It seems the central, one of the central issues here is the financial incentive that acute-care hospitals have to transfer these patients to the LTCH. And it seems like a lot of our effort is around, well, what

defines an LTCH patient and what defines an LTCH stay, and we seem to put all the emphasis on the LTCH.

Has anyone looked at this problem from the other side? Would a more resilient, high-cost outlier policy on the ACH side -- and this is a true Round 1 question. This isn't a comment. Has anyone looked at potential effect of a more resilient policy, something between, you know -- maybe an enhanced low-cost outlier or high-cost outlier policy to maybe blunt that financial incentive? Does that solve 50 percent of the problem or 80 percent of the problem? Is this really just an artifact of the all or none nature of our high-cost outlier policies in ACHs?

MS. CAMERON: So it's an excellent point, and I can say throughout our site visits, talking with acute-care hospitals, it has been a concern to them that there is this group of patients that are staying an incredibly long time and kind of the question of where do we discharge these patients to safely, who can take these patients. And then, you know, some cases, there may not be an easy or safe or available discharge destination, and they stay in the hospital -- and I'm sure Warner can speak to this better than I can -- for 180 days, you know, or longer.

When the Commission pondered and recommended the LTCH eight-day criteria, that was in tandem with a policy that would have also provided additional dollars to the acute-care hospitals for these cases in the acute-care hospitals. So the Commission did recommend those as kind of a package where I believe it was a budget-neutral recommendation and not -- you know, the money that would have been saved from the long-term care hospital policy would then be redistributed to the acute-care hospitals who are taking care of these patients, you know, with very high ICU stays and who would have otherwise kind of qualified for that LTCH payment.

DR. CROSSON: Thank you, and thank you for the creativity in your question.

[Laughter.]

DR. CROSSON: New Commissioners, take note. There is artistry to this work.

DR. DeBUSK: [off microphone].

DR. CROSSON: Okay. I think we are ready for the discussion. We've got the slide up. Stephanie has been very clear about the feedback she'd like. She's had some already. So we'll entertain further discussion.

[No response.]

DR. CROSSON: Stephanie was so clear that I think we have given her the input that we can give. Thank you, Stephanie, and we look forward to the future work.

Okay. So we'll move on to the final discussion of the afternoon.

[Pause.]

DR. CROSSON: So the final presentation this afternoon is, again, work on a mandated report relating to clinician payment of physicians, and Kate is going to take us through that.

MS. BLONIARZ: As Jay said, the last session covers a congressionally mandated report considering the payment updates for clinician services in Medicare, and I want to thank Ariel Winter and Kevin Hayes for their help in pulling it together.

So here's the outline for the presentation today. I'll start with background on how Medicare pays for clinician services and review the mandate. We've been asked to consider the statutory updates for the clinician services between 2015 and 2019 and their relationship to a set of indicators that are similar to but not exactly the

same as the indicators we use in our payment adequacy framework. So at the end I'll specifically discuss the implications of this work for our payment adequacy assessment that we do every year.

So starting with background, between 1997 and 2015, Medicare's payments for clinician services were governed by the sustainable growth rate formula. When the SGR produced rising negative updates starting in 2002, Congress delayed or overrode those negative updates in all but the first year they occurred.

Then, in 2015, Congress repealed the SGR system in total as part of the Medicare Access and CHIP Reauthorization Act, or MACRA.

In addition to repealing the SGR, MACRA also established permanent statutory updates for Medicare clinician fees, plus incentive payments for participants in certain models called Advanced Alternative Payment Models. And it also established a new value-based purchasing program for all other clinicians.

MACRA requires the Commission to review the statutory updates for clinician services between 2015 and 2019 and consider the effect these updates have in four

areas: the efficiency and economy of care, supply, access, and quality. The mandate also asks us to consider any future updates necessary to ensure beneficiary access.

I'll note that these indicators are similar to the measures that we use in our yearly payment adequacy assessment. But I'll use this list for the purposes of this presentation.

Because we won't have updated data for the entire time frame we are asked to review, we currently plan to report on these measures over the past decade, when the statutory updates were generally comparable to the updates between 2015 and 2019. And the updates in law during this time frame from about 0.2 percent per year to 0.5 percent per year.

We plan to follow up this material with a second presentation in the spring and finalize it in a chapter in our June report to Congress.

I'll go through each of the four indicators the mandate asked us to consider, starting with efficiency and economy, and we think that spending trends gives us some insight into that.

The background on Medicare's payment system is

that the program makes service-by-service payments for clinician services using a fee schedule of more than 7,000 discrete codes and updates the payment amounts for some of these services every year. And the payment updates that we're asked to look at apply to Medicare's conversion factor for the fee schedule.

But there are factors other than the payment update that affect total spending. The Medicare program makes policy adjustments to account for a variety of factors, and as the share of providers in each category shifts over time, that will affect spending.

Differences in Medicare's payments by site of service can also affect spending trends. As services migrate from the physician office setting to the hospital outpatient department, Medicare physician fee schedule spending goes down. But the program makes an additional payment through the outpatient prospective payment system, so the total Medicare spending amount goes up.

This chart compares the payment updates -- in the pink bars -- with clinician spending per beneficiary -- in the orange bars. So you can see that the updates in the pink bars have generally been in the range of zero to 2

percent over the past decade, but averaging about half a percent per year.

The year-over-year change in per beneficiary spending, however, is much more variable. Some of the factors I mentioned on the prior slide are in play. Some of the slowdown in per beneficiary spending growth we believe is due to the services migrating from the physician office to the outpatient setting, and because this is only fee schedule spending, you don't see the increase in total Medicare spending. And some payment incentive programs converted to penalty programs between 2015 and 2016, which contributed to the decline in spending per beneficiary in 2016. But another factor that I haven't covered yet is increases in volume and intensity.

Before discussing variation in volume, I want to talk about the reasons that volume might be responsive to payment rate changes. So I'll use a specific example of payment rate reductions.

There are two potential explanations of behavior resulting from a reduction in payment rates. The first explanation is that the volume or intensity of clinician services would go down when the payment rate goes down.

But the second idea is that the volume or intensity of clinician services would go up when payment rates go down, and this is also called a volume offset assumption. And the idea is, for any number of reasons, clinicians might be able to make up some of the reduction in the payment rate by increasing the volume or intensity of services they provide.

There are empirical findings supporting both explanations, and it's likely that the overall effect is dependent on the size and type of the payment adjustment, the type of services, the clinician specialty, and their payer mix.

This is a slide you've seen as part of the payment adequacy analysis measuring per beneficiary volume growth by type of service. And I want to note that our volume measure accounts for the number of services as well as the intensity of services.

There are many factors that can affect total volume growth, including changes in medical practice, input costs, new technology, patient illness and disease burden, and economic changes. But as you see here, changes in volume and intensity can be quite high and variable by type

of service. Imaging volume grew rapidly between 2001 and 2009, and then declined. Tests and other procedures grew more rapidly than other services. And evaluation and management services and major procedures -- the blue and green lines on the chart -- show relatively low and less variable rates of growth.

Another factor contributing to this volume growth by type of service is the relative profitability of certain services and the ability of some clinicians to more easily increase the volume of services they provide.

The mandate also asks us to consider the effect of the payment rates on supply. And, overall, despite the relatively modest updates for clinician services, the number of clinicians billing the program has been steadily grown, keeping pace or outpacing fee-for-service enrollment.

The number of primary care and other specialty physicians grew by 2 percent and 1.5 percent per year, respectively, from 2009 through 2016. Growth in direct billing by advanced practice registered nurses and physician assistants was quite robust -- averaging over 10 percent per year. And this growth occurred despite payment

updates averaging about a half a percent.

So the mandate also asks us to consider the effect of payment changes on beneficiary access. And as I stated earlier, there is evidence that changes in payment rates affect volume. But these changes in volume don't seem to translate into changes in direct measures of access.

We use such a set of measures in our payment adequacy assessment by sponsoring a yearly telephone survey of beneficiaries and individuals with private insurance, asking them about their ability to obtain needed care. And, overall, we don't find much difference in reported access between Medicare beneficiaries and individuals with private insurance.

I want to pause and make a point here. Private insurance payment rates for clinician services are significantly higher than Medicare's payment rates and has grown significantly faster over the past decade. But, to date, these diverging payment rates have not appeared to have resulted in a difference in patient-reported access to care in our survey.

If higher payments for clinician services bought

better access to care, we should have expected to see an improvement in access for privately insured individuals relative to Medicare beneficiaries. But that doesn't seem to be happening. And, in fact, access for Medicare beneficiaries has remained either comparable to or slightly better than access for individuals with private insurance.

As measure from the access survey that we track closely is whether individuals seeking a new primary care physician are able to find one without a problem. This has been a key indicator for the Commission given the importance of ensuring an adequate pipeline of primary care.

Note that only about 10 percent of respondents each year are even looking for a new primary care provider. And of that group, about 30 percent of Medicare beneficiaries report a small or big problem, compared with 40 percent of those with private insurance in 2017. The rates are a little noisy year to year, and the measures for both Medicare and private show a slight upward trend over time. But, overall, Medicare has generally been about as good or slightly better than private insurance. And the survey has been a pretty reliable early indicator of access

trends, subsequently corroborated by other, larger surveys.

The mandate also asks us to consider the effect of the updates on quality, and there's little evidence that higher payments have translated directly into higher quality in this sector. The way Medicare has been assessing clinician quality and applying a pay-for-performance system has a lot of issues, which we've discussed in some detail. The quality measures and use are granular, burdensome, don't allow for comparison of performance across clinicians, and we don't believe that the quality system overall is going to be successful. These issues are what led the Commission last year to recommend eliminating the current program.

In the context of MedPAC's payment adequacy framework, we've generally reported on a few population-based measures of clinician quality to track trends. But this is also not a complete picture of clinician quality. So, overall, we've generally concluded that quality is indeterminate.

I've discussed how the mandate asks us to consider a few indicators and their relationship to payment rates. But there's a clear mirroring of the yearly

analysis that MedPAC does for all sectors using the payment adequacy framework. And the next two slides describe that framework in more detail.

The payment adequacy framework that we use tries to balance three things: ensuring the Medicare program provides beneficiaries with high-quality care in an appropriate setting; ensuring the best use of Medicare taxpayer and beneficiary dollars; and giving providers an incentive to supply efficient, appropriate care and pay equitably. How the measures stack up against the framework, whether a payment update is needed, and the size of that update is a judgment call.

The payment adequacy framework has four elements: beneficiary access to care, providers' access to capital, quality, and Medicare's payments and providers' costs.

For access, as I stated, we review the results of our yearly telephone survey of beneficiaries and individuals with private insurance, supplementing it with an analysis of the number of clinicians billing the program and changes in the volume of services. We don't report access to capital because of the many small entities in this sector.

We review a few population-based measures to look at trends in quality. And because clinicians do not report their cost data to CMS, we can't calculate a margin. But we do review differences in compensation and the ratio of Medicare's payments to private insurance payments. And we look at a measure of clinician input costs. And we do this every year in case circumstances change.

This slide summarizes the measures that the mandate asked us to consider, which generally line up with the payment adequacy indicators. There's variable volume growth by type of service and an increasing number of clinicians treating beneficiaries. Access to care has been stable, and Medicare beneficiaries report comparable or slightly better access than individuals with private insurance, despite the significantly higher level and faster growth rate of clinician payments in the private insurance market. Quality remains indeterminate.

Overall, the key point is that the modest updates to payment rates, about 0.5 percent per year or less over the past decade, did not seem to result in worsening payment adequacy indicators in the clinician sector. And there does not seem to be a strong or consistent

relationship between the updates and these indicators.

The mandate asks the Commission to consider any future updates needed to ensure access to care for the program's beneficiaries. This work allowed us to review the patterns of spending, access, and quality over a longer time frame than we usually use in our payment adequacy work and also consider some of the empirical reasons that payment rates might affect these measures.

However, our yearly process conducting payment adequacy assessments for this sector allows us to best meet the Congress' needs because we will use the most updated information reflecting current circumstances in this sector, and we can update these findings every year.

Our current plan to execute the work is to have a follow-up session in the spring with a few new pieces of data and finalize the material as a chapter in our June report to meet the mandate deadline. I'm happy to take any questions you have and welcome any suggestions on other material or analyses that might be responsive to the mandate.

DR. CROSSON: Thank you, Kate.

We'll start with clarifying questions. I see

Marge, Jaewon, Kathy, Paul. Marge?

MS. MARJORIE GINSBURG: I'm interested in the statistics showing there's no difference in access to care whether they're private insurance or Medicare. And I wonder, do doctors even know what service their patients are on when they make appointments? I mean, I wonder whether this whole area, in fact, is sort of blind to the average physician so that a patient calls up to get an appointment and the office staff give them the first available appointment. Do they even know that they're, you know, a well-compensated private insurance patient or a Medicare patient? And if they don't know. then wouldn't that answer the issue why there's so little difference?

MS. BLONIARZ: I would say they do know, that most physician offices have, you know, a set of insurers that they are credentialed or enrolled in and sometimes will limit the number of slots in their panel by type of payer. But I would say that they generally have a very good sense of what insurance they're participating in. And, overall, you know, we've seen Medicare is -- the share of physicians taking Medicare is a little less than private, but, you know, still in the 90 percent range, so

significantly higher than Medicaid.

DR. CROSSON: Thank you. Jaewon.

DR. RYU: Yeah, it feels like we're trying to triangulate access through a bunch of different indicators. I'm just curious if you've looked at spillover effects, like ambulatory-sensitive conditions in the ED. You know, how has that trended as another proxy around access? Because I think there's a distinction between being able to get in and then having what we might call effective access, you know, adequate time with the provider, things like that that may not be fully captured in what we're tracking.

MS. BLONIARZ: So in the payment adequacy analysis, over the past couple years I've done things like look at wait times. So, you know, in the survey we ask, you know, did you see a provider when you wanted to? Did you have to wait longer than you wanted? But we have looked at, like, you know, the share saying they can get an appointment within, you know, one to three days, four to seven days, things like that.

I think the point about, you know, do people end up deferring care and then, you know, going to an emergency room when they have an urgent condition, we haven't seen a

big change in the number of people saying they had a problem that they thought they should see a doctor about but didn't.

Some work that Dan and Shinobu have done on geographic variation, you know, we do generally see that. Areas that have higher physician service use have higher service use in all other categories. It seems like they're correlated. It's not like there's an offsetting effect on service use in the physician and other settings.

DR. CROSSON: Kathy.

MS. BUTO: But, Kate, I thought we did do work on ambulatory-sensitive conditions and whether or not there's been an increase, and I thought we had found there really hadn't been an increase over time.

MS. BLONIARZ: Yeah, that's true, too. We look at ambulatory care sensitive conditions as a measure of kind of the ambulatory quality, and those rates have gone down over time. I think one thing that's a little -- that might be also in play there is just ambulatory admissions overall, hospital admissions overall have gone down. But, yes, those numbers did go down.

MS. BUTO: Okay. My question is on Slide 12,

which is comparing Medicare to private insurance, share of responses looking for a new primary care physician and reporting problems. So, you know, taking into account that private insurance pays way more than Medicare for these services, I was surprised to see the percentage of individuals who say they have a big problem getting primary care higher for private insurance than for Medicare.

Do we know why that is or what some of the other factors are? Is it just the narrow network? Or what is it exactly that -- and the reason I bring this up is that as we get to Round 2, we talk about raising primary care -- payments for primary care services or physicians. If high-paying insurers are not getting good access, then sort of what are we after here?

MS. BLONIARZ: So I'll not answer that second part of the question.

[Laughter.]

MS. BUTO: That's a Round 2 question, right?

MS. BLONIARZ: But I can give you some other kind of thoughts on this. So one thing that we've found, the AMA and other groups sometimes do surveys of what it's -- of providers, asking them, you know, how easy is to enroll

in and bill a program or a payer? And Medicare fee-for-service is often quite popular because there is virtually no prior authorization, step therapy, care plans, things like that. You know, it's any willing provider of that nature. I think that has a fair bit to do with it.

I think that, you know, it's a slightly different mix of providers and patients in each group, right? So cardiologists, for example, are likely going to take Medicare kind of no matter what; whereas, private insurers -- clinicians on the private side --

MS. BUTO: We're talking about primary care here, right? Aren't we?

MS. BLONIARZ: Right, yeah, this is primary care.

The other point I would just make is when we've looked at payment rates, if all providers were paid using the Medicare fee schedule, the difference between primary care and specialty care would actually be narrower than it is, which means that Medicare has -- there's less of a difference between primary care and specialty care payment rates in Medicare than there is on the private side.

DR. CROSSON: Okay. Paul, then Warner and Pat.

DR. PAUL GINSBURG: Sure, I wanted to ask about

the Medicare Economic Index. The text describes it, you know, it's input prices, and then a 1 percent multi-factor productivity, which I gather is not aspirational but it's data from the economy in general?

MS. BLONIARZ: Yes, it's multi-factor productivity economy-wide from BEA, and whatever the actual is, it's netted out of the input price market basket.

DR. PAUL GINSBURG: So, in a sense, it's quite possible that being a service industry, physician practices are not achieving a 1 percent productivity, which means that the Medicare Economic Index probably understates the cost pressures they face, which in a sense just makes this all the more dramatic as far as the 15-year period of very minimal increases in rates kind of adds to the puzzle of why no effect on access.

DR. CROSSON: I just mentioned, Paul, to Jim that the first question I ever asked as a Commissioner 14 years ago was the same question you just asked.

[Laughter.]

DR. CHRISTIANSON: You remember it.

DR. CROSSON: Oh, I do remember, yeah.

Warner?

MR. THOMAS: In analyzing the access options and differentials, did you see any difference or do you study differences of physicians who are independent versus in groups versus -- do you look at any sort of affiliation or bifurcate the results on affiliation?

MS. BLONIARZ: I don't. I'm trying to think if I could. I don't -- I might be able to. I would have to think about it. I think, yeah, you'd need kind of a survey of physicians.

DR. CROSSON: Okay. Pat.

MS. WANG: Can you just confirm that in the beneficiary access surveys -- is it specific to seeing an individual clinician in an office setting? Is it broader than that? Could it include different shifts in sites of care, urgent care centers, clinics? Does the survey capture that?

MS. BLONIARZ: Sure, it would, yeah. It's general to, you know, were you able to see a primary care doctor or a doctor for -- you know, one of the other questions is about regular routine needs or emergency needs. So it definitely would cover multiple settings.

When we've looked at where beneficiaries say they

see their doctor, that's changed a little bit over time in some other surveys. They're slightly more likely to use the outpatient department. But it hasn't changed a ton.

DR. CROSSON: Okay. We'll now move on to the discussion. The topic on the table really is advice for Kate with respect to the content of this mandated report, and we've had some of that already. But Paul is going to start the discussion.

DR. PAUL GINSBURG: Well, you know, this pattern of 15 years of very small Medicare updates and growing difference between what private insurers pay and its lack of apparent effect on access is really quite a baffling question. And, you know, we might be able to shed some light on it to perhaps -- I don't know if one of the years you've done adequacy you've tried to talk to some of the consultants that help physician practices manage and just asking them: What's going on? Why are we seeing these results?

One thing which you raise which I think is -- it's something that really concerns me -- is that if you pay independent practices too little, it's just one of the factors that pushes physicians to be employed by hospitals,

which can get paid much more because of the facility fee. And it kind of reminds me of, you know, some of the experience that I saw a long time ago of states like New York that have very low payment rates for Medicaid. You know, what was the result? Very few independent practices saw Medicaid patients, and Medicaid patients were seen by Medicaid mills or hospital outpatient departments, which were in a position to get paid much more. So, in a sense, you know, between the site of service differentials and a long-term period of having very low payment rate updates, Medicare may be in a sense contributing to this trend and, thus, in a sense, you know, spending a lot more money, but in the process access being maintained. So anything we could to shed more light on that.

And I think that's really the essence of what I have to say.

DR. CROSSON: Thank you, Paul.

We're open to further comments. I see Karen, Kathy, Jon.

DR. DeSALVO: What happens if you do Round 1 and Round 2? What's the penalty?

[Laughter.]

DR. CROSSON: I think that's allowed, yes.

DR. DeSALVO: Paul, I'm intrigued by your interpretation of the data, and I wanted to respond to that because I wonder if another way to think about it, though is that small updates we've been able to hold the gains, just ignore the private sector part for a moment, and is that -- is the concept that a quarter of Medicare beneficiaries have trouble getting access to primary care sufficient? And if we provided maybe some more resources to primary care, that that number would get to something that felt better. I suspect you feel the same way. I just wanted to flip it a little bit and say maybe we want to see that really go down and do more than just hold the gain.

DR. PAUL GINSBURG: Yeah, I think when we talk about the -- you know, given everything we've done in the past about distortions in the fee schedule, if we're going to entertain more money in physician fees, it should be targeted on not so much -- not just primary care but I think all evaluation and management services, because that's where there's the most potential for having an effect.

We know that, you know, physician productivity

may actually be increasing quite rapidly in some procedural specialties, so actually they may be doing very well in Medicare payments. And the problem may be localized in evaluation and management services.

DR. DeSALVO: For the private insurance, one thing I wonder, Kate, is if this is a reflection of new people in the marketplace from the ACA just adding -- most of the data, if I understand it right, the folks who are new on the ACA haven't had trouble getting access to primary care, but it may be a nuance to the data.

MS. BLONIARZ: So it's in there on the right side, but there's not -- it's not a big part of it. One thing we do is limit it to older people, age 50 to 64, and a lot of the enrollment on the marketplaces has been for younger people. They will be in there, and, you know, that could be playing a little bit of a role.

DR. CROSSON: We will be asking for a complete definition of the word "older."

[Laughter.]

MS. BLONIARZ: I'm very sorry.

DR. CROSSON: It can come later.

Kathy?

MS. BUTO: I just wondered if we could -- and maybe you're planning to do this anyway, Kate -- talk a little bit about the fact that, okay, maybe we're mystified that low payment rates haven't seemingly affected access. But there are other things that are happening. Among them are more physicians opting out, maybe not a significant number enough to make a difference at this point; concierge care; and I think the big, probably the big elephant in the room is the shift to outpatient hospital settings where the payment is higher.

So at least put a flag up that there may not be access alarm bells going off, but that we are seeing or beginning to see some trends that could have legs over time.

DR. CROSSON: Jon, and I've got Jon and then Brian.

DR. CHRISTIANSON: A couple of suggestions, one very minor. In the discussion of the literature on the relationship between payment change and access quality, you cite one paper related to Medicare, and then you have a text box on a bunch of things related to Medicaid because of exogenous price change for Medicaid services. So

research has jumped all over that.

One of the things I really liked about our discussion last year of the impact of readmission penalties was the attempt to sort of help the Commissioners understand what the limitations were in some of those studies and what the strengths were rather than just say this study says this, that study says that. I think that would be helpful here, too. You know, was this a strong study methodologically? Was this kind of a weak study? What should we place our most -- you know.

The other thing I wanted to point out is on Slide 14, where you have the things that you're going to track and you talk about in the bottom box on Slide 14 physician compensation, and so here I'm going to channel my inner Mary Naylor, which will mean something to some of the Commissioners, what about advanced practice nurses and their compensation, and PAs? And I think that also raises a whole big issue here because we want to understand what's happening to physicians.

The other big elephant in the room is the increase in the supply of and practices of nurse practitioners, and also the expansion in terms of what they

are being allowed to do by states. So you're having much more opportunity for nurse practitioners to practice independently and for some E&M services. I think that's becoming a big deal, particularly in helping people manage their chronic illnesses independently, which nurse practitioners by and large didn't used to be able to do.

So the increase in supply, the changing indications for services they can provide, and the fact that, as we see more and more employed physicians, we also see more and more employed nurse practitioners delivering primary care. And so they get paid at 85 percent of the physician's rate for the E&M services, but as an employee their compensation is less than half. So there is certainly an incentive in the employed physician clinician in large systems to sort of take advantage if you can of the nurse practitioners. So that's going on at the same time you have this outpatient facility fee that plays into all of this.

That's one part of the context, I think, that doesn't get addressed here at all and probably should, just to sort of help people think about what's going on.

MS. BLONIARZ: Just to advertise next month,

Brian O'Donnell and Carolyn San Soucie and me, we'll be back up here talking about APRN and PA billing and a lot of that material.

DR. CHRISTIANSON: I like that advertisement.

[Laughter.]

DR. CROSSON: Jon Perlin.

DR. PERLIN: Thanks. Also another terrific report, great information. A couple Round 2 comments on Elephants 1 and 2. Let me start with Elephant 2.

You know, my observation from working with lots and lots of practices is that, you know, we speak about this as if the care provided were purely by the physician or by the advanced practitioner but, in fact, it's really team-based. You know, so I think the numbers may not get behind the reality of how that care is delivered, and I think, Jon, you're absolutely right that when you take the arbitrage between rates that may not have been escalating as high as the commercial, it works out because the team is delivering at a rate that is in the aggregate lower. You know, that may affect on the positive side.

The second observation really in terms of working within our system, a thousand practices around 42 markets,

is that I know that one can assume that, oh, you acquire a practice, and it automatically flips to facility and OPD. But, in fact, the majority don't. I think that's the reality. If you think about what the economic incentive is, it's for the downstream referral for the hospital service. It's not necessarily for the fee in the office. And so I think we need to investigate below that level of detail to really understand this.

And that gets to a couple of methodologic questions. When you do the survey, is it market by market, and then the sum of the markets? Or is it a grand aggregate of everywhere?

MS. BLONIARZ: No, it's everywhere, and random digital dial.

DR. PERLIN: I'm just struggling with trying to understand whether in the survey your frame of reference tends to be biased by the general availability of care in a particular setting. In areas where there's a lot of provider availability, you'll notice that there's an increased rate of services. You know, it's a service. Not surprising.

On the other hand, it may also influence the way

beneficiaries might respond or commercial insured in the 50 to 64 group to what they perceive as the relative ease of access. So I'd just dig into that a little bit deeper.

And just a final sort of methodologic comment. I think the report is just terrific. It would be interesting to look at the service rates with respect to the Medicare beneficiary, a population change. In some of the charts, for example, between 2000 and 2016, the total number of beneficiaries appears to have increased from roughly 40 to say 58 million, and just do that on a service rate per beneficiary to better understand the magnitude of certain service changes. Thanks.

DR. CROSSON: So, Jon, there is an interesting point in there, and that has to do -- I mean, I think, Kate, it's true; before, we've noted that there is variability by area of the country in terms of accessibility, both for primary care and specialty care.

So I think, Jon, your raising the question of the weighting of the survey and whether it's -- what would be the right term? Population-weighted or geographically weighted? Is that close to what you were saying?

DR. PERLIN: Yeah, just trying to understand if

there's a sensitivity to another level of understanding access that may be associated with the particular dynamics in a market of how easy it is generally to access service. If it's a tough market, then all the people you know, whether they have -- whether they're Medicare or not, their frame of reference is: "Oh, man, it took me three weeks," "It took me three months," whatever. So your frame of reference may change geographically as to what's acceptable.

That's why I think this is -- we need to have a regional or market-based look at this as well as a sort of grand aggregate look to really understand that.

DR. CROSSON: Kate, do you want to comment on that?

MS. BLONIARZ: Sure. I mean, just from the way the survey is constructed, it's a telephone survey, and then it kind of weighted by, you know, total aggregate, you know, census data to, you know, match on a bunch of dimensions that we care about.

I do think that the questions that we're asking are relative. Right? So, can you see a physician as soon as you wanted? And that is going to vary for people. And

I mean, a point that Alice Coombs made -- has made in the past here is that that may change over time as people, you know, say, "Well, I used to be able to see my doctor tomorrow, and now it's more like a week."

But when we've looked at other, you know, other surveys that try to measure the same thing, we haven't seen a really big change there in the number, you know, when you say, "Okay, can you get in within three days or five days?"

I don't I'd have to think more about how it would work geographically, whether that would, you know, influence the findings one way or the other.

DR. CROSSON: Okay, Brian.

DR. DeBUSK: Well, thank you for a great chapter. I think we're off to a great start on the mandated report. I'm particularly excited about this because it does seem like a license for us to bring together some of the work that we've already done on rebalancing the physician fee schedule. I mean, a lot of the work that you're obviously more than familiar with, you've done. It seems like a great opportunity to package it in a somewhat new way.

What I wanted to focus on, I think, is what we were calling "Elephant #2," which was back to the extenders

issue. You know, your survey. We put a lot of emphasis on that survey and as we should. I mean, I can tell it's well thought out, and it's something that we put a lot of -- place a lot of credibility on.

I do wonder if the survey, though, can't see through nurse practitioners and PAs, especially when a lot of beneficiaries don't even realize in some cases that they're seeing a PA or an extender, and I do wonder if that's blunting some of what we're saying.

And to Jon's point, you know, I think when they work appropriately as a team I think that you can get high performance out of them, but I'm still a little concerned, especially in states that are giving them independent practice autonomy. Are these -- are we substituting people who have gone through four years of medical school, three years of residency for someone who's basically gone through 27 months of, in some cases, online courses. And I just don't see how that's educationally equivalent. So I am a little concerned about that. Actually, I'm really concerned about that, and I hope we can explore that when we look into the physician pipeline.

And then the third thing is my standard plug on

incident-to billing because I think the data is going to be more contaminated than we realize because a lot of this claim data is going to have incident-to information and we're going to have doctors who are working 130 hours a day thanks to that. Thanks.

DR. CROSSON: Warner.

MR. THOMAS: Just a quick comment, and I think we talked a lot about hospitals employing physicians and flipping the hospital-based departments. But I do think it would be interesting to look at, and see if there is, also more of a situation where physicians that are in those types of constructs are accepting Medicare patients more consistently than independent physicians who are not because I think generally it's any physicians that are part of an integrated system or a group or employed, I mean, they're going to be open to Medicare and accepting Medicare patients. And I think independent physicians, you may see a lower percentage of folks that are accepting Medicare or accepting new Medicare patients. So that may be something to at least investigate and maybe comment on in the report.

DR. CROSSON: Okay. Thank you.

Okay, Kate, I think you've gotten some good

feedback here. We look forward to will you be coming back again or?

MS. BLONIARZ: The spring.

DR. CROSSON: In the spring, okay.

MS. BLONIARZ: Yeah.

DR. CROSSON: Terrific. So I think that ends the Commission work for the afternoon except for the public session. So for our guests, if there's anyone who would like to make a comment, please come forward to the microphone so we can see who you are and that you are there.

[Pause]

DR. CROSSON: Seeing no one, we are adjourned until tomorrow morning at 8:30. How about that? I'm sorry.

[Simultaneous discussion.]

DR. CROSSON: I'm sorry. I'm sorry. The commissioners have a special session at 8:30. The meeting, public meeting, begins at 10:00. Thank you.

[Whereupon, at 3:07 p.m., the meeting was recessed, to reconvene at 10:00 a.m. on Friday, September 7, 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, September 7, 2018
10:02 a.m.

COMMISSIONERS PRESENT:

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

AGENDA PAGE

P R O C E E D I N G S

[10:02 a.m.]

DR. CROSSON: Good morning and welcome to Friday's session. Today we have one issue before us, and that's the hospital quality and value program, potential redesign. Ledia and Jeff are here to present, and, Ledia, you look like you're getting ready to start.

MS. TABOR: Good morning. In the June 2018 report to the Congress, the Commission laid out a set of principles for designing quality incentive programs. We used these principles as the basis for a new Hospital Value Incentive Program, or HVIP. The HVIP is simpler than the current hospital quality programs, focuses on outcomes and promotes the coordination of care, and overall aligns with the Commission's principles for quality measurement.

The Commission asked that we continue to refine a design for the HVIP that conforms with our principles for quality measurement.

I'll briefly review the design of the new HVIP and our initial modeling using current hospital quality data to determine HVIP rewards and penalties.

I'll then present analysis on four elements of

the HVIP design that the Commission asked to further consider: weighting of the measure domains; overall amount of the financial withhold; which patient experience measures to use; and monitoring hospital-acquired conditions, or HACs.

After the presentation, we would also like to discuss whether the Commission should move forward with recommendations to Congress on the HVIP.

To improve focus and clarity, the new HVIP would be one program as opposed to separate programs. As illustrated on the left-hand side of the slide, the HVIP would combine the current HRRP and VBP into one program and eliminate the IQRP, which is an obsolete pay-for-reporting program. This approach eliminates the HAC reduction program which ties payment to infection rates because of our concerns about the accuracy of hospital-reported data, and we'll talk about that later in the presentation.

Looking at the right-hand side of the slide, we would incorporate four existing, all-condition quality measures into the HVIP: readmissions, mortality, spending, and patient experience.

Per the Commission's principles, the HVIP would

translate quality measure performance to payment using clear performance standards. The HVIP also accounts for differences in provider populations through peer grouping. Using the peer grouping methodology, each provider is only compared to its "peers" -- which in the HVIP model is defined as providers that treat a similar share of fully dual-eligible beneficiaries.

Like the current VBP, the HVIP would redistribute a budgeted amount to hospitals based on their performance.

We assume that Medicare would continue to publicly report quality results on Hospital Compare.

Using current hospital quality data, we modeled the HVIP design as described in the previous slide. We found that about half of hospitals would receive a reward and about half would receive a penalty.

We also found that due to peer grouping, hospitals that serve a high share of poor patients are more likely to get rewards with the HVIP than compared to current programs.

I'll now present analysis on the first HVIP design element you'll discuss today, the appropriate weighting of the HVIP measures (or domains). For

illustrative purposes, our initial HVIP model weighted each measure equally to maintain the independence and importance of each of the four measures. The current hospital VBP program also weights domains equally.

However, policymakers could give the components different weights based on some prioritization that considers interests shared by the Medicare program and its beneficiaries.

As clinical outcomes, such as mortality and readmissions, may be more important to beneficiaries, an alternative is to weight clinical outcomes more heavily than patient experience and cost measures.

We modeled the HVIP weighting mortality and readmissions each at 35 percent of the total HVIP score and patient experience and MSPB at 15 percent, and we compared the performance of hospitals with that weighting to the original HVIP modeling using equal weighting of measures.

Given a 2 percent withhold amount, moving from an HVIP model with equal weighting to one weighting clinical measures more heavily would alter payment adjustments by 0.15 percentage points or less for 82 percent of hospitals.

There are many combinations of how to

differentially weight the HVIP measures; however, it is important to note that all four of the measures have modestly positive correlations with the other measures; therefore, small weighting changes will not have large effects on groups of hospitals' average HVIP score.

Today we would like the reactions to the different weighting options. The Commission can specify their desired weighting of HVIP domains or include that the Secretary shall develop appropriate weighting for the HVIP measures through the federal rulemaking process.

Moving on to the withhold amount, it is important to note that the current hospital quality payment programs affect hospital payments by different amounts. But, in aggregate, based on the structure of all the current hospital quality payment programs, hospitals have the potential to be rewarded by about 3 percent of their payments and penalized up to 6 percent.

Since our HVIP model is designed to be budget neutral, each peer group has a pool of dollars based on a percent payment withhold from each of the peer group's hospitals. The pool is redistributed to the peer groups based on their HVIP measure performance.

We originally modeled the HVIP using a 2 percent payment withhold, which is what the current VBP uses.

Commissioners could consider a larger withhold to further motivate hospitals to change their behavior and improve quality of care. We modeled the HVIP payment adjustments using a 5 percent payment withhold to demonstrate this increase. As expected, hospitals would have 2.5 times more HVIP payment adjustment compared to using a 2 percent withhold. The specific hospitals that receive positive or negative adjustments do not change, but the size of the adjustments increases two and a half times.

After accounting for the withhold amount, under a 2 percent withhold amount hospitals can have an HVIP payment adjustment ranging from a 1.5 percent penalty to a 1.6 percent reward. Under a 5 percent withhold, hospitals can have an HVIP payment adjustment ranging from a 3.5 percent penalty to a 4 percent reward.

A discussion question for the Commission is: What is an appropriate withhold amount that can change hospital behavior and motivate improvement?

One policy option is to phase in the higher withhold amounts allowing time for hospitals to focus on

quality improvement in preparation for more of their payment being affected by their quality performance. For example, in year one of the program the HVIP withhold could be 2 percent and the withhold would increase by one percentage point annually until reaching a maximum of 5 percent. The recently implemented Home Health VBP uses a similar approach of moving from a 3 to 8 percent withhold over five years.

Moving on to the third HVIP design element we'll discuss today, based on the Commission's principles, the new HVIP would ideally include patient experience measures. HCAHPS, which is the national standardized survey instrument for measuring patients' perspectives on their care during a hospital stay, determines ten core measures including an overall rating of care. The current VBP scores all ten measures.

For simplicity, we originally modeled the HVIP using only the single overall hospital rating measure. As a part of our policy, hospitals would continue to collect the entire HCAHPS survey from patients, and the other measure results would continue to be publicly reported on Hospital Compare.

The Commission discussed the possibility of including other patient experience measures in the HVIP that may be more meaningful to beneficiaries and capture more aspects of hospital care.

We modeled the HVIP using four measures to determine a patient experience composite. We selected four measures to balance the goal of using a small set of measures with that of capturing more specific aspects of the beneficiaries' experience with hospital care: communication with doctors, communication with nurses, responsiveness of staff, and discharge information.

Assuming a 2 percent withhold amount, moving from scoring an overall rating to a patient experience composite would alter payment adjustments by 0.15 percentage points or less for 78 percent of hospitals.

Patient experience measures also have modestly positive correlations with each other, so small weighting changes will not have large effects on average HVIP scores.

We spoke with several hospitals' quality leaders about their use of the patient experience survey. They generally favored scoring the single overall rating versus a composite in the HVIP because the results of the overall

rating are clearer, and they believe there is less potential bias in the individual measure than in measures based on multiple survey items.

During today's meeting we would like your reactions to using an overall rating or a patient's experience composite and whether the Commission should specify a set of patient experience measures or whether the Secretary should determine the measures through rulemaking and public comment.

Our final topic today is monitoring HACs. The monitoring and evaluation of infection rates through Medicare's programs, including the HAC reduction program, publicly reporting results on Hospital Compare, and other national initiatives such as the Partnership for Patients, have improved infection rates.

but over the years, there have been some concerns that some providers may have changed their clinical decisionmaking in response to financial incentives under the HAC reduction program -- for example, by ordering diagnostic tests in the absence of clinical symptoms to potentially identify infections present on admission so they are not considered hospital-acquired.

Hospital quality leaders we spoke with anecdotally confirmed some of our concerns about the accuracy of the data and the unintended effects of tying HAC results to payment. Our interviewees also expressed a concern that those hospitals not engaging in these behaviors may be penalized in the HAC reduction program..

Because of concerns about the accuracy of some patient safety data, the Commission initially discussed excluding patient safety measures in our HVIP payment model. Also, hospital performance on HACs will be tied indirectly to other HVIP measures -- for example, readmissions due to infections.

To emphasize the importance of HAC reduction while holding to our preference of tying payment to CMS-administered measures, the June report to the Congress discussed requiring as a Medicare CoP that hospitals report data to the federal monitoring site and that CMS continue to publicly report those results on Hospital Compare. Also, consistent with our principles, hospitals could choose to use the HAC measures to manage their own quality improvement, but those would not factor into Medicare payment.

The objective of this approach is to remove financial incentives to alter clinical decisionmaking but maintain the availability of data from monitoring.

The Commission asked to continue discussions about how to keep pressure on hospitals to monitor and take action on HACs given our removing the HAC from a payment program due to the adverse effects of HAC financial incentives. During the meeting we would like your feedback on the policy option that requires the Secretary to monitor performance on HACs over time and consider adding relevant measures to the HVIP if national performance falls.

This brings us to your discussion. After answering any clarifying questions, we would like your feedback on the four elements of the HVIP we just presented as well as any other issues. We would also like to hear whether the Commission should move towards a recommendation this cycle to implement the HVIP.

Thank you and we look forward to the discussion.

DR. CROSSON: Thank you, Ledia.

I'd actually like to start out with a question myself on Slide 9. I'm not sure I understand how the numbers work here. So this is budget-neutral, I believe

you said.

MS. TABOR: Correct.

DR. CROSSON: So just using the 5 percent withhold for a second, the maximum additional payment is 4 percent. Is that in addition to receiving the withhold back?

MS. TABOR: This is after the withhold.

DR. CROSSON: So that's what "net" means.

MS. TABOR: So we've taken your 5 percent and then we'll give you back --

DR. CROSSON: Thank you. Thank you. I understand.

Clarifying questions? Brian.

DR. DeBUSK: On Chart 3, where you list the programs out, some of them are currently budget-neutral in that they don't result in a net additional payment or penalty. Some of them, like the HACRP, I believe, generate a net penalty, so it's basically savings to the program.

What's the total -- and this is my question: What's the total amount of savings that all four programs currently produce for the Medicare program?

MS. TABOR: So the VBP is budget-neutral, and the

IQRP is basically budget-neutral because nobody is really penalized by it. The HRRP and the HAC are both taken away, and it's about 0.93 percent of payment, is what we figured out.

DR. DeBUSK: How much of that a year -- is that $1 billion a year?

MS. TABOR: The 0.93 percent sticks in my head. I don't know what that would translate to.

DR. STENSLAND: Something around that range.

DR. DeBUSK: Okay. So in this new merged program -- and this is the second part of my question -- you're presuming this new merged program, it's going to generate $1 billion a year or so in net savings to Medicare as well?

DR. STENSLAND: Yeah, I think if you're going to operationalize it, you would probably have to make an adjustment to the base payment rates initially. So that the base payment rates go back down to get that equal amount of savings of $1 billion or so. And then, from then on, everything within the program could be budget-neutral.

DR. DeBUSK: Okay. Thank you. I needed -- there was $1 billion missing there. I was just trying to figure out where it was.

[Laughter.]

DR. CROSSON: That can happen. Dana?

DR. SAFRAN: It's a great chapter, and my questions are all related to the way you're planning to set the targets. So you didn't talk about that very much in this presentation, but one of the things I thought was really interesting in the chapter was this intention to have the targets set in absolute terms and to have a range of targets which, you know, good behavior of economic principles. But the thing I didn't fully glean is how you're setting those targets, and, specifically, are targets different across the ten SES-defined peer groups?

MS. TABOR: Yeah, so the way that we set the targets is we tried to replicate a beta-binomial distribution by, let's say -- I'll pick the mortality. So we ranked all hospitals according to their performance, and we said zero points on the HVIP is equal to the second percentile of hospitals, and the 98th percentile equals 10 points. So like you explained, everybody kind of has the ability to get some points.

And then that target range was set -- then, you know, kind of the 0 to 10 points we spaced out equally

based on performance of hospitals. And the targets are the same for every single peer group, so also holding to the Commission's principles, hospitals are held to the same standards regardless of who they are. It just may mean that within their peer groups they may get more dollars associated to the points that they earn. But the points are calculated the same.

DR. SAFRAN: Awesome. I love that. So then my follow-up question is a little bit tagging on with Brian's. Part of the beauty of absolute targets in the experience in the programs I've been responsible for in the commercial space is that you're not setting up a tournament, and you talk about that a little bit in the chapter. But because of the budget neutrality aspect here, it sort of reverts to being a tournament. Does this have to be budget-neutral?

MS. TABOR: That would be a question for the Commission.

DR. SAFRAN: Okay. Thank you.

DR. CROSSON: Paul, I saw your hand.

DR. PAUL GINSBURG: I was going to ask about the tournament model. You know, actually before the Commission wades into it, you know, maybe you could sketch out some

possible approaches that wouldn't be tournament, the wouldn't be budget-neutral. So in a sense, if hospitals did very well in response to the program, they would come away with some of the savings.

DR. STENSLAND: I think when we've talked about this before, we said you could set it up with -- if they meet the certain expectation, it would be budget-neutral. If they end up doing much better than expectation, it could be -- it won't be exactly budget-neutral, but it's not exactly clear whether the program would lose or win.

For example, if they did really well on readmissions, the program might actually win and they might win, because the program would win by having lower readmission costs; they would win by having greater rewards through the VBP. If they just did really great patient satisfaction, well, then maybe it might end up costing a little bit more because you would have a target, and they would exceed the target for that year, and so you would be paying out a little bit more than you expected to.

And then the question is: Do you move those targets, or are you just happy because the quality improved that you're willing to pay a little more?

DR. CROSSON: Brian, on this point.

DR. DeBUSK: To follow up on Paul's question and your comment, conceptually couldn't those targets have actuarial values associated with at least some of them? I mean, couldn't we find the $1 billion a different way just by setting prospective targets that have actuarial value to them? This is a question. I'm just --

DR. STENSLAND: And to me you could do it either way, and it's almost an optics question, because when we had talked about it with the readmission program, we had talked about, well, let's just set our prospective targets low enough so that if they meet those targets, the program is making its savings one way or the other, through lower readmissions or through penalties.

And you could do it this way, too, but then you would end up having a VBP program where there's more money put in than comes out -- or more money is expected to be put in than is expected to come out, to come up the 0.9 savings probably. So you could do it that way. Or you could take it out of the base and then have easier targets to hit. You could get to the same end dollar point either way. It's almost an optics thing to me, that people would

-- would they feel better about this VBP program if they knew an equal amount of money was coming in as is going out or expected to come or expected to come out?

DR. DeBUSK: But, I mean, I get what you're saying, but then in theory, if you did it the former and not the latter way, the equal amount of money could go out as long as they still hit their perspective targets. So as long as the targets were attainable, you could still have a budget-neutral program, and the $1 billion a year would come from achieving those targets. Am I missing something?

DR. STENSLAND: Oh, you mean if --

DR. DeBUSK: You still get your benefit. You get your benefit by hitting the prospective target. So the program still saves money, but it saves money by hitting the target.

DR. CROSSON: It saves money by the behavioral change.

DR. DeBUSK: Yes.

DR. STENSLAND: I think that works on the readmission side. I don't know if it works on the other sides. It works on the spending side and the readmission side, probably not on the mortality --

DR. DeBUSK: Or the patient experience.

DR. STENSLAND: Yeah.

DR. CROSSON: Okay. Pat, were you on this point?

MS. WANG: Yeah, because I'm wondering if you can help me understand a little bit more basically how this works. Within each tier the performance targets are identical. Is it budget-neutral within each tier?

MS. TABOR: Within each peer group --

MS. WANG: Excuse me, peer group. And so somebody who achieves, you know, a 10 percent readmission rate could be getting more or less than somebody who has the same rate in another peer group. Is that correct?

MS. TABOR: Correct.

MS. WANG: Okay. Going back to Jay's original question on Slide 9, can you just -- I'm not sure I actually did understand the answer. The 5 percent withhold, does the minus 3.5 percent bottom of the range mean that somebody could lose their withhold and an additional minus 3 or just 3.5 percent of the 5 percentage points?

MS. TABOR: It would be the negative -- they could lose 3.5 percent.

MS. WANG: Net.

MS. TABOR: Net, yeah.

MS. WANG: Okay. Thank you.

MS. TABOR: But then also gain 4 percent.

MS. WANG: And can you remind me, in the computation of the sort of total cost of care, is there any adjustment for SES or -- I guess that it must be case-mix neutralized or anything. Is there any carryover of the concept of the peer groupings into the calculation of total cost of care?

MS. TABOR: There is not, no.

MS. WANG: Okay.

MS. TABOR: For the MSPB. There is some in the patient experience, but it's patient reported, like education, for example, goes into the case-mix adjustment for --

MS. WANG: Okay. Should there be in calculating total cost of care? It's just a question, your opinion.

DR. STENSLAND: I don't think there needs to be because in the end that will be factored in with respect to the amount of money you get per point. So for every point you get for your cost of care, if you're treating lots of

dual-eligible people, you will get more money for each of those points if you're in that kind of poor hospital.

MS. WANG: Yeah, yeah, I got you.

And can I just ask one other question, separate subject, on hospital-acquired conditions? I read the concerns about data integrity and possible gaming and so forth and so on. We've talked about this before. I think this is a very important concept, hospital-acquired conditions. Before letting go of it quite so quickly, I want to ask you whether -- my understanding is that the current program, number one, is a penalty and, number two, is a national tournament model.

In your view, would some of the anecdotal reports of gaming the data be mitigated if you moved to absolute targets, no more tournament model? Because I have concerns about making a judgment about such an important program based on anecdotes that some hospitals may be gaming the data. I don't know what to do with that, and so I'm kind of searching for reasons that that might be happening or that might be being encouraged to happen that would disappear under the new structure of what you're proposing.

MS. TABOR: I will say that the HAC infection

rates are actually scored twice right now, so hospitals are kind of dinged or rewarded twice based on the performance. It's the HAC reduction program, which, as you described, is a national program that basically for the bottom 25th performers penalizes them. But the HAC measures are also scored in the budget-neutral VBP. So there's kind of dual financial incentives for hospitals now.

MS. WANG: Okay. And what about the tournament model aspect of it? Is that driving -- or do you think that that could be driving some of the behavior that people are disapproving of?

DR. STENSLAND: I think it might be driving some of the behavior, but even without the tournament model, because you're going to know what your prospective target is, and you'll know how many points you're going to get. It's kind of a continual range. You'll know how many points you get -- you lose for each additional infection. So if you had the HACs in there, there would be a dollar figure that you could attach to saying this person has a fever and he has a catheter; I can give them antibiotics or I can culture them and see if they need antibiotics. And if you culture them and then it comes back as a HAC, you

know how much you'll have to pay back to the Medicare program for doing that culture, if we added HACs in there.

DR. CROSSON: Okay. Pat?

MS. WANG: I'm okay.

DR. CROSSON: So I just want to be clear. Kathy, do you have another point separate from this? Do you want to get in on this? Okay, so why don't you get in on this conversation? Jon also wants to get in, and then we'll come back to you for your other point. You too, everybody.

MS. BUTO: Yeah, yeah, everybody wants to get in on this.

DR. CROSSON: Okay.

MS. BUTO: My question is whether, sort of picking up on the issue of HACs seemed very important, are there some things that -- or some ways that we can capture using claims data -- and we might have to talk about capturing other information that's not currently captured -- on some of the really critical HACs, surgical site -- I mean, I guess the four that are laid out seem very critical to me. Central line infections, bloodstream infections, urinary track, surgical site, MRSA, and CDI all seem very critical. And I'm wondering if there's some way to pick up

on infection rates through claims data that we're not -- that would help us to avoid the gaming issue or reduce the gaming problem. Have you looked at that?

DR. STENSLAND: I don't think it's possible, because if the game is let's don't test, then you have no record and there's nothing going to be in the claims. Or if the game is let's test asymptomatic people when they come into the ED, you know, you'll have all those additional present on admission HACs when they come in. I don't think there's anything that we could do in terms of scrubbing the data or looking at other things to --

MS. BUTO: Well, I'm just thinking, isn't there -- I mean, I don't know if this affects the DRG classification. In other words, if you have a spike or a larger percentage of comorbidities and complications in a given hospital related to certain surgeries, might that raise a red flag? I mean, are there some other things that are actually picking up the infection rather than the testing that one could look at. That's really what I'm trying to get at.

DR. STENSLAND: I think some other things -- to a degree, other things that might pick them up would be other

things we're measuring, like readmissions, mortality, overall costs. You know, if you end up getting an infection, you know, back in the hospital, or you get an infection and your risk of mortality increases, or you end up needing additional services because you had an infection, that would show up on your 30-day --

MS. BUTO: Well, I get that. I guess I'm hearing from you, no, there isn't anything else. It's either readmissions or mortality, and there are really no other ways to pick up claims-related information that would give us at least a red flag that something else is going on from an infection rate standpoint. It sounds like --

MS. TABOR: I can give an example of that. Around 2008 CMS did say that they were not going to pay for any changes to a DRG based on hospital-acquired infections that were not present on admission. And there have been studies done that show that after that policy was implemented, the code of present on admission was used significantly more. So the policy was kind of, like, ineffective basically because the coding patterns changed to identify present on admission infections.

MS. BUTO: Okay. I'm going to drop this, but it

just seems to me like surgical site infections is one that couldn't be present on admission, right? So, I mean, there are just some things that you think you could pick up in the claims data.

DR. CROSSON: Okay. To be honest, I'm losing a little sense of what the thread is here. We started out with, you know, the adjustment of the payment, and then we got into hospital-acquired infections. So maybe somebody can help me, but we've got Jon and then Jonathan, so let's do that and then come back to Kathy.

DR. PERLIN: Thanks, Jay. This is directly on the hospital-acquired infections, and thanks for your work on this. It's a tremendously important area. I share the concern that we continue this. Hospital-acquired infections affect 4.5 percent of all hospitalized patients. That translates to 2.1 million individuals annually. Eighty thousand die annually. That's more than the aggregate toll of breast cancer, car accidents, and HIV combined. And the estimates of cost are about $20 to $50 billion, and there's been a great deal of progress in this area. So just that by way of some context.

I think the points you've made about the

potential for irrational incentives that would lead to culturing of asymptomatic individuals, et cetera, is driven by an unknown endpoint. You mentioned that there are two different measurements. The first is done by CDC through NHSN, which actually created a standardized infection ratio. The second is the tournament that's superimposed by CMS in terms of the HAC. And that's where we get into trouble. Using something aside from that, just to show a way in which we get to a better endpoint, for 39-week delivery it's absolutely appropriate not to have an elective delivery unless mom or baby are in distress. There is no one that can know 100 percent which patients will be in distress and which not. So setting a 100 percent goal is irrational there.

Here I think we have an analogous situation where you could actually go with the standardized infection ratio, understanding that it needs to be recalibrated periodically, but know what the endpoint is, and set it at such a level that it both inspires the continued progress but doesn't lead to this unknown endpoint that drives the perverse behaviors.

So I think you have the thread of something

there, and compared to making a condition of participation with all of the irrelevant things that factor in there and the importance of this inherently as something that's made 20 percent progress over the last decade and still has a ways to go, I think you have a solution within that.

Thanks.

DR. CROSSON: Jonathan.

DR. JAFFERY: I think Kathy got close enough to my question that I'll wait until Round 2.

DR. CROSSON: Okay. Further clarifying questions? Kathy, back to you.

MS. BUTO: And this can wait for Round 2, also, but it's really just a question for Round 1, which is: What do we think the impact has been on hospital quality and value from this program? Has there been a good analysis? I understand where we are on readmissions because the Commission has spent time on that. But, overall, given the complexity and additional complexity that we might be actually proposing, do you think it's working?

MS. TABOR: We do, and I will say our conversations with hospitals this summer, too, I think we

heard from the hospital quality leadership that they know that this has driven change, and they see that this HVIP is kind of Hospital Quality 2.0. And they see even kind of further places we need to get, but they agree that quality has improved and it's working and it's driving their work, and now it's time to kind of keep thinking about outcomes.

DR. CROSSON: Jaewon.

DR. RYU: Yeah, I just wanted to get back to the numbers and make sure I'm understanding it right. Figure 3, and this slide, I'm not sure the figure is on the slide deck.

MS. TABOR: Okay.

DR. RYU: But the slide you had up there, even with the 5 percent withhold, the upward and lower bounds of the range are less than what they would be under the current program. Is that right?

MS. TABOR: Correct.

DR. RYU: Okay. And then the other question I had was publicly reported quality data, Hospital Compare, is there any evidence that that's shifting or influenced consumer behavior in terms of who they're selecting to go to?

MS. TABOR: Not as much for consumer behavior, but, again, we've heard so much from hospitals that the public reporting really drives their work. But I've heard kind of mixed -- you know, people who look at the hospital quality data, if they know to go look, or have even the availability to go look, you know, because if it's not an emergency, they find it helpful. But, again, the number of people who do are pretty small.

DR. RYU: Yeah, I think the -- I've seen at least the evidence that it's changed and improved performance. I think I'm just curious if that's changed and gotten into the mind of the consumer at all.

MS. TABOR: I think it's pretty small numbers who use it, but those who do find it helpful.

DR. RYU: Okay.

DR. CROSSON: Okay. Marge?

MS. MARJORIE GINSBURG: Yes, looking at Figure 1, or Figure 2 or Figure 3, I just need some clarity about the peer grouping. So the way I read this chart, Peer Group 10, which is made up of the highest share of fully dually eligibles, scores lower than ones that are not so -- whose population is different. So, first of all, are these bars

an average of all the people in that particular peer group together? So any particular hospital that has high duals may, in fact, score much higher but all together this represents the composite of all those in this group?

MS. TABOR: Correct.

MS. MARJORIE GINSBURG: Okay. So all these charts would suggest that those with many duals always score lower than -- their composite scores are lower than those with --

MS. TABOR: Under the current system.

MS. MARJORIE GINSBURG: Under the current system. But isn't this also true under your proposed system?

MS. TABOR: No, because of the peer groups, there will be winners and losers within that peer group. So within all the hospitals that are serving a high proportion of fully dual eligibles. They have one pool of dollars, and those dollars are only doled out to those hospitals.

MS. MARJORIE GINSBURG: Okay.

MS. TABOR: Yeah.

MS. MARJORIE GINSBURG: Okay, so they're not being disadvantaged per se by the fact that they have a large portion of dual eligibles?

MS. TABOR: Correct.

MS. MARJORIE GINSBURG: Okay. Thank you.

DR. CROSSON: Good. Good questions.

We'll move now to Round 2. I'd point out let's go back to Slide 17. Staff is looking for feedback, as you see here, as well as additional issues people would like to bring up. And, Dana, you're going to start us off.

DR. SAFRAN: Thanks, Jay. I really want to commend you on this tremendous work. I'm so excited about this advance. I like that you're calling it "Hospital Quality 2.0." You know. I think it does all the things with quality measurement in a Medicare program that we started talking about yesterday, that you know, it gets to parsimony. It gets to sort of the "big dot" measures, meaning outcomes that matter to beneficiaries, but also that don't leave providers feeling micro-managed because they can manage to the "big dot" however they want to. We're not telling them process-wise how to get there. It simplifies, you know, the slew of programs that are out there right now. I love that you're, you know, using the beta-binomial and getting to absolute targets and that you've got a range of targets, so you're using good

behavioral economics. So there's just so much about what you've done here that I think is really tremendous. I'm very excited.

So I have two comments that I'll make, or concerns about specifications, and then I'll go to your four things that you want feedback on. The first is -- and this came up in discussion -- I really feel that your total cost-to-care measure needs to be risk-adjusted. What I heard you responding is almost to say that you think that peer grouping by SES takes care of risk adjustment on total cost of care, and I just think total cost of care should have its own risk adjustment methodology. So I would urge you to look at that.

On the way that the targets are being set and the tiering by SES group, I'm really pleased by what you show in the chapter around the improved equity that's achieved over what's currently happening for hospitals serving lower SES. But I am concerned that you still have within each tier a tournament model, and I am also concerned that that means that actually good performance in Tier 10 is not the same thing as good performance in Tier 1. So, in effect, we are setting different standards for lower SES

beneficiaries from higher ones.

So while I think it's an improvement over where you've been, I would wonder if we can do better. And one of the ideas that I would encourage you to think about is rather than doing the tiering, or maybe it's an addition to doing the tiering, can we instead have a multiplier that's given for good -- for the same level of good, great, outstanding performance, can you get a multiplier on your bonus or on your reward if you're serving a lower SES population? So in other words, really holding everybody to the same standards, but the rewards are bigger if you're doing it on a population that maybe it takes more or different resources to accomplish those results.

So I -- you look like you have a question about that.

DR. STENSLAND: I don't -- I just don't understand how that's different from what we're doing in that now the way this was done is for every -- everybody gets the same points for the same performance. Then if you're in the low SES group, one point might equal $1.2 rather than $1. So it's like there's a multiplier on the dollars is the way it's working now, and I'm not sure what

the difference is.

DR. SAFRAN: Okay. Well, maybe we should take it offline.

DR. STENSLAND: Okay.

DR. SAFRAN: And I could be misunderstanding, and maybe you're doing exactly what I'm talking about, but I -- my reading of this is that we still have a tournament, and now it's sort of low SES hospitals competing against each other and potentially being rewarded differently for the same level of good performance than, you know, Tier 1 hospitals. And that doesn't feel like it holds true to the principle that you're trying to put forward of having absolute targets and having everyone rewarded the same for the same level of performance.

So if I'm misunderstanding that, I'd be happy -- you know, I don't want to bog us down here, but I'd be happy to spend some time with you offline to understand it better.

DR. STENSLAND: [Off microphone] Sounds good.

DR. SAFRAN: Okay. So those are my comments outside of your four questions.

On your four questions, I don't know if I have

them in the right order here, but on the HACs I would say we've really got to include them. Yeah, I thought Jon was -- his points were tremendous and compelling. The additional things I was going to say about them are that, you know, I think it's interesting that hospitals have said to you, you know, we'll work on them just as hard as long as you keep publically reporting them.

So that kind of then says whatever I'll call it "bad behaviors" are happening, to do well on this in order to look good on public reporting, seems to me they would be the same behaviors. Some of them don't even seem necessarily like they're bad behaviors. You know. If somebody on admission appears to you to have an infection, it does seem like good clinical practice -- I'll leave it to others who are clinicians in the room to weigh in on this -- to actually test and confirm that so that you know what you're dealing with and document it that the patient on admission has an infection.

So ... but regardless of whether it's inspiring various behaviors, the truth of the matter is we know that any one of these measures -- readmissions have their -- you know, 30-day readmissions have their own behaviors that go

along with them of, you know, using observation and waiting until the 31st day and, you know, all kinds of things.

So we can't skirt those things. We can put in place methods that let us audit for them and look for those extreme bad behaviors, but I don't think concern about the I'll call them "unintended consequences" are severe enough that we should have this program move forward without a measure of hospital-acquired complications. And the Standardized Infection Ratio may be a better way to go, but I think we have to have something in there as a fifth "big dot."

The HCAHPS ... I did see what hospitals said about it, but I still would say that having clinically meaningful, actionable measures as part of this program and rolling them up to a composite is really important. Otherwise, if it's a global rating of the hospital by the patient, I think this will never get away from the label of "It's just patient satisfaction. It's not patient experience."

And I also think that hospitals might find all kinds of ways to do well on that global measure that don't have to do with good clinical care. So I really urge you

to use those composites. If you want to include the global rating along with the composites, that doesn't seem like a bad idea, and you could down-weight that within the composite. But I really would urge for the composites to be what this program uses.

On the weighting, I'd say my view would be we don't have a good empirical reason to say any one of these is more important than the other. So I'd have them unweighted and leave it to the public comment process to change that if it's going to change it.

And then on the withhold amount, I liked your idea about a larger amount phased in over time but starting with the 2 percent that hospitals are used to right now for these programs.

So, those are my thoughts.

DR. CROSSON: Thank you, Dana. Very comprehensive.

Let's have additional comments. Start down here with Brian.

DR. DeBUSK: First of all, thank you for a great chapter, and I do think this is very important work. So to answer the last question on Chart 17 first, absolutely, I

think this is very important work for the Commission, and I hope we pursue it.

What I wanted to focus on was the financial withhold and go back to the prospective targets and the penalties. I do think 2 percent and walking that up to 5 percent over a multi-year period seems appropriate, but I also hope that we take a look at this billion dollars. You know, again, the programs right now generate -- whether you want to call them "penalties" or "revenue," I mean, they generate a billion-dollar benefit.

I would love to see us assign actuarial targets to the prospective -- well, prospective targets, I'd like us to assign actuarial values to that and build that get that billion dollars back that way because I think it does increase the appeal of the program, to say, you know: This is no longer a net revenue generator. No one is going to take a penalty. No one takes a billion-dollar haircut up front. That's the good news.

The bad news is we're now going to hold you accountable for some continuous improvement that we're going to assign value to, and furthermore, we're going to walk that penalty from 2 percent to 5 percent over a multi-

year period.

So the reason I bring them together is I think it all comes together: the prospective targets, the actuarial value, the billion dollars and the walking-up of the fees. So, again, I hope we treat all that as one issue.

The second thing is I want to go back to peer grouping. I am a huge proponent of peer grouping, and I think it solves so many issues. And I hope that we as a commission can spend some time to really walk, not just ourselves, but the public, through what the potential that peer grouping has, not just within this specific program, but you know, for example, in the Voluntary Value Program that we worked at as an alternative to MIPS.

I mean, there's -- I think there are other, that some of the quality program, say in nursing homes, and I think you have something there. While full dual-eligibles isn't a perfect proxy for socioeconomic status, it's probably the only robust measure that's readily available today, and that doesn't preclude us from finding more robust measures and incorporating them in, but that would just allow us to improve the peer grouping methodology. But I hope that we as a commission spend some time

educating the public on just what this technique means and how it can address socio-demographic status.

The other thing and my final plug on peer grouping ... I think the other thing that I get really excited about is as we start looking at social determinants of health and start looking at things out -- you know, trying to capture some of these more difficult-to-measure things, at least having those 10 deciles, those 10 peer groups opens the door. It lets us tailor policies by decile.

So when you look at something -- and we talked about this last year. When you look at the Hospital Readmission Reduction Program, being a poor performer and having virtually no low -- no duals, there's no excuse for that. I mean, those people need penalties; they need steep penalties. But if you're in that bottom decile with the highest share of fully dual-eligibles, I'm not even sure those people need penalties.

I mean, I think the policies almost need to be tailored by decile, and I think peer grouping opens the door to that. So I think it's more than just a novel calculation that allows us to deal with some of these

socio-economic status issues. I think it also opens the door to some -- to tailoring policies around which decile we want to engage.

DR. CROSSON: Thank you.

Jonathan.

DR. JAFFERY: Yeah, so just walking through the points, I think I would support and urge you to try and lean on the side of simplicity. And so for that, I would keep --in keeping with that, I think equal weighting makes sense, and I think it will be simpler for hospital quality departments to manage and think about.

And similarly, with patient experience -- and this goes maybe a little bit away from what some folks have said, but I think because of that the composite score would be something that could be considered because it would adhere to that simplicity idea, particularly if it doesn't, as you pointed out, change the outcomes in a very significant way.

I'm also very supportive of going to 5 percent with the transition.

And then just to finally weigh in on the HACs, I, like others, strongly would support maintaining those. You

heard from hospital quality leaders that it really has helped them draw change, has helped them get attention from senior management. I would say that it also very much gets the attention of hospital boards. I mean, nothing really says attention to them like we're going to get a big penalty for things that could hurt patients. So I would urge that that stays in because of that.

DR. STENSLAND: Just a clarification, you said go with patient experience, go with the composite. Do you mean have just the one overall measure, or do you mean have several different measures and create a composite of them?

DR. JAFFERY: Oh, so I think because if they're going to -- if the outcome ends up being the same or very similar, I think the simplicity of having a single measure is helpful.

DR. STENSLAND: Thank you.

DR. MATHEWS: Jonathan, sorry, if I can just get a further clarification there, a single measure could be the single overall patient experience-of-care measure, or it could be a single measure that is a composite of more granular ones. And I don't mean to press you, but --

DR. JAFFERY: Right. No, I was leaning towards

the former.

DR. MATHEWS: Okay. Got it, got it. Thanks.

DR. CROSSON: Pat.

MS. WANG: I echo all of the praise for the work, and it's -- I think it's a huge step forward, what you've done.

To get to some of the specific questions, I appreciate Dana's comment on risk adjusting cost of care because I -- it feels like, Jeff, your response is if it's already accounted for in, you know, evaluation of your performance on the other measures, then why bother by the peer grouping? Why bother have a separate category? It feels like a little bit more of a look at if we're going to have it as a separate component, shouldn't we have some kind of evaluation of relative cost based on the characteristics of the patient?

DR. STENSLAND: Yeah, it is going to be adjusted for the characteristics of the patient and what condition they're in, in the hospital. It's just not adjusted right now for their socio-economic status.

MS. WANG: Okay, okay.

DR. STENSLAND: So that is what comes later in

the peer grouping. So why don't I say -- I don't want to say that there's no risk adjustment. It's not like we're thinking --

MS. WANG: Yeah.

DR. STENSLAND: -- your AMI person is going to have the same cost as your pneumonia patient. So there is, you know, that clinical risk adjustment added.

MS. WANG: Okay. And then you're kind of doing a bell-shaped curve within each peer group of that cost, comparing them to each other? Is that the idea?

MS. TABOR: It doesn't always work out to be a bell-shaped curve, but it is a distribution --

MS. WANG: Yeah.

MS. TABOR: -- from that 2nd to 98th percentile.

MS. WANG: Okay. I'd ask you to look at it anyway because, you know, share -- DSH share doesn't mean the same thing everywhere, and there's Medicaid, and then there's a different kind of Medicaid, and it may be that additional sensitivity around the cost measures is appropriate.

MS. TABOR: And we can get back to you on more information on what the risk adjustment currently is.

MS. WANG: Thank you. On the weighting of the measure domains, I'm -- I tend to think that the clinical measures should be more heavily weighted. I'm not as -- I know what everybody says, but I don't feel like the CAHPS measures have as much importance in weighting scheme as the actual outcomes measures. And it's mainly because I guess that I don't understand or I'm not convinced that they have such statistical validity to actually nail patient experience of care. I think they're very important, and I think they're very important for the hospitals to know about, but I would lean in favor of weighting the clinical measures more heavily. If CMS is going to wind up doing this through a comment period, I would at least say that the CAHPS measure not be weighted heavier than the clinical measures.

I'm also in favor of moving towards a bigger financial withhold, I think, you know, and phasing it in over time is a good idea.

On the patient experience measures, I have to say I have listened to the different comments. I don't really feel like I understand enough about how those work to give you a solid opinion on it.

On HACs, I'm with everybody else. I think they should be in because -- the thing I would ask you, though, to consider for the next round, frankly, is whether HACs should be in a peer group because, to me, one of the reasons to include HACs is the importance.

But it's also, to me -- and I defer to my hospital colleagues here to say whether this is true or not. It feels like a HAC is totally in the control of a hospital when it really doesn't matter what characteristics or socio-economic status your patient is coming in with. They shouldn't have a Hospital-Acquired Condition in the hospital, period. That's my feeling. So I'm throwing that out there, whether you really need to do any kind of peer grouping that adjusts for.

The only thing that that might recognize, if you peer-group it, is that high DSH hospitals have fewer resources, and you may be recognizing that they have fewer resources to deal with HACs, but I'm not sure that that's the purpose of this program. So if HAC is not included in a peer group, it would almost be like its own. It would be a national, not tournament model, but specific thresholds, almost like a threshold, separate category of the program

that I would recommend to consider.

DR. CROSSON: Pat, let me just ask you one question. So I think, if I heard properly, you were suggesting in terms of the weighting that maybe the patient experience weighting might be a little bit lower in favor of higher weighting for clinically relevant measures. But if in fact, with respect to what measures are used for the patient experience, and in fact what's being called the composite of, for example, four clinically relevant measures was the patient experience measure, as opposed to the general measure, would that change your viewpoint about weighting?

MS. WANG: No.

DR. CROSSON: Okay.

MS. WANG: No.

DR. CROSSON: All right. Thanks.

Jon.

DR. PERLIN: Thanks. Let me add to the chorus of just congratulations for absolutely brilliant work. I know we've been trying to find ways to get at this issue of social determinants and socio-economic status, and I think peer grouping is a very clever way to do that because while

there may, in theory, be ways to adjust outside of that, the fact is the data that are necessary are not consistently available. So, really well done.

Let me just go down a few of the items here. I think the step-up of weighting, I'm sorry, the step-up of the withholds is a good way to approach.

The weighting and measure debates, I want to link to my comment about the HCAHPS.

Let me ask you a question. Did you get good feedback from your commissioner? Singular. You wouldn't know how to interpret that. Patient in a hospital, and they receive the HCAHPS survey, I think is subject to a survey that is terrific but dated. The question is all about team care. And if you ask, how did you -- how was communication with your doctor, you know, was it the cardiologist? The nephrologist? The intensivist? The hospitalist? The nocturnist? I mean, who was it? I'm not sure I could answer that question, and having helped elderly parents through it, I think that needs to be updated.

And so my concern is actually less to do with whether we use a composite of some of the internal metrics

or the overall -- they co-vary so tightly anyway, and if you do both, they co-vary even more -- but that we encourage updating the questions to team-based care, so it's easier to answer the questions within that.

For that reason, I would actually discount that a little bit as I would the value which -- you know, the cost per beneficiary, medical spending per beneficiary, in deference to the clinical measures which, to Brian's point, really drive the actuarial value in terms of better performance.

Let me just -- obviously, I believe strongly in monitoring the HACs. A comment to your comment on this is that you can get a hospital with zero falls. Of course, you'd never ambulate the patients. So you want the patients ambulated, so there will be some level that is likely, unfortunately unavoidable but realistic.

The reason the Standardized Infection Ratio is so terrific is that we don't know which infections aren't avoidable, but we do know what the excess rate of infections are that are avoidable. And that Standardized Infection Ratio discriminates between what seems to be the observed level of infection per risk-adjusted population

versus excess infections over that. So that's why it seems as a good target to actually calibrate.

I wish we knew that we could avoid all infections, but then patients who actually haven't had interventions wouldn't get things like sepsis that -- you know, it feels like spontaneous combustion. You just can't predict when those occur. So I think that gives us a way to manage that. You know, as -- the great thing about Standardized Infection Ratio is as the overall performance improves, it gets recalibrated, and you work toward, you know, what is some ultimate level of perfection. So strongly in favor of keeping that in.

And to the other point, has there been progress, I think the most telling is that there's been 20 percent improvement in Hospital-Acquired Infections and, particularly, deaths from Hospital-Acquired Infections over the last decade and substantially correlates with these programs, which is why I support what's up there. Thanks.

DR. CROSSON: Thank you.

Paul?

DR. PAUL GINSBURG: Sure. Terrific report, like everyone else has said.

On the issue of weighting, I feel strongly that we should weight -- not equally, because to weight equally is throwing your hands up saying, you know, we have some measures, we don't know what's important.

I think we do know what's important, and I believe, like Pat, that we should -- and Jon, I think -- that we should give more emphasis to the clinical outcomes measures and less emphasis to the patient experience.

I've always viewed patient experience as a place holder that we use because we don't have anything decent in the clinical area. And once we do have decent things in the clinical area, then I think we ought to shift toward that.

I also don't think we should downgrade spending because spending is a huge issue in Medicare and in health care in general, and to pretend that we only care about quality, we don't care about spending, that's absurd. So I think that spending, which is very meaningful in this case because it's spending outside of the hospital in conjunction with these hospital stays. So I would keep that, maybe even raise the weighting for spending, maybe taking some of the patient experiences.

I agree with raising the overall amount of the withhold. I like the proposal of the transition from 2 to 5 percent. And as far as which patient experience measures to use, just based on the feedback that Ledia and Jeff reported about the greater confidence with the overall indicator, I'd go with that.

One other comment which maybe we ought to set up for the future is that when I came into this Commission, I heard the disdain for tournament models, and now I'm hearing not only disdain but kind of critiques of something, "Oh, that's a tournament model." And I've never been fully convinced that tournament models are a bad thing. To me, tournament models have their place when policymakers are very limited in their knowledge as far as, you know, how much can we improve infection rates? We don't know. Let's set up a tournament model and let's see what happens, and maybe later on we could replace the tournament model with a concrete goal as to what infection rates should be.

So in a sense, a lot of this is for a future time, but I'm not dead set against tournament models. I think they do have their place, and I think each time we

need to raise the question: Is this a situation where we need a tournament model because we really don't know what we're doing, and in which case do we have a good enough sense of how much we can accomplish that we don't need to use tournament models anymore?

DR. CROSSON: Thank you, Paul. Dana, did you -- no? I thought I saw your hand.

DR. SAFRAN: I'll wait. I do have something to say about patient experience, but I'll wait for [off microphone].

DR. CROSSON: You want the last word. Is that what you're saying?

[Laughter.]

DR. SAFRAN: [Off microphone.]

DR. CROSSON: Kathy.

MS. BUTO: So I want to also join the chorus of compliments for this chapter. I think it really opened up a good conversation among us that is relevant both to this issue, but I think generally to our discussion of value-based purchasing and these kinds of models.

I would agree with what Paul just said. I've been feeling that. In addition to the clinical measures,

the payment should be weighted as heavily and, again, patient experience, for all the reasons that people have already said, weighted lower.

The withhold, I would agree that it would be desirable to go to a higher weight. I don't really understand whether we think that's going to make a big difference. It sounds like the right thing to do, but it would be, I think, good to know in all your feedback with hospitals whether they thought that was make a difference in performance, having a larger withhold. But I support it. It just sounds like a sensible thing to do to sort of up the ante for performance.

I very strongly feel that we should leave in hospital-acquired conditions in some way, whether it's the way Jonathan described or other.

I will say this, that I think using the hospital conditions of participation will not work. I've worked a lot with the hospital conditions of participation. They are -- "blunt" is not even the right word. They are such an ineffective mechanism for moving behavior because they're so large and they encompass everything from safety and fire safety to the number of -- you know, staffing

issues and so on and so forth, that something like hospital-acquired conditions will get totally lost. You'd never pull the trigger and pull a certification because of failure to either report or perform on this one measure. So I don't even think it's relevant to have it in there, but other people may feel differently.

And I would definitely want to see us continue the work and move this recommendation forward as we refine it, because I think this work is work that no one else is doing. And I particularly like the peer grouping with -- I need to better understand the issue that Dana raised about tournament model within the peer group, but it just seems like the right way to go about making more equitable the reward system. So thank you.

DR. CROSSON: Thank you. David.

DR. GRABOWSKI: Yeah, a lot of good comments already around the table. I don't want to repeat them other than to say I'm really excited about this work.

I very much think we should phase in the financial withhold. I think that's a great idea, and once again, I won't repeat other comments.

The other issue I wanted to stress, I really

believe the hospital-acquired conditions, the HACs, need to be in there, and so I think that's a really important point.

Finally, to Pat's point, I do like -- sorry, Kathy's point. I do like the peer groupings as well. I think that's a really nice point. So thanks.

DR. CROSSON: Thank you. Karen?

DR. DeSALVO: Thanks. I really agree with everything very excellent, agree about the withhold plan, agree about keeping in the hospital-acquired infections.

I'm over here arguing with myself about the patient experience measure. I did a lot of work in my research on single auto-measure of self-rated health, which is, you know, a great way to get somebody's assessment of all their domains. But the nuances that I think you get that improve the experience of care and engagement is probably worth doing a composite measure. So I'd lean there.

And, oh, I would equally weight -- probably less thought through than everyone else, but more for simplicity and to not drive too much behavior on the part of hospitals in one direction to keep them focused on the balance

scorecard.

DR. CROSSON: Karen, just let me clarify one thing in what you said, because there's been a little bit of potential confusion here in terminology. So the general patient experience measure, if that's the right word, is one thing. The terminology here -- correct me if I'm wrong -- the composite measure is a subset, right, of selected -- you said you were in favor of that. Is that what you meant?

DR. DeSALVO: I'm still arguing with myself, but I think where this would do is there would be those little -- you know, those happy face colored bars that people would press. That's probably the direction that systems would take for a single response measure, so we'd have more data, and maybe even more data points. But, on the other hand, it's difficult to know what they're responding to.

DR. CROSSON: Right.

DR. DeSALVO: So I agree, you know, that we need to improve the instrument itself. But, on the other hand, I wouldn't want the perfect to be the enemy of the good. I think being able to have some sense of understanding the experience of care is -- we know it's valid because we know

that people's engagement in their care and their sense of empowerment and their sense of understanding of their care plan actually does influence their pathway to healing and whether or not they are readmitted. So I wouldn't want to throw the whole -- the detail of the questionnaire out just because we think it needs improvement. So when I say composite, I mean from the CAHPS, but actually rolling it up into a single measure.

DR. CROSSON: Okay. Thank you. Bruce?

DR. DeBUSK: Well, my compliments, Ledia and Jeff. A couple of things.

I heard from others, I think, in seeing no need for a phase-in to 5 percent. It's not like quality measures are some new discovery. This has been going on for decades. So I'm at a loss to see what an organization has to gear up in order to meet a higher target. All of that infrastructure should be there now and should be being used. So I see absolutely no reason to suggest a phase-in to the higher 5 percent.

I like Brian's idea of using the peer grouping to tailoring policies. I'm not sure how quite to do that in the construct and also the actuarial value of different

point levels.

I think I would ask for some thinking about how we define best practice here. We've got distributions, and I may have lost this, but we've got distributions by hospital of various measures and can actually perhaps define a tenth percentile or a fifth percentile in some way to say this is the best observed practice, and hopefully, you know, some stability in that over time would be useful in terms of understanding where we're going, to Jonathan's point, that maybe best practices is maybe not zero, but we can look at that.

In terms of the clinical measures and the spending measures, I think up-weighting those, the patient satisfaction, if you will, I think simplicity there with a single measure and not a composite, which is down-weighted, would be my preference.

Thank you.

DR. CROSSON: Thank you, Bruce. Marge.

MS. MARJORIE GINSBURG: Let me join the crowd in congratulating you on the fabulous report that you've put together. It's a great starting point for us.

A couple things. I agree with those who believe

we should increase the amount from 2 percent to 5 percent over time. The one thing I particularly wanted to note, which may be contrary to what others are talking about, is the importance of capturing the patient experience, even it's fluffy, if you will, it's qualitative, it's not highly measurable. But I think it's really important and has significance of its own; even if it doesn't go by the same standards of the other elements that are being measured, it has importance.

I'm sorry I didn't bring with me -- we actually did a project very similar to this with the public in California. It was funded by the California Health Care Foundation, and we were heavily into looking at hospital quality, and it was their idea to do a deliberative process asking the public to come together in discussion groups, looking at four domains, and these were the four domains: actually, it was clinical care, safety, patient experience, and cost. And I will dredge it up somewhere and mail it to you if that would be of interest.

A couple particular findings. They gave their initial impressions before they actually did case reviews. They actually looked at particular patient experiences

throughout all this, and they pooh-poohed safety until they got into the scenarios, and safety ended up being up there with clinical expertise as the top two. And even though the patient experience was number three, people talked about it with great passion, with great significance about their ability to trust in their doctor, to communicate well with the nurses, their feeling like they're in good hands. All this is very subjective, but really important to people.

The cost element was hardly on the chart. Even acting as citizens, they didn't care greatly about cost. So it's up to all of us to make that decision whether it should live to breathe.

But that's mainly it. It is my feeling that the patient experience is important, and I would try to not do a composite measure but to try to tease it out with two or three particular elements of what does it mean to have a positive patient experience. And it may be whether our report's helpful or others that have measured patient experience and how you ask that question in a way that gets you the most honest answer would be good.

Thank you.

DR. CROSSON: Again, I'll make the same point I made. So, Marge, you actually were saying that you would support what the staff is calling a "composite measure," which is a subset of measures -- not the -- I don't know what the right term is, but the general patient experience measure, just to be clear.

MS. MARJORIE GINSBURG: Yes [off microphone].

DR. CROSSON: Jaewon?

DR. RYU: Yeah, nothing really further to add other than on the issue of the withhold. It feels like stepping up to the 5 percent still leads to a net-net impact that would be less than the current program. So given that, I would advocate for just stepping up to the 5 percent. And if I'm understanding it right -- and you all let me know here, but is that just an issue of cash flow, timing, and mechanics as far as, you know, you're withholding more up front, but the net-net impact to hospitals actually decreases with the change. Is that a right to interpret this?

MS. TABOR: Yes [off microphone].

DR. CROSSON: Wait. Can we elaborate that? Because now I'm not sure I understand.

DR. RYU: Yeah, because I thought earlier -- you know, this is the Figure 3. Even in a 5 percent withhold environment, the net-net adjustment range would decrease versus current state. Is that right?

DR. STENSLAND: Yes, the max and the min would still be shrunk. Where you would end up on that distribution may differ.

DR. RYU: Okay.

DR. STENSLAND: Because you think of -- you know, you could have a 3 percent reduction on the readmissions alone, a 1 percent on the HAC, and you're already up to 4 just on those two things before the BBP kicks in, and we would have a --

DR. CROSSON: Okay. I think I'm dumb here, but is that because -- in what's depicted on Slide 9, that the t percent withhold is given back? I mean, the numbers here -- I know I'm missing something, but the numbers here show a broader range for the 5 percent withhold, and yet you're saying -- Jaewon, help me here.

DR. RYU: That's my confusion. And that's why it looks like -- and I think this is an important point. You know, if you dial up the withhold but the net-net impact of

the adjustment range still goes down, I would argue -- right? I mean, I'm probably missing something here, but --

DR. CROSSON: Yeah, maybe --

DR. PERLIN: Compared to the current, you're saying this is generally not only within the range, but may even be less than the range. I would agree with that. I think you raise a really important point in terms of the timing of when the withhold occurs compared to when the revenue is received, particularly given the negative operating margins of two-thirds of hospitals roughly.

That said, I think there's one other variable that we need to put on the table, which is that, to quote my favorite philosopher, Yogi Berra, in theory, theory and practice are the same, and in practice they're not.

[Laughter.]

DR. PERLIN: Whenever we introduce a new measure -- and I'll take like the electronic health record. It was wait times in the emergency department where you subtract the time of admission from the time of -- to the floor from the time of discharge from the ER, it was always positive because people figured out some went direct to the OR. You know, you had a negative time, and you just didn't count

it. Once it was electronic, you know, it was highly problematic because you got nonsensical variables.

We don't know how the different parts will operate relative to each other, and so my reason for the phase-in is not the magnitude of the dollar, but just to have some experience with how this will operate in the real world, whether there will be, you know, differences between the different components. So I just wanted to throw that out.

DR. RYU: Yeah, I think that's right. I think unpacking this, though, would be helpful because, to me, I start thinking of this as is this just a cash flow and timing issue for hospitals, and, you know, the day's cash on hand and they're making money off the float. Whatever that is, we just need to understand it. But the net-net impact, I get a little concerned when we're actually dialing it down. So I don't know how that comes out in the wash, but it would be good to tease that apart a little more.

DR. CROSSON: Okay, so when we come back -- we're going to come back. When we come back on this point, Ledia and Jeff, we probably need to, as Jaewon just said, tease

this out with some examples of the current situation, the impact, the range, and so we're clear what we're recommending here.

DR. PERLIN: I'm sorry. If a decision were to be made to actually go at the higher level, which I think would be challenging potentially if we hadn't modeled it, at least model it using retrospective data as an alternative to stepping it up, because I think you want to know how it behaves when actually applied.

DR. CROSSON: Yeah, right, I would agree with that.

Bruce, on this?

MR. PYENSON: Yeah, just on the cash flow issue. I think margin and cash flow are important, but credit rating is perhaps the thing to look at, a thing to look at in cash flow. And, as I think our analyses have shown, credit rating is not a problem for hospitals. So, just another consideration there on the issue of the withhold.

DR. CROSSON: I'm sorry, Bruce. So you're saying the withhold itself, the size of the withhold would be something to be considered by the bond rating agencies? Is that what you're saying?

MR. PYENSON: Well, if you can borrow cash, if you have a good credit rating, you can borrow cash short-term for -- to deal with cash flow.

DR. CROSSON: Fulfilling a cash flow issue.

MR. PYENSON: Yeah.

DR. CROSSON: Is that what you're saying?

MR. PYENSON: Yeah.

DR. CROSSON: Okay. All right. So this is somewhat more complex than it appears on the face of it. So when we come back to this, I think we'll need to, as several have said, play this out a little bit more. So we hear -- I heard almost complete support for moving in this direction, but I think we need to be -- yes?

UNIDENTIFIED SPEAKER: May I have one question on round one?

DR. CROSSON: Well, you want to go back? You want to go back to round one? Let me -- can we -- let me finish with Sue, who has been patiently waiting for her turn, and then we'll come back to final comments. How's that?

MS. THOMPSON: Then we'll go to round three, yeah.

DR. CROSSON: Right.

MS. THOMPSON: I just wanted to say "thank you" on behalf of hospital quality departments across the country in terms of working to not only make it more simple, but I think create more focus and not be caught up in trying to keep everything straight.

So I don't have anything to add other than if we're going to come back to this chapter I think there's enough confusion also around the patient experience composite versus taking selective questions, that that bears a little more illumination. So that would be something I would add to our next round of discussion, but thank you both for your good work.

DR. CROSSON: Okay. Thank you, Sue.

So we've heard good comments here. Again, Ledia and Jeff, your backpacks are now heavier than they were before. It's a good thing in many cases.

So we do have some final comments. We're going to take a trip back to round one with Bruce, and then Dana is going to have the last word.

DR. SAFRAN: Whatever. Whatever you want.

DR. CROSSON: Is that not what you want?

DR. SAFRAN: Yeah. It doesn't have to be the last word. I just want to comment --

DR. CROSSON: Oh.

DR. SAFRAN: -- on the patient experience.

DR. CROSSON: Okay. All right, all right. So then Bruce and then Dana, and we'll see where we are.

MR. PYENSON: I thought, Ledia and Jeff, you presented some very interesting information on the hospital-acquired infection issues, and I just thought there is -- that's such an important issue. I'm not familiar with the literature there and the different things going on there, and I'm wondering. You know, I'd ask you for your thoughts on if that's a measure to be added later or, you know, some of the questions that were asked about particular information on claims and things like that. So not necessary a question to answer now but -- unless you can, but more -- I'd welcome more information on that.

DR. CROSSON: Thank you.

Dana.

DR. SAFRAN: So, first just a clarification, when I was talking about total cost of care and risk adjustment, I didn't understand what you added later in this

conversation, which is it is already adjusted, it's just not adjusted for SES. So that's great.

On patient experience, since before being at Blue Cross that's how I made my living, I just feel compelled to clarify a few things. I think Sue's point that it just bears coming back and having a deeper conversation is the right one given I think we're two minutes from our public comment session.

But I was -- I am surprised by the lack of understanding among a lot of folks around this table about how much psychometric science there is in these measures, and that these are not just indications of whether patients are happy, and they're not subjective, and that in fact, if we just choose a global measure, like meaning the 1 to 10 rating of how much did you like this hospital, even though today that is highly correlated with the composite measures on clinically substantive things like quality of communication, quality of discharge instructions, by incentivizing it, we could force a divergence because hospitals will begin to do things to get a good rating on that. Just like car salesmen do by the way, for anybody who's recently bought a car and been told, "Please give me

a 10 so I can get my bonus," they will find ways to get a 10 from people that have nothing to do with good clinical care, and I don't think that's what we want.

The clinical composites that the staff have proposed really have, as Karen started to point to, demonstrated relationships to outcomes we care about. Discharge instruction quality is related to readmission risk. Quality of communication by -- you know, and totally agree with Jon's point that we need to get the concept of team in here. So the instrument has to be improved. But the clinically substantive composites that are in there are really valuable, and we shouldn't just think they're the same as a general rating of how was your experience today or this week. Thanks.

DR. CROSSON: Thank you, Dana.

Okay. Ledia, Jeff, thank you. You've got some work to do, but it's only because we are so excited with what you've got and have presented to us, and we had a very active discussion.

In general, I'd like to thank Jim and the staff for the work that we have seen in the last day and a half. It's been terrific.

And, I particularly want to thank the commissioners for their comments, and I especially want to thank the five new commissioners who have literally hit the ground running, and if we were being observed from space, no one would be able to say who was new and who was not. So that's a real credit to each of you and thank you for that.

So now we have time for the public comment period. If there's anyone in the audience who wishes to make a comment, please come forward to the microphone.

[Pause.]

DR. CROSSON: Seeing no one at the microphone, we are now adjourned until our October meeting. Thank you, everyone.

[Whereupon, at 11:29 a.m., the meeting was adjourned.]