

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
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Thursday, March 2, 2017
10:20 a.m.

COMMISSIONERS PRESENT:

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KATHY BUTO, MPA
ALICE COOMBS, MD
BRIAN DeBUSK, PhD
PAUL GINSBURG, PhD
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WILLIAM J. HALL, MD, MACP
JACK HOADLEY, PhD
DAVID NERENZ, PhD
BRUCE PYENSON, FSA, MAAA
RITA REDBERG, MD, MSc
CRAIG SAMITT, MD, MBA
WARNER THOMAS, MBA
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PAT WANG, JD

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P R O C E E D I N G S

[10:20 a.m.]

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2
3 DR. CROSSON: Okay. If we could take our seats,
4 we'll start the session, a bit late admittedly. Carol is
5 here to talk about the unified payment system for post-
6 acute care. And as we know, we are in the process of
7 moving not just to a report on this in June but also to
8 specific recommendations. Carol?

9 DR. CARTER: Good morning, everyone.

10 In January, we reviewed the Commission's past
11 work on a prospective payment system to span the four post-
12 acute care settings and discussed implementation issues
13 that will be a chapter in this year's June report. This
14 month's presentation will be brief, but there is more
15 detail in the paper.

16 For new folks in the audience, I've laid out the
17 timetable for developing a PAC PPS that was included in the
18 IMPACT Act. It required the Commission to prepare a first
19 report last June that recommended key features of a PPS and
20 estimated impacts. The act also requires PAC providers to
21 begin collecting uniform patient assessment information in
22 October 2018. Then the Secretary must use two years of

1 these data in a report recommending a PAC PPS design,
2 likely to be submitted sometime in 2022. The following
3 year, the Commission must propose a prototype design, and
4 we are expecting that in 2023. On this timetable, it is
5 unlikely that a PAC PPS would be proposed before 2024 for
6 implementation sometime after that. And to be clear, the
7 IMPACT Act does not require the implementation of a PAC
8 PPS.

9 Again for new folks, let's review why there's
10 interest in developing a PAC PPS. Currently, similar
11 patients can be treated in different PAC settings, and
12 because each setting uses its own payment system, Medicare
13 payments can be quite different even though the patients
14 may not be. The idea of a PAC PPS is to have one payment
15 system to establish payments for patients treated in any of
16 the four PAC settings. Payments would be based on patient
17 characteristics, not where they were treated, and would
18 eliminate the existing biases in the home health and SNF
19 payment systems that favor treating some types of cases
20 over others.

21 Last June, the Commission concluded that a PAC
22 PPS was feasible using currently available data and,

1 therefore, could be implemented sooner than the timetable
2 laid out in the IMPACT Act. Functional assessment
3 information should be included in the risk adjustment when
4 these data become available. To create a level playing
5 field for providers, the Secretary would need to begin to
6 align the setting-specific regulatory requirements.

7 The design includes a common unit of service and
8 risk adjustment method based on patient characteristics.
9 Payments to home health agencies would be adjusted to
10 reflect this setting's considerably lower costs. The
11 design should include two outlier policies: one for
12 unusually short stays and one for unusually high-cost
13 stays.

14 In January, the Commission discussed three
15 implementation issues. The first is whether the
16 implementation should include a transition. The second is
17 the level of aggregate PAC payments and whether the PPS
18 should be implemented to be budget neutral to the current
19 level of spending. The third issue is the need to make
20 periodic refinements to the PPS, just like in every payment
21 system.

22 The mailing materials that you were sent are very

1 similar to the information that you saw in January, but we
2 added some new things. Kathy, you asked to see a mix of
3 settings, so we included that in Table 2. Jay, you asked
4 to see other modeling scenarios, and we included that in
5 Table 6. Jon, you asked to see a little bit more about the
6 discussion of the pros and cons of a transition. And,
7 Warner, you asked us to include more discussion about
8 likely provider responses to the PAC PPS.

9 To evaluate the need for a transition and the
10 level of payments, we updated our analysis of 2013 PAC
11 stays to account for changes in costs and payments to 2017.
12 With these updates, the average payment per stay remains
13 well above the average cost, 14 percent higher. We
14 confirmed our previous directional impacts. A PAC PPS
15 would redistribute payments from stays with high amounts of
16 therapy unrelated to patient characteristics to medical
17 stays. With that redistribution, the equity of payments
18 would increase and there would be smaller disparities in
19 the relative profitability across different types of
20 patient conditions. As a result, compared to current
21 policy, providers would be less likely to prefer to treat
22 certain types of patients over others.

1 The first implementation issue is whether to
2 include a transition when the PPS is implemented. A
3 transition would phase in the PAC PPS over multiple years,
4 blending new PAC PPS rates with the current setting-
5 specific rates.

6 By phasing in the PAC PPS, a transition would
7 dampen changes to payments during the phase-in period. But
8 it would delay the redistribution of payments and extend
9 the current inequities in the home health and SNF payment
10 systems. It would give providers more time to adjust their
11 costs and their mix of patients.

12 The size of and variation in the changes in
13 payments suggest the need for a transition. Estimates of
14 the impacts on stays and providers are in the paper. We
15 found that providers whose average payments would be
16 lowered were more likely to have above-average
17 profitability and vice versa. Therefore, we conclude that
18 the transition should be relatively short.

19 If there is a transition, one decision is whether
20 providers could elect to move directly to the full PAC PPS
21 rates and bypass the transition. Providers whose payments
22 would increase are likely to elect this option, just as

1 they did when they were given the option to bypass their
2 setting-specific PPSs. Therefore, a bypass option is
3 likely to raise program spending.

4 In January, we heard different opinions about
5 this option. Some of you thought it was a good idea
6 because it would speed up the shift to payments based on
7 patient characteristics and to more equitable payments
8 across different types of stays. Others questioned whether
9 the program should invite higher spending during the
10 transition. Some of you noted that this higher cost could
11 be mitigated by lowering the aggregate level of spending.
12 We didn't hear a consensus about whether or not to allow
13 providers to bypass the transition, so the chapter would
14 lay out this issue, and it's something that you can
15 discuss.

16 The second implementation issue is whether the
17 level of payments should be lowered. We estimate that in
18 2017, the average payment is high relative to the average
19 cost of a stay, 14 percent higher. Given the Commission's
20 long-standing update recommendations, it would be
21 consistent to lower the level of PAC spending when the PAC
22 PPS is implemented, if the Congress has not already done

1 so.

2 We modeled reductions of varying sizes, from 2 to
3 5 percent. Under any of these scenarios, the average
4 payment across all stays would remain substantially above
5 the average cost of stays, from 9 to 12 percent higher.

6 Looking at the impacts by different patient
7 groups, the average payment would also remain above the
8 average cost of the stays for the 30 different patient and
9 severity groups that we examined. Here I show the impacts
10 of a 2 and a 5 percent reduction for the high-volume
11 clinical groups. Table 6 in the paper has the rest of the
12 groups. The ratios compare the average payment to the
13 average cost of stays in that group. You can see that even
14 with a 5 percent reduction, the average payment would be 9
15 percent higher than the average cost across all stays. And
16 for the 30 patient groups we looked at, payments clustered
17 in the range of 7 to 9 percent higher than costs.

18 For groups whose payments are estimated to be
19 below costs (such as stays with high therapy costs
20 unrelated to the patients conditions and stays treated in
21 IRFs and LTCHs), therapy practices and the cost structures
22 of these high-cost settings explain these results.

1 The last implementation issue is the required
2 maintenance of any payment system. As with prior payment
3 policy changes, we expect providers to change their costs,
4 patient mix, and practice patterns to maintain or increase
5 their profitability. The Secretary should, therefore,
6 periodically evaluate the need to make refinements to the
7 PAC PPS, and these refinements fall into two broad groups.
8 The first are the revisions to the case-mix groups and
9 their relative weights to help maintain the equity and
10 accuracy of payments across the different types of stays.
11 The second group of refinements include rebasing payments
12 if the cost of stays change. This rebasing realigns the
13 level of payments to the cost of stays.

14 Both types of revisions are part of the ongoing
15 maintenance of any PPS, and the Secretary should be given
16 the authority to do both.

17 The conclusions of this chapter include:

18 A PAC PPS could be implemented as soon as 2021.
19 When uniform functional assessment data becomes available,
20 it should be incorporated into the risk adjustment method.

21 Given the range of impacts, the implementation
22 should include a short transition.

1 Given the high level of PAC spending relative to
2 the cost of care, the implementation should lower aggregate
3 spending.

4 Concurrent with the implementation of the PAC
5 PPS, the Secretary will need to begin the process of
6 aligning setting-specific regulatory requirements.

7 And, finally, the Secretary will need the
8 authority to revise and rebase payments to keep payments
9 aligned with the cost of care.

10 This leads us to the Chairman's draft
11 recommendation, and it reads:

12 The Congress should direct the Secretary to:

13 Implement a prospective payment system for post-
14 acute care beginning in 2021 with a three-year transition;

15 Lower aggregate payments by 3 percent, absent
16 prior reductions to the level of payments;

17 Concurrently, begin to align setting-specific
18 regulatory requirements; and

19 Periodically revise and rebase payments, as
20 needed, to keep payments aligned with the cost of care.

21 The text below the recommendation would note that
22 if the Congress has already lowered payments to PAC

1 providers, the Congress should compare the reduction it has
2 already taken with this recommended amount and make an
3 additional reduction if necessary to reach the 3 percent.
4 We would also note that the 3 percent reduction would be
5 taken in one transaction at the beginning of the transition
6 and that providers could be allowed to bypass the
7 transition. Since the level of payments would remain
8 relatively high, there would be a transition, and providers
9 would be allowed to bypass it. We believe that this is a
10 reasonable course of action.

11 Alternatively, the Secretary could opt to phase
12 in the reduction over the course of the transition. We
13 would also note that MedPAC will continue to monitor
14 provider performance and make subsequent recommendations if
15 necessary.

16 In terms of implications, spending will be lower
17 compared to current policy. We expect providers to respond
18 to this major change in payment policy, just as they have
19 done in the past. By rebalancing the financial incentives,
20 the PAC PPS will correct the current inequities in the SNF
21 and home health PPSs that favor certain types of patients
22 and providers over others.

1 For beneficiaries, providers will be more willing
2 to treat all types of patients. Therefore, patients with
3 complex medical care needs will be easier to place at
4 discharge from the hospital.

5 For providers, the PAC PPS will redistribute
6 payments across them. The impacts will vary widely
7 depending on a provider's costs, their mix of patients, and
8 their current treatment practices. Payments will be more
9 equitable as disparities in profitability will narrow
10 across the different types of conditions.

11 And with that, I'll put up the draft
12 recommendation and turn the discussion over to Jay.

13 DR. CROSSON: Thank you, Carol.

14 We'll take clarifying questions.

15 DR. SAMITT: So I have a question about spending
16 impact. You talk on Slide 15 about the fact that this will
17 lower spending versus current policy. But you also suggest
18 in the recommendation that we allow providers to bypass the
19 transition. How do they play off of one another? And have
20 we modeled what the spending impact would be in the setting
21 of expecting everyone that will benefit to bypass?

22 DR. CARTER: We haven't modeled that. I think we

1 probably could do a back-of-the-envelope. As you probably
2 know, we send our recommendations over to CBO and get the
3 estimate from them, and so that's something, an interaction
4 that they would surely take into effect.

5 Let's see. So the SNFs are, you know, a big
6 block of dollars, and their payments are projected to
7 increase. But the other two settings, payments would go
8 down, and for home health there's a slight downtick. But
9 we haven't done that modeling to sort of know how those
10 play out. But you're right, there are those conflicting
11 things. And it would depend a lot on what share of
12 providers because -- you think would bypass.

13 DR. SAMITT: Remind me. We did the estimate of
14 what the range would then be of kind of those that would
15 see increases versus those that would see decreases. And
16 so we likely could develop a pretty ready estimate of what
17 the additional cost would be in bypassing the transition
18 versus the --

19 DR. CARTER: I think we could get a ballpark,
20 yeah.

21 DR. MILLER: Yeah, and the only thing I would say
22 -- and I think you said this -- is from a policy

1 perspective -- and, again, there wasn't entire consensus on
2 this, but if you were to let them bypass, then you'd want
3 to think even more about taking something off of the top
4 during the transition, just that connection, and you can
5 balance it off.

6 DR. SAMITT: It's more for me speaking to what
7 percentage we would recommend given what we think would
8 happen in the transition to make it budget neutral, so to
9 speak, if that's what we want early on.

10 DR. CROSSON: Thank you.

11 MS. BUTO: Mine is a related question, Carol. As
12 I understand the reductions that we would take in aggregate
13 PAC PPS payments, those would be done by provider type,
14 right? So, in other words, we'd take, I think, a larger
15 reduction in the base payment or the baseline or whatever
16 we're calling it, aggregate SNF payments than, say, another
17 provider type. Is that correct? Or are we talking about
18 an across-the-board reduction --

19 DR. CARTER: We're talking about across the
20 board.

21 MS. BUTO: Okay, because I'm just wondering,
22 particularly if SNFs are the beneficiaries of higher

1 payments, is that what you said earlier to Craig?

2 DR. CARTER: The impacts to SNFs --

3 MS. BUTO: They would tend to go up, even though
4 they are the ones that have high degree of therapy payments
5 --

6 DR. CARTER: Yeah, the reason why that is is the
7 payments are based on the average costs across all
8 settings, and their overlap in patients is with IRFs and
9 LTCHs, and so the --

10 MS. BUTO: Which are more expensive.

11 DR. CARTER: Which are more expensive.

12 MS. BUTO: Yeah.

13 DR. CARTER: So the average -- you know, that's
14 something that would change over time as patients start to
15 be more uniformly placed and payments get more uniformly
16 distributed across settings. That's exactly the kind of
17 recalibration that we would expect to happen.

18 MS. BUTO: Okay. So as I understand, the idea t
19 some providers might choose to go directly to PPS, we might
20 like that because it eliminates that therapy payment, sort
21 of overpayment, if you will, even though they might benefit
22 financially by making that change. It changes to a better

1 payment approach that's more accurate. Is that your
2 thinking?

3 DR. CARTER: Yes, and also it increases payments
4 to medically complex patients, which I think is part of
5 what you're saying.

6 MS. BUTO: Yeah, exactly.

7 DR. CARTER: Yes.

8 MS. BUTO: Thank you,

9 MR. PYENSON: A related question. The Chairman
10 has recommendations for the transition to start in 2021.
11 For that to happen, when would Congress have to act?

12 DR. CARTER: Well, so part of that would be kind
13 of working back for how much time you think CMS would need
14 to develop this. Probably next year would be my guess. I
15 mean, CMS takes at least a year -- I mean, more than that,
16 but to develop -- I think we've developed a good prototype,
17 but if they were inclined to develop case-mix groups, I
18 think that they would use this kind of -- this work would
19 be a very good stepping stone to a classification system
20 that they could then use, and that would take, I think,
21 about a year.

22 MR. PYENSON: So if Congress acts in 2018, we

1 could have a fully implemented system in 2024?

2 DR. CARTER: So we're talking about beginning the
3 transition, and if there was a transition with blended
4 rates, it would begin sort of the transition. So when you
5 say full implementation, you mean having a payment system
6 ready to then use part of the payment as a blend? Is that
7 what you mean?

8 DR. MILLER: He said 2024.

9 MR. PYENSON: 2024 --

10 DR. CARTER: Oh, I'm sorry. I misheard that.

11 MR. PYENSON: -- the transition would end in
12 twenty --

13 DR. CARTER: Yeah, right. I'm sorry. I misheard
14 you.

15 DR. MILLER: And I think that's what we're -- I
16 would have answered 2017, 2018 is when they'd have to act.
17 A few years to construct the system and the regulations.
18 And, yes, 2024, thereabouts. And, of course, all our
19 recommendations are predicated on when they act, and so you
20 just push it all back if they acted at a different time.

21 DR. HOADLEY: You were starting down this -- the
22 three-year transition, you're envisioning two years with

1 blended rates, and then the third year is fully in the new
2 system? So in a sense, it's two transition years and then
3 a third year --

4 DR. CARTER: Right, one third, two third --
5 right.

6 DR. HOADLEY: So, in fact, if you started in
7 2021, in 2023 we'd be at the point where it would be fully
8 paid under the new rules, it sounds like.

9 DR. CARTER: Right [off microphone].

10 DR. MILLER: So you're saying Bruce was wrong.

11 [Laughter.]

12 MR. PYENSON: I have trouble adding.

13 MS. THOMPSON: Thank you, Carol. A couple of
14 thoughts about other things going on in the environment,
15 including the bundles. I'm wondering how does this play
16 with those organizations and providers that are under --
17 are participating in orthopedic bundles, the joint
18 replacement bundles that many times the post-acute care is
19 a substantial piece of that expense. So I'm just curious
20 if we've thought about that and how these new payment rules
21 will play.

22 And the second piece I've thought of is the

1 demonstration around hospital at home. We're involved in a
2 situation where we're working -- it's a project out of
3 Johns Hopkins where patients who actually qualify for
4 inpatient care are sent immediately from the emergency room
5 back home with diagnoses like COPD, congestive failure,
6 pneumonia, where the care can actually be rendered at home.
7 I just wanted to make sure as we think about other things
8 going on in the environment, that over the course of two,
9 three, four years may advance very quickly as we look to
10 further coordinate care between providers, that we don't
11 end up with some unintended consequences. So any thoughts
12 about that?

13 DR. CARTER: Well, the bundled payments are going
14 to and have encouraged providers to use a lower-cost
15 setting when it's possible and to shorten stays where
16 possible. And so over time, something like this would --
17 those practice patterns and changes in costs would be
18 captured in the recalibration. So over time, those mix of
19 patients and the costs of those patients should be folded
20 into kind of what becomes then the new base rate.

21 MS. THOMPSON: So in the spirit of promoting care
22 coordination, there would be an incentive for organizations

1 to want to work together.

2 DR. CARTER: Yes.

3 DR. CROSSON: Okay. Further clarifying
4 questions?

5 DR. DeBUSK: Just to further Susan's question, if
6 I were an orthopedic surgeon under a BPCI, right now
7 rationalizing those, say, SNF days or something is in my
8 financial -- to my financial benefit. If I were under a
9 truly prospective model, though, that cost would become
10 fixed for the purposes of calculating how I'm performing
11 against my benchmark. You would disincent -- well, remove
12 the incentive for me to manage those SNF days, wouldn't
13 you?

14 DR. CARTER: Well, no, your cost would -- so then
15 your payment would be based on a discharge. But the costs
16 you incur, let's say you're now having an average 24-day
17 length of stay. You'd still have an incentive to lower
18 your own costs with shorter stays.

19 DR. DeBUSK: Okay.

20 DR. CARTER: Right now providers in the SNF
21 setting have an incentive to have -- or there's no
22 disincentive and there's a slight incentive to increase

1 your days because that's how you're paid.

2 DR. DeBUSK: Right.

3 DR. CARTER: If you're paid on a discharge,
4 you're going to get paid that amount whether they stay 15
5 days or 20 days.

6 DR. DeBUSK: Okay.

7 DR. REDBERG: Thanks again for the review of this
8 great system, which I'm anxious to see implemented. I'm
9 just curious. You modeled on Slide 10 a 2 percent
10 reduction in payments and a 5 percent and showed even at 5
11 percent that it was about 8 or 9 percent over cost of
12 stays. But then the draft recommendation says 3 percent,
13 and so I was wondering how you came to that.

14 DR. CARTER: We didn't hear a broad consensus for
15 a small reduction or a large reduction, so we picked
16 something in the middle. I think that that's something, if
17 you want to revisit, you certainly can. This is a draft
18 recommendation.

19 DR. NERENZ: I was just going to follow on
20 Brian's comment. I had the same thought, and I'm not sure
21 we've got that settled. But I was going to make the same
22 observation, that if right now in a bundled payment program

1 you can save money by shifting a post-acute episode from a
2 higher- to a lower-cost setting, this model reduces or
3 eliminates that opportunity. Now, you can still find
4 savings in things like, you know, how many visits and
5 shorten the episode, but you can't achieve savings by
6 moving from what currently is a higher- to a lower-cost
7 setting. I was going to make the same point.

8 DR. DeBUSK: I was actually -- we are on the same
9 page there, and the reason that I had backed off is because
10 I was thinking, well, in theory, if I'm the physician that
11 initiated the bundled episode, what I would do is I would
12 try to code the patient characteristics down somewhat so
13 that the prospective payment would be less, and then you'd
14 get the same effect.

15 DR. NERENZ: Okay. So I guess in the spirit of
16 Round 1 clarification, I just want to make sure that at
17 least we're seeing this particular feature the same way.
18 Now, in Round 2 we can debate whether it's good or bad or
19 important or unimportant, but at least the phenomenon would
20 exist, right?

21 DR. CARTER: Well, so yes. So this isn't an
22 episode-based payment, as we know, and over time if the mix

1 of patients and where they were treated changed, you would
2 see that in how the average cost per stay was calculated.

3 DR. MILLER: Just to nail this point, I think. I
4 had the same reaction to the exchange, and I think as a
5 matter of principle, he's correct, that right now if you go
6 into a bundle, there may be incentive to move from one
7 setting to another based on the reimbursement differences
8 as you jump from silo to silo and you're starting to
9 flatten that out; or to put it differently, give everybody
10 that incentive or remove the current incentive. And, two,
11 your actual utilization controls become more what you focus
12 on in the episode, and I think that's what David is saying.
13 And I think in principle -- I'd have to think about it at
14 least ten more seconds, but I think he's correct on that
15 point.

16 DR. CROSSON: Well, I think Pat had a point
17 first. No? Okay. Bruce.

18 MR. PYENSON: Just on that point, there is still
19 a huge financial gain in bundles to move to home health,
20 because that's going to be always significantly lower. And
21 when you look at the orthopedic bundles, that's probably
22 the current biggest potential in many parts of the country

1 and will continue to be. So I think it's a magnitude
2 issue, but the principle is there, I agree.

3 DR. MILLER: And the only thought I had when Sue
4 was asking her question was: Do you think of that as
5 complementary, as in, you know, get rid of thinking about
6 the highest revenue setting? Or do you think of it as
7 saying, well, I used to have two incentives in the bundle,
8 now I have one? And then I think that starts to bleed over
9 into what's the judgment.

10 DR. DeBUSK: I think your decision then becomes
11 home health versus SNF utilization versus trying to, say,
12 manage those numbers of days in the SNF from, you know, 20
13 days down to 13 or so, like they do in the orthopedic
14 bundles.

15 MR. THOMAS: Just a quick question on the
16 regulatory changes that would go with the payment changes
17 as far as, you know, licensing of LTCH and SNF and rehab
18 versus going to a bundled, you know, one kind of post-acute
19 payment. What are the thoughts on the transition from a
20 regulatory perspective for those different entities as we
21 think about going to just kind of having a post-acute
22 entity versus having, you know, an LTCH versus a SNF, et

1 cetera?

2 DR. CARTER: Some of the things we've talked
3 about are the obvious ones, like the 60 percent rule or the
4 requirement for intensive care therapy for IRFs or the 25-
5 day length of stay for LTCHs. Those are things that we
6 think should be sort of at the top of the list of
7 considering waiving. We do plan to do a deeper dive into
8 kind of what would be reasonable things to begin with in
9 terms of regulatory compliance and sort of making that more
10 consistent across settings, and that's a block of work that
11 Dana actually is planning on heading up over the next year.

12 CMS has already the authority to do many of these
13 changes, but it doesn't have the authority to do others
14 like the LTCH length of stay. So that's why the
15 recommendation is clear to give the Secretary the authority
16 to make those changes because that isn't possible right
17 now.

18 So some of the easy things we've outlined in the
19 paper, but I think there are other things that are
20 definitely more complicated, and we plan on doing that work
21 over the next year.

22 MS. WANG: Related to Warner's question just now,

1 how dependent do you feel the payment changes are on
2 achieving at least the minimum level of regulatory relief
3 to allow more flexibility among PAC providers? So, for
4 example, if no regulatory changes were made, if none of the
5 items that you mentioned were addressed, do you feel that
6 the PAC PPS would still -- should still be launched?

7 DR. CARTER: I think that some of those
8 regulatory requirements do raise providers' costs, and so
9 that would put them on unequal footing. So I think some of
10 those things do need to -- at least the Secretary needs to
11 begin that process of aligning the regulatory structures
12 across the settings by the time this is beginning to be
13 implemented.

14 DR. MILLER: That's exactly what I would have
15 said as well, and I will use Kathy as my reference point
16 here, although she may disavow this immediately. And when
17 you get into your conversation, there's always this
18 question of, you know, do you wait for all of this to
19 happen, or do you set the train in motion so that people
20 have a strong incentive to get it to happen? And Kathy
21 has, I think, made comments like that, and that might be a
22 point of discussion for you. But I agree with her that

1 some of these, if they weren't removed, you know, you would
2 have a certain inequity for providers.

3 DR. CROSSON: Okay. So we'll move to Round 2.
4 Could I just see the hands of Commissioners who think they
5 want to make comments on the recommendations? Okay. So
6 it's about half. We'll start at this end and move this
7 way.

8 Again, we have recommendations before us. What
9 we would in general like to hear is a level of support or
10 not for the recommendation and any specifics for
11 improvement of the recommendation. We'll start with Craig.

12 DR. SAMITT: So I support the draft
13 recommendation. The only proposed modification that I
14 would make, given our recommendation in support of an
15 earlier transition or a bypass option, would be to raise
16 the reduction of aggregate payments from 3 percent to 5
17 percent.

18 DR. CROSSON: Thank you.

19 MS. BUTO: I agree with Craig. I would raise it
20 to 5 percent or at least say something like "up to 5
21 percent," absent prior reductions. I'm conflicted on the
22 issue of letting providers move quickly through the

1 transition, but I think if it means they will adopt a more
2 appropriate payment system, I think it may be worth the
3 additional money that we'd have to spend to have that
4 happen.

5 The other thing we haven't talked about but I
6 hope can find its way into the text is I worry about some
7 subcategories of patients who might not do equally well in
8 every setting. We mentioned -- I think Alice at the last
9 meeting mentioned ventilator-dependent patients, and we
10 talked about ventilator units and so on. I think we have
11 from time to time talked about stroke patients. So
12 somewhere in the text, I'd like there to be a reflection of
13 the fact that as they move through a transition, you know,
14 CMS, the Secretary, really needs to identify any potential
15 subcategory of patients who they'd want to watch carefully
16 to make sure they were getting appropriate access even as
17 we move to a more uniform system.

18 MR. GRADISON: I agree with the recommendation,
19 with the 5 percent change as well. I would only comment
20 with regard to permitting early adoption, I think there's
21 an advantage in that once that happens, I think it's going
22 to be much harder for the Congress or the administration to

1 back off on the original timetable which they lay out,
2 because there are going to be people out there who already
3 will have committed to and support of this, and also be
4 financially a loss if the time period were extended. So I
5 think that the early adoption is a very good idea.

6 DR. CROSSON: Okay. Moving up this way, Bruce.

7 MR. PYENSON: Yeah, I support the Chairman's
8 recommendation with the suggestion that Craig had of the 5
9 percent.

10 From a wording standpoint, since we're talking
11 about implementation in Congress in 2017 or 2018, I'd
12 suggest we change the wording from a three-year transition
13 to a six- or seven-year transition. And that's not a
14 transition payment, but we're giving providers three years
15 to get ready and then another three years for changes in
16 payment. That seems like a generous amount of time to
17 prepare, especially in the era of IPAB.

18 DR. MILLER: Can I --

19 DR. CROSSON: Yeah, go ahead -- no. So you're
20 saying six to seven years after the regulations are
21 launched?

22 DR. CHRISTIANSON: No.

1 DR. CROSSON: No?

2 MR. PYENSON: I might have counted it wrong, but
3 we're going to have a full implementation by 2023, and the
4 provider community will be aware that this is coming in
5 2017 or 2018. So that means we are assuming that providers
6 need that amount of advanced notice in order to get ready.

7 DR. CROSSON: Go ahead, Mark.

8 DR. MILLER: What I would do is take this
9 suggestion and ask if what we can do is be very clear in
10 the text that the industry will have six years to do it. I
11 think if you write the words "six-year transition" in the
12 recommendation, it will be interpreted as six years, you
13 know, from 2021. And so what I would like to do -- but,
14 you know, you guys decide in the end -- is to say it's a
15 three-year transition from 2021 and make a big deal in the
16 text that they will have six years to be aware of it, if
17 you could find your way to that.

18 DR. CROSSON: Okay. Bill? I'm sorry. Did I
19 miss you, David?

20 DR. NERENZ: No. I just put my hand up late. I
21 do support the recommendation. I just wanted to say for
22 the record, commend Carol for the excellent work on this

1 and the other staff who have done this. I think this is
2 maybe possibly the most substantively significant body of
3 work that has been taken up during my tenure on the
4 Commission, if not "the," at least it's in the top segment
5 of the list. I think it's good work. I think it's been
6 challenging. I think it takes payment in this area in the
7 right direction, and I just want to make sure that you are
8 commended for the excellent work you've done. Thank you.

9 DR. CROSSON: Thank you.

10 DR. HALL: I totally agree with David on this.
11 I'm very excited about this and certainly support it. Just
12 a couple of provisos here.

13 What I like about this -- there are a lot of
14 things that I like, but a couple that I think are really
15 going to make enormous progress is, first, that the idea of
16 we're going to agree on common units of service. So post-
17 acute care, PAC, isn't just one entity, but it can be lots
18 of different things. But it's measurable in terms of how
19 we're going to measure what it is that we're paying for.

20 I like the idea that we're saying this, although
21 I wish we said it even more clearly, that one of the units
22 of evaluation will be functional state. We're making a lot

1 of progress on this in sort of the field of geriatrics,
2 much more so than when I first joined the Commission six
3 years ago when it was just kind of a word that we were
4 looking too define. It's in here, but I hope that it isn't
5 forgotten as we go forward.

6 One other thing. Okay. The other feature here
7 that I hope does not get lost in our desire to have
8 uniformity throughout the measurement and the payment
9 system is that there's a huge difference trying to evaluate
10 hospitals and evaluating this new entity of post-acute
11 care. Let me just give you a very quick example of that.

12 After reading this and thinking about this, one
13 of my routine things I do is see patients in what would be
14 called our acute-care service in our major hospital, which
15 is a major university hospital. And then I skedaddled in
16 the afternoon down to within 50 miles of Rochester to parts
17 of the world that you wouldn't recognize in terms of what
18 hospitals look like and what the delivery of health care
19 is. It's neither better nor worse. It's different.
20 Hospitals are very well regulated. There's an enormous
21 opportunity in the country to take this post-acute care
22 concept and to try to make it much more explicit as to what

1 we're trying to do, is to take advantage of the fact that I
2 think that there are incredible opportunities for
3 innovation and creative activities throughout the country.

4 If I think about a small community and compare it
5 to our large place, I see opportunities in every one of
6 these small communities to encourage innovation,
7 incentivize innovation in terms of post-acute care. Things
8 that you couldn't do in the big city you can sometimes do
9 much more readily in the community. And unless the
10 providers have the opportunity, I think, to be creative and
11 not be tied into regulation, which is well-meaning in its
12 application, a good example is I know places where home
13 health care is very easy to put together if people are
14 incentivized to use it. There are other places in rural
15 areas where to talk about much more serious care it's going
16 to be difficult for them, but there are different ways of
17 adapting.

18 So this is one I hope that this recommendation
19 goes very far, but it does more than kind of give a uniform
20 post-acute care concept out there, but it doesn't become so
21 rigid that it allows people not to innovate. I think some
22 of the best innovations in post-acute care are going to

1 come outside of the major cities in the United States.

2 That's my way of saying I really think this is a
3 good idea.

4 DR. CROSSON: Thanks Bill. Alice.

5 DR. COOMBS: Thank you very much, Carol.

6 Back when this was a baby and its development, I
7 think we talked about a couple of things. One concern that
8 I have had was when there is a separation of state
9 regulations versus the regulatory changes that are what we
10 see with the difference between the LTCHs and the SNFs. So
11 I still am concerned about some of the state regulations
12 and state jurisdiction and how much of this is going to be
13 impaired in terms of being able to transition into this
14 based on state governing rules.

15 I know in our state we had this whole thing and
16 it's been -- I know it's been a battle in many states, in
17 terms of the ratio of nursing and each one of the different
18 entities in terms of what is the allowable ratio. And
19 those are regional and those are state-run kind of
20 regulatory issues, so that it comes into play when it comes
21 to how well -- what the margins look like in these
22 facilities where the state has a greater footprint in the

1 operational capacity of the PACs.

2 I agree with the transition of three years, but I
3 like the idea of if you're going to do a three year
4 transition to have a lower aggregate percentage. And I
5 thought 4 percent, but there was a bunch of people who
6 thought 5 percent over there. I'm not opposed to that, at
7 all.

8 I think that if you do a higher aggregate payment
9 decrease, then the transition period becomes not much of a
10 discussion because there will be movement that will occur
11 as a result of that, I think, in general.

12 The other issue is the rebasing. I really think
13 for home health agencies we really should include that in
14 here because that's going to be a big factor -- it should
15 be aligned with the recommendations because that's going to
16 be a big factor going forward, especially when it comes to
17 knees and hips and the ortho procedures because many of
18 them, at my institution, they're actually going home. They
19 are going home post-op, and that's their PAC. Their PAC is
20 a home health agency coming in.

21 Just a specific line that says that. I know
22 we've kind of incorporated it.

1 DR. MILLER: A specific line that says?

2 DR. COOMBS: The Secretary make a readjustment --
3 what we're looking for is we want a uniform PAC but
4 including home health agencies within that. And the
5 Secretary is going to make some kind of adjustment as to
6 what that looks like, because the resource utilization is
7 very different in home health agencies.

8 So I think that -- I mean, there is some estimate
9 of what is the operational costs of a SNF, an LTCH. But
10 those are not the important things here. What we're
11 looking at is what kind of adjustment you're going to have
12 for instead of someone going to a SNF, to make it move
13 people toward a home health agency, the choice, the
14 decisionmaking.

15 So that if the home health agency is very, very
16 expensive relative to the other pieces of the puzzle, they
17 may select to go that way when the difference is smaller.

18 DR. MILLER: The thing that I would just run you
19 and others back through is, a couple of things. In the
20 unified system -- this is back to the exchange over here
21 across Brian and David.

22 There will be incentives to seek out the lowest

1 cost environment that you can deliver the care in and still
2 get a good outcome. And so I think there's some of the
3 home health is just contemplated by the system -- the move
4 to home health is contemplated by the system itself. It is
5 very explicit that all four settings are in it.

6 And then the other thing -- and this is the most
7 important point I want to remind you about -- deeper in the
8 modeling, when we went through and did the analysis and
9 structured the payment model and did the impact, we had an
10 explicit adjustment for home health.

11 So even though I don't know the words need to be
12 present here, in the models themselves I think your concern
13 has been addressed pretty head on. And we can just make
14 sure -- and actually, I think -- pretty present. But we
15 can just make sure in the discussion of the methods and the
16 construction of the model, that home health factor is in
17 there.

18 And I think it goes to the point that you're
19 talking about.

20 DR. CARTER: So I was thinking maybe in the text
21 below the recommendation we come back to the design
22 features and we could address that concern that way.

1 DR. MILLER: And do it right coincident --

2 DR. CARTER: Yeah.

3 DR. MILLER: That's better.

4 DR. CROSSON: Jack.

5 DR. HOADLEY: Like David, I really want to
6 compliment the work that's gone into this project by Carol
7 and the others on the team. It really is top-notch work.

8 And I think we've got a recommendation here that
9 is a really nicely well-designed package of pieces that
10 puts things together.

11 I agree with the suggestion that Craig started,
12 that we can move the payment reduction to 5 percent, and I
13 think partly taking into account the notion of those
14 providers that would be bypassing to the end point.

15 And I was initially going to be a little
16 skeptical of whether we wanted to allow that. I really
17 like Bill Gradison's point about some of the advantages
18 that bypassing might do in creating some leverage to keep
19 the schedule of this on time. I just think we really have
20 a package that fits together very nicely and achieves our
21 ends and the combination of the recommendation and the text
22 that has been indicated here that would follow it really, I

1 think, builds the case very nicely.

2 DR. CROSSON: Warner.

3 MR. THOMAS: I support the recommendation, as
4 well.

5 I would like to comment on Alice's points around
6 the -- things like state licensure, CONs, things like that,
7 as far as if organizations need to reconfigure or modify
8 services, I think there just needs to be a lot of
9 consideration around that to allow organizations to have
10 the flexibility as they go to try to adapt their business
11 to deal with a broader array of patients.

12 I know that in the text there are certain
13 regulatory comments made. I just would like to see maybe a
14 little bit more detail around that, that's going to allow
15 the providers to have maximum flexibility in order to deal
16 with a broader population of patients because ultimately
17 that's what we want. We want to see a post-acute facility
18 versus an LTCH, a rehab, a SNF.

19 And I think that's going to require probably a
20 little bit more flexibility regulatory-wise in order to
21 achieve that. Especially given a short-term -- I mean,
22 three years is not a short period but in the scheme of life

1 it's a relatively short period of time to have such a
2 significant change. So I just want to make sure we align
3 the regulatory pieces, as well.

4 DR. CROSSON: Rita.

5 DR. REDBERG: I'll add my congratulations. I
6 really think this unified payment system really
7 incorporates the principles that we talk about as paying
8 appropriately, the same care for the same type of patients,
9 regardless of setting. And so -- and I think it will
10 improve post-acute care, where we know there are a lot of
11 issues now.

12 So I support the draft recommendation with the
13 suggested change to 5 percent payments.

14 And I understand that it is changes, but I do
15 feel that we have been now talking about this for several
16 years and the transition period is still another few years.
17 And so I feel that the industry is probably have been
18 thinking about it already and thinking about where to go
19 with the prospective payment system.

20 Thanks.

21 DR. CROSSON: Brian.

22 DR. DeBUSK: I strongly support the Chairman's

1 draft recommendation. I do agree with some of my
2 colleagues here that we could do more than 3 percent -- 3,
3 4, or even 5 percent.

4 The one thing I wanted to point out here is just
5 the contrast. To understand the nature of this problem as
6 well as we do, and to know that it has, for example, the
7 secondary impacts of altering MA benchmarks, of altering
8 benchmarks in APMs, you know, the contrast between where we
9 are now and the improvements, what an elegant solution this
10 is.

11 Between the magnitude of the current problem and
12 the power of the solution, these strike me as extremely
13 reasonable recommendations. I mean, this is not radical
14 when you consider where we are now and where these
15 recommendations take us to.

16 So thank you and I think it's outstanding work.

17 DR. CROSSON: Thank you very much and I, Carol,
18 underscore the comments that have been made about the
19 quality of this work. I guess my only question is what
20 have you got left to do?

21 [Laughter.]

22 DR. CARTER: Oh, we have a lot.

1 DR. CROSSON: Thank you so much, and we will
2 return in April and have a chance for further discussion
3 and a vote on these recommendations.

4 [Pause.]

5 DR. CROSSON: Okay, so we are going to proceed
6 now with a discussion again about the issue of hospital and
7 SNF use by Medicare beneficiaries who are residing in
8 nursing facilities.

9 Stephanie, you're on.

10 MS. CAMERON: Thank you.

11 Good morning. Today I will provide a brief
12 overview of the context for this presentation and an
13 overview of information that I provided during our
14 September and October meetings on this topic. This
15 includes a summary of the strategies that nursing
16 facilities are using to prevent hospitalizations of their
17 long-stay residents and a summary of the risk-adjusted
18 rates of hospital and SNF use for this population.

19 In addition, I will highlight new information
20 requested by commissioners during our fall meetings and
21 provide considerations for future policy. Today we seek
22 your input on the draft June chapter included in your

1 mailing materials.

2 We began discussing the issue of hospital and SNF
3 use by long-stay nursing facility residents based on the
4 Commission's concerns about quality of care for the dual-
5 eligible population -- that is, beneficiaries that receive
6 both Medicare and Medicaid benefits.

7 Since the majority of long-stay nursing facility
8 residents are dual-eligible beneficiaries, the nursing
9 facility provides an easily-defined population for better
10 care coordination. While Medicaid generally pays for the
11 long-term services and supports provided by the nursing
12 facility, Medicare pays for care that these beneficiaries
13 receive in a hospital or during a subsequent post-acute SNF
14 stay. Transferring these residents to a hospital for
15 conditions that could have been prevented exposes
16 beneficiaries to several health risks, unnecessarily
17 increases Medicare program spending, and could indicate a
18 potential program integrity issue. Existing literature has
19 shown that a substantial portion of hospital admissions of
20 long-stay nursing facility residents may be avoidable
21 through better prevention or management by the nursing
22 facility.

1 While the facilities that we are discussing today
2 are typically the same facilities who provide care to
3 beneficiaries under Medicare skilled nursing facility
4 benefit, this presentation and our June chapter will focus
5 on the long-stay nursing facility resident population. We
6 defined our study population as having more than 100 days
7 in the nursing facility. Unlike the purely SNF population,
8 these beneficiaries are mostly dual-eligible and are not
9 typically discharged to a community setting.

10 So, some background. As you will recall, the
11 Commission conducted 10 interviews to learn about the
12 strategies employed by facilities to reduce hospital
13 admissions of long-stay nursing facility residents. We
14 interviewed facilities and groups currently participating
15 in initiatives being implemented through either the
16 Medicare fee-for-service program or a Medicare Advantage
17 environment. The Initiative to Reduce Avoidable
18 Hospitalizations among Nursing Facility Residents includes
19 about 140 facilities and provides financial support for
20 onsite training for staff, data support, and enhanced
21 direct patient care.

22 Certain MA beneficiaries have access to Optum's

1 CarePlus model, which provides onsite nurse practitioners
2 to manage and treat participating beneficiaries in
3 participating nursing facilities. Some nursing facilities
4 have also attempted to reduce hospital use by long-stay
5 residents without participation in a formal initiative.

6 Interviewees reported several common strategies
7 to reduce hospital use among long-stay nursing facility
8 residents, which we discussed in detail in September. The
9 strategies included improving communication between
10 residents, facility staff, and offsite clinicians,
11 increasing the level of clinical training, expanding the
12 medication review process, broadening advanced-care
13 planning efforts, and implementing telehealth programs.

14 Amy, in October you asked about telehealth's role
15 in the nursing facility setting. Interviewees reported
16 that there were several barriers to implementing telehealth
17 broadly in a facility, including general workflow issues
18 with requirements of additional staff time to go through
19 any telehealth protocols, a low volume of beneficiaries
20 making integration into everyday process is difficult, and
21 the relatively high cost of investing in telehealth
22 technology and its maintenance.

1 Next, we turn to the results from our analysis of
2 hospital and SNF use rates. The Commission developed three
3 measures of hospital use for the long-stay nursing facility
4 resident population, including an all-cause hospital
5 admission measure, a potentially avoidable hospital
6 admission measure, and an all-cause ED visit and
7 observation-stay measure.

8 Bill, as you requested in October, a detailed
9 list of the potentially avoidable conditions is included in
10 Appendix A of your mailing materials. And as a reminder,
11 we risk-adjusted these measures based on age, function, and
12 co-morbidities.

13 We found relatively low average rates of the
14 three hospital-use measures. However, we found a wide
15 variation in rates across the facilities for each measure.
16 As we indicated in October, the variation and rates, and
17 the level of rates above the 90th percentile, results in
18 the Commission's focus on facilities with the highest
19 rates.

20 For example, the risk-adjusted rate of hospital
21 admissions at the 50th percentile equaled 1.6 per 1,000
22 long-stay nursing facility resident days. However, the

1 variation between the 10th and the 90th percentile was more
2 than twofold. We found a more than threefold variation
3 between the 10th and the 90th percentiles for the rates of
4 potentially avoidable hospital admissions and an almost
5 fourfold difference in the all-cause ED visit and
6 observation stay measure.

7 We looked at the characteristics of the
8 facilities with hospital admission rates at or above the
9 90th percentile and found that these facilities were more
10 likely to be for-profit, rural, or smaller. We also found
11 that the frequency of visits from physicians or other
12 health professionals was inversely related to the rates of
13 hospital use. Facilities with access to onsite x-ray
14 services had lower rates of potentially avoidable hospital
15 admissions and ED visits and observation stays.

16 Now we move to our measure of SNF use for the
17 long-stay resident population. We considered this measure
18 based on Commission concerns regarding facilities using SNF
19 services to maximize Medicare payments rather than meeting
20 the care needs of the long-stay residents. We found that
21 the rates of SNF days per 1,000 long-stay nursing facility
22 days were skewed based on extremely high rates at or above

1 the 90th percentile.

2 Facilities at the 90th percentile had rates of
3 SNF use over 10 times higher than facilities at the 10th
4 percentile. These rates indicate a potential programming
5 integrity issue with the facilities at the highest end of
6 the distribution. When we analyzed the facilities at or
7 above the 90th percentile, we found that these facilities
8 tended to be for-profit or freestanding. At the most
9 extreme, facilities above the 99th percentile were heavily
10 concentrated across three states and were primarily for-
11 profit.

12 Before I discuss inter- and intrastate variation,
13 please note the correction to the national average SNF days
14 into the national average variation in SNF days compared to
15 Tables 5 and 6 of your mailing materials.

16 State-level policy could influence hospital and
17 SNF use rates. For this reason, we examine the rates for
18 each measure across states and the variation of each rate
19 within-state. We stratified our data by state and then
20 compared the rates of the top five states, which is those
21 with the highest rates, with the rates for the bottom five
22 states, those with the lowest rates.

1 We found that the variation in state-level
2 average rates for our four measures was about twofold.
3 This degree of variation, seen in the far-right-hand
4 column, suggests that state-level policies and geographic-
5 specific practice patterns may help explain the variation
6 in hospital use rates.

7 Amy, in October you asked about within-state
8 variation. As you will recall, the variation of rates of
9 hospital use was between twofold and fourfold when we
10 compared facilities of the 90th percentile to facilities of
11 the 10th percentile, which is represented in the first data
12 column of the table. Then at the state level, we
13 calculated the variation between the facilities with the
14 highest rates to those with the lowest rates. When we
15 compared the states with the most variation to the states
16 with the least variation, we found that hospital-use
17 measures largely followed the national average, which is
18 available in the second and third data columns.

19 However, we found that five states had extremely
20 high levels of variation in their facilities' SNF-use
21 measure. For these states, the difference between
22 facilities with the lowest rates and those with the highest

1 rates was over 25-fold. This finding supports the
2 Commission's concerns about the skewedness of the data and
3 policy considerations focused on facilities at the highest
4 end of the distribution. The intrastate variation across
5 providers indicates that facility-specific practices also
6 contribute to the large variation we see across the
7 measures.

8 Our work suggests several options for future
9 policy. For example, CMS could develop measures of
10 hospital and SNF use for long-stay nursing facility
11 residents. Once measures are developed, CMS could report
12 the measures to providers and ultimately publicly report
13 them for consumers through a website such as Nursing Home
14 Compare.

15 Following public reporting, Congress could
16 consider expanding Medicare's SNF value-based purchasing
17 program to include one or more of these measures. Our
18 findings support setting a threshold for the applicable
19 measures in a way that captures the true outlier
20 facilities, not necessarily those with slightly above-
21 average rates.

22 Alternatively, as Kathy mentioned in October, the

1 high variation in the rates of hospital and SNF use at the
2 extremes of the distributions could signal a program
3 integrity issue. CMS and its auditors could consider
4 focusing on facilities with aberrant patterns of hospital
5 use and SNF use for long-stay beneficiaries with further
6 congressional action.

7 Today we are interested in the Commission's
8 feedback regarding the new material we presented, including
9 considerations for future policy. In addition, we seek
10 your input regarding any next steps you are interested in
11 pursuing regarding this topic.

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

13 DR. CROSSON: Thank you, Stephanie.

14 We have clarifying questions. Let's see, Brian
15 and Sue.

16 DR. DeBUSK: If you could take us back to Chart 8
17 where you talk about the characteristics of nursing
18 facilities with high rates of hospital use, I noticed that
19 you have rural hospitals as well as -- you also looked at
20 the frequency of physician and other health care
21 professionals and the access to x-ray equipment. Did you
22 look for any collinear relationships between those two? I

1 mean, could we be measuring -- could the rural hospitals,
2 for example, have lower frequencies of physician visits
3 just associated with rural access issues?

4 MS. CAMERON: We did look at those actually
5 separately, and I do not remember why variation, but I
6 would certainly get back with you and make sure that's
7 highlighted in the chapter. I am just not remembering
8 offhand if that was -- I do not remember anything jumping
9 out but I cannot remember how close they were either.

10 DR. DeBUSK: I just wondered if there was a
11 collinear relationship.

12 The other question I was going to ask, the gap
13 measure that you were working with. I noticed you switched
14 back to the SNF days per thousand. Did the gap measure
15 just not pan out?

16 MS. CAMERON: That's right. So we did look at
17 another measure when we were developing this work that
18 considered the number of days between when a beneficiary
19 who was a long-stay resident would be able to qualify for a
20 new SNF benefit or a new benefit period, which starts with
21 a hospitalization. And when we looked at that, the model
22 had very, very low explanatory power. It was under .1, so

1 therefore we have dropped that measure and really focused
2 on the SNF-day measure.

3 And when we consider the SNF-use measure, I think
4 thinking about kind of the extreme, those above kind of the
5 99th percentile, maybe even those above the 90th
6 percentile, you know, that could be getting at some of this
7 cycling that we have talked about in the past.

8 DR. CROSSON: Okay, Sue.

9 MS. THOMPSON: Thank you, Stephanie. Have we
10 visited with any of the ACOs or the folks that have been
11 working, whether it be in at-risk or MSFP ACOs in terms of
12 their experience with what is happening with this
13 population? And is there anything to learn from them?

14 MS. CAMERON: I know there is a large ACO, I
15 believe out in California, that does have a long-stay
16 resident population, but I do not believe that that is kind
17 of the norm in terms of the ACO population.

18 MS. THOMPSON: [Off microphone.]

19 MS. CAMERON: So we have not been able to kind of
20 overlap the two at this point.

21 MS. THOMPSON: There might be some value.

22 DR. CROSSON: Okay.

1 MS. THOMPSON: There might be some value.

2 Also, you know, on page 5 of the materials that
3 you sent to us, you refer to the use of nurse practitioners
4 and perhaps there is some benefit to the nurse
5 practitioners who either make visits to see these patients
6 on a regular basis in the nursing facility, but yet we do
7 not call it out as a strategy on the list of strategies
8 that are identified, so I am just curious about that. Was
9 there just not enough evidence there, or what was your
10 thought?

11 MS. CAMERON: So the two strategies that I do
12 mention, the Optum CarePlus model as well as many of the
13 seven demonstrations and the CMMI project -- I believe it
14 is either four out of seven or five out of seven of those
15 do, in fact, use nurse practitioners or other health
16 professionals in the facilities.

17 I am happy to be more explicit that that was, you
18 know, a piece of it. In some situations they provide
19 direct patient care. In others they provide other levels
20 of support. But I am happy to add that in because I think
21 you are right; we did see that. In the kind of two tiers
22 of initiatives we looked at, nurse practitioners did play

1 an integral role in working with the beneficiaries.

2 MS. THOMPSON: And last but not least, in the
3 spirit of continuing to support the need to get after the
4 opportunity to use telehealth, I think there is an
5 opportunity to connect the nurse practitioner and the
6 access to nurse practitioner into these facilities. And I
7 would suspect there is some incentive then to the nursing
8 facilities to get into investing in telehealth if there is
9 enough disincentive to not be performing. So I think all
10 those pieces start to connect pretty nicely, which is
11 probably a round-two comment --

12 [Laughter.]

13 MS. THOMPSON: -- but I am just including it now
14 since the mic is on.

15 DR. CROSSON: But you snuck it in very, very
16 skillfully. We will let it go this time.

17 MS. CAMERON: And I do want to say, keep in mind,
18 in terms of telehealth, that at this point it is really
19 primarily a rural benefit. So, you know, I want to keep in
20 mind that even with the expansion of telehealth in nursing
21 facilities, right now that would really only be targeting
22 the rural population.

1 MS. THOMPSON: And to add one more comment --

2 DR. CROSSON: Yeah, go ahead.

3 MS. THOMPSON: -- back to Brian's question about
4 the x-ray and kind of what was going on there with the
5 rural facilities, I am curious about how many of rural
6 hospitals also have nursing home beds either on their
7 property or adjacent, actually contiguous in the physical
8 setting, which makes x-ray available. It is just down the
9 hall, happened to be in a different designated bed. So I
10 think there is a piece there that is at play.

11 DR. MILLER: Yes, swing beds, that's a good
12 point.

13 [Pause.]

14 DR. CROSSON: Stephanie, are you looking to
15 prepare an answer? Or what are you doing?

16 [Laughter.]

17 MS. CAMERON: I was skimming a document because I
18 do have it, but I need a moment. So I will look at the --

19 DR. CROSSON: Go ahead. Take your time. I was
20 not sure.

21 [Pause.]

22 MS. CAMERON: We did find that there were -- so

1 in terms of the access to X-ray anyway for rural versus
2 urban, a larger percentage of urban facilities do have
3 access to X-ray services compared to the rurals.

4 DR. CROSSON: Okay. Clarifying questions?

5 MR. GRADISON: Is there any relationship that you
6 know of between the five states that are the outliers at
7 the 90 percent level or higher and states in which CMS has
8 found a concentration of program integrity issues?

9 MS. CAMERON: I do not, but that's a great thing
10 to look into, and I think that's worth doing. Thank you.

11 MR. GRADISON: Thank you.

12 DR. CROSSON: Okay, Jon.

13 DR. CHRISTIANSON: I think this might be the same
14 thing, but are the three states you referred to in the
15 risk-adjusted NSF, are they also a subset of states that
16 are aberrant or really high on other measures as well?

17 MS. CAMERON: When I looked at the analysis, we
18 did look to see if there were correlations with other
19 measures that exist. So, for example, we do have a measure
20 of SNF readmissions, and their correlation was positive but
21 not high. I want to say depending on which measure you
22 looked at, from what we worked on for the long-stay

1 population and whether or not you were looking at the
2 potentially avoidable SNF readmission or the all-cause SNF
3 readmission measure, the correlations I believe were
4 between about 0.2 and 0.3.

5 DR. CHRISTIANSON: I guess I was probably asking
6 a simpler question. If you were to name the three states
7 in the one area, would you be naming the same three states
8 in some of these other measures as well?

9 MS. CAMERON: In terms of like a SNF readmission
10 rate? That I would need to double-check on, and I'll do it
11 in the same spirit as what Bill Gradison asked.

12 DR. CHRISTIANSON: Yeah.

13 MS. BUTO: I think this is a really interesting
14 area. To my mind, anyway, the question I have for you
15 about the topic is whether it's possible for us to look at
16 all at kind of the outcomes. So I think intuitively we
17 think this is not a good thing to have a lot of
18 readmissions to SNFs and hospitals. But I wonder -- it's a
19 lot more compelling if we have a sense of what the actual
20 harm is to beneficiaries. And I know it's even harder to
21 figure out what the additional cost is to the program. But
22 down the road, as we continue the analysis -- I'm assuming

1 that we wouldn't want to do this right now -- is that
2 something that you think we could look at, or are the
3 reasons for readmissions so scattered that it's hard to
4 make -- draw any conclusions?

5 MS. CAMERON: I think we would need to put some
6 more thought into kind of outcomes measures. As you're
7 aware, with this long-stay population, mortality rates are
8 pretty high generally. I mean, when most beneficiaries go
9 into a nursing home and become a long-stay nursing facility
10 resident, they aren't discharged to the community. You
11 know, there's a variation in how long they stay in the
12 nursing facility before they pass. But, you know, one
13 year, a little more than one year is kind of the average,
14 and the outcome is mortality, is death.

15 So I think we would need to think about what
16 those measures would be, and, you know, at this point I'm
17 not sure they necessarily exist.

18 MS. BUTO: Okay. So in a sense, we're interested
19 in this almost more from the standpoint of quality of care
20 maybe, or even quality of life, toward the end of life.
21 The readmissions complicate that and make it more
22 hazardous, is what I'm getting from your analysis. If it's

1 hard to figure out what the outcome is other than death,
2 then that tells me that it's either that or the expenditure
3 that really worries us.

4 MS. CAMERON: And I think it's -- you know, the
5 Commission looked at this I think as a quality issue, and
6 there is research showing that sending these beneficiaries
7 to a hospital further detracts their health with exposure
8 to, you know, infections, more falls, a lot of confusion.
9 This is a very frail population, and removing them from the
10 everyday environment becomes a very confusing and frankly
11 very stressful situation for them. And when it occurs, you
12 know -- I think the Commission's concern was, well, if that
13 exposure is occurring for something that could have
14 otherwise been preventable, then that's a problem.

15 DR. MILLER: And I think you guys have come to a
16 comfortable place in your exchange. The only thing I would
17 add -- and I'm doing this carefully, Stephanie. You know,
18 in a sense you were saying but what do we know about the
19 outcome, and then you got to your mortality conversation
20 pretty quickly. I think upstream from that a little bit --
21 and it's a little different take, but I feel it's something
22 of the same question or same point, although Stephanie's

1 going to correct this if not -- is that's why we're looking
2 at a little bit of the potentially avoidable in the sense
3 of like, you know, maybe there's readmissions that should
4 have occurred, but could you construct a measure where we
5 have some clinical input of like this shouldn't have
6 happened, and then the whole cascade of your comments
7 begins to, well, then that's lower quality of life for the
8 bene and then there's detriment, that type of thing, and
9 very imperfectly, and that's it.

10 DR. CROSSON: Okay. I've got Bruce and then Pat
11 and then Amy.

12 MR. PYENSON: Stephanie, I noticed on what looks
13 like page 10 of the report, there is a reference to
14 medication therapy management as one of the strategies
15 people you interviewed to avoid hospitalization with
16 medication errors and things of that sort. I think it's
17 safe to say that virtually everybody in this population, if
18 they have prescription drugs, are getting it through a Part
19 D plan. And Part D plans -- probably with the LIS, low-
20 income subsidy. And Part D plans are supposed to have
21 medication therapy management as part of their services.

22 So to the extent -- my question is whether we can

1 evaluate whether the Part D plans are doing an adequate job
2 with this population through the data. So, for example,
3 whether there's particular admissions that we might
4 recognize as medication errors or things of that sort.

5 MS. CAMERON: So I think you're absolutely right,
6 and the Commission has done other work kind of on this
7 topic more generally, not necessarily for this long-stay
8 population. But, in general, the Commission has done prior
9 work on medication therapy management through Part D.

10 I think what we heard from our interviewees was
11 that having someone in the facility also really managing
12 the medications, especially as beneficiaries kind of went
13 from a hospital back to the facility, you know, if there
14 was an intervening hospitalization, there was often, you
15 know, the immediate need for a review of the medications
16 because there -- what we were told was there were often
17 inconsistencies with dosing amounts of the drugs that were
18 provided, and there really wasn't any coordination between
19 the hospital and the facility.

20 And so I think when we talk about medication
21 therapy management in kind of this setting, it's more the
22 immediate following, you know, another -- following the

1 beneficiary's either hospitalization or visit to an ED that
2 they have talked about as being really important.

3 DR. CROSSON: Okay.

4 MS. WANG: The discussion before about quality I
5 think is a really important one because there's tremendous
6 variation in SNFs across the country. They play different
7 roles in different communities and sort of the concept of
8 who goes to long-term care for this, that, or the other I
9 think is different from place to place. So, you know, the
10 measure of avoidable hospital admissions is one measure of
11 quality, but, you know, sort of prioritizing quality might
12 also -- you know, we might also agree that for some of the
13 smaller facilities, for example, we want those people to go
14 to the hospital because there's no way that that SNF can
15 actually take care of that person adequately inside. And
16 so, you know, it raises questions about like if the
17 expectation is that folks don't go to the hospital anymore,
18 what are the eyes on the SNF to make sure that care is
19 really -- you can avoid a hospital admission in a lot of
20 ways, but if death is the only measurement of quality in a
21 setting where people die a lot -- you know, what I'm trying
22 to say is what is the -- part of this is -- this is very

1 interesting information. I think it's really important.
2 But what is the end-state vision of what we think a SNF
3 should look like? Okay? If I look at Table 3 on page 19 -
4 - and this may be a bridge too far -- it seems to me that
5 when you look at -- when you rate the characteristics of
6 SNFs with highest hospital admissions, 90th percentile,
7 certain things popped out and that, in general, the
8 facilities that did a better job were larger, not-for-
9 profit, and hospital-based. Is that fair to say? Not so
10 much urban-rural, but those other characteristics, if we
11 think that those are sort of leading edge and sort of best
12 practice, it might suggest future work in the direction of
13 connecting those sort of smaller, more poorer performer
14 facilities with SNFs with these characteristics. It's
15 inherent in some of the comments about access to
16 physicians, access to telehealth, access to nurse
17 practitioners. Maybe there's a more direct correlation
18 there. I'm just suggesting.

19 The other observation I would make, just looking
20 at this table, going back to the earlier discussion about
21 the PAC PPS, is that my recollection is that hospital-based
22 SNFs would benefit from the uniform PPS, so maybe looking

1 at this table, which is an indication of quality, further
2 suggests that that's the right direction to go in. But I'm
3 trying to grasp the conversation that we had about quality.
4 Like what is the end state here that we're all looking for?

5 DR. CROSSON: Okay. Just a reminder, we're on
6 clarifying questions. Do you have a comment on --

7 DR. NERENZ: A clarifying question just on Pat.
8 These are not necessarily SNFs, right? In fact, for the
9 most part they are not SNFs?

10 MS. CAMERON: So this is -- and, again, I think
11 stepping back to an earlier slide, this is where it does
12 get confusing in that, you know, we use the term "nursing
13 facility" and "SNF" very interchangeably, I think, in our
14 everyday lexicon, and really SNF is a Medicare concept,
15 it's a post-acute Medicare concept. And so many facilities
16 do provide SNF services and long-stay nursing facility
17 services. Most, in fact, do. There are some that only
18 provide -- truly do only provide post-acute care, and there
19 are some facilities that really want to focus on long-stay
20 nursing facility residents. So there is a wide variation
21 of what nursing facilities as kind of an umbrella term
22 serve in terms of post-acute and long stay. But we are

1 focused on a population of long-stay residents in this
2 work.

3 DR. NERENZ: Okay. Well, that's why I wanted to
4 clarify, because one of the measures that you talked about
5 was actually the transition from non-SNF to SNF, which
6 implies that the main denominator is not SNF. I just
7 wanted to clarify that.

8 MS. CAMERON: That's right. All of our
9 denominators are only beneficiaries that exceed 100 days in
10 a facility.

11 DR. NERENZ: Got it. Okay.

12 MS. BRICKER: At the risk of being
13 oversimplistic, I thought it was fascinating, the
14 observation around on-site X-ray. In your opinion, based
15 on what you know, is this something that could actually be
16 solved for? Would it make, you know, enough of a
17 difference either having incentives or penalties for not or
18 trying to solve for they should all have access to on-site
19 X-ray?

20 MS. CAMERON: You know, I think there's an
21 association there. It makes me nervous to think on my feet
22 and give a policy about whether or not all nursing

1 facilities should provide a service. We know there's an
2 association with lower risk of hospitalizations, and the
3 access to X-ray services, which are mostly contracted
4 services, nursing facilities typically don't own their own
5 X-ray equipment. This is a service that is provided where,
6 you know, an X-ray service will come to the facility when
7 necessary. But that is something -- you know, and
8 Medicare obviously pays for those X-rays, so that is
9 something, you know, that was associated with lower rates
10 of hospitalization and would avoid -- you know, if a
11 beneficiary is going to the hospital for purposes of an X-
12 ray, they are exposed to the things that we talked about a
13 little bit earlier, and this having on-site prevents that
14 exposure.

15 DR. REDBERG: Just on that point, Jay?

16 DR. CROSSON: Okay.

17 DR. REDBERG: It just doesn't seem -- you know,
18 looking at the list in Appendix A of the potentially
19 avoidable hospital admissions, I mean, in X-ray I think
20 we're mostly talking about a fall and you're looking for a
21 broken bone. Very few of those. I just don't think it
22 will make a big difference.

1 DR. MILLER: And the other thing I would add --
2 and, you know, again, this then will spillover into
3 discussion as opposed to clarification. You know, a
4 question for you guys always to be thinking about in all of
5 these conversations is: Do you see something and say, "I
6 want each provider to do this," and be directive? Or do
7 you want to say, "I want to measure an outcome I'm looking
8 for, avoided hospitalizations, you guys figure out the way
9 to do it"? And so that always becomes a question, which
10 gets us into Round 2, which gets me into trouble with him.

11 DR. CROSSON: Paul, keep us out of trouble.

12 DR. GINSBURG: I'll try. Earlier we were having
13 this discussion about the particular geographic areas of
14 states that had particularly high rates of events like SNF
15 admissions, and I started thinking about the Commission's
16 prior work on overall -- this was actually by county rather
17 than by state, but Medicare spending per beneficiary and
18 the variation. And if I recall properly, the key factor
19 behind variation was post-acute care. I was wondering if
20 there is some correlation between the areas that came out
21 in your screens and the ones that came out in that prior
22 work. It could be all part of the same story.

1 MS. CAMERON: Yep.

2 DR. CROSSON: Okay. So we have really a two-part
3 discussion period here. Stephanie has asked for comments,
4 having received some since the last presentation, to
5 improve the June chapter, which she will now proceed to
6 draft -- write, actually. So that's one.

7 And the second one, which you can find on Slide
8 12 -- and we've heard some already in the question period -
9 - priorities for future work in this area. We've already
10 heard a few. So those are the two things.

11 So can I see roughly who would like to make
12 comments at this point? Okay. I see more over here, so
13 we'll start with Alice.

14 DR. COOMBS: I just wanted to speak to something
15 that Amy had talked about, and having a chest X-ray at a
16 facility may be a proxy for having robust access to
17 resources. So that same facility may have more nurse
18 practitioners.

19 One of the things I was concerned about is that
20 there was a tool that -- I think it was CMMI was conducting
21 on communications on transfer from acute-care facilities to
22 nursing homes or to PACs. And I'm wondering if that ever

1 was able to lend itself to any information that may be
2 something we could apply in this entity. So it was a data
3 system whereby information was collected from one health
4 care resource facility or entity to transfer that
5 information to a long-term-care nursing home or a short-
6 term facility. And I looked at the tool just briefly
7 because it was proposed by an entity in Massachusetts, and
8 I saw that it had some really neat things about not just
9 med reconciliation, because I think everyone is on board
10 with med reconciliation, but the whole thing from having
11 the discussion for end-of-life care, whether or not a
12 patient was no resuscitation. It was very comprehensive,
13 and I think that piece is really important to have the
14 family engagement, you know, the bracelets and the whole
15 works.

16 And so I'd be interested to know if some of the
17 facilities you've looked at have been engaged in that kind
18 of work.

19 MS. CAMERON: So I can speak to this a bit.
20 There are suites of resources that provide facilities, and
21 many of the facilities in, for example, the CMMI demo that
22 we've been talking about use that provides all sorts of

1 kind of communication forms, and that might be, you know,
2 what the facility needs to communicate with the on-call
3 physician prior to -- you know, and what information needs
4 to be gathered by the nurse's aides, the nurses on site,
5 before initiating a call. There are also forms that do
6 talk about, you know, end-of-life preferences and, you
7 know, making sure that those forms get transferred if the
8 beneficiary is going to the hospital, that all of that goes
9 with the beneficiary.

10 So we have seen definitely -- or I should say we
11 have heard about steps and suites of communication kind of
12 forms that have been carried forward that the facilities
13 are really trying to implement to help communication and
14 get at, I think, exactly your point.

15 DR. COOMBS: And the literature about states with
16 most forms and what that looks like in terms of
17 inappropriate admissions to acute-care hospitals, and I
18 think that we have most forms within our state, but I would
19 look at that as well, because that may be another clue as
20 to inappropriate admissions and ED visits.

21 MS. CAMERON: I actually did touch on this a
22 little bit in my analysis. What I did was I looked at the

1 states that either had some level of pulsed or most or --
2 you know, every state I think has a little bit of a
3 different name for these. And when you kind of do a very,
4 very high level analysis looking at the states that
5 actually have implemented these programs, those states do
6 tend to have -- there's a correlation between the lower
7 readmission rates and the use of those programs. But it's
8 a very high level, and, you know, every state is at a
9 different developmental standpoint from that perspective.

10 DR. COOMBS: So I was just saying a negative
11 predictive value of states that don't have any initiatives,
12 then that might be very valuable going forward.

13 DR. CROSSON: Okay.

14 MS. THOMPSON: Well, my comments really echo
15 yours, and that just gets back to, Stephanie, my suggestion
16 that we visit with some of the folks who have been in the
17 ACO work because my prediction would be we will find a lot
18 of pretty mature palliative care programs where good time
19 is spent, you know, talking with patients and families
20 about what do you want and what do we want these last days
21 to look like. You know, I think we had some conversation
22 in our discussion about outcomes in terms of what's the

1 end-stage vision for what does this facility look like and
2 what are the characteristics. Maybe if we put our focus on
3 what is our work around helping patients and families to
4 find their end-stage vision, because I think this is the
5 most vulnerable population in terms -- do they even want to
6 go back to the emergency room? Do they even want to go
7 into the hospital and go through ICU and antibiotics and
8 all the things that on the financial side of this equation
9 we're very concerned about?

10 So I think upstream here we could get ahead of
11 this and be very, very appropriate and dignified to the
12 Medicare beneficiary. So I just think there's an
13 incredible opportunity here. So I do, I love this work, so
14 thanks.

15 MR. THOMAS: Just a real brief comment. I think
16 that just putting a focus and daylight on this will impact
17 it in a positive way, and I think you'll see that in ACOs
18 or integrated organizations that are more active and
19 engaged with these organizations, you'll see improved
20 reductions in readmissions or admissions to hospitals.
21 There is such wide variation there. You know, we find that
22 our experience is organizations that are focused on it do a

1 much better job and have programs that are in place to
2 reduce this type utilization.

3 I would agree with Sue that, you know, palliative
4 care has a big focus on it as well, but I think this is
5 great work just to put daylight on it and to make it a
6 priority. And the more we do that, I think you'll see
7 improvement in this area.

8 DR. DeBUSK: I would second that. I do think
9 there's some great work in this area. My question is:
10 Would we want to weigh in on bed-hold policies at some
11 point or maybe even tie some of that back to utilization
12 rates?

13 MS. CAMERON: Well, I think bed-hold policies,
14 you know, have been shown to influence hospital use in
15 other research. Bed-hold policies are decisions that are
16 made at the state level. It's truly a Medicaid payment
17 issue, so, you know, there are right now 51 different
18 policies, and it really affects the Medicaid payment piece,
19 although, yes, I mean, it then blends into Medicare because
20 Medicare is obviously paying for the hospitalization. But
21 a bed-hold policy is a state-level policy.

22 DR. DeBUSK: Agreed, but it does impact program

1 spending on the SNF side, which, I mean, just simple, hit-
2 it-over-the-head solution, what if you deducted bed-hold
3 payments from SNF reimbursement?

4 DR. MILLER: So since we are putting Stephanie on
5 the spot, maybe I'll --

6 DR. DeBUSK: Sorry.

7 [Laughter.]

8 DR. MILLER: That's all right. It's an
9 interesting thought. It's not one that I had, and so what
10 I would say at this particular point is I think as a
11 Commission you'd have to be careful and even by law not be
12 making recommendations about Medicaid. That I think would
13 be out of our lane. The notion of, however, pointing out
14 the relationship, which I think is somewhat contemplated in
15 the chapter -- or is it not in there?

16 MS. CAMERON: It's briefly contemplated because
17 of the issue that every state has a different policy with
18 varying degrees of --

19 DR. MILLER: Right. And so what I would say is
20 we can certainly make it clear that there is this
21 relationship, because this relationship is established in
22 the literature. People know it, you know, and that type of

1 thing. And if there was appetite for it, revisit it on the
2 Medicare metric and payment side. But I wouldn't want to
3 do that on the fly. I'd want to take your thought and, you
4 know, kind of parse through it. But I think it would be
5 out of our lane to say Medicaid law or policy should be
6 changed. That, we would be out of our lane.

7 DR. CROSSON: Okay. Can I see hands on this side
8 again? David and Bruce.

9 DR. NERENZ: Yeah, just a couple things, and
10 these I think involve possible expansions as this moves
11 forward. One is I'd like to learn a little more about the
12 financing pieces of the CMMI models or other similar
13 initiatives. I think the text makes some sort of brief,
14 passing mention that, you know, project funding was used
15 for X, which implied to me that there's some kind of
16 special or supplemental funding streams that's sort of
17 characteristic of CMMI projects. And then the sobering
18 part, though, is that there's not a clear net savings
19 benefit, so even though you can do some extra things,
20 presumably pay for them, it's kind of this classic offset
21 problem that looks good, and then you don't see it in
22 practice, where you can reduce admissions but then you net

1 it all out, it's not necessarily better.

2 I guess I'd like to see more of that, and the
3 reason -- to the extent it's there to be had. The reason I
4 think that that takes us in the direction of possible
5 Medicare payment initiatives that squarely are in our lane
6 that we might consider. So, for example, if one of the
7 reasons that patients get admitted too much is that there's
8 not enough physician time in the facility, is there some
9 sort of tweak to Medicare payment that would solve that
10 problem, that would pay physicians to be in the facility?

11 I think the CMMI project sounds like there may be
12 examples of that. There may be other examples. But I
13 guess I'd appreciate seeing sort of in front of us are
14 there very specific Medicare payment changes that might be
15 considered that would speak to the issue of too many
16 admissions or too many ED visits in this setting.

17 And the second thing is I'd like to know a little
18 more about the physician or possible nurse practitioner
19 models that are present in these facilities. We've used
20 the term "on-call," and that has certain meaning. It's
21 implemented in certain ways. It implies to me just by its
22 terminology that possibly it's a little late in the game,

1 meaning the patient's already in trouble and then somebody
2 gets called, and by that time the patient is on his or her
3 way to the hospital anyway. It's not necessarily so. But
4 I'm thinking also that there are relationships in which a
5 nursing facility has some standing relationship with a
6 physician or with a nurse practitioner or perhaps with a
7 group and that's paid in some way, and that suggests that
8 all the residents in the facility come under sooner or
9 later the auspices or the care of that physician.

10 Now, that's a different model from saying that
11 every single resident in that facility has his or her own
12 physician that he or she has had for 20, 30, or 50 years,
13 and that it's multiple physicians who deal with individual
14 patients, but not necessarily responsibility for the whole
15 place.

16 I'd just like to know more. How did that work?
17 And is there any evidence that one model works better than
18 another or that as a matter of payment policy, we should be
19 shifting things preferentially in one direction or another?

20 DR. CROSSON: Bruce.

21 DR. COOMBS: I'm sorry, can I comment on this?

22 DR. CROSSON: I'm sorry. Alice, go ahead.

1 DR. COOMBS: I just want to say what you're
2 looking at is closed systems versus open systems. And it
3 varies across the country but what he's saying may make a
4 difference because when you have closed systems where there
5 is one team of internists or primary care doctors who are
6 working in a group they more likely -- and this is my own
7 bias -- may have protocolized care, where something happens
8 and there's like a way to do something in a predictable
9 fashion.

10 Whereas the other, it may be more of a division
11 of what this practitioner is used to who's covering the
12 nursing home for a month, 24 hour call. So that may make a
13 difference with the utilization of ED services and services
14 outside of the institution.

15 DR. CROSSON: Bruce.

16 MR. PYENSON: Stephanie, terrific report. Thank
17 you very much.

18 I am wondering if in the future iterations we
19 could look at the role of end-of-life care for these
20 patients. In particular, it strikes me that when a patient
21 in a nursing home receives hospice care, that's in effect a
22 transfer of liability for the daily rate from the Medicaid

1 program to the Medicare program. And to see, to look at
2 how that works, some of the statistics on that and the
3 variability in that.

4 And another issue that I am curious about is the
5 variation in the use of nursing home in the context of
6 long-term supports and services, in particular home and
7 community-based waivers. There is a big variation by state
8 in the use of long-term care site, whether it's nursing
9 home or community, and whether that plays a role in some of
10 the variations that we've seen.

11 DR. CROSSON: Okay, Craig and then Jack. Last
12 comments.

13 DR. SAMITT: So I want to tag on to Sue's
14 comments actually about digging deeper into some of the
15 benchmarking. And I'm not so sure I would suggest looking
16 at ACOs, per se. And I certainly let a session go by
17 without referencing encounter data. Sorry.

18 [Laughter.]

19 DR. SAMITT: But I do wonder, I mean the
20 benchmarking that's been done really is analyzed, I would
21 say, more from the provider prospective, what is unique
22 about these facilities. I am interested in more from a

1 plan perspective.

2 So if we were to look at some of the MA plans, in
3 particular, I would be curious to know which have encounter
4 data that suggests that they have achieved good results and
5 favorable results in admission rates for hospital for the
6 long-term residents. I would be interested to know which
7 MA plans are doing that very well. And what specific
8 payer-driven interventions they've put in place that can
9 drive to those great results. And I don't know whether
10 there are policy recommendations that can be learned for
11 CMS from what some of those private plans are doing.

12 DR. CROSSON: Okay, Rita, do you have a point on
13 what Craig said?

14 DR. REDBERG: Yeah.

15 DR. CROSSON: Go ahead.

16 DR. REDBERG: And I think that would be valuable.
17 I think there is some data thought currently that suggests
18 that when MA plan patients start getting expensive in those
19 -- they move to fee-for-service Medicare. And so it would
20 be hard to account for that.

21 DR. CROSSON: Jack and then you.

22 DR. HOADLEY: So this last set of comments makes

1 me think -- and I don't think this was mentioned anywhere
2 in the chapter -- whether the financial alignment
3 demonstrations, the dual demos, give us any insights,
4 whether -- I mean, it's almost a special case of what
5 Craig's talking about. Here are the managed care plans
6 where both streams of dollars are put together and where
7 some of the issues we're talking about are supposed to not
8 be a problem.

9 But I don't know if we know enough yet from any
10 of those, and whether any has specifically looked at that.
11 But that might be something to bring into the discussion
12 down the road.

13 DR. CROSSON: Okay, so I think, Stephanie, we
14 have good support for the chapter. Go for it.

15 But then, with respect to future work, I think
16 Mark would like to make some closing comments.

17 DR. MILLER: Yeah, I want to manage expectations
18 here a little bit. Stephanie will work through the weekend
19 and we'll take care of all of this.

20 I want to manage expectations in a couple of
21 ways. I do want to just deal with your comment. You know,
22 we have done site visits on the dual integration

1 demonstrations. At that time, there wasn't -- beyond
2 process issues and that type of stuff -- there weren't
3 results. But we're going to be -- we're going to keep
4 looking. We're going to keep going at it. And I think
5 that issue will continue to be -- even rise, given some of
6 the directions other policy areas are going.

7 The second thing I want to say is you made a lot
8 of suggestions for future ideas. For example, the payment
9 stuff that you guys were saying other ways to -- Brian and
10 David, other ways to incent payment. And Bruce, you were
11 asking about the end-of-life, and there were other comments
12 that we could look at.

13 So what I would like to do in the chapter is to
14 end up with a list of possible directions. I'm not going
15 to be able to deal these out in time for the June report.

16 And then, as we go forward, we'll have to figure
17 out the priorities here because you guys also ask for other
18 things. And so we will get Stephanie to flesh out the
19 things that we said in the chapter, put a list of ideas at
20 the end of that chapter, and then going forward we will
21 figure out which one of those we want to chase down.

22 That's what you should expect to see in the

1 chapter. That's all workable? Stephanie, you're okay?

2 DR. CROSSON: Okay, seeing no further comments,
3 Stephanie, thank you again on behalf of the Commission for
4 this work. We look forward to future work, as well as
5 naming rights.

6 [Laughter.]

7 DR. CROSSON: So now we have time for the public
8 comment period. If there are any members of the public who
9 wish to make a comment, now is the time to come up to the
10 microphone.

11 [No response.]

12 DR. CROSSON: Seeing none, then we are adjourned
13 until 1:30.

14 [Whereupon, at 12:11 p.m., the meeting was
15 recessed, to reconvene at 1:30 p.m., this same day.]

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AFTERNOON SESSION

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[1:29 p.m.]

DR. CROSSON: Okay. Good afternoon, everyone. We have a busy afternoon. The first agenda item is our return to the issue of Part B drug payment, and we will have a presentation by Kim Neuman, Nancy Ray, and Brian O'Donnell. And we will proceed to our first examination of the draft recommendations, which will be revisited again in April for a final vote.

So, Brian, you looked poised to begin. Please go ahead.

MR. O'DONNELL: Good afternoon. In this session, we are continuing to examine ways to address the rapid growth in Part B drug spending. In particular, we will be discussing a package of policy reforms that the Commission has been developing over the last two years and that was most recently refined based on the Commission's feedback from the January meeting.

The goal for our discussion today is to solicit feedback on the Chairman's draft recommendation, with the intent of having final a recommendation ready for a vote during the April meeting.

1 In terms of background, I know this information
2 is not new to the Commission, but it's worth reviewing a
3 couple basic facts regarding Part B drugs as they help
4 motivate our discussion today.

5 First, Medicare spent \$26 billion on Part B drugs
6 in 2015, with the program paying \$21 billion and
7 beneficiaries being responsible for \$5 billion.

8 Beyond the magnitude of expenditures, the
9 Commission's interest in reforming the payment structure of
10 Part B drugs over the last several years has been driven by
11 a couple of concerns, including potential incentives under
12 the ASP+6 system for providers to choose higher-priced
13 products and the rapid growth in the prices of and
14 expenditures for Part B drugs.

15 In fact, Part B drug expenditures grew 13 percent
16 from 2014 to 2015, the most recent year for which we have
17 complete data. This growth rate is part of a longer-term
18 trend as well. From 2009 to 2015, growth in Part B drug
19 expenditures averaged 9 percent per year, which far
20 outstrips the growth in the economy and many other health
21 care sectors over the same time period.

22 Part of that growth has been driven by price

1 increases. For example, from 2009 to 2013, half of the
2 growth in expenditures was driven by price growth, which
3 includes price increases for existing drugs and a shift in
4 the mix of drugs to higher-priced products.

5 This next slide gives some broader context for
6 how our package of reforms could fit together and the
7 potential timing of the reforms. As the figure shows, our
8 first set of reforms is aimed at improving the current ASP
9 system and can be implemented almost immediately.

10 The Commission has also expressed substantial
11 interest in a longer-term reform, which is the creation of
12 an alternative, voluntary program that providers could
13 choose to enroll in instead of remaining in the traditional
14 buy-and-bill system. The design of this new market-based
15 program, which we refer to as the Drug Value Program or
16 DVP, is informed by Medicare's experience with the
17 competitive acquisition program for Part B drugs, with
18 several key improvements. Kim will discuss the details of
19 the DVP later in the presentation.

20 Also, as part of the transition to the DVP, the
21 current ASP add-on of 6 percent could be reduced to give
22 providers an incentive to enroll in the DVP.

1 Now I will start walking through the specific
2 policy reforms, beginning with improving ASP data
3 reporting.

4 As we discussed in January, only manufacturers
5 with Medicaid rebate agreements are required to report
6 their ASP data. Some entities, such as repackagers and
7 manufacturers of drugs that are considered devices by
8 Medicaid, do not have Medicaid rebate agreements and are,
9 therefore, not required to submit ASP data. Also, some
10 manufacturers who are required to report ASP data fail to
11 do so in a timely manner.

12 A policy reform for the Commission to consider is
13 requiring manufacturers to report ASP data for all Part B
14 drugs and increase the civil monetary penalties for failing
15 to report the data in a timely manner.

16 As part of this policy, the Commission could
17 consider giving the Secretary the authority to exempt
18 special cases from reporting. For example, repackagers,
19 entities that buy and then repackage drugs into smaller
20 doses, could be excluded from reporting to ensure drugs are
21 not double counted (as repackagers' drugs would already be
22 included in another manufacturer's ASP submission).

1 Our next issue is drugs that are paid based
2 solely on manufacturers' list prices, which is referred to
3 as the wholesale acquisition cost or WAC. Importantly,
4 WAC-based prices do not incorporate discounts that
5 manufacturers commonly provide.

6 New single-source drugs and the first biosimilar
7 to a reference biologic can be paid at WAC+6 for nearly
8 three quarters because ASP is based on the first full
9 quarter of data and there is a two-quarter lag due to data
10 reporting.

11 Our analysis found that for a subset of new,
12 high-expenditure drugs, small discounts were common while
13 the drugs were WAC-priced. Consequently, Medicare
14 currently pays more for the same drug when it is WAC-priced
15 compared to when it is ASP-priced.

16 To bring WAC-based prices and ASP-based prices
17 for the same drug closer together, the Commission discussed
18 the possibility of reducing the WAC add-on by three
19 percentage points, roughly the high end of the discounts we
20 observed.

21 In addition, to maintain parity to ASP-priced
22 drugs in the future, the WAC add-on could be further

1 reduced if the ASP add-on is reduced to encourage
2 enrollment in the DVP. For example, if the ASP add-on is
3 reduced by one percentage point -- going from 6 percent to
4 5 percent -- then the WAC add-on could be reduced by the
5 same amount -- going from 3 percent to 2 percent.

6 Now Nancy will now take over with a discussion of
7 the ASP inflation rebate.

8 MS. RAY: Thank you, Brian.

9 Growth in the ASP payment rates are driven by
10 manufacturer pricing decisions. There is no statutory
11 limit on how much Medicare's ASP payment for a product can
12 increase over time. For example, between 2010 and 2017,
13 about half of the top 20 highest expenditure Part B drugs
14 had annual price growth of 5 percent or more.

15 During the October and January meetings, we
16 discussed improving the Part B ASP system by implementing
17 an ASP inflation rebate. This policy would require
18 manufacturers to pay Medicare a rebate when ASP growth
19 exceeds an inflation benchmark. Under this policy, the
20 savings from rebates would be shared with the beneficiary
21 by basing cost sharing on the lower inflation-adjusted ASP.
22 The provider add-on payment would also be based on the

1 inflation-adjusted ASP.

2 To address the concern about CMS administrative
3 resources to implement a rebate, lower-cost drugs could be
4 excluded from the policy. Also, duplicate discounts could
5 be avoided meaning that the ASP inflation rebate could
6 exempt Medicare utilization already subject to a 340B
7 discount or Medicaid rebate.

8 An inflation benchmark would need to be chosen.
9 It could be CPI-U like the Medicaid inflation rebate, or an
10 alternative could be considered. If an alternative is
11 chosen, a principle that could be considered is that the
12 inflation benchmark be in a similar range to the annual
13 payment updates received by Medicare providers.

14 Next, under the current ASP system, to promote
15 maximum competition the brand drug and its generics are in
16 one billing code, and all biosimilars associated with the
17 same reference biologic are paid in one billing code. By
18 contrast, we do not have maximum competition for most
19 single-source drugs and for reference biologics because
20 they are each paid under their own billing codes.

21 It is widely recognized that separate billing
22 codes do not maximize price competition, and your briefing

1 paper provides examples.

2 In more than one policy area, the Commission has
3 held that Medicare should pay similar rates for similar
4 care recognizing clinical differences. For example, the
5 Commission has recommended site-neutral payments for
6 certain services across the physician fee schedule and the
7 hospital outpatient department, as well as for select
8 patients across long-term-care hospitals and acute-care
9 hospitals.

10 During the October and January meetings, we
11 discussed improving the Part B ASP system by implementing a
12 consolidated billing code policy for the reference biologic
13 and its biosimilars.

14 This policy would require the Secretary to group
15 the reference biologic and its biosimilars in the same
16 billing code and pay them the same rate based on the
17 volume-weighted ASP for the products in the code. To group
18 the reference biologic and its biosimilars, the Secretary
19 would rely on the FDA approval process for biosimilars
20 established by the Biologics Price Competition and
21 Innovation Act of 2010 to determine what products to group
22 together.

1 Under a combined billing code policy, the
2 clinician would continue to have the choice to prescribe
3 the most appropriate product for the patient, with
4 Medicare's payment based on the volume-weighted ASP of all
5 the products assigned to the code. The Secretary could be
6 given the flexibility to implement a limited payment
7 exception process under which Medicare would reimburse the
8 provider based on the ASP of the higher-priced product. A
9 limited payment exception process addresses the concern
10 that beneficiary access could be harmed if some providers
11 are unwilling to supply the higher-cost product to a
12 beneficiary who needs a particular product due to clinical
13 reasons.

14 While there was most consensus for using a common
15 billing code to pay for a reference biologic and its
16 biosimilars, there was also some consensus for using
17 consolidated billing codes more broadly beyond the
18 reference product and its biosimilars. The text in the
19 draft chapter will include language encouraging the
20 Secretary to examine the potential of using the
21 consolidated billing code policy for groups of drugs with
22 similar health effects and for groups of biologics with

1 similar health effects.

2 And now Kim will take you through the Drug Value
3 Program.

4 MS. NEUMAN: The policies Nancy and Brian just
5 discussed would seek to improve the current ASP payment
6 system. Next we will talk about developing a second
7 system, which would be a voluntary market-based alternative
8 to the ASP buy-and-bill system.

9 This policy would give the Secretary the
10 authority to create a Part B Drug Value Program that would
11 use private vendors to negotiate prices and offer providers
12 shared savings opportunities.

13 The Drug Value Program, or DVP, would be informed
14 by lessons learned from the former competitive acquisition
15 program for Part B drugs, but structured differently to
16 increase vendors' negotiating leverage and encourage
17 provider enrollment.

18 The DVP would be voluntary for physicians and
19 outpatient hospitals. Each year these providers would
20 decide whether to enroll in the DVP or remain in the ASP
21 buy-and-bill system.

22 To encourage providers to enroll in the DVP, the

1 ASP add-on would be reduced gradually in the buy-and-bill
2 system. The reduction to the ASP add-on could be timed to
3 coincide with the target date for operationalizing the DVP.
4 The add-on reduction could begin by that target date
5 regardless of whether the DVP has been operationalized to
6 create pressure for implementation of the DVP.

7 The DVP program would involve a small number of
8 private DVP vendors. This would give providers a choice of
9 which DVP they wanted to work with while consolidating
10 volume among a small number of vendors in order to
11 facilitate negotiating leverage.

12 The DVP vendors would negotiate Part B drug
13 prices. DVP prices would be kept confidential. DVP
14 vendors would not directly ship product to beneficiaries;
15 rather, providers would buy drugs in the marketplace from
16 distributors, wholesalers, or directly from manufacturers
17 at the DVP-negotiated rate.

18 In terms of Medicare payment rates, providers
19 would be paid for drugs at the DVP price and would continue
20 to be paid for drug administration services under the
21 physician fee schedule or the outpatient prospective
22 payment system.

1 An important feature of the DVP program would be
2 shared savings opportunities for providers. If the DVP
3 program resulted in lower total cost of Part B drugs,
4 enrolled providers would share in those savings.
5 Beneficiaries would also share in savings because they
6 would pay lower cost sharing.

7 Vendors would be compensated through an
8 administrative fee, which might be a fixed dollar fee or a
9 fee per enrolled provider, or a combination of approaches.
10 Vendors would also be eligible for shared savings if the
11 DVP resulted in lower total cost of Part B drugs and they
12 met standards for promoting quality or met other
13 performance benchmarks.

14 We've talked about this model as being similar to
15 a GPO. But one key difference is that Medicare would share
16 in the savings under the DVP; whereas, it does not share in
17 the savings under existing GPOs. With the DVP model,
18 Medicare shares in savings because the Medicare payment
19 rate for the drugs under the DVP would be set at the DVP-
20 negotiated rate.

21 One of the challenges that the prior CAP program
22 faced was that vendors had little leverage to negotiate

1 discounts. With that in mind, the DVP would be structured
2 to include several tools to increase negotiating leverage.

3 First, private vendors would be permitted to
4 develop a formulary. We would expect that a formulary
5 would spur price competition among products with
6 therapeutic alternatives -- for example, when there are
7 multiple brand products in the same therapeutics class --
8 and this would result in lower prices for these products.
9 Recall that a problem with the CAP program was that CAP
10 vendors had to offer all drugs, giving them little
11 negotiating leverage. Permitting the DVP vendors to
12 operate a formulary would address this.

13 Second, prices under the DVP would be limited to
14 no more than 100 percent of ASP. This would ensure that
15 vendors can get at least typical market prices for all
16 drugs.

17 Third, vendors could be permitted to use
18 additional tools like step therapy and prior authorization.

19 Fourth, binding arbitration could be used in the
20 DVP for expensive drugs without close substitutes.

21 A couple other key elements of the DVP structure:

22 DVP prices would not be included in the

1 calculation of ASP in order to give vendors more
2 negotiating leverage with manufacturers.

3 Finally, it will take time to develop the DVP so
4 it could be phased in beginning with a subset of drugs
5 where the savings potential appears to be greatest and
6 which are most straightforward to implement.

7 In the description of the DVP program we just
8 went through, we talked about reducing the ASP add-on in
9 the buy-and-bill system to encourage DVP enrollment.

10 At the January meeting, there was some
11 conversation about the sequester, which reduces the
12 provider's payment from 106 percent of ASP to 104.3 percent
13 of ASP and the implications of this for reducing the ASP
14 add-on.

15 In our June 2016 report, we had some work that
16 was relevant to that discussion.

17 In that report, to get a sense of how the prices
18 providers pay for Part B drugs compare to Medicare payment
19 rates, we analyzed proprietary invoice price data from IMS
20 Health Incorporated. These data break out prices for the
21 clinic channel of purchasers, which includes physician
22 offices, hospital outpatient departments, and certain other

1 purchasers. The IMS invoice prices reflect all on-invoice
2 discounts but do not reflect off-invoice rebates.

3 Our analysis found that for two-thirds of the 34
4 Part B drugs we examined, at least 75 percent of the volume
5 was sold to clinics at an invoice price less than 102
6 percent of ASP.

7 In addition, we looked at pricing data for the
8 quarters before and after the sequester went into effect
9 and found that manufacturers appeared to alter their
10 pricing patterns in ways that mitigated the effect of the
11 sequester on some providers.

12 To make the DVP program more concrete, here is a
13 hypothetical example of how it would work. In this
14 example, we have a drug with an ASP of \$500. The DVP
15 vendor in this example negotiates a price with the
16 manufacturer of \$400.

17 Providers enrolled in that DVP would buy the drug
18 in the marketplace from wholesalers or distributors and
19 would pay \$400 per dose for the volume they estimate will
20 go to Medicare beneficiaries.

21 Once the provider administers the drug to a
22 beneficiary, the provider will submit a claim to Medicare

1 for the drug and for drug administration services.

2 The provider payment rate for the drug would be
3 \$400, the same amount as they purchased the drug for.

4 The provider would also continue to be paid for
5 drug administration services through the physician fee
6 schedule or outpatient prospective payment system.

7 In addition, the provider would have an
8 opportunity to share in that \$100 savings that comes from
9 the drug costing \$400 instead of \$500. Also, beneficiaries
10 would save in this example through lower cost sharing.

11 From a technical perspective, one thing to note
12 is that there'd be a retroactive true-up that would occur
13 between the provider and the distributor or wholesaler
14 after the drugs are administered to identify the quantity
15 supplied to Medicare fee-for-service patients and ensure
16 that the price paid for that quantity was \$400.

17 So next we'll move to the Chairman's draft
18 recommendation, and as you see, we've put up the overview
19 slide one more time. This gives you sort of a visual
20 picture of the potential policy and how all the pieces work
21 together.

22 So this brings us to the Chairman's draft

1 recommendation, and that reads:

2 The Congress should change Medicare's payments
3 for Part B drugs and biologicals as follows:

4 (1) Modify the average sales price system in 2018
5 to:

6 Require all manufacturers of products paid under
7 Part B to submit ASP data and impose penalties for failure
8 to report.

9 Reduce wholesale acquisition cost-based payment
10 to WAC plus 3 percent.

11 Require manufacturers to pay Medicare a rebate
12 when the ASP for their product exceeds an inflation
13 benchmark, and tie beneficiary cost sharing and the ASP
14 add-on to the inflation-adjusted ASP.

15 Require the Secretary to use a common billing
16 code to pay for a reference biologic and its biosimilars.

17 (2) No later than 2022, create and phase in a
18 voluntary Drug Value Program that must have the following
19 elements:

20 Medicare contracts with a small number of private
21 vendors to negotiate prices for Part B products.

22 Providers purchase all DVP products at the price

1 negotiated by their selected DVP vendor.

2 Medicare pays providers the DVP-negotiated price
3 and pays vendors an administrative fee, with opportunities
4 for shared savings.

5 Beneficiaries pay lower cost sharing.

6 Medicare payments under the DVP cannot exceed 100
7 percent of ASP.

8 Vendors use tools including a formulary and, for
9 products meeting selected criteria, binding arbitration.

10 (3) Upon implementation of the DVP or no later
11 than 2022, reduce the ASP add-on under the ASP system.

12 In terms of implications, the draft
13 recommendation would be expected to result in lower payment
14 rates for Part B drugs and decrease program spending
15 relative to current law.

16 In terms of implications for beneficiaries and
17 providers, the draft recommendation would: generate
18 savings for beneficiaries through lower cost sharing and
19 would not be expected to affect beneficiaries' access to
20 needed medicines.

21 In terms of the effect on providers' revenues,
22 for providers choosing to remain in the ASP system, the ASP

1 add-on payments would be reduced but the effect on
2 providers' net revenues would depend on how manufacturers
3 respond to the policy.

4 For providers that choose to enroll in the DVP
5 program, they would be paid the DVP price for the drug and
6 would have shared savings opportunities.

7 Beyond the specific text of the Chairman's draft
8 recommendation, we would intend to add in the June report
9 additional text to reflect more detail about certain issues
10 or to reflect conversations that occurred among
11 Commissioners about alternative approaches or ideas that
12 could be explored further.

13 For example, on the ASP inflation limit, the
14 Commission discussed two approaches: a manufacturer rebate
15 and a provider payment limit. Although both approaches
16 have merit, there has been broader Commissioner support for
17 the manufacturer assuming financial risk for price
18 increases rather than the provider. So the Chairman's
19 draft recommendation specifies a manufacturer rebate, but
20 the text of the report would mention there is another way
21 to structure the policy and discuss the pros and cons.

22 On consolidated billing, as Nancy mentioned, the

1 text would encourage the Secretary to examine the potential
2 for consolidated billing codes more broadly beyond
3 biosimilars and reference biologics.

4 The text would also discuss the timing of
5 gradually reducing the ASP add-on from 6 percent to 3
6 percent and would make the clear that the WAC add-on would
7 be reduced further as the ASP add-on is reduced.

8 Finally, the text would discuss in more detail
9 design options for binding arbitration under the DVP.

10 So that concludes our presentation. We'd be
11 happy to answer questions and look forward to your
12 discussion.

13 DR. CROSSON: Thank you, Kim, Nancy, Brian. We
14 now have the opportunity for clarifying questions.

15 DR. SAMITT: So starting on Slide 13, you talk
16 about the fact that DVP prices would be excluded from ASP.
17 Can you play back a little bit more of the implications of
18 that? As the DVP utilization grows, what implication will
19 that have on ASP pricing? And does that lead to any
20 dynamics that we would need to be cognizant of?

21 MS. NEUMAN: So ASP reflects the price paid to
22 all purchasers with certain exceptions, and one of the

1 exceptions would be DVP prices. So as the DVP became
2 larger and got greater volume, that would mean that the
3 Medicare volume that is effectively in the ASP would be
4 there no longer. And so you might wonder, is there enough
5 volume in there to calculate an accurate ASP?

6 Since there are other payers besides Medicare in
7 the marketplace and other types of purchasers, you would
8 think that you would generally still have a solid ASP.
9 But, you know, we'd have to think about on a product-
10 specific basis if maybe -- you know, you could imagine
11 there could be situations where there could be an issue,
12 but, by and large, because there's other purchasers and
13 other insurers, we should still have data to be able to
14 calculate the ASP.

15 DR. SAMITT: Okay, thanks. And my second
16 question is on Slide 15 on your example. You talk about
17 provider opportunity for shared savings, and I assume the
18 implication here is that the shared savings percentage
19 would be sufficient enough to incent the use of DVP against
20 the alternative of the buy-and-bill. So, in essence, I
21 think what we would be looking at is, you know, you could
22 do the math, that 6 percent of 500 is \$30, that the shared

1 savings would need to represent at least 30 percent to --
2 you know, as a provider is thinking of alternatives A or B,
3 that we would need to compare and contrast the two.

4 MS. NEUMAN: And with the ASP add-on effectively
5 being ramped down, that 30 would go down a bit to sort of
6 help with that calculus.

7 DR. SAMITT: Got it. Thank you.

8 DR. CROSSON: Clarifying questions, coming up
9 this way.

10 MR. PYENSON: A question for Nancy on the
11 inflation index. On the bottom of page 26 to the top of
12 page 27, you suggest a principle that could be considered
13 for the inflation index benchmark is similar in range to
14 the typical payment updates received by other providers in
15 the Medicare program, particularly physicians and hospitals
16 that purchase these drugs. And my question is whether
17 there's other principles that you've thought of that could
18 be applied here. And what prompts my question is that for
19 sure in the Medicare payments for many kinds of services,
20 some services have -- the payment rates have gone down,
21 including dramatically. So the Medicare system has a way
22 of identifying fees that should be decreasing over time,

1 and whether that's a -- if there's a principle that you
2 could -- other principles that you've thought of other than
3 this one.

4 DR. MILLER: What do you want to do, Nancy? Do
5 you want to take it, or do you want me to?

6 MS. RAY: Why don't you take it [off microphone].

7 [Laughter.]

8 DR. MILLER: Okay. No, I could see the -- but
9 jump in, okay, because I see you were hesitating a little
10 bit.

11 I would say one of the reasons that this
12 principle is expressed and written very directly is it came
13 out of a comment that Warner made in one of our
14 conversations, well, wait a second, you know, if the drugs
15 are allowed to grow at this rate and my rates only grow --
16 you know, shouldn't there be some symmetry there? And we
17 were trying to capture that as probably the strongest and
18 clearest statement on this front that, you know, folks
19 said. We're still open to discussion, and, also, we're not
20 taking a very hard line on what the index is. We're using
21 one for illustrative purposes.

22 Other principles here, you could think about what

1 index, you know, reflects affordability and, of course, how
2 you define that and what that would be I think is, you
3 know, hours of conversation. You could try and capture an
4 index that talked about, you know, the cost of production,
5 but at that point in time, you know, the production of a
6 drug or a biologic is very different than the development.
7 And, again, thinking through all of that I think could be
8 hard. But there's other principles you could try and
9 pursue. I think what we're trying to do is some reasonable
10 proxy for inflation and also being mindful of what Warner
11 said in a different meeting.

12 Nancy, am I close?

13 MS. RAY: Yeah, I guess the other item you could
14 throw out there perhaps is, just like we do for other
15 providers in fee-for-service, some sort of principle to
16 promote efficiency.

17 DR. MILLER: Yeah.

18 DR. CROSSON: Paul, on this?

19 DR. GINSBERG: I was going to raise this in our
20 next go-round, but one of my thoughts is that it would be
21 very useful in the chapter to have some conceptual thing on
22 why there is a need to constrain price increases for

1 existing drugs. And, you know, the framework that I am
2 thinking in terms of is that the market out there for
3 prescription drugs has changed a great deal in the past 15
4 years, mostly because of better coverage. We have Part D
5 in Medicare. We have out-of-pocket maximums in commercial
6 insurance and in the ACA insurance that apply to drug
7 spending as well as hospital physician services.

8 So, in a sense, a lot of the demand restraints in
9 the market has been removed. And what would you expect?
10 You would expect that, you know, the equilibrium price,
11 which we may not think is wise, is likely to go up. And
12 that is why we are seeing some of these substantial
13 increases which cannot be driven by production costs,
14 because in many cases -- because, you know, the fixed cost
15 of developments were already reflected in the introductory
16 price and we are just talking about increases.

17 So I think just some reasoning in the report
18 about why the rates of increase are just not consistent
19 with our notion of an efficient market. This is really an
20 adjustment to a market that has very little demand
21 constraint, and that is the reason we are getting into
22 this.

1 DR. CROSSON: And what I am hearing also -- what
2 you are saying is that the dynamics of this market are
3 further deteriorating as a function of demand change.

4 DR. GINSBERG: Right.

5 DR. CROSSON: Okay, so now a new one on this.

6 MS. WANG: On this.

7 DR. CROSSON: Oh.

8 DR. MILLER: No. Bruce, I think, was still --

9 DR. CROSSON: Oh, Bruce, you were still -- yeah.

10 MR. PYENSON: Just as a follow up, what is
11 different about Part B drugs in particular? I am wondering
12 if this was part of the considerations that Part B drugs
13 are not a consumer-facing service, not nearly in the same
14 way that a physician's service is or even a hospital
15 service. So, I think some of the analogy is perhaps more
16 like producer price or wholesale price as it is sold to the
17 physician.

18 So, as we think about it, I think Paul's
19 suggestion would be very helpful, but to have -- I am
20 curious about this thinking about consumer versus producer
21 or wholesale.

22 DR. CROSSON: Okay, clarifying questions. Pat.

1 MS. WANG: Kim, can you talk about how Medicare
2 Advantage participants are not in the DPP in your --

3 MS. NEUMAN: So the model, as we have constructed
4 it thus far, is a fee-for-service model to this point.

5 DR. MILLER: Yeah, the presumption here is that,
6 you know, the MA plans right now may have their own ways of
7 kind of purchasing, negotiating drugs. They are getting a
8 capitated rate that encompasses all A and B, and they may
9 have their own, you know, strategies for purchasing drugs
10 and we do not have to cross into that area.

11 MS. WANG: Can I request --

12 DR. CROSSON: Let me just say there is one
13 element in our set of recommendations that is a tool that
14 is not available to MA plans right now, and that is binding
15 arbitration. But otherwise, for the most part, the MA
16 plans right now are capable of negotiating and, for the
17 most part, using the tools that we envision in the fee-for-
18 service model.

19 MS. WANG: Can I ask for a little bit more
20 thinking or research into this? I mean, part of what you
21 are describing is the dynamic that occurs with Part D. But
22 Part B, being a provider-driven acquisition process, is --

1 I am not sure that most MA plans have any participation in
2 the purchase of Part D --

3 DR. CROSSON: Yeah. And I apologize because I am
4 thinking of a certain model, or I am used to --

5 MS. WANG: Yeah.

6 DR. CROSSON: -- being as a physician.

7 DR. SAMITT: Well, and to tag on to that, I think
8 the question is could we consider suggesting that
9 prescribers in MA plans could acquire drugs through the DVP
10 program as well? If the infrastructure is being created,
11 wouldn't we want to encourage the same prescribers to
12 acquire drugs through the same vehicle as DVP?

13 DR. CROSSON: Yeah. I mean, it would seem to me
14 to be reasonable, yes. I am sorry for the confusion. I
15 made a mistake, yeah.

16 Amy?

17 MS. BRICKER: My question was similar to what I
18 thought Craig was asking. But further, if I am a physician
19 or a buyer today and I am contemplating joining the DVP or
20 not, I would assume that the majority of the people that
21 would raise their hand are the ones on the wrong side of
22 ASP, bringing the average up.

1 And so, is that the right way to think about it,
2 that if I am a buyer that is doing well, if I -- you know,
3 with ASP I am actually making money when I am reimbursed to
4 ASP because I am a sophisticated buyer, I am less likely to
5 probably join the DVP until such time that ASP
6 reimbursement is no longer attractive to me. And so if am
7 thinking about that right, then the largest buyers that
8 have the most share and the most clout would hold back, not
9 enroll as quickly in the DVP. Is that the right theory, or
10 no?

11 MS. NEUMAN: I think that, in general, that is
12 sort of the incentive on the margin, right, that the
13 smaller purchases who might not be getting as favorable a
14 price might find the DVP more attractive relative to fee-
15 for-service than the larger purchaser. And so, that might
16 happen as you are sort of laying it out.

17 I think that the unknown is, you know, to what
18 extent can formularies and other management tools for some
19 of these very expensive products lead to large savings?
20 And if that is the case, then the DVP could be attractive
21 as well to some of these bigger purchasers because they
22 might be purchasing a bit below, but if you could get

1 substantial savings for the DVP there might be sharing
2 opportunities that are attractive to them in the DVP
3 program.

4 DR. MILLER: Can I get you to continue one more
5 round on this, just like -- in the middle of what you said,
6 you said something about it being more expensive as a
7 result of it. So just for the moment, stipulating to it is
8 the small practice who is on the wrong side of ASP who
9 jumps, where is the additional -- when you said -- what do
10 you think happens when that happens? Could you add a few
11 words on that?

12 MS. BRICKER: So in order for the DVP to be
13 successful, you need the lives, you need the participation.
14 You need to be able to go to the manufacturer and say, I am
15 representing a large population of --

16 DR. MILLER: Ten-thousand lives.

17 MS. BRICKER: -- buyers, right, or large health
18 systems, right?

19 And so, presumably -- I am just thinking, if I am
20 a very large, sophisticated entity, and ASP reimbursement I
21 am absolutely fine with -- even if you cut it by a couple
22 percent I am going to wait and see; this is still

1 profitable to me -- I am making an assumption -- then I am
2 not going to be as interested in moving into DVP. So the
3 ASP, how does ASP change over time if the bad buyers come
4 out of the ASP calculation and they go sit in DVP? Does
5 DVP -- is it able to be successful with just the small
6 fish?

7 And so, how do we think about the structure of
8 kind of in the in-between and what we think the tipping
9 point would be so that it would actually be beneficial?

10 DR. MILLER: I will answer what I think needs
11 some close attention here. I will answer what I think are
12 the easier parts of your question. And then the tipping
13 point, I do not know.

14 So out of the distribution, if this is the
15 distribution around ASP, and this is the middle here with
16 the mean, you would expect people who are not doing well as
17 ASP to move over to DVP, let's say. That would lower the
18 average on this side. Over here it is the big fish, little
19 fish concept: Well, as a little fish I could not get this
20 price, but as 10,000 of us little fish, now can I get a
21 lower price on the DVP? The tipping point? We are making
22 a market here. I do not know.

1 And I think you are right, like, the big
2 purchaser that you are talking about, at first blush -- you
3 know, if I am extracting -- I am at this end of the
4 distribution, I may not have a lot of reason. And I think
5 in some ways Warner has been saying things like: I am in a
6 GPO. I am getting -- well, whatever. You know, I may be
7 already getting my discounts.

8 And then, I think what Kim was saying is it
9 depends. If you really thought you could bring some clout,
10 there may be some, you know, shared savings there. But I
11 think our initial response would be people on this side of
12 the distribution would have the first incentive to jump and
13 not be little fish anymore.

14 MS. BRICKER: Because the way it is structured --
15 and if I understand it, you are saying in the DVP you would
16 never pay more than ASP. And if ASP is actually not a
17 reflection of the big fish buyer, are we in fact just
18 setting pricing at the big fish average?

19 DR. CROSSON: Setting the ceiling, not the actual
20 price?

21 MS. BRICKER: Right.

22 MS. BUTO: Yeah, but the big fish get the biggest

1 discount.

2 MS. BRICKER: Right.

3 MS. BUTO: So ASP should probably go down in that
4 calculation.

5 MS. BRICKER: Right. Yeah.

6 MS. NEUMAN: We would expect it to go down a bit.

7 DR. CROSSON: You know, and I think, Amy, the
8 other implication of your point -- and we will get to this
9 a little bit later -- has to do with the other side of the
10 dynamic, and that is when, on a calendar basis, and how
11 quickly the ASP is taken down, because arguably the earlier
12 and the more rapid production in the ASP add-on, the more
13 that balance begins to tilt. And we have a choice to be
14 made there as well.

15 MS. BRICKER: Okay.

16 DR. CROSSON: Clarifying questions?

17 DR. DeBUSK: I had a -- on a related --

18 DR. CROSSON: On this point, Brian?

19 DR. DeBUSK: On this point.

20 Amy, to your earlier observation, let's say we
21 did take down that top 20 or 25 percent of the least
22 sophisticated, highest-priced buyers. Well, they would

1 disappear from the radar screen because, you know, their
2 new price is not used in the ASP calculation anymore. So
3 you would get immediate ASP reductions.

4 Well, then I would think -- back to your comment
5 about the institutional buyer, they are used to operating
6 on a margin. They are used to being able to buy X points
7 better than ASP. Well, when ASP slips, my guess is that
8 the sophisticated buyer comes back now and says: Make me
9 whole. I want that margin back.

10 Well, that creates a second wave that would push
11 ASP ever further, which would actually bounce back into the
12 DVP. You have actually created a positive feedback there
13 as the institutional buyers want to maintain that spread.
14 So I think there is actually a virtuous cycle here that
15 would continue to help pricing.

16 DR. CROSSON: Another question?

17 MS. BRICKER: I was just thinking about it in
18 terms of if I am a manufacturer and I have mapped all this
19 out -- and we have just outlined exactly, for them, what we
20 think will happen anyway, so they do not really have to map
21 it out -- how likely am I to provide some great discount to
22 this DVP when exactly what you just said is going to happen

1 with the ones that are actually my largest buyers?

2 DR. DeBUSK: Well, I think the plan was they had
3 to sell into the DVP at ASP. So you are going to lose that
4 top 20 or 25 or 15 percent of your premium customers the
5 day DVP is available, presumably because they would want to
6 access the better pricing.

7 DR. MILLER: I think the other thing I would say
8 is that -- and, you know, we are making something here, so,
9 right, with all those caveats, is you could say, you know,
10 I am not going to provide this discount because I am
11 worried about this cycle. But if there are four or five,
12 you know, drugs or bios that could be used there and they
13 say, okay, I will go on to the manufacturer -- I mean, I
14 will go on to the formulary, then you are frozen out of
15 that percentage of the market that has actually jumped.

16 So part of this, as we see, is, you know, if
17 there is a set of name brands or bios that could be used
18 here and the DVP comes along and says, you know, I will
19 take one or two of you, then that is -- you have got to be
20 looking over your shoulder to see if everybody is going to
21 go, no, we are not doing this, or somebody decides, I am
22 going to jump and take the market share.

1 The other thing I will just say, with all respect
2 to Bruce, is Bruce has also said, yeah, and do not forget
3 there may be some generic competition here. I described
4 everything as name brand and I know Bruce has some other
5 views on that, but just out of respect.

6 DR. CROSSON: Okay, clarifying questions, coming
7 down this way. Alice and Jack, and we will proceed down.

8 DR. COOMBS: I will be quick.

9 On page 25, last paragraph, you allude to the
10 issue regarding manufacturers' exemption from multiple
11 rebates, and I just wanted you to talk a little bit about
12 when there is Medicaid -- there is a Medicaid stipulation
13 for rebates as well as the overlap between Medicaid and
14 Medicare. You make a statement and I was just wondering if
15 you could kind of map that out.

16 MS. NEUMAN: So right now how it works is that if
17 you have got a dual-eligible who is getting a drug in a
18 340B hospital, there is not two discounts. There is either
19 they get it at the 340B price or the manufacturer pays a
20 Medicaid rebate, but not both. And usually it is the
21 provider who decides how they want to handle it.

22 And so this policy here, which is for using the

1 same principle to say that, you know, with the Medicare
2 inflation rebate we would not be subjecting the Medicare
3 utilization to two or three rebates. It only would get --
4 the manufacturer would only need to provide one.

5 DR. COOMBS: I am curious as to does Medicare
6 know whether that is a 340B versus a Medicaid rebate? Does
7 that matter at all?

8 MS. NEUMAN: So HRSA has a list of the 340B
9 hospitals, so Medicare can know if it is a 340B hospital or
10 not. And then there is information as well on who are
11 duals and not. So there would be ways to structure this to
12 be able to effectively exempt utilization that is getting
13 those discounts.

14 DR. CROSSON: Alice, are you still unclear?

15 DR. COOMBS: Well, I can ask in Round 2 the
16 significance of that, why --

17 DR. CROSSON: You mean in a later round? Okay.
18 Jack?

19 DR. HOADLEY: So, I am just trying to make sure I
20 understand exactly what the chairman's draft recommendation
21 includes. So, on Slide 17 on the inflation -- I think this
22 was clear in the earlier conversation, but the

1 recommendation is not picking a particular inflation
2 benchmark; it is just saying use one. And then we will
3 have text that talks about there being these various
4 alternatives, right?

5 DR. CROSSON: Correct.

6 DR. HOADLEY: And then, secondly, in the
7 discussion we talked about potential exclusion of lower-
8 priced drugs and I do not see any of that language here.
9 So that is another thing that is --

10 DR. CROSSON: In the text?

11 DR. HOADLEY: Text.

12 DR. CROSSON: As you can imagine, there is a fair
13 amount of supportive text --

14 DR. HOADLEY: Yep. Okay, thank you.

15 DR. CROSSON: -- including, you know, on the
16 slide --

17 DR. HOADLEY: The other alternatives.

18 DR. CROSSON: Slide 20, you know, other
19 alternative directions.

20 DR. HOADLEY: And I will come back to that in
21 Round 2.

22 DR. CROSSON: Yeah. Okay.

1 Clarifying questions? Sue.

2 MS. THOMPSON: I want to go back to Amy's point
3 that she was thinking and asking the question about the
4 tipping point, and just calling out the change management
5 strategy of making DVP a voluntary alternative.

6 I am wondering if, just for purposes of
7 discussion, taking the discussion to the extreme of it not
8 being voluntary but rather this is how it -- this is how we
9 will operationalize payment for Part B in DVP so we get the
10 full benefit of the Medicare numbers and not this sort of
11 incremental -- I am just wondering, have we thought about
12 that, and thinking a little bit more about the why
13 voluntary and what is the thinking behind that change
14 management strategy and the potential that it could fail
15 because there will not be enough buy-in quickly enough.

16 DR. MILLER: I think you --

17 DR. CROSSON: Do you want me to take it?

18 DR. MILLER: Well, I think you and I are taking
19 it.

20 DR. CROSSON: Yeah.

21 DR. MILLER: And I will do it, or you --
22 whichever way you want.

1 DR. CROSSON: Well, I will start and then you can
2 do it right.

3 [Laughter.]

4 DR. MILLER: I do not know that there is a right
5 answer.

6 DR. CROSSON: So we did consider this. From the
7 earliest time when Kathy first suggested let's take a look
8 at the CAP program, you know, we looked at the elements of
9 it and what we thought were the strengths and weaknesses of
10 that. And the fact that it was voluntary was potentially a
11 weakness of it, compared with making it mandatory, very
12 much for the reasons you say.

13 Then you have to consider, you know, kind of the
14 feasibility -- and I mean this both from a modeling
15 perspective and the ability to, you know, have this policy,
16 you know, enacted. You know, one, mandatory is potentially
17 viewed one way by actors in the industry and other
18 policymakers and people who are determinative in this
19 process. And, you know, doing it on a voluntary basis and
20 constructing it in such a way -- and some of the elements
21 that we have here I believe are constructing what is a new
22 market-driven mechanism that, you know, over time shifts

1 power to the DVP -- you know, power or influence or
2 acceptability, or all of those things -- versus the old
3 buy-and-bill system.

4 So it is a design element and a design choice
5 that you are absolutely correct to raise, because we could
6 have gone in the other direction. And there are, as you
7 say, strong arguments for doing that. In the end, I think
8 we felt that the arguments for doing it in this way,
9 particularly if we constructed the DVP in such a way that
10 it had, you know, significantly more impactful tools than
11 certainly the CAP model -- so, for example, you know, a
12 formulary, other tools such as are used more broadly with
13 respect to managing drug costs.

14 And then the added issue to try to deal with the
15 launch price problem because, you know, one of the
16 difficulties we had in putting this all together was that
17 if, in fact, we put in an annual cap, the first objection -
18 - we have not gotten to that yet, but the first objection
19 we heard to that was, well, that will simply blow back into
20 higher launch prices. But if we also have, on the DVP
21 side, the ability in certain circumstances with certain
22 drugs at certain price levels to implement mandatory

1 binding arbitration, then that further strengthens that
2 model.

3 So it was a judgment call as well, and I
4 perfectly understand the argument that you are making.
5 Does that --

6 DR. MILLER: I do not think I would add anything.
7 We were trying to leave choice for the provider, you know,
8 but that is implied in everything that he said.

9 DR. CROSSON: Clarifying questions? Warner?

10 MR. THOMAS: On Slide 15 you give an example of
11 the DVP negotiating a price -- \$400 versus ASP at \$500.
12 Have you thought about, or has there been any estimation on
13 what you think the discount might be from ASP, because that
14 shows a pretty material differential. And I just want to
15 know, is that illustrative? Is that where you think this
16 could go directionally? Have we thought about what that
17 might look like?

18 DR. CROSSON: Personally, I think it would be
19 unfair to try, because, you know, we are setting up a
20 different marketplace.

21 MR. THOMAS: Right.

22 DR. CROSSON: We do not know the questions about

1 what the volume of this would be, how fast that volume
2 would come up, what the mix of incentives between buy-and-
3 build and the DVP would be. And I think to hazard a guess
4 -- even for me to say what I actually think is that over
5 time it would grow to be pretty significant has no basis in
6 fact.

7 [Laughter.]

8 DR. MILLER: And just in case, you know, it is
9 not clear to anyone else, yeah, the \$500 and \$400 are not
10 real numbers. We are trying to do simple math just to sort
11 of give people a sense. And I know you know that, but now
12 that you mentioned it I want to make sure everyone else
13 knows that.

14 MR. THOMAS: And then just -- I should know this,
15 but just to clarify, so on -- for Part B and D, or the
16 ASP+6 is used in this pricing. How does that compare to,
17 you know, Part D and then Part A as far as -- is that
18 consistent across all of those, or how -- what are the
19 differentials there between Part A, B, and D?

20 MS. NEUMAN: Are you asking the differentials in
21 the payment rates across those?

22 MR. THOMAS: Yeah, so the ASP+6, is that -- you

1 know, how does that compare across the different components
2 of Medicare, roughly?

3 MS. NEUMAN: So, I do not know that we have a
4 direct comparison of the Part D and Part B prices, in part
5 because we do not have rebate information on the Part D
6 side to be able to say that. And then on the Part A side,
7 I think that the payments are generally bundled, so there
8 is not a sort of separate payment rate to compare to.

9 DR. CROSSON: Let me try it conceptually. And
10 sure I am going to make some conceptual errors here.
11 Please point them out immediately.

12 MR. THOMAS: It is probably a bad question
13 anyway, so --

14 DR. CROSSON: But fundamentally, at least in my
15 mind -- and I think this applies, for example, to hospital
16 payments better than some others, Warner, but the notion is
17 that Medicare tries to pay on the basis of what it costs to
18 deliver the services and then with some reasonable margin,
19 right? In this particular case, the payment is based upon
20 the putative cost, which is ASP, but in fact we know that
21 purchasers -- physicians, hospital purchasers -- are
22 purchasing a drug for less.

1 In addition, there is the administrative fee.
2 And as I think we have mentioned in the presentation, we
3 are not suggesting the administration fee, or whatever is
4 the proper term, should be changed. But in Part B we ended
5 up with this additional idea, and that was that there was
6 going to be -- of course, as there are -- a mix of
7 purchasers purchasing at different prices.

8 And we wanted to avoid the situation where some
9 physicians in this case, particularly smaller physicians,
10 were put in the position of having to purchase the drug at
11 a loss, and so 6 percent was added onto the ASP to kind of
12 cover that distribution curve with the notion that even the
13 least-able negotiators among the physicians would at least
14 not have to purchase that drug and administer it at a loss.

15 The problem for the Medicare program with that
16 model is that you can imagine that, as a consequence of
17 trying to deal with the physicians and prevent them from
18 providing the drug at a loss, Medicare is expending huge
19 amounts of money for that 6 percent coverage. And that is
20 money that, from my perspective anyway, even though I
21 understand well it is built into the income expectations at
22 the moment, the revenue expectations, that money is, in

1 fact -- a large portion of it is simply wasted and could be
2 used more effectively and more efficiently for Medicare
3 beneficiaries in other ways.

4 Yes, Amy, on this point?

5 MS. BRICKER: Yes.

6 So, yes, you do not have that rebate information,
7 but Part D is reimbursed off of AWP, which is a derivative
8 of WAC. So you could compare -- every drug has a WAC. You
9 could compare the difference, on average, of what ASP on a
10 given drug is, and then also reimburse it or reprocess it
11 as a discount off of AWP. I am happy to give you some, you
12 know, range of, on average, what those contracts look like.

13 Yes, you are right, it would not have the plan
14 cost in total, but what the provider is paid in Part D
15 would be known as a comparator to B. Does that make sense?

16 MR. THOMAS: I guess the actual answer is we
17 really don't know.

18 DR. MILLER: No, but wait, because I was
19 surprised that your first answer wasn't this, okay? At
20 least on Part B -- and I'll come to D late, but on the Part
21 B side, the ASP+6 is the same in the physician's office and
22 the same in the outpatient department of the hospital.

1 Right? Okay. And so I thought you were asking do you pay
2 the same across sectors. Is that what you're asking?

3 MR. THOMAS: Yes, and.

4 DR. MILLER: And?

5 MR. THOMAS: How does that compare to Part A and
6 Part B?

7 DR. MILLER: Part A?

8 MR. THOMAS: Yeah.

9 DR. MILLER: Okay. Then that gets to the bundled
10 part. But I misunderstood A. I thought you were saying
11 hospital -- right, okay.

12 DR. CROSSON: I thought you were asking a broader
13 philosophical question, which is why are we paying this way
14 for Part B drugs when we pay another way in Part A, another
15 way for the rest of Part B, another way in Part D.

16 MR. THOMAS: That's the question. That's the
17 question.

18 DR. CROSSON: What I was simply trying to do was
19 to sell, well, they're different, and it was constructed
20 this way, and I think at the moment, in terms of our
21 policy, we're questioning whether or not that's the right
22 way to do it.

1 MR. THOMAS: I guess my first question that I
2 didn't know was are they paid -- you know, are they at
3 different rates across the three components of Medicare?
4 And the answer sounds like it's yes.

5 DR. CROSSON: Yes.

6 MR. THOMAS: So that was really -- that's the
7 fundamental question.

8 DR. CROSSON: Different philosophies driving
9 payment mechanisms.

10 MR. THOMAS: Okay. All right. Thank you.

11 DR. REDBERG: So the question on -- actually, a
12 footnote on the mailing materials. On page 4, where you're
13 referring to home infusion drugs that were paid 95 percent
14 of AWP, but that's changing this year to now be paid ASP
15 plus percent, I'm just wondering if you could give some
16 examples of -- because I was trying to picture what those
17 were. And if you could then also say how big like a
18 financial market is that and will that change to be paid
19 ASP+6, meaning Medicare is now paying more for those drugs?

20 MS. NEUMAN: So examples of the drugs are like
21 subcutaneous immunoglobulin, insulin, a few heart products,
22 and there are differential effects up and down across

1 drugs, but in aggregate, the switch to ASP+6 saves money.
2 And I don't have the total dollars, but that's something we
3 could give you, about what the pool was last year.

4 MR. O'DONNELL: Yeah, and also I'd say the OIG
5 did some good work looking at the top kind of infusion
6 drugs and how the switch from that previous payment policy
7 to ASP+6 affects them.

8 DR. REDBERG: Great.

9 MR. O'DONNELL: So it's good it's out there.

10 DR. REDBERG: Thank you. And two more small --
11 on page 11 of the mailing materials, in the discussion
12 about WAC, it says WAC is the manufacturer's list price and
13 does not incorporate prompt pay or other discounts. Do you
14 know about how much prompt pay discount usually is? And
15 what are the other discounts that you're referring to?

16 MR. O'DONNELL: Right. So I think Kim and Nancy
17 have heard that prompt pay can be 1 to 2 percent, so that's
18 what's been kind of refuted. The other discounts are
19 really anything that the manufacturer offers. So, for
20 instance, just as an example, for Zarxio, the discount that
21 we observed was much larger than 1 to 2 percent and is a
22 discount given by the manufacturer. I don't know what you

1 want to call it, but it was a bigger discount than what the
2 1 to 2 percent kind of prompt pay discounts are.

3 DR. REDBERG: Thanks. And then the last Round 1,
4 again, from the mailing materials on page 14 -- and you
5 mentioned it also in your presentation -- that some
6 manufacturers of Part B drugs don't have Medicaid rebate
7 agreements, so they're not required to submit ASP data. Do
8 you know about what percentage part of the market that is
9 that's not required as opposed to the ones that are
10 required but just don't?

11 MR. O'DONNELL: No, I don't.

12 DR. REDBERG: Thank you.

13 DR. CROSSON: Brian, do you have a clarifying
14 question? No. Warner.

15 MR. THOMAS: Just another question. I'm sorry.
16 For the companies that do not report ASP data, how are they
17 reimbursed? How are they paid?

18 DR. GINSBURG: The physician pays them. This is
19 just a report to CMS.

20 MR. THOMAS: How is the fee set? I mean, if they
21 don't report ASP data, then how is the fee set that they
22 get paid?

1 MR. O'DONNELL: Right, so if there's no -- if no
2 one reports the data, which happens in a couple instances -
3 - the OIG has a report on this -- then it's paid at WAC.
4 It can be paid on WAC. Right? And if only, let's say, one
5 out of three manufacturers don't report, then it's just
6 based on those kind of manufacturers who do report the
7 data.

8 MR. GRADISON: Is there anything preventing a PBM
9 from starting a DVP right now without a change in the law?

10 MS. NEUMAN: Yes, given how we've structured it
11 with this DVP price lowering the Medicare payment amount,
12 that could not be done without a statutory change.

13 MS. BUTO: Also, prior authorization and some of
14 the other things couldn't be done without a statutory --

15 DR. MILLER: The formulary.

16 DR. CROSSON: Binding arbitration. Are people
17 going for more questions, or are we going to the next
18 round? Pat.

19 MS. WANG: In sort of examining lessons learned
20 from the voluntary CAP pilot demo, was there any issue with
21 manufacturer participation?

22 MS. NEUMAN: I am not aware of issues of

1 manufacturer participation. What I do recall is the vendor
2 reporting issues with manufacturers offering them good
3 prices. That's what I recall.

4 DR. CROSSON: All right. And, Pat, I read the
5 RTI report as well, and my memory is the same as Kim's.

6 MS. WANG: So this proposal address that by
7 putting a ceiling price on at ASP. Is that right?

8 DR. CROSSON: Addresses the question of the --

9 MS. WANG: Poor pricing by basically saying --

10 DR. CROSSON: Well, I think it addresses it in a
11 number of ways. It addresses it through the formulary
12 mechanism, which wasn't present in the CAP model. It
13 potentially addresses it as well through the binding
14 arbitration as well.

15 MS. WANG: I just wonder whether -- and, Sue, you
16 triggered this thought in my mind -- there is any concern
17 about getting robust manufacturer participation. In order
18 to get robust provider participation, there has to be full
19 manufacturer participation.

20 DR. CROSSON: So you're absolutely correct, this
21 is -- as Mark said earlier, we're suggesting something new,
22 a new business, a new market mechanism, a new Medicare

1 payment mechanism. In anything that is new, there's always
2 the chicken-and-egg problem. You know, now I'm going to go
3 off on this because, you know, for example, Tesla, right?
4 Do you build a battery plant to make 10 million little
5 batteries? Or do you sell the car first and see how many
6 people want the car? And in my mind, these are sort of
7 unknowable market dynamics. Our hope is that the elements,
8 particularly a lot of the detail elements, of how this is
9 constructed and ultimately gets implement will tip the
10 balance in the right direction. But it is by its nature
11 unknowable, I think.

12 DR. MILLER: In a sense, it does go back to Sue's
13 point, which, you know, do you set this up in such a way
14 that you do your best job of saying, okay, there was this -
15 - and I'm sorry, Alice, but, you know, to try and correct
16 what went wrong on CAP and maybe it will succeed. But if
17 it fails, you still have all of your changes on the buy-
18 and-bill side, so you're not left empty-handed.

19 I think Sue's point is why aren't you going full
20 force on the other side, and I guess I don't have, you
21 know, an opinion in this group. But, I mean, it's also the
22 fear of like have you designed this in a way that there's

1 actually a there there. And that's, I think, the walk
2 we're trying to walk at this point.

3 DR. CROSSON: Alice, on this point?

4 DR. COOMBS: Yeah, I just want to say there was a
5 key factor with the clinicians with CAP, and that was,
6 instead of the logistics of negotiating for price and the
7 doc would go directly to the drug companies, CAP was
8 responsible for acquiring the chemotherapeutic agents and
9 making sure it got to the doctor's office. So patients
10 would show up, and they would not have their chemotherapy
11 or whatever medication they were going to be administered.
12 So that was a key reason why there was a disconnect between
13 the clinician saying, "I don't want to be a part of this
14 CAP program," and so this actually circumvents that in the
15 sense that they can still go to the manufacturers and still
16 maintain that relationship, but now they have a negotiated
17 price for it.

18 DR. CROSSON: That's correct. And that was
19 another early decision model choice that we made as well.

20 MR. PYENSON: I think this is a question for Kim.
21 On the section, improving ASP data reporting -- or was that
22 Brian? My question is: How is that audited? This seems

1 to be self-reported data, and even in audited situations,
2 there's lots of choices and decisions to be made, timing
3 and other things like that. So I'm curious if there have
4 been descriptions of the audit process for that from OIG or
5 elsewhere.

6 MR. O'DONNELL: Yeah, and I think what you just
7 said there is exactly right, and I think I gave a bad
8 answer to -- I think someone asked is there anything known
9 about how often this non-reporting happens, and I think OIG
10 has put out studies, and they've looked at, using multiple
11 data sources, kind of what are the types of entities that
12 don't report, how many NDCs are not reporting on a given
13 drug and things like that. So the OIG does kind of look
14 into the reporting process.

15 MR. PYENSON: That's on the specific issues of
16 non-reporting and so forth. I guess I'm asking more of a
17 fundamental financial accounting basis and whether there
18 has been financial accounting standards on how this should
19 be reported and whether those are -- because without that,
20 there's lots of different things that could go on.

21 MR. O'DONNELL: I'll say something, and then I'll
22 let Kim say things. I mean, there are standards for what

1 should be included into the ASP, so it's not just kind of
2 free-wheeling, so certain discounts like prompt pay
3 discounts have to be included in there. But I don't know
4 if you have anything else to add to that.

5 MS. NEUMAN: So CMS has guidance, as Brian is
6 saying, on, you know, sort of what kinds of discount have
7 to be included and what kinds of service fees can be
8 excluded. You know, there's some broadness to some of
9 those definitions, and the OIG does have authority to audit
10 the actually ASP submissions. And I do know that they have
11 done that from time to time, but we don't have a good
12 window on that process. That's more in their sort of
13 ballpark.

14 MR. PYENSON: Would that -- and forgive me if
15 this is in here, but is improving that audit process part
16 of the improving ASP data reporting?

17 MR. O'DONNELL: That's not part of our
18 recommendation.

19 MR. PYENSON: Thank you.

20 DR. CROSSON: Okay. I see no further hands for
21 clarifying questions, so we're going to move on to the
22 commentary portion here. Could I just roughly see the

1 number of hands of people who want to comment? So it's
2 most of the Commission.

3 So let's put up that summary slide of the
4 recommendations -- no, further on, the one that's -- so
5 this is a summary. You can go to the details in the prior
6 slides.

7 So as we do when we have recommendations on the
8 table, I'm going to ask for comments from the
9 Commissioners, the degree of support for the
10 recommendations that you have in front of you, as well as
11 any thoughts that you may have as to try to improve what we
12 have done, starting with Brian.

13 DR. DeBUSK: Well, I support the Chairman's draft
14 recommendation both on the changes to the average sales
15 price as well as the DVP. What I'd like to comment on for
16 a moment is the DVP. Obviously, I've been a big advocate
17 for that program.

18 I think it is a very cleverly designed ratchet to
19 bring pricing down. I think some of the agency issues that
20 you guys addressed in the text where you gave yourself the
21 leeway to do, say, value-based pricing or indication-
22 specific pricing and some of the different permutations on

1 shared savings, I know, you know, that didn't come out in
2 the presentation, but just in the pages around 48 and 49, I
3 felt that was very well done and very well thought out.

4 My one thought is to show -- we may have to do
5 just one example and show how an ASP would be affected if,
6 say, that top 15 or 20 or 25 percent of the customers did
7 participate in the DVP, just to simply show how that shifts
8 the mean and triggers this downward spiral. Now, it will
9 bottom out, but I think it wouldn't be hard to illustrate
10 how the mean iteratively shifts. And I think a lot of
11 light bulbs would go off because people would realize that
12 you're losing what would be your premium customers day one.
13 And I think that would be very helpful in clarifying what
14 you're doing there.

15 DR. CROSSON: Thank you. Comments?

16 MR. THOMAS: So, generally, I'm in favor of the
17 recommendation with some caveats that I think it could go
18 further to do more on the pricing side.

19 I guess, first of all, on the inflation cap, I
20 come back to that if you look at all the other fees that we
21 are involved in setting, the rate increases have been
22 negative to maybe 1 to 1.5 percent. And if you look at

1 drug pricing, it's been many multiples of that for multiple
2 years. So I would just encourage us to be very disciplined
3 about setting an inflation cap going forward.

4 On consolidated billing codes, I think it's a
5 very good idea. I think it's something that should be put
6 in place as well.

7 I would like us to think about this idea of drug
8 pricing across Medicare, and, you know, whether it's
9 considered as part of this recommendation or just
10 considered in general, the idea that we pay different
11 prices for drugs across A, B, and D to me just doesn't make
12 a lot of sense given that we've had a policy we've put in
13 place around site neutral. To me, this is like site
14 neutral for drugs. Why wouldn't we pay the same for a drug
15 across A, B, and D? It sounds like we could probably get
16 the pricing if we wanted to, and I think that's something
17 that should be considered.

18 On the concept of companies that don't report
19 ASP, I think if they don't report ASP, we shouldn't pay for
20 the drug, period. I just think we ought to force them to
21 provide that information, and if they don't want to, it's
22 hard to understand why they wouldn't be willing to do that.

1 And then, finally -- and I know this is
2 controversial, but I would come back to -- I think I would
3 be remiss if I didn't say, you know, drug pricing is such a
4 huge issue for the industry. The idea that we do not set
5 pricing for drugs versus going through a DVP or another
6 model versus just setting a price, a Medicare price for a
7 drug, I still think is something that should be considered.
8 It's the fastest growing area from a cost perspective, and
9 it's really the only area that we're purchasing goods or
10 services where we're not setting pricing. And I just think
11 it's a major issue that -- hopefully the DVPs work. You
12 know, we're sitting here debating whether they will work or
13 not. If we were to set a price, we know that would work,
14 and we know it would have a significant benefit to the
15 program and a significant benefit to the beneficiary. So
16 thank you.

17 DR. CROSSON: Thank you.

18 DR. REDBERG: I wanted to let Warner speak first
19 so I could just agree with him and then add on. So thank
20 you, Warner.

21 [Laughter.]

22 DR. REDBERG: You know, I always -- first, it was

1 a great chapter and a lot of really important ideas. And,
2 clearly, you know, \$26 billion, \$5 billion in beneficiary
3 costs, is a lot of money, and I do agree that it doesn't
4 seem particularly well spent in terms of the view from the
5 Medicare program. So the first thing I always like to look
6 at is, you know, what are we spending this on and, you
7 know, how many of these drugs are even appropriate -- by
8 "appropriate," I mean improving beneficiary health, which
9 is kind of out of your purview. But I will say that
10 certainly my oncology colleagues have said to me that a lot
11 of chemotherapy given these days is not appropriate, not
12 necessary, not improving health.

13 Certainly taking that kind of incentive out of
14 the system, which clearly there is a lot of -- you know,
15 I'm sure some is, but some is not appropriate. So the
16 restructuring that is part of the Drug Value Program I
17 think is really important for program and for
18 beneficiaries.

19 And then, you know, the numerous examples in here
20 and our discussion, clearly, you know, the market doesn't
21 operate in drug pricing and the fact that, you know,
22 biosimilars and even now generics for the small-molecule

1 drugs, you know, there are numerous examples of multiple
2 generics or biosimilars on the market and the prices
3 haven't come down and in some cases are going up. But
4 where a biosimilar could launch at a higher price than the
5 reference price drug is just astounding to me, and clearly,
6 there's not a market that is operating for these drugs.
7 And I agree again that the launch price is another big
8 issue that we haven't dealt with, and it gets back to the
9 sort of lack of competition. And I don't think the launch
10 price is particularly related to production cost, as one
11 would hope or expect.

12 And so I do support the Chairman's draft
13 recommendations and again would just reiterate I think
14 consolidated billing codes are really important and make a
15 lot of sense. You know, it's consistent with our
16 principles of paying similar prices for similar drugs or
17 treatments.

18 Thanks.

19 DR. CROSSON: Thank you.

20 MS. THOMPSON: I'll be quick, and I'm really
21 happy I sat next to Warner and then Rita, because I want to
22 say I agree with both of them. And I agree with the

1 Chairman's draft recommendations. You heard my concerns in
2 my question about the voluntary versus mandatory change
3 management strategy, so I won't further comment. But on
4 consolidated billing codes, I'm quite supportive.

5 DR. HOADLEY: So, first of all, I want to just
6 again thank the staff. This has been kind of like a two-
7 year journey in getting to this point, and it's been a lot
8 of hard work that's gone into this, and I think we --

9 DR. MILLER: Don't say that.

10 [Laughter.]

11 DR. HOADLEY: We should recognize it.

12 I do support the draft recommendation. I think
13 like all of us, there are items I like better than others.
14 But I think we're all there, and I think it comes together
15 as a package that gives a good set of things to try. I
16 remain -- and I've said this in numerous other
17 conversations -- skeptical about the ability of the DVP to
18 accomplish some of the things that we hope it will, but
19 having said that, I think it's well designed. We've done a
20 lot of smart things in putting this together, and we should
21 go ahead and see what happens, assuming Congress wants to
22 follow our fine advice.

1 Where I want to spend a minute or two is on the
2 list of text items that are sort of some of the
3 alternatives that you identified on one of the previous
4 slides. I think there are a couple of things that I might
5 add to that list.

6 One is in talking about consolidated billing is
7 to maybe raise the issue of other ways to define a price.
8 You know, we talked a long time ago, I guess, in a chapter
9 a year ago about the least costly alternative, and maybe
10 it's worth sort of referencing that again. There's a
11 January policy brief by Pew Charitable Trust that sort of
12 puts that in the context of exactly the situation we're
13 looking at, which is the biosimilars, and pointing out that
14 if you go to the lowest price, you can potentially get
15 different dynamics of pricing and just some reference to
16 that and some discussion of that as a different
17 alternative, even though I think we're -- you know, I like
18 the one we have in the recommendation, but I think it's
19 worth identifying that.

20 Secondly, I think you implicitly, if not
21 explicitly, would be doing this, the potential exclusion of
22 low-priced drugs, although I think in saying that, we

1 should also acknowledge the issue that some of those low-
2 priced drugs sometimes see some very large price increases,
3 and maybe in talking about excluding low-priced drugs, we
4 would suggest there's the possibility of still applying an
5 inflation rebate in any case where they go up dramatically,
6 say by 50 percent or 100 percent or some kind of much more
7 substantial threshold and then apply the policy that we
8 would otherwise apply. It's just other things to put in
9 that mix, I think.

10 And, third, the potential of talking about the
11 ASP add-on reduction, you talk about delaying and sort of
12 doing it on a more gradual basis. We could also raise the
13 possibility it could be done more immediately in the
14 shorter term as another piece of the short-term reforms,
15 and I think those are things that we could add.

16 The other thing I would suggest -- and this is
17 not in that same section in the text, but somewhere in the
18 text -- is to maybe put this in the context of
19 acknowledging that, you know, we're limited to tools that
20 we can use within the purview of Medicare, and that a lot
21 of the things that would have a larger impact on drug
22 pricing are outside of our purview, but at least to put

1 that -- I don't think that's in the chapter now, but put
2 that in explicitly and talk about the fact that patent law,
3 patent term, Hatch-Waxman, FDA approval processes are all
4 parts of the dynamics that will really potentially have a
5 much larger influence on pricing than the things we're
6 doing, but, of course, they're not in our purview, so we're
7 not in a position to comment on those, but at least
8 acknowledge that those are other factors out there. And I
9 think it addresses maybe some of the frustration that we've
10 all had at times that, you know, we're doing a bunch of
11 things which are good recommendations, but they may in the
12 end not have a big effect, I mean, the kind of comments
13 that various of us have made around the table that some of
14 these steps are only going to be relatively small impact
15 changes. Some of them could turn out to be bigger, and
16 that would be great if they do. But some of the biggest
17 potential changes are clearly outside of our purview. So I
18 think just some acknowledgment of that somewhere in the
19 chapter would be helpful.

20 DR. CROSSON: Yeah, just on a couple of points
21 you made, I do believe the third bullet point here about
22 discussing the timing of the ASP add-on reduction, we'll

1 cover that. That's the intention, anyway.

2 And with respect to the issue of those elements
3 that are outside of our purview or even outside of
4 Medicare, did we not do that in a previous report last --

5 DR. MILLER: I can't remember if it made its way
6 into -- was it in the D?

7 DR. CROSSON: In the D. In the D.

8 DR. MILLER: Yeah.

9 DR. CROSSON: So I think --

10 DR. MILLER: Well, I was going to say I don't
11 mind stealing that text and, you know, reiterating it here,
12 because we did sort of say it when we were making our D
13 reforms and saying, remember, we have to work inside
14 Medicare. And we're doing this -- it's the same phenomenon
15 here.

16 Now if you don't want it repeated again, I think
17 we can just --

18 DR. CROSSON: No, I was trying to agree with you.

19 DR. MILLER: Okay. All right. I think we can
20 steal it, rework it, and put it right in there.

21 DR. HOADLEY: Thank you.

22 DR. COOMBS: So I agree with the Chairman's

1 recommendation, and there are several issues that I would
2 like for us to address, either in the reading materials --
3 one is specifically regarding the development of the DVP
4 and not increasing the amount of administrative cost to the
5 providers, because we've actually assessed what that looks
6 like. In terms of whether or not there will be an
7 additional requirement for the provider with the DVP in
8 terms of paperwork, there's going to be the prior
9 authorization, which may be somewhat labor intensive under
10 some categories, but things outside of the usual tool sets
11 that are going to be necessary for the DVP to function. So
12 I would include that.

13 I like what was mentioned on page 26. Kudos to
14 you for considering that.

15 I think we ought to think about this whole notion
16 of moving oncologists to hospital-based practices, and that
17 changes the paradigm for costs in general. It is cheaper
18 cost for patients to be cared for at physician offices, and
19 I would like for us to consider the whole notion of what
20 consolidation does to escalating costs. So that's really
21 important.

22 The other piece on page 26 which I'm trying to

1 reconcile is if you exempt manufacturers because they
2 participate in 340B as well as the Medicaid rebate, what
3 happens to the non-duals in terms of the beneficiaries
4 getting some of that feedback? Is that a concern of
5 Russia? Because, you know, in the reading, it talks about
6 68 percent or something like that of DSH hospitals having
7 340B programs, but then there's this large group of
8 hospitals that are 340B that are not necessarily
9 disproportionate share hospitals. So is there a
10 significant amount of patients who have, I guess, hospital-
11 based systems that are exempt such that the beneficiaries
12 don't get the benefit of decreasing their co-pays?

13 DR. MILLER: Okay. I'm going to need some help
14 here. Right now in a -- I'm going to need some help here.
15 Everybody ready?

16 Right now in a 340B hospital, you know, the
17 discount is deeper on the acquisition of the drug, but
18 Medicare's payment continues to be 106. So all of the
19 changes that you make on the buy-and-bill side would affect
20 what Medicare pays, but leave the hospital free to, you
21 know, get their 340B discount. Is that -- those are all
22 true statements.

1 So to the extent that that brought the ASP down
2 and the beneficiary's paying 20 percent off of that, then
3 the beneficiary would get the benefit of it.

4 DR. COOMBS: We had said in the other session --

5 DR. MILLER: So the only thing I wanted to say
6 really clearly just before you go on is we're not exempting
7 whole hospitals from the policy. We're just not counting
8 the price and discounts in the 340B in the calculations of
9 the ASPs or the DVPs.

10 MS. NEUMAN: I was wondering, is it the -- are
11 you worried about the duplicate discount issue? Is that
12 what's driving the question?

13 DR. COOMBS: I was more concerned that one of the
14 goals was the beneficiary having access to a reduced co-
15 pay, and do we do that with this system?

16 MS. NEUMAN: So are you talking about the DVP
17 versus the ASP? Or are you talking about --

18 DR. CROSSON: 340B.

19 MS. NEUMAN: Oh. So when we -- what would happen
20 is that anybody in the DVP or any beneficiary who went to a
21 provider who participated in the DVP would be eligible for
22 reduced cost sharing, so they would all -- anyone who went

1 to one of those providers would benefit. So I think that
2 in general you can stay in the ASP and you would have the
3 same thing you do today, or you could go to a provider who
4 chooses to participate in the DVP, and as a beneficiary,
5 you'll save more than you would have if you had stayed in
6 the old system.

7 DR. MILLER: But all I was saying, Kim, is if
8 they stay on the buy-and-bill side, there will be some
9 reduction even relative to steady state because we're
10 walking the ASP add-on down.

11 MS. NEUMAN: That's true.

12 DR. MILLER: So my only point was that I thought
13 you were worried about the bene's co-payment, let's say in
14 a 340B hospital, and in this example let's say the 340B
15 hospital sticks on the buy-and-bill side, even relative to
16 current law the bene will get some benefit out of that, and
17 then what she said about DVP is also true.

18 DR. COOMBS: And I know it's probably a small
19 number because many of these patients are LIS patients, but
20 I was wondering, one of the discussion points, was it not
21 the discussion point that we voted on the 10 percent with
22 the 340B program -- and maybe that was the D part. That

1 was the whole discussion.

2 MS. BUTO: We had a separate recommendation on
3 that, Mark, on 340B and how to split the discount reduction
4 between the beneficiary and the program, and that's already
5 out there.

6 DR. MILLER: Right, but I thought she was talking
7 about this proposal and how the beneficiary -- whether the
8 beneficiary gets some benefit from it.

9 DR. COOMBS: So since we don't know what the 340B
10 program -- what kind of discounts they get -- remember we
11 talked it could be as much as 50 percent?

12 DR. MILLER: We were thinking about 29 or 30.

13 DR. COOMBS: Yeah, 29 or 30. Is that translated
14 to the patient's co-pay?

15 DR. MILLER: No. And under current law, it isn't
16 either, and so one more time --

17 COURT REPORTER: Can you keep your mic on?

18 DR. MILLER: Yeah, except I don't want anybody to
19 hear it.

20 [Laughter.]

21 DR. MILLER: Other than that, I'm fine.

22 So right now you're in a hospital, the hospital

1 takes a 30 percent discount on acquiring the drug.
2 Medicare pays 106, and the beneficiary pays 20 percent of
3 that. And so in that sense, the beneficiary doesn't get
4 the benefit of that discount. And I know we have that
5 small thing that we did, but if I could just hold that
6 aside for a second. In this world, if buy-and-bill drives
7 the ASP add-on down, which is part of our proposal, then
8 the beneficiary would get the benefit of that change, even
9 though we haven't messed with the physician -- or, sorry,
10 the hospital's discount that they took the drug at. So the
11 hospital gets its discount. Medicare's payment comes down.
12 There's a bit less revenue, and the beneficiary benefits
13 from that on the buy-and-bill side. On the DVP side, it's
14 her story. If the DVP negotiates underneath it.

15 So that's how this proposal works. You're
16 correct, we did talk about a small adjustment to the 340B a
17 year back or whenever it was. We could talk about that
18 again. But in this context, the beneficiary should get
19 some benefit on both sides of this proposal, whether it's a
20 little bit or a lot, and that's unclear.

21 DR. COOMBS: So my question was: Is it going to
22 be comparable if you just happen to be in a 340B program

1 versus -- okay.

2 DR. MILLER: My reaction is it should be
3 comparable.

4 DR. CROSSON: And just to note, Alice, on your
5 earlier comment about consolidation, to the extent that
6 smaller practices -- and I think your use of oncology was
7 the correct analogy. To the extent that the inability to
8 purchase pharmaceuticals without a loss by those small
9 practices is one of the elements that drives practices into
10 hospital employment -- certainly not the only one, but we
11 have had some comments that it is one -- then the DVP
12 process should provide an escape from that for practices.

13 DR. COOMBS: And one last thing. Is it possible
14 that we could put in a footnote, the impact of the
15 sequester on the ASP as well?

16 DR. MILLER: Yeah.

17 DR. CROSSON: Yeah.

18 DR. NERENZ: Thanks. I'm generally supportive of
19 the recommendation. I just wanted to make one point about
20 the shared savings component of the DVP program. I think
21 it would be nice if in the evolution of this in the next
22 month, if we could either illustrate an example of a shared

1 savings model that we think might be useful, or at least
2 identify some desirable features. We currently don't
3 really say anything about it, and as I'm reading the
4 proposal, at least from the perspective of incentives to
5 physicians, the only attraction to DVP is the shared
6 savings, because right now you've got your plus 6 percent.
7 Even if we drop it down to WAC+3 percent, there's a
8 positive margin there that is predictable, it is certain,
9 and it is immediate.

10 Now, if you move to DVP, it is uncertain, it
11 might be weak, it might be two years delayed. You never
12 know. I think our examples currently of shared savings
13 model are not that positive, they're not that strong. So
14 we could just --

15 DR. CROSSON: Are you talking about ACO models?

16 DR. NERENZ: ACO, bundled payment, what-not. You
17 can call it shared savings, but there's good, powerful
18 shared savings features that will draw people into this
19 model, and you could have a shared savings model that is
20 utterly unattractive. And I think we could say something
21 about what would be of the one type and the other. And I
22 presume we'd want to recommend shared savings features that

1 would be positively attractive for physicians in the
2 program.

3 I was thinking of this one, Sue made the comment
4 about mandatory. You make it mandatory -- except one
5 reason you don't is that everybody's going to be up in arms
6 and they're going to revolt about it if it is not
7 attractive. They won't do it. And they certainly won't be
8 forced to do it.

9 DR. CROSSON: I agree with that, and I think this
10 is predicated on the notion that if you're looking at
11 population-based pharmaceutical costs and the DVPs have
12 these tools, that given what we know about the escalation
13 of pharmaceutical costs, there ought to be opportunities
14 there to produce shared savings which are materially
15 different from, for example, MSSP ACOs.

16 DR. NERENZ: I agree. I just would like to see
17 it explicitly stated, and just noting there probably are
18 some nuances in there. So, for example, on the example you
19 showed about 500 versus 400, well, that \$100 difference
20 could feed a shared savings model. But let's say there's a
21 second drug in that class that's \$1,000, and the negotiated
22 price is \$800. Now, there's a bigger savings. That could

1 even drive shared savings. But wait a minute. In order to
2 get that savings, you have to do the \$1,000 drug.

3 So there's all kinds of details about how you
4 build the shared savings. You know, do you build it on the
5 savings at each individual drug regardless of the overall
6 package and pattern of use? Do you build it on pattern of
7 use? You know, if there are 10,000 docs in the system,
8 each one sort of goes along with what happens with 9,999 of
9 his or her colleagues and their prescribing patterns, which
10 makes it look a whole lot like SGR. So there's a lot of
11 detail about the shared savings.

12 DR. CROSSON: Right, and for that reason, I think
13 we've stopped short of trying to, you know, suggest, well,
14 it has to be this method. I certainly think the point that
15 you're making, which is that the success of this will be
16 predicated on both the reality and the early perception of
17 the shared savings opportunity.

18 DR. MILLER: And I also agree with you that it's
19 largely the shared savings on, you know, the positive
20 incentive. And as you were talking, you know, maybe what
21 we can do is take a section and sort of -- you know, what
22 is the incentive here for the physician to do this? And I

1 think what you've gone through is part of that. And then
2 the other side of it is the push side, so, you know, Amy's
3 comments were there's a group of people up in this part of
4 the distribution who aren't doing that, while you were
5 saying six, it's clear, everything's good, unless you're on
6 the far right tail of that distribution, in which case life
7 isn't potentially all good. And so that would be a push.
8 And then the notion that if the add-on is going to come
9 down, that begins to push. And so the incentive would
10 include this is what's drawing you, this might be what's
11 pushing you, to try and speak to Sue's point, which is, you
12 know, there's mandatory but there's also pushing. And we
13 can put that in a section and make it all try and make some
14 sense.

15 MS. BRICKER: Okay. So I am in support of the
16 Chairman's recommendations on improved ASP and WAC+3
17 revisions. Consolidated billing codes, I'm supportive of
18 all except for inclusion of biosimilars. I think this is
19 still in its embryonic state. There are only two on the
20 market. And I feel like we're trying to regulate a market
21 that doesn't yet exist and is not mature. So I'm not in
22 favor of that aspect from consolidated billing codes, the

1 rest yes.

2 Inflation rebate. So this isn't a new concept.
3 This exists today in the drug space, but they are, in fact,
4 rebates, and they're negotiated by PBMs and health plans.
5 So if we were to do this, I wouldn't be in favor of CMS or
6 Congress setting some, you know, global inflation rate, but
7 instead maybe you give it to the DVP to negotiate with
8 those manufacturers so that it's confidential and it
9 doesn't have the effect that I think this would have on the
10 entire pharmaceutical market, if, in fact, that were to
11 take hold. And I think it would -- you're actually more
12 likely, I think, to get success or get manufacturers to
13 engage in a dialogue around this versus essentially the
14 government setting drug pricing, which this sort of is.

15 Lots more comments. So back then to DVP. So
16 I've given this a ton of thought since we've been talking
17 about since the summer, and you're right, this is a new
18 model. It's not a GPO, and it's not a PBM. It's something
19 else. For me, prior authorization and step therapy is
20 utilization management, and I don't know that -- is that
21 what we're trying to create? We're trying to create almost
22 like a health plan that also acquires drugs. And if not,

1 maybe instead it's not -- it's not an infrastructure around
2 appropriate utilization. I think what we're trying to
3 solve for is formulary compliance. And so is it instead a
4 bonus to those participants of the DVP a formulary
5 compliance, which would then be their incentive to use the
6 drugs on formulary? Because this isn't about coverage.
7 When I think about prior auth and step, this is about what
8 our health plans, our sponsors are willing to pay for. And
9 ultimately we're not saying we're not going to pay for
10 anything. It's just, you know, acquisition cost.

11 Back to your comment, Warner, about D and B. So
12 I want to make sure, just to clarify. Drugs are either
13 covered under B or covered under D. They're not typically
14 covered under both, so it's not a site-of-care issue.
15 There are some exceptions. Like test strips typically are
16 B, but they can be under D. So, yes, I think we could look
17 at a few of those exceptions where they bleed over. But
18 drugs are just typically covered under B or covered under
19 D, but the methodology for reimbursement is different.

20 There's an exception in the paper around
21 inflation rebate and if it's a single-source brand, and I
22 want to make sure I understood the comment that you would

1 exempt them from the inflation rebate. And if that is, in
2 fact, our recommendation, I'm not in support of that.
3 You're looking at me funny. Maybe I misunderstood it.

4 MR. PYENSON: Where is that?

5 MS. BRICKER: It's page 26, talk about if there's
6 a high-cost drug, that there's a shortage. So to me,
7 that's EpiPen, and we could name other ones that are our
8 favorites, but I wouldn't incent -- I wouldn't say because
9 there's a shortage or what have you that we're not going to
10 hold you to some sort of inflation cap.

11 I'm not in favor of arbitration. Again, I think
12 it's a bridge too far. If I'm a DVP operator, I just go to
13 arbitration for everything because ASP is the worst I can
14 do, so I'm just not sure that -- it's a bridge too far for
15 me.

16 One last thing. If you don't have the DVP
17 negotiating inflation cap, ASP is on a two-quarter lag. So
18 inflation, though, I would assume we would measure that at
19 a calendar year, but the ASP was from six months ago, so
20 you'd have to also solve for that. Are you looking at the
21 inflation over which period of time? So it goes back to my
22 recommendation if you're going to do inflation cap, give it

1 to the DVP, and they would, you know, measure inflation
2 based on, you know, the same periods of time, their ability
3 to buy for that calendar year and then the inflation
4 associated with that.

5 And I would just generally try not for us to
6 create any loopholes. I would not exclude repackagers. I
7 would not exclude low-cost drugs. You know, we regulate
8 the heck out of this, and we create loopholes that we think
9 are sort of harmless, and then people exploit. So to the
10 extent that we can not have exceptions or loopholes I think
11 is a positive.

12 DR. CROSSON: Thank you. Those are all good
13 comments, Amy. I'll just talk about one, and that's the
14 binding arbitration. So it was not our idea, because I
15 agree with you, to just say, for example, DVP, anytime we
16 want to do binding arbitration, you have the right to
17 enforce it. It would be -- the model would be that the
18 Congress in constructing this would set the guardrails for
19 that and would say essentially -- and this would be across
20 all DVPs, not one at a time. But if a manufacturer comes
21 in with a launch price, for example, or is a single-source
22 provider by some other mechanism, that exceeds some

1 benchmark in terms of cost -- and we have not tried to say
2 what that would be, whether it would be an annual cost for
3 a patient or whatever -- then that would open the gate for
4 binding arbitration, but only in those circumstances.

5 MS. BRICKER: So then the output of that binding
6 arbitration would be then all DVPs could acquire that drug
7 at the same price?

8 DR. CROSSON: Or no more than that, yeah.

9 MS. BRICKER: Okay. I'm still not in favor.

10 [Laughter.]

11 DR. CROSSON: Well, I did my best. Okay.

12 MR. PYENSON: I support the Chairman's
13 recommendations, and I have a concern over the quality of
14 ASP reporting, not so much from the completeness of who's
15 reporting and who isn't, but I have not seen in these
16 discussions the kind of rigorous definitions that apply,
17 for example, to medical loss ratio by insurance companies.
18 It could be they're there and we just haven't gotten there,
19 but it could also be the case that there is a fair amount
20 of flexibility in what could be considered in and out of
21 ASP. And I think -- I'm not sure how to incorporate that
22 into a recommendation or if that's Round 3 of Part B drugs.

1 DR. CROSSON: There ain't no Round 3.

2 [Laughter.]

3 MR. PYENSON: So I want to express that concern.

4 DR. MILLER: Let me commit to only this: that I
5 will talk it out with the crew and see if there is some
6 adjustment, either in text or in a recommendation, that can
7 be brought to this, because I don't get the sense that a
8 lot of other people would object to the notion if there was
9 some more oversight and how rigorously the data was
10 defined. Assuming there's not a bunch of objections here,
11 we'll talk about it.

12 MR. PYENSON: Ask Amy [off microphone].

13 DR. MILLER: No. Amy--we're clear where she is.

14 [Laughter.]

15 DR. MILLER: But we'll at least talk through this
16 and see if there's some there there. So we'd make that
17 much commitment to you.

18 MS. WANG: I'm generally with the direction of
19 the draft recommendations, although I think that some of
20 the questions and comments that the Commissioners have
21 raised are really worth -- I'd like to understand more.
22 I'd like to understand Amy's comments about consolidated

1 billing for biosimilars. It's a very important comment.

2 On DVP, which we are kind of talking about, it is
3 like it's a new thing completely, something in between
4 organizations and models that exist today, worth a try. I
5 think it's worth a try. I think, you know, some of the --
6 to David's comments and, Mark, your response about what's
7 the pull, attraction from providers, is really quite
8 important to try to tease out a little bit. And so I agree
9 with it as a voluntary for providers for sure, so it has to
10 have a strong pull. I wonder whether it should be
11 voluntary for manufacturers, because I think that if it is
12 well designed, it will be for some people and not for other
13 people, and it will be a new market alternative. I would
14 hate for it to be -- I think that it's something to
15 consider, the danger of a pocket veto, if there's not
16 participation by manufacturers. And I think it's something
17 that we should think about. If you're going to have your
18 drugs, your Part B drugs reimbursed under the buy-and-bill
19 system, you also participate in the DVP.

20 DR. MILLER: And that is precisely the construct.
21 If you're not willing to negotiate with the DVP, then you
22 can't play in buy-and-bill. But, of course, we're not

1 saying that each manufacturer has to come to a negotiated
2 agreement with DVP. And so, you know, we're just saying
3 you want to play, you have to sit down at the table. They
4 could decide not to offer a discount. I've got all that
5 correct, Kim? Again, an enthusiastic -- right, okay.

6 MS. NEUMAN: [off microphone] the DVP.

7 DR. MILLER: Right. And so the mechanism that,
8 you know, you're frozen out of a \$26 billion market in
9 general if you're not willing to come and have
10 conversations with the DVP is assumed here. Okay.

11 DR. GINSBURG: Yeah, I support the
12 recommendation. On the shorter-term things, I think the
13 consolidated billing codes for biosimilars is one of the
14 most important things, and because I'm concerned, given
15 what the staff drafted in the chapter, that we're in a
16 situation where we're -- you know, current rules are
17 actually undermining the potential of the entire biosimilar
18 market by not having a mechanism to drive volume towards
19 the biosimilars when they have a price that's lower than
20 the reference drug. So even though we don't have much
21 experience, I don't think we're going to get a lot of
22 experience unless we do this right. So that just, you

1 know, the reason generics succeeded is because there was a
2 mechanism through formularies to drive large amounts of
3 volume to the generics. And biosimilars take a lot more
4 investment on the part of fair manufacturers, so I really
5 want to make sure that there's an incentive there for them
6 to do it.

7 On the DVP, I want to make sure that when we
8 write this up that we focus on the fact that, yes, it is a
9 hybrid of functions that different parts of the health care
10 system play, and the GPO part I think is the least
11 important. And I think David's comment is important that
12 just the GPO part, just buying at a lower price may not be
13 enough to coax the physicians into this. To me, the
14 functions that are provided by Part D plans with a
15 formulary, step therapy, prior utilization, and the like,
16 that to me is where the big upside is. That is what can
17 produce substantial savings and really attract the
18 physicians to volunteer for the DVP.

19 So I'd like to make sure that we're always
20 emphasizing this is not just, you know, a purchasing thing
21 like a GPO. This is really recognizing that a lot of the
22 health plan functions that have been really critical to the

1 success of Part D don't exist in Part B. And we need to
2 create some entity that can take on these health plan
3 functions for Part B drugs; otherwise, we're not going to
4 be able to get significant savings.

5 DR. CROSSON: Thank you.

6 MR. GRADISON: I hope you all will bear with me a
7 little. I'm going to take a little more time than usual.
8 I haven't voted no on anything in six years, and I'd like
9 not to have to vote no on anything here. There are parts
10 of this I like and parts of this I strongly dislike. And
11 it would certainly be my hope that rather than having a
12 single vote on the whole package we could vote on it in
13 pieces. Whatever the Chairman decides, that's fine with
14 me. It makes it an easier choice at my end because there
15 are parts I would like to be able to support, and let me go
16 down this one at a time.

17 Data reporting, yes.

18 With regard to the WAC+3 percent, I think there's
19 a better way than what's been discussed. The problem is
20 there's a lag in the data, a six- to nine-month lag in the
21 data. But after six months, after nine months, let's say,
22 the average sales price is known for that previous period

1 of time. And it seems to me a very simple matter. We have
2 WAC+3 say during the first nine months, and then you go
3 back and there's a clawback of the excess between WAC+3 and
4 what the actual sales price was. I don't think it's that
5 big a deal because it isn't going to happen that often with
6 that many products. I've suggested that before and it
7 hasn't sold, but I want to mention it again because I
8 personally think it's not a bad idea, or I wouldn't mention
9 it.

10 With regard to the inflation rebate, you could
11 just put this down to prejudice on my part. I have not
12 seen a price support system for anything that has worked
13 successfully over a long period of time, period. And there
14 are people -- you can go back way -- this has nothing to do
15 with any current politics. It started, I think, with St.
16 Thomas Aquinas trying to figure out the just price. And he
17 was not very successful in doing so and giving much
18 guidance to us today.

19 There will be, I think, unintended consequences
20 of doing that. Leaving out the low-priced drugs is okay
21 with me, but that's not where the problem could be. It
22 would be in the low-margin drugs where the problem could

1 arise, where increases in costs, new regulatory burdens
2 that might be imposed by the Food and Drug Administration,
3 quite legitimately, where the use of the facility might
4 more profitably be directed to some new product rather than
5 being a new plant. And I just think that it's an
6 invitation to shortages. That's my opinion. And I can't
7 prove it, but that's why I would not support that.

8 Consolidated billing codes, I happen to agree
9 with that.

10 I don't have any particular problem with the DVP
11 with regard -- that sounds weak. It's fine. It's fine.
12 Worth a try.

13 The arbitration, here's how I think the
14 arbitration is going to work out. I acknowledge that with
15 high volume like oncology drugs, manufacturers have got to
16 find a way to get into the Medicare market. I got that.
17 But they don't have to start there. If I were introducing
18 a new drug, let's say setting the launch price or dealing
19 with something else that was sole source for some other
20 reason, what I would do first is offer it in the private
21 market through employer plans, through health plans,
22 through MA, I guess, and try to establish a price through

1 that mechanism. And it may be sky high. I don't know what
2 it would be. Certainly it's not going to be a bargain.
3 But I would establish a price that I could go into
4 arbitration and say we are selling such-and-such at
5 quantities that people are paying these prices, that is
6 what the market shows. And then I would say in coming up
7 with my proposal, if I were a manufacturer in arbitration,
8 but in order to close this deal, I'll offer it for 20
9 percent off, I'll go -- my price in the arbitration will be
10 20 percent off what people are already paying.

11 Now I grant the arbitrator could say go with some
12 lower price, but I think that there would be a lot to
13 overcome and going about it, and I just think that's sort
14 of what it would end up being. That's my opinion.

15 With regard to -- well, we've already in the past
16 suggested a reduction in the 6 percent add-on. In a sense,
17 that's nothing new. Here it's being used as an incentive
18 for something else. Bear with me just a second because I
19 want to make -- this is my chance. I don't want to leave
20 anything out.

21 Yes, I'm dis -- this is not a reason that I'm
22 raising questions about this package at all. I am

1 disappointed that we have just focused on B. Warner has
2 already brought this up. It's been on my mind, too. I
3 think what we're trying to do here legitimately is say we
4 don't like these rapidly rising costs, prices, for
5 pharmaceuticals. Okay. I think we're also saying, since
6 our scope is Medicare, Medicare is going to set an example
7 and demonstrate what can be done to do something about
8 this. I think our position would be stronger if we didn't
9 say, well, just for Part B, because even if the spillovers,
10 Amy, are just very limited between B and D, they are
11 significant between A and B because some of these same
12 drugs might be purchased for hospital use for, you know,
13 non-340B hospitals. And so I just think if it were up to
14 me, I'd say let's broaden our recommendation and spend a
15 little more time on it. But I won't be around here after
16 April, so this is my chance to -- and thank you for
17 patience -- explain why for the first time in six years I'm
18 losing sleep over this. I'd like to get to yes. I can't
19 on every item. And I only use this opportunity to extend
20 in public a deep sense of appreciation to Jay for his
21 patience. He's patient with all of us, but he's certainly
22 been patient with me, not just on this issue but on others

1 when we've talked these things out. We must have spent 45
2 minutes just on this item before, and I deeply appreciate
3 that courtesy.

4 DR. CROSSON: Thank you.

5 MS. BUTO: So I generally support the Chairman's
6 draft recommendations and, like others, want to comment on
7 some of the specifics. So I would pick up the suggestion
8 that the text talk about the alternative ways of setting an
9 inflation limit on price increases. Again, my preference
10 would be do it through the payment rate. It's simpler, and
11 there are a lot of reasons to do it that way, in my
12 opinion. I'd rather do it that way.

13 On consolidated billing, you know, I guess I'm
14 180 degrees from where Amy is because I think probably the
15 best case for consolidated billing is with biosimilars and
16 the originator biologic. And the main reason I feel that
17 way is it's an externally scientifically derived analysis
18 by the FDA. I'm very concerned about extending
19 consolidated billing to "therapeutically similar"
20 products." I'm very comfortable extending the idea of
21 bundling to include drugs that are similar and even going
22 with some kind of a weighted average rate for the drug

1 inside a bundle for an episode treatment, but give the
2 clinician the right and the ability to make those tradeoffs
3 rather than say we're setting the price for your drug
4 regardless of what you have to pay for it, this is what it
5 is, and driving -- letting price drive or at least highly
6 influence clinical decisionmaking. I just think that's
7 wrong.

8 I want to get back to the A, B, D question with
9 drugs. You know, I would hate to see A pulled apart, the
10 DRG system, and for us to say we think we ought to be
11 setting a payment rate for drugs inside the DRG bundle,
12 because I am generally more favorable to larger bundles to
13 allow greater flexibility clinically than for us to set
14 every component of payment. I think we cannot possibly get
15 it right.

16 Between B and D -- I think Amy makes a good point
17 -- there is some overlap, not a lot of overlap. I just
18 started thinking, how would you operationalize that because
19 we have got all these D contractors negotiating their own
20 rates and then you potentially have a B contractor using
21 competitive methods to come up with a rate. I do not even
22 know how you come up with a rate that is the same across

1 the board, so it is just very hard to operationalize, in my
2 mind.

3 Binding arbitration, I will be honest, I had not
4 thought deeply about it until I started listening to the
5 other commissioners. I think, first of all, this is going
6 to be hard to pull off. I do not mean politically; I mean
7 operationally. It is very tough to do. The benchmarks are
8 tough to come up with. I think we may want to look at this
9 whole issue of high launch prices and look more broadly.
10 Are there other mechanisms? Are there other things we
11 should be considering? I know we are trying to give all
12 the tools to the DVP, but I worry that this one sounds very
13 appealing but I fear cannot be done. So that is something
14 I have sort of developed a greater appreciation for.

15 I want to go back to something Rita said about
16 appropriateness. I do not think -- we have talked a lot
17 about payment rates. We rarely talk about appropriateness,
18 and that is at least, in my mind, more than half of the
19 consideration of what treatment people get, whether they
20 are appropriately getting drugs at all, whether they are
21 getting the right drugs, et cetera. And somewhere we ought
22 to at least address this and say we are going to come back

1 to it, because otherwise I just feel like we sound like we
2 are only interested in paying the lowest rate for drugs in
3 a category.

4 Oh, and then the issue of participation by
5 manufacturers in the DVP. I feel as if they are going to
6 come because that -- you know, Medicare lives are pretty
7 hard to resist. You know, CBO looked at what would happen
8 if Part D plans -- I am looking at Rachel -- did not
9 participate in Part D. And of course we know what
10 happened.

11 Manufacturers are going to want to get that part
12 of the market and participate in whatever options there
13 are. I think they are just going to tie themselves in
14 knots about, you know, what the strategy is around buy-and-
15 build versus DVP, but they will look both at the long game
16 and the short game and try to figure out how to make it
17 work. But I do not have any doubt they are going to
18 participate.

19 DR. CROSSON: Thank you, Kathy.

20 Craig.

21 DR. SAMITT: So the danger of going last,
22 everything has been said, but I would say that my thinking

1 is most in line with Warner's. I fully support these
2 recommendations. In fact, I do not think they are bold
3 enough. And I worry as I hear the discussion that we are
4 talking about watering down this recommendation when,
5 thinking back to why we are here, you know, the
6 unsustainable increase in drug costs are unmanageable and
7 we need some strategies to really help assure that, you
8 know, the majority of everything we pay for in health care
9 is not all about drugs.

10 And so, I think these levers are all very
11 important, and so I would not be in favor of removing
12 anything. I mean, there have been some good suggestions
13 about alternatives, whether it is the clawback alternative
14 for WAC. So I would say are there improvements to continue
15 to use the strategy as opposed to remove it, because I
16 think we need all of these things.

17 And, you know, we recall that there were other
18 things also that we considered on the list that I also do
19 not want to lose, whether it is the use of clinical
20 pathways -- suggestion of clinical pathways or other
21 potential approaches -- the one we talked about earlier,
22 the inclusion of MA Part B purchasing as part of this

1 strategy as well through the DVP. There are probably even
2 more that we should and could be doing to help bend the
3 curve here. So I fully endorse this and, frankly, think
4 that we should continue the discussions and go even bolder.

5 DR. CROSSON: Thank you, Craig. And to make you
6 not be last we will go back to Bill, because we jumped over
7 Bill.

8 DR. HALL: I just want to save you from going
9 last.

10 [Laughter.]

11 DR. HALL: In case it goes off, I am in favor of
12 the Chairman's recommendations.

13 [Laughter.]

14 DR. HALL: Well, I am in the minority in terms of
15 expertise in this area, for sure, but one thing I do know
16 is that there is not a week in my professional life that
17 goes by that I do not see a drug misadventure in a real-
18 live person. Sometimes it just means a few more days in
19 the hospital. Sometimes it means they die.

20 And the whole issue of the use of drugs -- and I
21 guess "appropriateness" is probably a pretty good word --
22 is that it seems to me a shame that we have come so far and

1 yet we have not really reached the real benefits of some of
2 that expertise. We introduced Medicare. Let me put it
3 another way: When we introduced Medicare there were only
4 about two drugs or three drugs that were in use. They did
5 not cost anything. They were derivations of plants.

6 Many, many decades later we got coverage of drugs
7 for Medicare recipients. In the meantime, the science got
8 incredibly good. We got drugs for the first time that
9 worked. We have made great progress in the science of
10 pharmacology, we got better at expertise, and yet here we
11 are in this sort of nirvana era. And the people that we
12 are representing here are still dying, sometimes because
13 they do not get the right drug because they cannot afford
14 it, other times because they get the wrong drug. This is
15 not just rhetoric. This is the really -- this is really
16 what is happening out there in the world.

17 And you cannot separate one part of this puzzle
18 from the other. So even though I may not get entirely what
19 we are talking about on some of these issues, I do know
20 that this whole business of constantly trying to rectify
21 how we distribute the right drug at the right time to the
22 right patient is one of the most important things that we

1 do. So I think this particular topic is well worth the
2 struggle and the expertise and you simply cannot separate
3 that from other types of medical misadventure or
4 negligence, or just not getting the right drug to the right
5 person.

6 I know that does not help our dialogues so much,
7 but I sort of put this at a very, very high level of what
8 is really important in what we are doing here. And this is
9 something we can do something about. This is not magic.
10 This is just very careful, hard thinking. So, thank you.

11 DR. CROSSON: Amy, last word.

12 MS. BRICKER: I forgot to mention we are going to
13 go back and look at the Part D chapter around the policy,
14 you know, conversation and maybe bring that forward. If we
15 could -- if it is not included, the pay-for-delay that
16 exists today where brand manufacturers, in some cases, will
17 pay generic manufacturers to delay coming to market, so we
18 should highlight that. And currently, I believe FDA has a
19 backlog of 4,000 generic drug applications as we speak. So
20 competition is what is going to drive costs down. And I
21 agree that this is not a B issue.

22 So, you know, bringing those policy issues to

1 light and making recommendations around, you know, more
2 global issues I think will be quite relevant and timely.
3 Thanks.

4 DR. CROSSON: Thank you, Amy.

5 DR. MILLER: Can I just --

6 DR. CROSSON: Mark, on that?

7 DR. MILLER: One quick thing. And this links
8 comments Amy made, Bill made, and Kathy made, and to some
9 extent Warner as well.

10 So there was some angst expressed by a few people
11 of, like, you know, C, D -- or, sorry, B and D -- B and D.
12 You know, we were not completely unconscious on this point.
13 I mean, remember Amy's point was, you know, the drugs in B
14 and D kind of look like this. They do not fully overlap.

15 I appreciated Kathy's comments because, you know,
16 it was like operationally they came from two very different
17 worlds. They are on two very different platforms --
18 rightly or wrongly, but that is where they are -- and how
19 you would meld those.

20 Remember -- and I am saying this mostly for the
21 public -- we just made a set of recommendations on Part D,
22 and at the end of the June report in '16 and at the end of

1 the June report in '15 -- or '17, or whatever -- Bruce, I
2 am going to need help with numbers, but at the end of, you
3 know, the June report in 2016 and the end of the June
4 report in 2017, this commission will have tried to address
5 the issues on the D side and on the B side.

6 And to your last round of comments, yeah, we have
7 all discovered things we need to come back to in both of
8 these areas, including bundling in oncology, which we had
9 talked about in different points in time, and some follow-
10 up issues in the D world. So another way to look at it is
11 in a one-year period you will have spoken on D and B, even
12 if you did not put them all in one policy and make one, you
13 know, issue around them. So I just want to remind
14 particularly the public that there has been action taken on
15 D.

16 Sorry.

17 DR. CROSSON: Last word, Warner, and then we have
18 to move on.

19 MR. THOMAS: I will just take 30 seconds.

20 I appreciate Kathy's comment on Part A and the
21 difficulty with the bundle and the fact that -- I think we
22 could create a situation where you do not have to unpackage

1 the DRG but still look at a drug price that is paid for
2 drugs within Part A. And I would not bring it up because I
3 know that it is a complicated situation if the cost
4 escalation was not so significant and so material in an
5 area where we are seeing, you know, 1 to 1.5 percent cost
6 inflation.

7 The last comment I will make, because I know that
8 these recommendations will probably be -- will face a lot
9 of opposition, is that one of the things we do in other
10 areas when we talk about price increases or looking at
11 pricing is we give kind of an overview of the industry.
12 And we do this in inpatient, we do this in home health, we
13 do it in other areas. I would encourage us to do the same
14 type of thing in drugs to provide kind of an overview of
15 what is going on in the industry, what the margins look
16 like the ability to reinvest, because I think it puts it in
17 the context of what we are trying to do.

18 So, thank you.

19 DR. CROSSON: Thank you, Warner. And thank you,
20 Brian, Kim, and Nancy, particularly Kim. You all have been
21 working on this. Kim has been laboring in this vineyard
22 for a number of years. She has purple feet, as a matter of

1 fact, from this work.

2 [Laughter.]

3 DR. CROSSON: That is a California reference.

4 Sorry about that.

5 [Laughter.]

6 DR. CROSSON: But really, I mean, this is just --
7 you know, from the earliest stages of trying to figure out
8 what we could do here to the point we have come today has
9 been herculean. So thank all of you.

10 [Pause.]

11 DR. CROSSON: We'll go ahead and proceed. Now
12 we're going to move to the relatively uncomplicated --

13 [Laughter.]

14 DR. CROSSON: -- area of MACRA physician payment
15 reform combined with our long-term issue of trying to
16 encourage the growth of flagging interest in primary care
17 among young physicians. So we've got Kate, David, and
18 Ariel, and it looks like -- who's starting? Kate? Take it
19 away.

20 MS. BLONJARZ: So the last session today builds
21 off your discussion in January on two topics in clinician
22 payment: refining MACRA and supporting primary care. And

1 so a special thanks to Sydney McClendon, Ledia Tabor,
2 Jennifer Podulka, and Kevin Hayes.

3

4 So the topics are fairly complex on their own,
5 and we are merging them. So the next two slides will lay
6 out what we heard from your January discussions and some
7 potential policies, and also where we see linkages between
8 the two policy areas. So starting with MACRA and then
9 moving to primary care.

10 First, the MIPS system is a very overbuilt system
11 that's unlikely to be successful at identifying high-value
12 clinicians. And ideas for fixing it include eliminating
13 all measure reporting by clinicians and replacing it with a
14 set of CMS-calculated outcome and patient experience
15 measures. Assessing performance and adjusting payment
16 would happen at an aggregate level.

17 Second, we heard some interest in designing the
18 policies so they help move clinicians from MIPS to A-APMs.
19 Ways we've talked about addressing that are limiting the
20 potential upside in MIPS and moving the \$500 million MIPS
21 exceptional performance bonus to A-APMs, and David will
22 talk about a way to do so.

1 Third, there was interest in also making A-APMs
2 relatively more attractive, and the interest here seemed to
3 be in two areas. One is to address the ability of
4 practices who receive a small share of total AB spending as
5 their own revenue to take full population risk. The idea
6 that we've come up with is a model that would allow small
7 clinician-only or primary care-focused entities to limit
8 their risk to a share of practice revenue.

9 The second idea is to create an additional upside
10 for two-sided ACOs. This could use some of the \$500
11 million MIPS exceptional performance bonus money to fund an
12 asymmetric risk corridor in two-sided ACOs. And I've moved
13 into talking specifically about two-sided ACOs here because
14 two-sided ACOs and models like them are the A-APMs
15 currently in existence that are most consistent with
16 Commission principles.

17 The fourth area is better supporting primary
18 care, and the first idea is an upfront payment for primary
19 care providers in two-sided ACOs. And the linkage to two-
20 sided ACOs also brings it back to MACRA.

21 The second idea is a per beneficiary payment for
22 all primary care providers, and this would go to the bigger

1 issue of mispricing of primary care services in the fee
2 schedule and would redistribute spending from non-primary
3 care to primary care.

4 On the next few slides, I'll go through the MIPS
5 piece in detail. To reiterate some of the issues with
6 MIPS, first, MIPS uses hundreds of clinician-reported
7 quality measures. Second, two of the other components of
8 MIPS, meaningful use and clinical practice improvement
9 activities, only require attestation by a clinician and
10 haven't been proven to correspond to high-value care.
11 Third, for any given clinician, there are a relatively
12 small number of Medicare cases, which can contribute to
13 noisy performance. Fourth, under MIPS each clinician is
14 judged based on their own set of measures that they
15 reported, and so the results aren't comparable across
16 clinicians. In total, we don't expect that MIPS will be
17 able to identify high- and low-value clinicians and will
18 not be useful for beneficiaries, clinicians, or the
19 program.

20 So what could the Medicare program do instead?
21 And I'll lay out one idea that we'd like your feedback on.

22 In this new framework, all clinicians would

1 contribute to a quality pool, let's say a 1 percent
2 withhold. Clinicians would receive this withhold back if
3 they joined an A-APM.

4 Then clinicians could be eligible for a positive
5 or negative quality adjustment if they elect to be part of
6 a clinician-defined virtual group or elect to be measured
7 at a CMS-defined referral area. These virtual groups or
8 referral areas must be big enough to detect performance of
9 the group as a whole on certain population quality
10 measures. Clinicians who do none of these three things --
11 join an A-APM, join a virtual group, or elect to be
12 measured at a referral area -- would lose the withhold.

13 As I said on the previous slide, clinicians would
14 elect to be measured at either a clinician-defined virtual
15 group or CMS-defined referral area. And the performance of
16 each group or area would be based on a set of population-
17 based outcome measures, and it could build off the set of
18 measures contemplated in the Commission's premium support
19 work for comparing performance across different payment
20 models. Each virtual group or referral area would receive
21 a single performance score and would result in a uniform
22 payment adjustment that would be applied to all clinicians

1 in the virtual group or referral area.

2 This would be a real pivot from the current MIPS
3 program. As a reminder, the MIPS program is a
4 redistributive budget-neutral payment adjustment, aside
5 from the \$500 million. Our illustrative proposal is also a
6 redistributive payment adjustment, but the downside could
7 be limited to the amount of the withhold, and you could
8 also limit the upside. The proposal would also remove all
9 clinician quality, practice improvement, and EHR reporting
10 from the current system. Third, it would use a uniform set
11 of claims-calculated and patient-reported measures to
12 assess all clinicians. Fourth, probably one of the biggest
13 changes is that clinicians are no longer measured on an
14 individual basis. There is only the option for group or
15 area measurement. Fifth, the resulting payment adjustments
16 are for the entire group or referral area and wouldn't vary
17 among clinicians within that group or area.

18 So I'll stop here on MIPS and turn it to David to
19 talk about A-APMs.

20 MR. GLASS: Thank you, Kate.

21 So we now turn to rebalancing the program from
22 MIPS to A-APMs. As Kate just discussed, under the

1 illustrative MIPS proposal, there would be a tilt toward A-
2 APMs because clinicians would automatically get their
3 withhold back if they joined one, so they would have an
4 incentive to do so.

5 A second way to rebalance the program would be to
6 move the MIPS "exceptional performance" fund to A-APMs and
7 use it to fund asymmetric risk corridors. That fund is
8 \$500 million each year from 2019 to 2024. So this would
9 lower rewards in MIPS and increase the attractiveness of A-
10 APMs. So I will discuss this proposal in the next few
11 slides.

12 As background, last month we discussed several
13 issues. First, removing the 5 percent incentive payment
14 cliff by making payment proportional to a practice's
15 revenue coming through an A-APM rather than the current
16 approach that establishes an arbitrary threshold. For
17 example, if 25 percent of revenue was through an A-APM, you
18 get the 5 percent bonus; if 24.9 percent of revenue is
19 through the A-APM, you don't get anything.

20 Second, you asked for a design to make it more
21 attractive for small practices to take on two-sided risk.
22 The law requires that an A-APM have more than nominal risk,

1 and CMS has to establish that standard. The design
2 discussed has a revenue-based standard instead of a
3 benchmark-based standard and defines the risk corridor,
4 that is, the limit for savings and losses in revenue terms.
5 It would define revenue as a practice's fee-for-service
6 revenue coming through the A-APM. Savings and losses would
7 still be based on total Part A and Part B performance
8 consistent with the Commission's principles. This model is
9 also consistent with the Commission's other principles, and
10 two are shown on the slide.

11 The idea was to create an incentive that is large
12 enough to motivate improvement but limit the loss to
13 something a practice might take on. And the design could
14 be incorporated into the Track 1+ ACO model as that is
15 defined.

16 The concept addressed the underlying fact that
17 there is a disproportion between a clinician group's
18 revenue and the entity's benchmark because a primary care
19 group, for example, has only about 5 percent of the
20 benchmark as its own revenue. The other spending goes to
21 other providers. That is a lot of leverage, which works
22 fine if you are in a one-sided risk model, but can be too

1 much to venture if you are at two-sided risk.

2 So with that model in mind, we now turn to moving
3 the \$500 million exceptional performance money in MIPS to
4 the A-APM side of the ledger to encourage clinicians to
5 join two-sided ACOs.

6 This builds on the new model by making the risk
7 corridors that we just discussed asymmetric, that is, they
8 would have a higher upside than downside.

9 This would rebalance from MIPS to A-APMs because
10 it would encourages practices to accept risk by increasing
11 the expected value of that choice.

12 Asymmetric risk corridors require funding because
13 if you look at it from the Medicare program prospective,
14 given random variation, the program will pay out more on
15 the upside than it collects on the downside, and we can get
16 into this point in more detail on question.

17 In addition, this is an indirect approach to
18 promoting primary care. It works to the extent that
19 attribution favors primary care, practices that emphasize
20 primary care case management are successful, and that those
21 successful ACOs then reward the PCPs in them.

22 ACOs have to be successful to benefit from the

1 higher upside so it meets that requirement which Craig
2 proposed last meeting to limit rewards to successful
3 entities.

4 So here is just a quick numerical example of how
5 this might look. So we'll assume this entity is attributed
6 1,000 beneficiaries under some A-APM model. And we'll
7 further assume the benchmark spending per capita is
8 \$10,000. Then the total A and B benchmark for the entity
9 will be \$10 million. Finally, let us assume that the
10 clinicians in the entity receive \$500,000 in Medicare fee-
11 for-service revenue through the A-APM. That is 5 percent
12 of the benchmark A and B spending which is about what
13 primary care accounts for.

14 We then compare two possible designs. In the
15 first column, we have a symmetric risk corridor of 20
16 percent up and down, which would translate to \$100,000 of
17 up- or downside risk. The next column has upside of 100
18 percent of revenue and downside of 20 percent as before.
19 Thus, the limits are \$500,000 up which is an increase and
20 \$100,000 down as it was before.

21 By the way, in addition, the practice would get
22 the 5 percent incentive on its revenue, which would be

1 \$25,000, so the total upside would really be \$525,000.

2 Remember this is the practice's revenue through
3 the A-APM, and, in fact, the practice's total revenue would
4 likely be much higher, so the risk would be much less than
5 20 percent of practice's total revenue. That said, the 20
6 percent and 100 percent are just for illustration, not
7 policy proposals.

8 Ariel will now take us through ways to better
9 support primary care.

10 MR. WINTER: Continuing with the theme of two-
11 sided ACOs, the first approach to supporting primary care
12 would allow primary care practitioners in two-sided ACOs to
13 receive an upfront, lump sum payment. This upfront payment
14 would be voluntary, and it would be financed by reducing
15 the fee-for-service payment for each primary care visit
16 provided by a PCP during the year.

17 So PCPs in ACOs would not receive new money for
18 this upfront payment; instead, they would be shifting some
19 of their own revenue from fee-for-service payments to the
20 upfront payment.

21 The advantage of this upfront payment is that it
22 would give providers more flexibility to invest in

1 infrastructure and staff for care coordination activities,
2 and there would be no change in beneficiary cost sharing.

3 Before discussing the next approach, I want to
4 take a step back and remind you of the issues that we have
5 identified with primary care in the fee schedule.

6 First, primary care services are underpriced in
7 the fee schedule relative to procedures and tests.

8 Second, the fee schedule is not well designed to
9 support care coordination and primary care because it is
10 oriented towards payment for discrete services.

11 Third, mispricing in the fee schedule contributes
12 to an income disparity between primary care and specialty
13 physicians. This disparity may encourage medical students
14 to choose careers as specialists instead of primary care
15 physicians, which raises concerns about the primary care
16 workforce.

17 In light of all these concerns, the Congress
18 created a bonus for primary care practitioners called the
19 Primary Care Incentive Payment program, or PCIP, which
20 expired at the end of 2015.

21 In 2015, we recommended that the Congress
22 establish a per beneficiary payment for primary care to

1 replace the expiring PCIP program. The Commission was
2 concerned that if the PCIP expired without a replacement,
3 Medicare would be sending a negative signal to primary care
4 clinicians. However, the PCIP has not yet been replaced.

5 This slide goes into more detail about a per
6 beneficiary payment for PCPs and has a couple of ideas for
7 how much to spend on this payment.

8 The first idea is that the funding level would be
9 based on the amount of money in the PCIP program when it
10 expired -- about \$700 million -- and this was the
11 recommended funding level in our 2015 recommendation. At
12 this level, the per beneficiary payment would equal \$28 per
13 year, or almost \$3,600 per clinician, on average. It would
14 be funded by reducing fees by 1.3 percent for all services
15 other than primary care visits.

16 There would be no reduction in fees for primary
17 care visits provided by primary care clinicians or
18 specialists. This funding method is budget neutral and
19 would help rebalance fee schedule between primary care and
20 specialty care.

21 Alternatively, you could roughly double the
22 funding level to \$1.5 billion per year. At this level, the

1 per beneficiary payment would equal about \$60 per year, or
2 \$7,800 per clinician, on average. It would be funded by
3 reducing fees by 2.8 percent for all services other than
4 primary care visits. And there would be no beneficiary
5 cost sharing under either funding level.

6 At future meetings, we plan to discuss broader
7 fee schedule issues. These issues include: the need for a
8 greater focus on overpriced services; the importance of
9 improving the process for pricing services; and the
10 inadequacy of the data used to maintain the fee schedule.

11 We also plan to revisit prior Commission
12 recommendations for CMS to establish an expert panel to
13 help them set payment rates and to collect data from a
14 cohort of selected practices. We will also explore
15 combining CPT codes into larger families of codes.

16 So for your discussion, we are seeking your
17 comments on redesigning MIPS, rebalancing from MIPS to
18 advanced APMs, creating a two-sided ACO risk model with an
19 asymmetric risk corridor, and how to better support primary
20 care.

21 With regard to primary care, we'd like to get
22 your comments on the two approaches we discussed: an

1 upfront payment for PCPs and two-sided ACOs, and the level
2 of funding for a per beneficiary payment for PCPs.

3 We look forward to your discussion.

4 DR. CROSSON: Okay. Thank you very much. We are
5 open for clarifying questions. Can I see hands for
6 clarifying questions? Okay. Mostly over here, so let's
7 start with Bill Hall this time.

8 DR. HALL: When you look at the low end of
9 participation, some of these models, what would you say
10 would be the smallest group that would be able to
11 participate?

12 MR. GLASS: Well, you could probably start with a
13 fairly small group, but they'd have to aggregate with
14 others so that the numbers coming out of it all would be
15 meaningful. So on the MSSP, the minimum size is 5,000
16 beneficiaries, and I think when we analyzed that, that
17 still left a fairly substantial amount of variation. But
18 we could start with that.

19 DR. HALL: Thank you.

20 DR. COOMBS: So under the 1 percent withhold, if
21 I am in a small practice and say I can't graduate and go
22 over to the APM side and I'm stuck where I am for a number

1 of reasons, logistic reasons, maybe not having the
2 infrastructure, what happens at the end of the year to my
3 small, onesie-twosie practice?

4 MS. BLONJARZ: Yeah, so the 1 percent is just
5 illustrative. You know, you could set it wherever you
6 wanted. But the idea would be that, you know, if they did
7 not want to join an A-APM to get it back, you know, they
8 could either join a virtual group of clinicians -- there is
9 a provision in MACRA for that -- or they could elect to be
10 measured at a local area. So, you know, and CMS could set
11 what that local area is, but it would have to be big enough
12 to detect performance on the measures. If they don't do
13 any of those things, they would not be eligible to receive
14 it back.

15 DR. COOMBS: Do we have the capacity to go
16 outside of the geographic region?

17 MS. BLONJARZ: Yeah, I mean, I think that's
18 definitely a policy you could talk about, is how would you
19 want to let these virtual groups form. I think the one
20 contemplated in the law, which CMS hasn't implemented yet,
21 I don't think it's limited to geography. But, yeah, those
22 are policy questions that we could talk through.

1 DR. HOADLEY: So I'm kind of building on Alice's
2 question and trying to think through this MIPS kind of
3 thing. The 1 percent withhold that you used for
4 illustration, that would be 1 percent of what? Of Medicare
5 revenues?

6 MS. BLONJARZ: Yeah, a 1 percent reduction in the
7 Medicare payment rates.

8 DR. HOADLEY: And I guess it would be useful at
9 some point to sort of play that out a little bit in
10 illustrations, you know, sort of what amount of revenue
11 does that amount to, what kind of dollar for a typical
12 physician are we talking about. And then I guess I'm also
13 trying to get some sense of, you know, this is tied now to
14 these performance measures, these population-based outcome
15 measures that CMS would calculate, and sort of what that
16 might look like in terms of what it might take to get your
17 full withhold back or, you know, to get the maximum
18 increase and the maximum decrease, and just, you know,
19 trying to understand what this looks like.

20 I know one of the concerns I've always had on
21 some of these programs is, okay, you build up all this
22 mechanism, and we're talking about a few hundred dollars in

1 revenue at the end of a year, and it's sort of like, you
2 know, somewhere it shows up in your accounting, but it's
3 not something you're ever going to really notice, so it
4 doesn't end up having any behavioral incentive. And, you
5 know, that either calls for doing a bigger number, but that
6 may have other downsides. But at least as a starting
7 point, sort of what do these numbers potentially look like
8 and what kind of a change in behavior would be required to
9 be at the top or the bottom.

10 MS. BLONJARZ: So just a couple things. So the 1
11 percent, you know, you could think of that as being a
12 little less than \$1,000 if the average clinician is getting
13 somewhere between \$60,000 and \$100,000 in Medicare revenue.

14 I think the other questions that you've raised at
15 completely relevant. There is, you know, a belief that for
16 value-based purchasing to work well, it has to be a
17 substantial, you know, amount of money that is at stake and
18 very transparent on that.

19 I think, you know, when we were kind of thinking
20 through the policy, one of the things we were thinking
21 about is would you want to create a minimum reduction that
22 is no worse than whatever the withhold is. So if you elect

1 to be measured, you can't do much worse than if you made no
2 election at all.

3 I think on the other side, you know, we were
4 thinking about keeping it somewhere so that it would not be
5 particularly attractive, so with the idea that, you know,
6 you're not going to do great by staying in MIPS, and that
7 helps move people to A-APMs. But these are all kind of
8 different policy tradeoffs that we can work through.

9 DR. HOADLEY: The other thing I would also -- you
10 know, when you look at these kind of population-based
11 measures with a virtual group or a geographically based
12 group, it certainly doesn't feel like it has any potential
13 for anything I do as a clinician to make those measures go
14 up or down. So it's sort of like, okay, if I'm lucky
15 enough to be in an area that performed well or improved its
16 performance, you know, whether it measured this improvement
17 or absolute -- or I happen to align myself with this
18 virtual group that, because it's virtual, doesn't have a
19 whole lot of meaning to it, so, again, trying to think --
20 you know, if that's part of the strategy to make these less
21 attractive, I get that.

22 DR. CROSSON: Let's -- I think we need to --

1 MR. GLASS: The virtual group could be something
2 that you recognize, such as your hospital and its
3 associated physicians. It doesn't have to be some
4 ephemeral --

5 DR. CROSSON: Right, I wouldn't take that term
6 "virtual" too far, because one model for that --

7 MS. BLONIARZ: Yeah.

8 DR. CROSSON: Maybe the most common model we had
9 in mind was a hospital medical staff, and so there would be
10 at least putatively mechanisms to do what you say.

11 DR. MILLER: Right, and we're drifting out of --

12 DR. COOMBS: Round 1.

13 DR. MILLER: Round 1? Is that what we call it?
14 You know, and some of it was driven by comments that, you
15 know, we went back and forth with David on, the notion of,
16 like, well, maybe the hospital, because they would know; it
17 wouldn't just be virtual. It would be, you know, the
18 people that work in the hospital. So I want to reinforce
19 that.

20 In your exchange of, like, well, could this be
21 small and meaningless, I mean -- and I know you get this.
22 Obviously, the first toggle would be 1 percent, 2 percent,

1 you know, how much do you want to put into the game? But
2 the other thing I'd do is keep in mind the reference point
3 right now. The reference point right now is that you're
4 reporting lots of information. We're very concerned that
5 the detectability is approaching zero, and you're being
6 compared to people on completely different bases. So, you
7 know, you're right, but also keep in mind -- you know,
8 you're also right about the current system, like how much
9 signal is the person getting out of the current system?

10 MS. BLONJARZ: Can I just make one other point?
11 You can also think about having these broad measures that,
12 you know, an individual clinician may say I have very
13 little control over that. But one thing it could do is
14 align the clinician's incentives with, you know, the
15 incentives of other parts of the sector, so with hospitals
16 and other sectors. And to the extent that these measures
17 are used to compare across MA and fee-for-service and ACOs,
18 again, it's just trying to make sure everybody is facing
19 the same set of kind of global incentives.

20 DR. CROSSON: Brian, you have a point on this
21 question?

22 DR. DeBUSK: I had a related question. Have you

1 explored ways to prevent negative feedback loops where, for
2 example, in a geography, let's say one of these broad
3 population measures, let's say they're doing poorly, could
4 you find yourself in an underserved area that now has a
5 significant negative adjustment? Because to Mark's point,
6 we've cranked it up from 1 to 2 to 3 percent, and now we
7 have trouble actually bringing physicians and providers
8 into that area because they know they're coming into a
9 negative adjustment.

10 MR. GLASS: Well, they could join a group. You
11 know, they could join either one of these virtual groups,
12 which could be real things --

13 DR. DeBUSK: So could I gerrymander my group
14 perhaps? And even though I practice in Georgia, pick a
15 group in New York?

16 [Laughter.]

17 MR. GLASS: Well, I don't know. That might be a
18 possibility.

19 DR. CROSSON: I think -- and correct me if I'm
20 wrong, because I don't know if we've gotten this far. But
21 at least the way I've been thinking about it is when we're
22 talking about a group here, we're talking about a

1 collection of physicians who have an economic connection
2 with each other in some way, not necessarily a formal
3 medical group. It could be an IPA, for example, a certain
4 sort of IPA anyway. Whereas, a virtual group would be
5 physicians who either by dint of the way their practice is
6 organized -- for example, they're part of an organized
7 medical staff -- or they choose to create some sort of a
8 looser coalition for this purpose, but they're not
9 economically linked in the way that physicians are who are
10 employed, for example, or owners of a medical group. Is
11 that fair enough?

12 DR. MILLER: It is true, and this might be the
13 shakeout for is this a group of physicians or other
14 providers that I might want to think about going into an
15 APM model with. And I get in this group, and I think, you
16 know, Jay's a good guy, I'm going to work with him, or not.
17 You know, so you could use it both to get your MIPS reward,
18 but also you could sort of align loosely and see if these
19 are people that then you want to go in with on a model.

20 DR. DeBUSK: I was just thinking like let's say
21 you're in a rural underserved area, and let's say you're
22 having trouble getting -- recruiting physicians to begin

1 with. You had terrible health outcomes. Would you create
2 a situation where you say, sure, come to Cookeville,
3 Tennessee, come to Crossville, Tennessee, and, oh, by the
4 way, here's your minus 5 percent payment adjustment in our
5 system? I mean, there's still merit in the idea. I just
6 wonder if there's a way to safeguard against that negative
7 feedback loop.

8 DR. MILLER: And I guess there's a few things.
9 You know, there's also other adjusters when people go to
10 underserved areas, so you have numbers and dollars that
11 move in the other direction. And I guess the other
12 question I would ask -- and, unfortunately, that means we
13 have to answer it, too -- is, you know, you're sort of
14 positing, well, it's this geographic area and I'm going to
15 get that negative adjustment. But under the current
16 system, collecting information, some of it is outcomes
17 based, and, you know, are you going to be any better off?
18 I mean, if the health of the people in that area is bad and
19 you're being measured either as an individual physician
20 with a lot of noise -- and maybe you're better off, but
21 you're better off because basically you can't measure it.
22 And that's the problem.

1 We can think about the mechanics, but it will get
2 to something of a philosophical question. At what level do
3 you want to --

4 DR. SAMITT: And I think the ultimate punchline
5 here is there's always the option of joining an APM and, in
6 fact, is this what we're encouraging, the adoption of more
7 APMs as opposed to the potential risk of uncertainty as to
8 who is going to be in your virtual panel.

9 DR. CROSSON: All good points.

10 Now I'm going to make the argument that we're now
11 in substance as opposed to questions. So let's try to get
12 through the questions, and then we'll come back to this set
13 of points, if we can.

14 DR. COOMBS: Round 3.

15 DR. CROSSON: Round 3, right.

16 Sue.

17 MS. THOMPSON: Kate, I think you answered this,
18 but I just want to make sure. In terms of reconciling the
19 quality measures between APMs and ACOs and across the board
20 here, just talk to me about the attention being paid to not
21 creating another whole set of --

22 MS. BLONIARZ: So what we were kind of thinking

1 is, so the Commission has done work on comparing across
2 various models, payment models, and this linked to the
3 premium support discussion. But the idea is you would
4 assess a local area based on basically the top four
5 measures on the slide, so potentially preventable
6 admissions, ED visits, mortality and readmission, patient
7 experience, some measure of healthy days at home, and you
8 could think of those as kind of the broader systemic
9 measures that you have. And then one thing we were
10 thinking about is maybe you could supplement it with a few
11 things that are important for the clinician sector, and so
12 what we were thinking there are rates of low-value care and
13 relative resource use.

14 So it's not the same, but it's consistent. It's
15 largely the same set of measures, but it doesn't have to be
16 done that way. But the benefit is you get kind of all the
17 signals going in the same direction.

18 DR. CROSSON: Clarifying questions? Moving down
19 that way, Craig and then Pat.

20 DR. SAMITT: Let me put on glasses here. Slide
21 12, please.

22 In terms of the redistributed PCP payment, would

1 this be within a distinct two-sided ACO, or is it so it
2 would be a singular ACO's redistribution of a per-visit
3 payment to an up-front payment, not more broadly for all
4 PCPs?

5 MR. WINTER: Correct. Yeah. And one reason to
6 do that is -- the way we think of it is the PCPs and the
7 ACO would have an option to determine the percent of their
8 payments for primary care visits they want to take as the
9 up-front payment. They could say 20 percent, 40 percent,
10 60 percent. So you would have to do an adjustment within
11 the ACO to take that money -- to recoup that money, in a
12 sense, and offset the up-front payment.

13 DR. SAMITT: Got it. Thank you.

14 MR. GLASS: And this is being done in the Next
15 Gen model already.

16 MR. WINTER: Right.

17 DR. CROSSON: Pat.

18 MS. WANG: You said it's being done in Next Gen
19 with a partial up-front payment?

20 MR. GLASS: Yeah. The Next Gen model has a --
21 one of the options, payment options, is they can choose to
22 have basically a partial capitation payment, and they can

1 actually agree with different providers on different
2 percentage of up-front payments versus --

3 MS. WANG: I guess that I -- maybe I lack
4 imagination, but I was wondering if you could talk more
5 about -- this seems like partial-partial capitation because
6 the doctors electing to get a portion up front, which seems
7 like a nice cash flow advance, but they still have to bill
8 a recognizable billable service of the same number of
9 visits in order to break even, whereas if it's -- think of
10 PCP capitation. It's a little more flexible than that
11 because the capitation is for the whole amount. So I guess
12 I was just trying to figure out like --

13 MR. GLASS: Well, it's the kind of classic
14 partial capitation theory of you pay the -- well, Paul can
15 explain it. You pay the up-front amount -- that's your
16 fixed cost -- and then the amount you get per visit is your
17 variable cost, so you have no reason to over-provision or
18 under-provision care. So it's that kind of idea. So I
19 want the PCPs to get 60 percent of their payment up front,
20 and then each time they do a visit, they get 40 percent, so
21 they don't have a reason to do more or fewer.

22 MS. WANG: Okay, I understand.

1 MR. GLASS: Yeah.

2 MS. WANG: But that is an approach that covers
3 fixed cost as opposed to provides funding to may be switch
4 the composition of services. I don't know. So I was
5 wondering about that.

6 DR. MILLER: Can I just try one thing, though?
7 So are you saying -- and I'm driven by your words where you
8 say, well, this really just sounds like a cash flow type of
9 thing, and I think you're right. This is getting a portion
10 of what we assume you would have gotten anyway or this
11 particular provider up front.

12 Next question or next point, the second thing
13 that Ariel was talking about was to actually shift dollars
14 and make the reimbursement for the primary care more than
15 it currently is. So I think the thinking process -- and
16 you guys back this up or not -- is you get the cash up
17 front. That gives you some white space that you don't have
18 to do everything visit by visit, a little more
19 coordination, a little more flexibility, hire help in order
20 to run the office, and then the primary care shift in the
21 fee schedule is to actually put more resources in the hands
22 of the primary care physician. And then if the ACO works

1 out, maybe you get some bonus out of that, but that's
2 obviously behavioral.

3 MS. WANG: Okay.

4 DR. GINSBURG: On this thing, I think it's a
5 combination of a lot of things that the partial capitation,
6 meaning that, say, half of what you get is going to be
7 capitated and half per visit, is an attempt both to reflect
8 more the nature of primary care, the fact that there are a
9 lot of important primary care services that don't occur
10 during face-to-face visits.

11 But also, as David was getting into, this is a
12 classic thing of any time you pay fee-for-service, you get
13 too much use, and in a sense, if you can blend part of it,
14 which is covering your fixed costs and then the other part,
15 which is covering your marginal or variable cost, you
16 actually get ideal incentives for the physician in the
17 context of traditional Medicare.

18 MR. WINTER: If I could just point out one
19 difference between this approach here on Slide 12 and
20 what's allowed in Next Gen ACO is that the up-front payment
21 in Next Gen ACO could include the entire payment for all
22 the services -- across clinician services, hospital

1 services, post-acute care -- whereas what we're talking
2 about here is much more limited.

3 MS. WANG: Yeah, yeah. I mean, I would have --
4 so thank you for the explanation. I think of the ideal in
5 terms of clinical flexibility to be capitation for
6 everything, so that you can mix the services. It's just
7 doing it part way, you still have to have medically
8 billable services, and maybe that doesn't give as much
9 flexibility.

10 The only other question I had was there was a
11 statement that -- so this is a good idea to limit it to
12 ACOs because it solves the attribution problem. Can you
13 talk about why it solves the risk adjustment problem?

14 MR. WINTER: So the concern with having a partial
15 capitation approach is that there is variation in the
16 disease burden, comorbidities of patients, and so you might
17 want to increase that per-beneficiary payment for PCPs that
18 treat sicker patients and decrease it for those that treat
19 healthier patients.

20 The way we think that it addresses that concern
21 in a two-sided -- in an ACO is that the up-front payment
22 would be set based on the ACO's historical level of

1 spending for primary care visits. So if the ACO has
2 historically treated sicker beneficiaries who require more
3 visits, their up-front payment would be higher than another
4 ACO.

5 The other way to address it is if you wanted to
6 expand this to general fee-for-services to base it on the
7 risk score or the HCC risk score of beneficiaries, for
8 example, which is how CMS is doing it in CPC+.

9 DR. CROSSON: Clarifying questions. Bruce.

10 MR. PYENSON: A question for Kate. In the
11 original MIPS, there were some really impressive double-
12 digit reductions in the outer years. Is the intent here to
13 create a road, glide path towards something like that?

14 MS. BLONJARZ: I mean, I think that's a policy
15 question. By 2022, they're up to 9 percent up and down,
16 and it can be even higher on the up side in MIPS.

17 I think it kind of just goes back, again, to what
18 would be the point of building a different MIPS system.
19 Would it be that you would want clinicians to see a very
20 large payment reduction and make changes around that, or
21 would it have another set of goals?

22 I don't think we've really figured all that out,

1 and I think that would probably play into do you want --
2 you could also think of something like making it less
3 comfortable over time if you want to move everyone from
4 MIPS to A-APMs, but those are just kind of policy choices.

5 DR. MILLER: And it might be worth just saying it
6 again. What we're trying to do here is we've had a few
7 conversations with you, and we've gotten lots of comments.
8 And we're trying to pull these into a framework and figure
9 out, in a sense, "Bruce, is this" -- you know, this is one
10 of the rare instances where we can put the question back on
11 your guys.

12 In the MIPS world, very burdensome. We're
13 worried about signal to noise. Are we actually getting --
14 are we encouraging concern that people might stay?

15 A second signal was, Can you make APMS more
16 attractive? Many of you said that. Craig was leading that
17 charge pretty hard, and other people have said, "But what
18 about primary care?" And so we're trying to thread this
19 needle here. The numbers, the specifics, 1 percent, we're
20 just trying to get the concept in your head to see if we're
21 even in the ball park, and then if you want to -- like, "I
22 want this to be 9 percent in 2022," then we can have those

1 kinds of conversations.

2 DR. CROSSON: Okay. It looks like we're
3 questioned out. So now we'll have a discussion. Have we
4 got the discussion slide up? Can you throw that slide up
5 there?

6 Again, comments on the proposed models here,
7 including MIPS, A-APMs, and the primary care incentives.
8 So could I see hands for people that want to make comments?

9 [Show of hands.]

10 DR. CROSSON: Okay. I think this time, we'll
11 start at this side. Craig.

12 What? Did I miss something? What?

13 DR. SAMITT: Alice is going to kick it off.

14 DR. CROSSON: Oh, I'm sorry.

15 DR. COOMBS: I was just going to say --

16 DR. CROSSON: I did it again. I did it again.

17 Alice, go ahead.

18 DR. COOMBS: Thank you, Craig.

19 [Laughter.]

20 DR. COOMBS: So a couple of things. I think this
21 is such a hard job to get to the marrying or finding a home
22 for the primary care physician and the MIPS and MACRA, and

1 I think what we're trying to do is a very difficult thing,
2 which is move a primary care doctor from one entity to the
3 other.

4 It's easier if you start with a robust health
5 care delivery system like Partners or Ochsner or anyplace
6 like that, but I think this is a varying heterogeneous
7 group across the country, and so I'm a primary care doctor,
8 and I'm looking for a home. And you tell me I can actually
9 go and join a group. Virtual, geographic, or somewhere,
10 I'm going to go join a home, and so I'm working on Benning
11 Road in Washington, D.C. So where do you think I'm going
12 to try and find a home? I would probably marry someone who
13 is rich and famous.

14 [Laughter.]

15 DR. COOMBS: Or I'm trying to make my stats look
16 a little better.

17 That being said, we actually showed -- at the
18 Mass Medical Society, we had a RAND study that looked a
19 reliability of quality measures, and this study was very
20 good because when you have multiple specialties caring for
21 one patient, you have to have enough of a numbers threshold
22 to be able to differentiate who is responsible for what

1 good outcomes or what bad outcomes.

2 My greatest concern is that even under a primary
3 care umbrella, I may take care of X number of diabetics,
4 but I may have decided that I want to be an addiction
5 specialist or a weight management person, and so that even
6 for the given diagnosis and the risk adjustors to apply to
7 my heterogeneous practice -- and I fall as an outlier for
8 internal medicine -- it's going to be a very difficult
9 thing to do. The whole notion of attribution within a
10 geographic region, it's sealed with a lot of problems.

11 Solutions to the problems? I think if you can
12 have a little mercy on the onesie-tvosie groups, I think
13 that's where we could probably do focus groups and find out
14 from local and regional internists and family practice docs
15 what kind of things they're doing on an innovative scale
16 because they're trying to adjust to this changing landscape
17 just like anyone else, and we have to remember that primary
18 care doctors are roughly 25 to 30 percent in a given area.
19 So we're taking -- and each of the proposals that we have,
20 we have one proposal that says take from the 75 percent,
21 2.8 versus whatever the 1-plus percentage, and pour that
22 into primary care. Something needs to be done with primary

1 care.

2 And I absolutely agree, that first option seems
3 like it's probably the less threatening option. The 1
4 percent option, I only fear that people will have a
5 different type of compensatory mechanism to adjust to the
6 change. So it's going to take something much more
7 creative, especially when the attribution is imperfect.

8 The population measures that are being applied to
9 me in the trenches, I may have a hard time becoming a part
10 of that in terms of my participation and what did I lend
11 myself to in that whole process.

12 I think there's a great example in the anesthesia
13 and surgery literature, and it's called ERAS, and it's
14 early recovery after anesthesia, where they've actually
15 been able to combine care. So if you can combine care and
16 you can kind of say, okay, you're responsible for this kind
17 of outcome, that's an easier type of -- but in the
18 landscape of primary care, unless you're from the Dean
19 Clinic or someplace that has a robust integrated system,
20 integrated IT that can actually pinpoint, okay, this is
21 where we have a deficit -- I mean, there are people who do
22 hemoglobin Alc, and that's still up for discussion. Jeff

1 Drazen will tell you that measure changes daily. So if
2 you're going to use things like that, those process
3 measures, it's very hard to tell.

4 I think the population measures is where we
5 should be, but how to get the internal medicine doctor, the
6 family practice doctor being inculcated in, that's your
7 part over there. That's what you all -- I think that's
8 where the problem is going forward.

9 DR. CROSSON: So, Alice, help me because it's
10 been a while for me, but let's just think about the
11 organized medical staff model for a moment. As you well
12 know, as I do, it's kind of a group but not really a group
13 because you've got -- it's a mulling-alone model.
14 Essentially, everybody is in practice, but they're
15 nominally working in the same institution yet.
16 Historically, the organized medical staff has had a role.

17 DR. COOMBS: They have a --

18 DR. CROSSON: And I'm thinking more functionally.
19 They have had a role in trying to oversee and manage
20 quality within that institution, right?

21 Now, some are effective, and many have not been,
22 and in fact, the enthusiasm for the value of the organized

1 medical staff model has kind of waned over the last couple
2 of decades.

3 So at least one of the ways I've been thinking
4 about this -- and correct me if I'm wrong -- is that -- and
5 remember this is just an option. So joining an A-APM would
6 be an option, but then you would have the other option,
7 which is to organize your organized medical staff to be the
8 unit of measurement on these population-based measurements.

9 DR. COOMBS: So there's an underlying assumption
10 that you just made.

11 DR. CROSSON: Yeah.

12 DR. COOMBS: In our community, 80 percent of docs
13 don't even come to the hospital. The hospital's program
14 has superseded on every single service. Pediatrics has an
15 inpatient hospitalist. It's hospitalist internal medicine.
16 So that question of where does care happen, believe it or
17 not, the majority of care happens outside the hospital, and
18 so what we're trying to do is coordinate the outside of the
19 hospital to say let's have it on the premise of what the
20 hospital looks like.

21 In the olden days, you're right --

22 DR. CROSSON: Yeah.

1 DR. COOMBS: -- it would be a physician hospital
2 organization, and we would work from that premise, but this
3 is a very different practice now because some doctors, they
4 don't even come to medical staff meetings. So just that
5 information flow about what's happening --

6 DR. CROSSON: No, I think that's fair enough, and
7 you're right. Hospital care has been reduce as a
8 proportion of care, both through technology and through use
9 of hospitalists. So that's an imperfect -- I'll grant you
10 that's an imperfect model, but the notion here still
11 applies, which is that either using the hospital as a base
12 or the county medical society, for example, or some other -
13 - and this could be specialty based, potentially, as well,
14 you would have the option here, as defined, to choose, as
15 Mark said earlier, the physicians that you want to be
16 associated with. And the whole point of that is to achieve
17 a volume of care of Medicare beneficiaries that is actually
18 measureable, measureable against relatively simple, simple
19 in terms of collection and simple in terms of concept,
20 measures of quality, so --

21 DR. MILLER: In listening to you guys, you are
22 absolutely right. Tons of physicians do not set foot in a

1 hospital, but you could almost have the hospital-based
2 physicians be a nucleus and begin to say, okay, let's reach
3 out and get these sets of physicians so that we can all be
4 measured together.

5 And then I will just say this again: Keep in
6 your mind, what is the alternative? You know, if you are
7 sort of saying, well, it is really hard to kind of
8 coordinate and know your place in the system and what your
9 effect is, then you are also saying that under the current
10 system where we are trying to -- where we are, in fact,
11 imposing a bunch of burden and collecting a bunch of
12 information, we are still talking about a physician who is
13 completely disconnected and not coordinated. And what we
14 are actually measuring there and getting out of that is
15 kind of the question.

16 And so I am going to -- each time you guys say
17 this I am going to, you know, kind of force you back to the
18 status quo of, like, you are right, this has a bunch of
19 problems; so does the status quo. And so if there is
20 another idea, that is what we are searching for.

21 DR. CROSSON: The status quo being a lot of work
22 on the part of physicians, a lot of reporting requirements,

1 and down at the bottom of the end of it virtually nothing
2 in terms of this will work for nothing.

3 So I admit, you know, if this is the choice --
4 creating or reenergizing a virtual group -- that is work.
5 But in the end, the argument would be it is work with some
6 reasonable expectation of gain at the end as well as
7 actually improving quality.

8 Okay, you still do not believe me. I know. I
9 know.

10 DR. COOMBS: Well, I am just saying that -- Mark,
11 you bring up a very good point because you are thinking
12 what the counter-factual might be, what if this -- but the
13 situation is, I think, a lot of physicians are in the place
14 where they are looking at, well, it will not be so bad if I
15 continue to do what I am doing right now. And so that is
16 the other piece of it is that --

17 DR. MILLER: But do not be so bad -- or will not
18 be so bad, sorry, I think is, at least in the current state
19 of place -- given the lack of reporting and the inability
20 to distinguish, they are just saying, okay, we are going to
21 just sort of do this nominal thing for everybody.

22 So you have this reporting requirement, you have,

1 you know, nothing that really says, oh, you are really good
2 and you are not. So that is not really happening. And you
3 are not sort of pushing, you know, physicians together to
4 say, okay, is there a coordination effort there?

5 And at least, you know, early on, remember --
6 another way to make the point that I am making -- I am just
7 making the same point -- is -- she did not know my
8 microphone was off.

9 [Laughter.]

10 COURT REPORTER: I do.

11 DR. CROSSON: She just copied and pasted your
12 earlier remarks.

13 [Laughter.]

14 DR. CROSSON: This is so great.

15 [Laughter.]

16 DR. MILLER: Sorry, man.

17 Remember, you know, your first reaction when we
18 started taking you through MIPS. I mean, your reaction
19 was: I do not understand any of this. How is a physician
20 and other provider going to see what the signals are? And
21 that is what -- that and subsequent conversations are what
22 we are trying to rebuild from. And you are right; there

1 are problems with these things.

2 Sorry, Kate.

3 MS. BLONJARZ: And I just wanted to make another
4 point.

5 I mean, one question you could go directly at is,
6 if MIPS as it currently exists is not appealing and, you
7 know, other ways are dealing with it, do you want to go
8 directly at the question of should there be value-based
9 purchasing for clinicians in Medicare? I think you could
10 go right at that.

11 DR. CROSSON: Okay, and now we have got Alice --
12 now Alice's head is going this way, so --

13 [Simultaneous discussion.] [Laughter.]

14 DR. CROSSON: All right, so let's go back --

15 MR. GRADISON: Jay?

16 DR. CROSSON: We will start at that end with
17 Craig and then come up.

18 DR. MILLER: You know, Kate's question actually
19 is the right place to start. You know, should we -- do we
20 want value-based incentives? For clinicians in Medicare I
21 would say absolutely yes.

22 The discussions that we have been having now for

1 years -- you know, I think what we are trying to accomplish
2 is we want to reward PCPs and other physicians who deliver
3 high-quality, affordable care. And, in fact, we want to
4 encourage the development and movement toward more of those
5 types of clinicians.

6 And so, I think the -- when I looked at your
7 proposal, which I think is really good work, what I kept
8 thinking about is, does it do that? And I very much think
9 it does. I like a lot of what you have suggested. You
10 know, starting on the APM side, part of it is I think I
11 need a tally of all the parts because I got lost in all of
12 the bonuses and the, you know, imbalanced upside.

13 And I think it would be good to sort of recognize
14 what is it that you are offering to APMs, but when I
15 glanced at the total package, it is very much lucrative for
16 high-performing APMs, that organizations that are truly
17 demonstrably best in quality and affordability will do
18 well. So I think you have done well on the APM side. In
19 fact, perhaps you have gone a bit farther than you need to.
20 On the MIPS side I am not so sure. I think, for all the
21 reasons that you described, MIPS does not distinguish
22 between high performance and low performance, and it is

1 very complex.

2 I also do not -- I wonder whether 1 percent --
3 and I know you said the number can be anything, but is 1
4 percent a significant disincentive? So now, regardless of
5 the upside for APMs, if what you are telling me is you are
6 no longer going to measure my performance, it is a 1
7 percent withhold, I could get 1 percent back if I become
8 part of a virtual panel, I am wondering if I am just
9 inclined to stay exactly where I am, no change.

10 So, I am not an expert in behavioral economics,
11 but I think the intent here is to say, if we want to
12 encourage movement to APM, how significantly do these
13 recommendations do that? And maybe it is not a 1 percent;
14 it may need to be higher than 1 percent to continue to
15 encourage movement toward APMs. Let me end there.

16 DR. CROSSON: Comments? Kathy.

17 MS. BUTO: Mine will be brief.

18 I keep looking at the primary care portion and
19 feeling like it is not enough. I do not know what it is
20 but it does not feel like it is enough. And it would be
21 really helpful as we flesh this out more if we could say,
22 what is it we want primary care to be doing that it is not

1 doing now? And then, what do we think it is going to take
2 to make that possible, whether it is more money -- and it
3 may be more authority, so it is not just more money -- I
4 think that would be helpful, or more information.

5 But I do not know what we are trying to do with
6 primary care, except we keep trying to give them a little
7 more money but we also talk about how great the disparity
8 is. So I feel like we are not really -- we are not really
9 getting underneath all we need to do there.

10 DR. CROSSON: Bill.

11 MR. GRADISON: With regard to MIPS, it sounds
12 like we would be moving from the current system, which
13 really does not distinguish high quality from low quality,
14 to a system which does not distinguish high quality from
15 low quality at the provider level.

16 A question in my mind -- and I know there are a
17 lot of people thinking about this, but it might be
18 something you want to do for another -- at another time --
19 how much progress, if any, could be accomplished through
20 the use of data that is already available in terms of the
21 risk assessment of the individual patients in terms of the
22 claims, data, and so forth? I am very aware of the

1 limitations, but I just wonder about that because the
2 current system where you -- gosh, I wish we had that in
3 college, where you could take a course in European history
4 and you could decide which country you were going to be
5 examined on ahead of time. That would be marvelous.

6 [Laughter.]

7 MR. GRADISON: You know, that is what we have
8 here. You are going to pick something where you look good,
9 obviously, and that is easy to fill out. And it does not
10 mean a thing.

11 DR. CROSSON: So, moving from Lichtenstein, we
12 will go to Paul.

13 [Laughter.]

14 DR. GINSBURG: Yeah, I liked the paper a lot and
15 the presentation a lot too. It has a ton of good ideas
16 that really reflect the work that we have been doing over
17 the months I have been here.

18 The way I see it is that, you know, MIPS came out
19 really as a misfire. I just do not think you can do very
20 much in measuring the value of -- you know, of small
21 practices, especially, you know, just with readily
22 available data. And I think the big mistake on MIPS was

1 making MIPS way too large and, you know, offering some big
2 gains for large practices to stay out of APMs because they
3 could do so well with MIPS in driving the small practices
4 into the hospitals because it looked like it was going to
5 be a disaster for them -- so, in a sense, just getting rid
6 of the worst features of MIPS even if you do not believe
7 much in the way of incentives to improve your value because
8 you really cannot do that effectively.

9 And I am very comfortable with that because I
10 think that -- I believe in value-based payments, but I
11 believe that getting physicians into organized -- you know,
12 organizations which have the numbers to measure it is
13 really the way to go. And I cannot say whether you have
14 the best ways of drawing people into APMs, but I really
15 think that we need to give up on pushing people out of --
16 pushing people -- repelling people from unorganized care
17 and drawing them into organized care. There is a lot of
18 work to be done.

19 I will stop now. You know, I also agree with
20 Kathy that the things we are doing for primary care are
21 very small. I think they are positive things, and maybe
22 when we -- so I certainly support them, but keep looking

1 for bigger things we can do. And maybe we just need to
2 think bigger.

3 DR. CROSSON: Comments, coming up this way?

4 Bill.

5 DR. HALL: It seems to me that with MIPS and a
6 number of other things that we are doing now, besides maybe
7 some very poor planning that maybe could be corrected
8 somewhat, is that we are asking a group of physicians who
9 call themselves primary care providers -- which means they
10 are sort of the generalists of medicine -- and we are
11 saying: You are responsible for some kind of a catchment
12 area or some kind of a group. And as we look at your area
13 where you are, you have some problems -- like maybe
14 diabetes is not being cared for in general very well, or
15 there seems to be too much alcoholism in your community.
16 And we are saying: Why don't you fix that? And they do
17 not have anything to do with that. They are out in the
18 `burbs somewhere.

19 And so, I think we have very muddy expectations
20 what modern primary care should do. Maybe the burden of
21 proof of this quality should not be put so much on the
22 individual physician -- some should be -- but maybe it

1 should be put on the people who gain from having a cadre of
2 physicians and health care providers who are really trained
3 and paid for what they are supposed to do. I mean, one
4 could say maybe it is the hospital system that should be
5 responsible for recruiting, organizing people to do the job
6 correctly.

7 So I do not know that we are targeting -- getting
8 the right target. When many of these things came out,
9 including MIPS, it was almost as if somebody was at an art
10 institute and looking at pictures of the -- you know, the
11 famous --

12 DR. CROSSON: You are not going to say Roy
13 Lichtenstein, are you?

14 [Laughter.]

15 DR. HALL: No, I have never been to
16 Liechtenstein.

17 DR. COOMBS: It is a Rorschach test.

18 [Laughter.]

19 DR. HALL: And they say: Well, here is primary
20 care. What is that on the wall? That is a picture of a
21 primary care physician.

22 [Laughter.]

1 DR. HALL: So anyway -- what did I do?

2 [Laughter.]

3 DR. HALL: What did I do this time, besides
4 pulling an all-nighter and not sleeping -- not staying
5 awake?

6 [Laughter.]

7 DR. HALL: So anyway, I think it is well worth
8 our while discussing these issues but I do not know that we
9 have the right target yet for measuring quality circa 2017.

10 That is not very helpful. I am sorry.

11 DR. CROSSON: Okay, Bill.

12 Alice on redirect?

13 DR. COOMBS: Well, I think our heart is in the
14 right place. And Kate, her recommendation about value-
15 based purchasing might be something we would look at.

16 But I think it is a complex -- it is a complex
17 issue. I do support the first tier of what we said in the
18 box in terms of the traditional PCIP approach. As for the
19 1 percent, I think it is fraught with problems right now in
20 the current climate.

21 DR. CROSSON: Okay.

22 Comments? Sue.

1 MS. THOMPSON: Well, at the risk of stating the
2 obvious I just want to say, in general I am quite
3 supportive of the direction that we are going. And I feel
4 a little bit like we get into all the detail and lost in
5 the weeds a little bit, of wondering about quality metrics
6 and individual physicians and how do they fit into the big
7 picture, and have to remind ourselves, in the beginning,
8 what were we trying to accomplish when we left SGR and
9 moved to this business called MACRA?

10 And I think it had something to do with a sense
11 that there was value in coordinating care for our Medicare
12 beneficiaries, and that to do this required a new set of
13 incentives for our provider communities. And I agree with
14 you; I think there is some accountability more
15 appropriately placed on whether it is an accountable care
16 organization, as we see in the Next Gen structure, or if it
17 is in some organized medical staff -- however we chose, or
18 individuals chose, to be organized.

19 I think we have got to get out of some of those
20 weeds and remind ourselves, what is it we -- what is the
21 problem we were trying to solve? And I believe the
22 recommendations you have here, where we think very, very

1 carefully about what makes becoming part of an APM much
2 more advantageous than being in MIPS? And I think if we
3 keep our eye on that question, we will continue to drive
4 the detail in an appropriate way. And I believe you are
5 doing that as you get this work put together, so thank you.

6 DR. CROSSON: Okay, I think you have got the
7 executive summary for the next version of the chapter.
8 Warner?

9 MR. THOMAS: Just briefly, I think that -- you
10 know, with this it looks to me like you are trying to
11 create incentives for primary care physicians going to
12 APMS, which I think makes a lot of sense. I do think that
13 there needs to be a downside if folks do not gravitate in
14 that direction, because I still think there is a lot of
15 people that just say, I am just going to kind of maintain
16 as I am today. And I think there has to be incentives and
17 also a downside if you are going to be able to create the
18 type of change that we need going forward.

19 DR. CROSSON: Okay.
20 Rita?

21 DR. REDBERG: As long as we are waxing
22 philosophical, I thought I would share my concept of

1 primary care , not that -- I know we will get back to it.

2 But, going back, when I was a medical student at
3 the University of Pennsylvania and I was thinking about
4 family practice, we did not have a department there. So I
5 spent a month in North Carolina working with a GP, Jane
6 Carswell, who I think is my idea of what primary care I
7 wish was like now, because she had a huge panel of
8 patients; she took care of them.

9 You know, she did forceps deliveries, which OBs
10 do not even do now, all the way through. And, you know,
11 she did very few referrals because she went into medicine
12 because she wanted to take care of these patients. And she
13 knew them and she was -- she bought -- I saw her buy
14 medicines for people that could not afford to buy their own
15 and she knew they would not buy them. You know, she
16 started practicing before Medicare even existed.

17 And so when I think, you know, how do we get back
18 to that kind of model, you know, it was kind of when we had
19 this newer concept of a patient-centered medical home. I
20 mean, that really -- and a lot of primary care physicians
21 said this -- that was what the primary care doctor used to
22 do but, you know, now we kind of created another entity.

1 And now we have shifted -- and obviously I am a
2 specialist but, you know, when I look even now, I think
3 primary care doctors have given up a lot of what they used
4 to take care of. You know, chest pain, it is coming to
5 cardiology, and things -- and it leads to a lot more care
6 than is probably in patients' interests when you have so
7 much specialty care.

8 So, you know, I think this is -- and I think this
9 is a good start to rebalancing -- I am saying it is a big
10 problem. You know, we have workforce issues here. We
11 have, you know, geographic issues here, training issues. I
12 think the idea of shrinking the measures is a great idea
13 because that is very burdensome, you know. And looking at
14 population-based outcome measures and trying to take these
15 much broader ones rather than, you know, the European
16 history analogy is a good -- really good idea.

17 I am not sure, you know, how much money is the
18 right amount of money because it is more than, I think,
19 just money. It is sort of the autonomy and what physicians
20 went into medicine for that I think we need to try to
21 capture again. So I think this is a really good start.

22 DR. CROSSON: Okay, thank you.

1 Brian.

2 DR. DeBUSK: I am really excited to see us take
3 on MIPS redesign. You know, we have talked about the
4 shortcomings of the model here earlier. I think the more
5 illustrative we can be -- and you have been fantastic so
6 far on just showing how it is just not going to work,
7 between pick your own measures and PQRS.

8 I also hope that we can steal a page from the PAC
9 PPS, where not only do we show what is broken but we say,
10 here is what we can do; maybe here is what we can get from
11 administrative data or from claims data, realizing it is
12 not going to be perfect.

13 And Mark made the point earlier, you know, as we
14 do virtual groups or look at geographies, that is not going
15 to be perfect either. But I do wonder if we could double
16 down on our fair criticism of the shortcomings of the
17 current MIPS, PQRS design, but also paint a picture -- and
18 it is not a perfect picture. It may not be a Picasso, but
19 it will be a lot better than the picture that is out there
20 now. And I think that would -- number one, that may
21 facilitate change.

22 The other thing, I love the idea of the

1 asymmetric risk corridor in the ACO. I mean, I think it is
2 time to put our thumb on the scale for ACOs. We need them
3 to be successful, and it is going to require some money. I
4 would support an asymmetric risk corridor. I would also
5 support tinkering with their benchmarks a little bit so
6 that it is a little easier for them to hit those goals.

7 You know, I have made this comment before. When
8 we launched Medicare Choice, what would become Medicare
9 Advantage, I mean, what kind of -- what kind of subsidies
10 did that program have coming out of the gate? I mean, it
11 has taken us seven years to walk those subsidies down, and
12 we are still, what, 3 or 4 percent -- 3 or 4 percent high.
13 You know, I am not advocating crazy subsidies, but maybe it
14 is time to put our thumb on the ACO scale and make sure
15 these things work.

16 And then my final comment -- you know, obviously
17 primary care, we have to do something about primary care.
18 And I think a number of people mentioned this. I do not
19 think we -- we need to do something dramatic, we need to do
20 something big.

21 My one thought is, if we are going to double down
22 on ACOs and ensure their success, maybe we do not want to

1 be quite as prescriptive with primary care because -- and
2 again, need to go back and reread, but I could have sworn
3 reading something about this first round of ACOs, a
4 disproportionate amount of the settlement payments I think
5 did go to primary care.

6 So I do wonder, if we were a little less
7 prescriptive on exactly how primary care is to be paid but
8 doubled down on helping ACOs to be more successful, if they
9 could solve some of these issues around how do you align
10 the primary care physician themselves? And I would rather
11 have 400, 500 test tubes around the country looking at
12 different ways to pay primary care than maybe us sitting in
13 a room saying this is the way to do it.

14 So those are my thoughts.

15 DR. CROSSON: Okay. Thank you, Brian.

16 Seeing no further comments, Kate, Ariel, David,
17 thank you very much. We will be returning to this issue
18 probably early in the next MedPAC term. So thank you for
19 the work. We are going in the right direction.

20 So it is now time for the public comment session.
21 Could I see the people who want to make public comments
22 please come to the microphone and line up?

1 [Pause.]

2 DR. CROSSON: I'm just waiting to see how many
3 people are moving where. It looks like everybody is
4 heading for the hills. So we have a couple.

5 Let me make a couple of preliminary remarks.
6 This is an opportunity to address the Commission on issues
7 that we have had before us this afternoon. It is not the
8 only opportunity, you may know that. There are
9 opportunities to contact the MedPAC staff before we have
10 our meetings, both in person and online through the
11 website.

12 I would recommend those opportunities to you.

13 However, we do have this opportunity. I would
14 ask you to identify who you are by name, any association or
15 organization you are affiliated with. And please keep your
16 remarks to two minutes. When this light returns to red,
17 then that's two minutes.

18 Go right ahead.

19 MS. O'CONNOR: Thank you.

20 My name is Mallory O'Connor and I'm with the
21 Biotechnology Innovation Organization.

22 The Biotechnology Innovation Organization

1 appreciates the opportunity to provide comments during this
2 public meeting of the Medicare Payment Advisory Commission.

3 BIO is the world's largest trade association
4 representing biotechnology companies, academic
5 institutions, state biotechnology centers and related
6 organizations across the United States and in more than 30
7 nations.

8 BIO's members develop medical products and
9 technologies to treat patients afflicted with serious
10 diseases, to delay onset of these diseases, or to prevent
11 them in the first place.

12 BIO would like to take this time to express our
13 continued interest in engaging directly with the MedPAC
14 staff to identify and consider policy solutions that
15 balance our common goal of improving Medicare's
16 beneficiaries' access to high quality care, decreasing
17 overall program spending, and incentivizing future
18 innovation in medical technologies.

19 BIO is concerned that some of the proposals
20 currently under consideration may fall short of these
21 goals. Specifically, consolidated billing codes as we are
22 concerned these practices may preclude patient access to

1 the most appropriate therapies for them individually,
2 undermine market-based reimbursement, and provide a
3 disincentive to innovation.

4 The Drug Value Program, as we ask MedPAC to
5 provide additional details with regard to the structure of
6 the program and prioritization of beneficiary protections
7 and cost savings.

8 And an ASP inflation rebate, as we are concerned
9 that this policy will effectively create a price control
10 that will negatively impact the market-based reimbursement
11 system that works to foster patient access to critical Part
12 B medicines.

13 Thank you for the opportunity to comment today
14 and we look forward to the opportunity to discuss these
15 perspectives in more detail with the MedPAC staff in the
16 coming weeks.

17 Thank you.

18 DR. CROSSON: Thank you.

19 DR. BENNETT: My name is Susan Bennett and I am
20 here by happenstance, no prepared statement.

21 I am a cardiologist. I have been in practice for
22 20 years. I have obviously had a lot of interface with

1 primary care physicians.

2 I also resigned my position in October and since
3 then I have been reading a lot of Health Affairs, so I am
4 familiar with some of these acronyms.

5 With that as an introduction, I would say there's
6 several -- listening to all of the comments and all of the
7 proposals, which is a lot of work that's been done and I
8 can really see, from all of your perspectives, you have
9 really been able to combine a lot.

10 One of the things I can tell you, though, about
11 primary care and emphasize is that I think they are
12 absolutely the linchpin to how we solve fee-for-service to
13 value-based care. I do not think there is any other
14 important group that we can identify, other than the
15 primary care physician.

16 In the models that I've looked at, and some of
17 them I've had a chance to actually see on the ground, I
18 think the most effective have been when you really put a
19 lot of risk in those people's hands.

20 To coordinate care requires a group. It may not
21 require a large group. I am sure you can get better
22 examples than I could give here of medium-sized groups and

1 small groups, but I think it's possible to do. I think
2 combining the fact that primary care physicians really have
3 to be able to see patients as frequently as they need to,
4 that's relatively low cost.

5 The upside would, of course, be that they are
6 able to identify these patients that are ready for
7 admission or readmission.

8 The use of subspecialties, I think, is very, very
9 crucial to this. A good primary care physician will know
10 when to refer and not to refer. I think the concept of a
11 curbside is very important. In other words, having primary
12 care physicians be able to readily access a subspecialist
13 to say, for instance, I get a lot of consults for abnormal
14 EKGs. 80 percent of the time I could look at those EKGs
15 and ask them one or two questions and say you know what,
16 they really don't need to have a consult. So we will avoid
17 all of that extra testing.

18 So in summary, thank you very much for all of
19 your work. It is an extraordinarily difficult, incredible
20 thing that you're going and I hope that you can maybe, for
21 future meetings, get more input on the ground from primary
22 care physicians who have made it work in various ways.

1 DR. CROSSON: Thank you.

2 MS. BRENNAN: Good afternoon. My name is Allison
3 Brennan with the National Association of ACOs.

4 I obviously really appreciate the discussion
5 today and support the work that you're doing to encourage
6 providers to move into advanced APMs.

7 One thing that wasn't discussed today, which I'd
8 kind of like to raise and encourage you to consider is as
9 we're looking at payment models, value-based payment models
10 geared towards primary care, we also have to look at the
11 overlap of other payment models, particularly those related
12 to episodic payments and bundled payments.

13 We're seeing a lot of new things come out and the
14 overlap of all of these things on top of each other really
15 can have a negative effect and kind of take the wind out of
16 the sails on some of these original models that I think
17 sometimes we're viewing as kind of the linchpin to this.

18 So I would just encourage you, as you're
19 considering your work on primary care at the same time to
20 consider the overlap of those other payment models so that
21 we're not unintentionally undermining the primary care
22 models.

1 Thank you.

2 DR. CROSSON: Thank you.

3 UNIDENTIFIED SPEAKER: I'm Zach. I'm an intern
4 with the National Association of Community Health Centers.
5 I am also a future medical student.

6 I wholeheartedly agree that primary care is
7 struggling. I am a medical scribe back home in Minneapolis
8 and my doctors are consistently telling me don't enter
9 primary care, this isn't a job for you, we don't like this,
10 our jobs suck. I am doing a study right now on burnout for
11 the community health centers. It has increased 9 percent
12 in the last three years to now up to 54 percent is the
13 average physician burnout, and then 63 percent of family
14 medicine physicians have burnout.

15 And so how do you get that comparative to others
16 when it's so high in that field? And what are we doing to
17 incentivize people to go in it when people like me, who
18 want to be in primary care, are being told not to enter
19 that field?

20 And so what are we doing to help? And how are we
21 going to make that better?

22 And then if you do groups, you're incentivizing

1 that you want to do groups where doctors are highly trained
2 and that you want to be with people who have already proven
3 that they're worth -- if I'm a new medical student and I
4 know I'm going to make mistakes, are people going to take
5 me into that group and want me to be part of that if I may
6 hurt whatever projections you're trying to meet?

7 So those are just my comments on what I see from
8 being a young student.

9 DR. CROSSON: Thank you.

10 Okay, seeing no one else at the microphone, we
11 are adjourned until 8:30 tomorrow morning. Thank you very
12 much to the Commissioners and staff.

13 [Whereupon, at 5:07 p.m., the meeting was
14 recessed, to reconvene at 8:30 a.m. on Friday, March 3,
15 2017.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, March 3, 2017
8:31 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
ALICE COOMBS, MD
BRIAN DeBUSK, PhD
PAUL GINSBURG, PhD
WILLIS D. GRADISON, JR., MBA, DCS
WILLIAM J. HALL, MD, MACP
JACK HOADLEY, PhD
DAVID NERENZ, PhD
BRUCE PYENSON, FSA, MAAA
RITA REDBERG, MD, MSc
CRAIG SAMITT, MD, MBA
WARNER THOMAS, MBA
SUSAN THOMPSON, MS, RN
PAT WANG, JD

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P R O C E E D I N G S

[8:31 a.m.]

1
2
3 DR. CROSSON: Okay. Let's take our seats and we
4 can begin. For this morning's session, we are going to
5 expand our discussion and thinking about the issue of
6 premium support. As the Commissioners know and some of our
7 guests may want to know, for about the last year or so, we
8 have been looking into a range of aspects with respect to
9 the concept that is roughly called premium support.

10 The purpose of this is not to -- and the
11 Commission has not and does not intend to -- take a
12 position on whether this direction is the appropriate
13 direction for the future of Medicare. However, we are
14 aware that policymakers have been working on this, thinking
15 about this for some period of time, and our belief is that
16 the Commission could be helpful to that thought process, to
17 provide information about essentially if the policymakers
18 were to proceed in this direction in the future, what are
19 the most appropriate considerations and modeling aspects
20 that ought to be taken into consideration with respect to
21 the premium support?

22 It is our intention, assuming the discussion goes

1 forward properly today, that we will be putting together a
2 report for the June report according to those parameters
3 that I just described.

4 So we have two presentations today to further
5 expand and actually begin to complete our work on premium
6 support. The first one has to do with a set of issues with
7 respect to standardization across the various models that
8 would be part of premium support. And Carlos Zarabozo is
9 going to take us through that. It is quite a piece of --
10 what a master work that you have put together, Carlos.
11 It's taking an extremely complex set of concepts and
12 putting them into a form that I think we'll be able to
13 analyze and have a robust discussion about. So you have
14 the microphone.

15 MR. ZARABOZO: Thank you, and you pretty much did
16 my first slide, so I will try to salvage something from the
17 text here.

18 DR. CROSSON: You may notice I have a tendency to
19 do that.

20 MR. ZARABOZO: So, in conclusion --

21 [Laughter.]

22 MR. ZARABOZO: So far the Commission has

1 discussed options for setting the government contribution
2 in a premium support system and the effect that different
3 approaches might have on the costs beneficiaries would face
4 in such a system in a given geographic area, including a
5 discussion of how to mitigate any large changes in
6 beneficiary costs in moving to such a system.

7 Most recently, in October 2016, the Commission
8 discussed the issue of reforming quality measurement and
9 implications for premium support, and in November, the
10 Commission reviewed issues in determining the government
11 contribution and beneficiary premiums. This morning, I
12 will be discussing issues related to standardization, and
13 then Amy, Scott, and Eric will talk about the impact a
14 premium support system might have on beneficiaries and
15 plans.

16 Here is the road map for this first presentation,
17 which consists of some discussion of the terminology used,
18 the rationale for standardization, a look at the extent of
19 standardization in current programs (that is, in Medigap,
20 Medicare Advantage, and Part D); how standardization might
21 apply in a premium support system and what the rationale
22 would be; and, finally, I'll discuss some additional

1 related issues.

2 First, to define standardization. For purposes
3 of today's discussion, what is meant by complete
4 standardization in health insurance is that there are no
5 differences among the products that different insurers
6 offer in the marketplace, a definition that will become
7 clearer in looking at the Medigap model. Aside from
8 complete standardization, there can be standardization of
9 components of health insurance offerings.

10 We will talk about three components today:
11 benefits, cost sharing, and plan offerings. An example of
12 the standardization of benefits is the skilled nursing
13 facility benefit in Medicare fee-for-service and Medicare
14 Advantage plans. Medicare fee-for-service covers 100 SNF
15 days, and MA plans are required to cover 100 SNF days.
16 Medicare fee-for-service has a fixed cost-sharing amount
17 for SNF days beyond the 20th day. If one wanted to
18 strictly standardize cost sharing in Medicare Advantage for
19 the SNF benefit, the requirement would be that MA plans
20 would also charge the same daily co-payment as fee-for-
21 service.

22 By the last term listed here, offerings, what is

1 meant is the products that are sold to Medicare
2 beneficiaries. With SNF coverage, for example, the
3 Medicare program could tell MA plans that they must cover
4 100 days, but CMS could permit plans could offer another
5 option that has expanded SNF coverage, but it could only be
6 coverage of exactly 150 days by an MA plan. No other
7 variants would be permitted if you were standardizing plan
8 offerings.

9 What might be viewed as an alternative type of
10 standardization is to use an actuarial equivalence
11 standard, which is relevant in our discussion of cost
12 sharing. In cost sharing, one insurance product is
13 actuarially equivalent to another if average overall cost
14 sharing is equal. For example, Medicare Advantage has a
15 requirement that a plan's bid to cover the Medicare Part A
16 and Part B services must have cost sharing that is equal to
17 that of Medicare fee-for-service. This requirement can be
18 met by using the exact same cost-sharing structure as
19 Medicare fee-for-service, or it is met if the total average
20 of all the expected amounts that enrollees pay in cost
21 sharing for Medicare-covered services is the same as the
22 average total that the enrollees would have incurred in

1 fee-for-service Medicare, regardless of how a plan might
2 apply the cost sharing to individual items and services.
3 So, for example, if fee-for-service cost-sharing averages
4 \$100 per person per month, then plan cost sharing must
5 equal, on average, \$100 per enrollee per month in the basic
6 bid.

7 Benefit standardization has a number of
8 advantages, not the least of which is that it helps
9 beneficiaries choose among various options because there is
10 clear pricing information and the beneficiary knows that
11 benefits are the same across all plans. Benefit
12 standardization also makes for a level playing field among
13 plans, with price differences that reflect relative
14 efficiency rather than a reduced level of coverage.

15 Standardizing benefits also helps to avoid
16 selection strategies, where plans use the benefit design as
17 a way of avoiding sicker beneficiaries, and the uniformity
18 helps with program administration and the evaluation of
19 bids. The benefit design can also be used to specify an
20 adequate benefit level that all plans would be providing.
21 The drawbacks are that standardization can limit plans'
22 flexibility and innovation, and it consequently may limit

1 beneficiary choices.

2 Looking now at specific programs and their degree
3 of standardization, the most well-known example relevant to
4 Medicare is the standardization in Medigap, where (in the
5 majority of states), for the three elements we are looking
6 at, there is standardization for all three: benefits, cost
7 sharing, and plan offerings. The way standardization works
8 is that, in the case of benefits, standard plan F from any
9 insurer covers the same benefits as the standard plan F of
10 any other insurer, and similarly for cost sharing. In
11 Medigap offerings, an insurer cannot deviate from the
12 design and features that characterize the ten packages that
13 can be offered to Medicare beneficiaries. An insurance
14 company can offer up to the ten Medigap packages identified
15 by a letter designation. They are not required to offer
16 all ten, but any offerings that the insurer chooses to sell
17 have to be chosen from one of the ten standard packages.

18 Now let's look at Medicare Advantage, or Part C,
19 which is the coverage of Medicare's Part A and Part B
20 benefits through Medicare Advantage plans. There are two
21 broad categories of plans in Part C. There has to be a
22 basic bid, which is used to determine whether a plan has a

1 basic premium and whether it will have rebate dollars for
2 bids below the benchmark. Coverage in the basic bid is
3 standardized -- that is, plans are bidding on benefits that
4 are exactly those of fee-for-service Medicare, and the cost
5 sharing is standardized in such a bid -- as I mentioned,
6 either by mirroring fee-for-service cost sharing or using
7 an actuarially equivalent level of cost sharing.

8 However, there is no requirement that a basic
9 package has to be one of the offerings. The offerings of
10 MA plans, apart from the Medicare component of the benefit,
11 are not standardized across plans except in the case of a
12 basic plan. There can be additional non-covered benefits
13 and optional riders, for example. Cost sharing is not
14 standardized as it would be in a basic plan for Medicare-
15 covered services, though there are limits applied to cost
16 sharing. So in MA, given that there are very few basic
17 plans being offered, there is a broad array of varying plan
18 designs in the current market.

19 Turning now to Part D, the basic benefit is
20 standardized to the extent that specific classes of drugs
21 must be covered; cost sharing is standardized as specified
22 in the statute for the standard benefit, but an actuarially

1 equivalent cost sharing is also permitted, as in Part C.
2 However, what is different from Part C is that all Part D
3 sponsors are required to offer -- that is, market to the
4 public -- a standard benefit plan or an actuarially
5 equivalent plan. Enhanced plans offered under Part D are
6 not standardized with respect to benefits, once the basic
7 requirement is met, or with respect to cost sharing, though
8 there are certain rules regarding cost sharing in the Part
9 D program that apply to enhanced offerings.

10 So here is a summary of the current landscape in
11 standardization, with Medigap, shown in the first column,
12 standardized in all three elements. In Part C and Part D,
13 the basic or standard plans have benefits that are
14 standardized and cost sharing that is standardized or
15 actuarially equivalent to the standard. But looking at the
16 columns labeled for Part C "other offerings" and for Part D
17 also "other offerings" -- where you see all the "NOTs" --
18 you can make the generalization that they are not
19 standardized beyond meeting some basic requirements of
20 coverage and rules about cost sharing. What you see in the
21 green box is a difference between Part C and Part D. What
22 is different in Part C is that a sponsor does not have to

1 offer or market a basic benefit package, even though for
2 bidding purposes, Part C plans must prepare bids for the
3 basic package to determine whether there will be a plan
4 premium or rebate dollars. Unlike in Part D, a Part C
5 sponsor's offerings can consist solely of what you could
6 call enhanced benefits, meaning that beneficiaries could be
7 required to pay for benefits beyond what Medicare covers as
8 a condition of enrolling with the organization, or they
9 have rebate finance benefits that are not standardized.

10 So here is a schematic of what a premium support
11 system might look like with respect to the features we are
12 talking about that is modeled on Part C and Part D
13 features. It would have a standardized benefit package,
14 with cost sharing that is standardized or actuarially
15 equivalent across plans, and a standard option would be
16 available for beneficiaries to buy. There could be
17 supplemental plans and optional additional coverage. In
18 the next few slides, we will review what the rationale
19 might be for this kind of design.

20 In the current system in Part C, plans bid on the
21 equivalent of the fee-for-service benefit package -- that
22 is, a standardized benefit package -- for purposes of

1 determining the government payments to the plan and member
2 premiums. That is why you have a standard bid. This
3 structure would be an appropriate structure for a premium
4 support system that has bidding as such an important
5 component. However, although the Medicare Advantage
6 program is referred to as a bidding system, what plans are
7 doing is bidding in relation to an administratively
8 determined benchmark that establishes the maximum Medicare
9 program payment available.

10 In the type of premium support system the
11 Commission has been examining, plan bids determine the
12 government contribution towards a beneficiary's choice, and
13 fee-for-service Medicare is treated as a bidding plan. The
14 competition among plans determines the benchmark. In order
15 to have competition on a level playing field, there needs
16 to be comparability across plans and between plans and fee-
17 for-service. Note also that when we talk about a
18 standardized benefit, we should keep in mind that the
19 Commission has recommended modifications to the basic
20 Medicare benefit to incorporate various features, some of
21 which are found in MA -- for example, an out-of-pocket
22 maximum and a preference for copayments over coinsurance

1 for some services. Such a standard benefit would be the
2 benefit plans bid on, and offer, in the premium support
3 illustrative examples the Commission has been examining.

4 The same arguments made for standardization of
5 the benefit package apply with regard to the
6 standardization of cost sharing, as is currently done in
7 Part C, using Medicare fee-for-service levels of cost
8 sharing or the actuarial equivalent of fee-for-service cost
9 sharing. Such standardization enables comparisons across
10 plans on a level playing field when fee-for-service is a
11 bidding plan that defines the standard benefit.

12 In Part C currently, cost sharing that is
13 equivalent to fee-for-service can be cost sharing that
14 exactly matches fee-for-service on a service-by-service
15 basis or, as I mentioned, an actuarially equivalent level -
16 - the example that I used of the \$100 per member per month
17 average. By allowing actuarial equivalence, plans can
18 design cost sharing in a way that seeks to avoid the
19 sickest patients or the highest-risk patients. Until a
20 statutory change was made, for example, some MA plans were
21 charging 30 percent coinsurance on Part B drugs -- which in
22 fee-for-service Medicare have a 20 percent coinsurance. To

1 avoid the use of cost sharing as a selection strategy, the
2 statute and CMS rules impose service-by-service limits on
3 cost sharing for certain services. There is also a general
4 rule that CMS will reject bids that have a benefit design
5 that is discriminatory. This type of program management
6 and oversight should likely continue in a premium support
7 environment.

8 If you remember the green boxes showing what is
9 different between Part C and Part D with regard to basic or
10 standard bids, it was that in Part C, unlike Part D, a
11 sponsor does not have to offer or market a basic benefit
12 package, even though for bidding purposes, Part C plans
13 must prepare bids for the basic package to determine
14 whether there will be a plan premium or rebate dollars. As
15 I previously mentioned, unlike in Part D, a Part C
16 sponsor's offerings can consist solely of what would be
17 enhanced benefits, meaning that beneficiaries again would
18 be required to pay for benefits beyond what Medicare covers
19 as a condition of enrolling in the organization.

20 There are advantages to having all plans market a
21 basic benefit package, as is true of Part D. This approach
22 is consistent with key concepts in premium support, where

1 beneficiary decisionmaking is a key factor. By having
2 basic benefit offerings, beneficiaries can directly compare
3 the cost of those offerings with the cost of fee-for-
4 service Medicare in the market area. In addition, the
5 offering of basic benefit packages gives beneficiaries
6 greater choice. Some beneficiaries may not wish to pay for
7 extra benefits that they may not anticipate using.

8 Having standardized basic offerings also ensures
9 that in the bidding process, there are plan bids that are
10 directly comparable across sponsors and comparable with
11 fee-for-service, and that the bids that plans submit for
12 the basic package are good-faith bids and that they are
13 likely to be an actual best price bid.

14 Moving on to some additional related issues, Amy
15 will have something to say about research on the number of
16 offerings and how beneficiary decision making is affected -
17 - that is, at what point is information overload an issue.
18 The current policy in MA and in Part D is that when a
19 sponsor has multiple offerings in a market, those offerings
20 must have meaningful differences in order to be approved.
21 In the Congressional Budget Office's options paper on
22 premium support, the illustrative option had a very limited

1 set of offerings, consisting of at most two basic options,
2 each of which could have one enhanced option.

3 We have not suggested that in premium support we
4 would eliminate enhanced benefits or optional supplemental
5 benefits like those that are currently offered in Medicare
6 Advantage. However, given the history with Medigap, where
7 standardization was introduced in part because of the
8 proliferation of benefit designs, and given how much
9 variation we see in extra benefits in MA today,
10 policymakers could consider having some level of
11 standardization in enhanced benefits and optional
12 supplemental benefits to facilitate beneficiary
13 decisionmaking and to streamline program administration.
14 The disadvantage of such a policy is that plans have less
15 flexibility to innovate and beneficiaries may have fewer
16 choices.

17 The last issue is the matter of induced
18 utilization, which is handled differently in Part C and
19 Part D. In Part D, only standard bids or actuarially
20 equivalent standard bids are used to determine the
21 government contribution or subsidy level. In the case of
22 enhanced benefits in Part D, any costs from additional

1 utilization arising from reduced cost sharing are to be
2 borne by the beneficiaries who purchase the enhanced
3 products. This is not the case in Part C currently, but
4 such an approach is consistent with the recommendation made
5 as part of the set of the recommendations for redesigning
6 the Medicare benefit package. That set of recommendations
7 from the Commission included the recommendations to impose
8 an additional charge on holders of supplemental coverage to
9 offset the additional program costs from induced demand
10 when reduced cost sharing generated that additional demand.

11 So for your further discussion, we would
12 appreciate comments on the structure and the content of the
13 material as we have presented it here and in the mailing
14 material and any changes or additions you would like to see
15 on the topic of standardization in the June chapter. I
16 look forward to your questions because I will be forwarding
17 them on to the next group. Thank you.

18 [Laughter.]

19 DR. CROSSON: That sounds like a lateral to me.
20 Okay. Thank you, Carlos.

21 Can I see hands for clarifying questions? Maybe
22 more this way, so we'll start with David and go down.

1 DR. NERENZ: Thanks. If we could go to Slide 15,
2 I think this would be a good anchor point. I just want to
3 make sure I understand. In this model as we're thinking
4 about it, if there's a beneficiary, I want a plan that has
5 less than the compliance A and B package of benefits. Can
6 I do that. The implication to me here is that I cannot.

7 MR. ZARABOZO: That is the implication.

8 DR. NERENZ: Okay.

9 MR. ZARABOZO: Yeah, because it's -- again, the
10 fee-for-service benefit defines the standard benefit. If
11 you're going to set government contributions and so on, you
12 want the plans to have a basic bid. Now, we didn't -- I
13 mean, you could argue about whether actually they -- I
14 mean, that is a point to talk about, whether there could be
15 a lesser offering. But we --

16 DR. NERENZ: That's Round 2. I just want to
17 clarify here that is what this all implies.

18 MR. ZARABOZO: Right.

19 DR. NERENZ: Okay.

20 DR. MILLER: I hadn't thought about it quite this
21 way, and I think one way to think about this is that there
22 is a basic benefit in an area that a beneficiary can get if

1 they want; two, that there is a bid that's actually tied to
2 a real plan as opposed to a bid that's theoretical in
3 nature, which I think was some of the thinking in Part D.
4 But when you do enhanced plans, I think general -- or
5 variations of that, which you can offer alongside of it, I
6 think we generally think of things like extra benefits and
7 you pay an extra premium. But there's also things like
8 HSAs and that type of thing, which could be actuarially
9 equivalent, but I wonder if there's a conversation we
10 should have at some point about offering those types of
11 things alongside the basic --

12 MR. ZARABOZO: That's one issue, but I think that
13 David's question is, for example, if I as a company said,
14 well, I don't want to offer the SNF package, so I'm going
15 to drop it from the benefit, can I have such an offering?
16 Is that what you're saying?

17 DR. NERENZ: Well, I'm actually thinking of it
18 from the beneficiary point of view, that if part of what
19 we're trying to do here is enhance beneficiary choice, it's
20 an asymmetrical range of choices. You can have the basic
21 Part A/B benefit, and you can go up from there, but you
22 can't go down from there. And, first of all, I just want

1 to clarify that that is indeed what you're talking about.

2 MR. ZARABOZO: And as you say, that is a Round 2
3 issue of what --

4 DR. MILLER: Yeah, I just wanted to build it out
5 for when we got to Round 2 [off microphone].

6 DR. CHRISTIANSON: Amy, did you -- Bruce.

7 MR. PYENSON: Yeah, thank you very much. I liked
8 the structure of standardization and the different types of
9 standardization. One of the implications of that is how do
10 we deal with supplemental benefits in fee-for-service.
11 Today, as we know, many beneficiaries buy Medicare
12 supplement insurance, and that's not allowed for Medicare
13 Advantage. This may be going too far into the
14 practicalities, but would you envision that if health plans
15 had to, MA plans had to offer the standard Medicare
16 benefit, that the beneficiary would be able to buy a
17 separate Medicare supplement policy the way they can on the
18 fee-for-service side?

19 DR. MILLER: There is some work that we did a few
20 years -- this is the direction you were going to go, right?
21 Fee-for-service standardization? Or the fee-for-service
22 reform. So a few years ago, what we worked through as a

1 Commission was the notion of taking the fee-for-service
2 benefit and beginning to kind of update that and bring it
3 into more alignment with what you find in the standard MA
4 plan. And so in 30 seconds or less, you know, we said
5 there would be a catastrophic cap, you restructure the
6 deductibles, and then we had co-payments as opposed to co-
7 insurance, through the range, and we kept the actuarial
8 value of the benefit constant to the beneficiary.

9 MR. PYENSON: I think I'm talking about something
10 a little --

11 DR. MILLER: Well, I'm going to get you there.

12 MR. PYENSON: Oh, okay.

13 DR. MILLER: And part of that process, once you
14 had a reformed benefit, you would say you can have and
15 purchase supplemental insurance, but you have to pay for
16 the full value of that, which is one of the issues Carlos
17 has raised here, which is, yeah, I'm buying a supplemental
18 benefit, and here's the pricing of those benefits. But it
19 also imposes cost, you know, because that can have an
20 induction effect. And we're saying you have to pay
21 something closer to that true cost.

22 I think what's happening here is we would answer

1 -- I'm sorry -- your question as follows: This is sort of
2 discussed in the presence of a reformed fee-for-service
3 system. You could purchase supplemental, but your premium
4 would track more precisely to the cost of it. And then
5 here I think what Carlos is spelling out is if you go to
6 enhanced benefit off of the basic, your premium also has to
7 track the true cost of that benefit. And if it's, you
8 know, relieving you of cost sharing and so forth, it has to
9 track that benefit and the induction effect. So that on
10 both the fee-for-service and the MA side there's a certain
11 at least conceptual continuity. Is that about right?

12 MR. ZARABOZO: Yes. And from a practical point
13 of view, what you're proposing -- if you said, for example,
14 in premium support, yes, we will allow supplemental
15 coverage, and if we're saying -- and, by the way, induction
16 is always paid for in that premium, so you would have one
17 company offering supplemental coverage for 20 different
18 plans, let's say, in the United States, so all 20 of those
19 plans would have to say, well, this is the induction
20 resulting from this external, you know, supplemental
21 coverage, and they're going to have to pay that. So it
22 would be very complicated to include induction and allow

1 that kind of additional external coverage of supplemental
2 coverage, just from a practical point of view.

3 MR. PYENSON: So just to clarify my question, the
4 supplemental coverage that's offered, you know, A through Z
5 or M through Z for the changed fee-for-service side, those
6 same supplements you would envision being offered by the
7 Medicare Advantage plan.

8 MR. ZARABOZO: No. No. We're -- okay.

9 MR. PYENSON: Then --

10 MR. ZARABOZO: Yeah, fee-for-service. So in the
11 redesigned Medicare, where we have the recommendation about
12 redesign and we have the recommendation about there will be
13 additional charge on Medigap holders for the induction,
14 that's one side. We didn't touch the issue of Medicare
15 Advantage where, currently, as you said, there are no --
16 you don't have supplemental, except as offered by the plan.
17 The plan itself can say we have a benefit package that
18 essentially fills in all the cost sharing.

19 MR. PYENSON: So that aspect would not be
20 standardized?

21 MR. ZARABOZO: Yes, a plan could have -- I mean,
22 what we're talking about here, a plan could have an enhance

1 benefit. To the extent there was induced utilization, the
2 induction would be part of the member premium.

3 MR. PYENSON: Right, I get the utilization side.
4 But from a fee-for-service side, we would have a new
5 Medigap plan, say Plan M --

6 DR. MILLER: So I think we're getting close,
7 okay? So, you know, be positive. We're going to get
8 there. So actually what the Commission talked about on the
9 fee-for-service side -- and then we'll go back over to the
10 MA side, but for the moment, we're still on the fee-for-
11 service side. The Commission talked about this, and in the
12 Medigap -- you know, how Medigap bumps up against the newly
13 reformed fee-for-service system, there were a couple of
14 conversations, and they were fairly -- we went through this
15 a couple of times.

16 You're absolutely correct -- and a lot of people
17 come to a starting place where they say actually what I'm
18 going to do in the list of Medigap plans is I'm going to
19 start saying your offerings have to change. They can't
20 cover the full deductible, half the -- I know you're very
21 familiar with this stuff. Or you have to have at least \$20
22 of co-payment before it starts indemnifying you against

1 additional co-payment, that type of thing. And the
2 Commission -- that's all discussed in the report, but the
3 Commission sort of moved away from that and said allow
4 offerings to occur, but just make sure that what the
5 beneficiary pays in premium fully reflects the cost that it
6 imposes.

7 So if I take a plan that covers half a
8 deductible, that has less induction effect, and the premium
9 might be less; whereas, if Jay takes one that covers the
10 full deductible, he has to pay a higher premium. And the
11 Commission settled on sending the signal through the price.
12 That's on the fee-for-service side.

13 On the MA side, what Carlos just said to you in
14 his sentence is the plan can enter the market, and we've
15 got this basic concept in play, and say here's your basic
16 benefit. But if you want to indemnify yourself against
17 cost sharing, here's an enhanced benefit and here's how the
18 premium changes in order to cover that enhancement, and it
19 has to track the induction effect as well.

20 So on both sides, you can offer ways to indemnify
21 the beneficiary out of their cost sharing, and for the most
22 part, it's through the price that they pay that the signal

1 of do you want to buy this or not buy this is expressed --
2 either the premium on the Medigap or the premium on the
3 enhanced plan. That was what you were asking?

4 MR. PYENSON: Yes. Thank you.

5 DR. MILLER: Okay. I have to go home now.

6 [Laughter.]

7 DR. MILLER: I'm going to go lay down.

8 DR. CROSSON: Clarifying questions.

9 MS. WANG: So I think maybe my question is
10 related, but I'm going to ask it in sort of a different
11 way. Sort of bottom line, I'm interested in whether you
12 think that the kind of construct that you've conceptualized
13 here, which is very, you know, extensive, would reduce and
14 lower levels of Medicare spending compared to what exists
15 today. So, in particular, standardization of sort of
16 everybody has to offer the A/B benefit, because today it's
17 -- as you say, the distinction is you bid against it, but
18 plans flex around that. And, second, whether the sort of
19 peeling out induced utilization and converting it into like
20 an extra premium to the beneficiary, you know, my -- and I
21 guess maybe if you wanted to talk about duals and LIS
22 members separately, that might be -- because there is a

1 different bidding process for them now, as you know, and a
2 lot of what is in here I sort of see as a step back from
3 what's available to them. So just overall, Carlos, would
4 this reduce program spending?

5 MR. ZARABOZO: Are you still there? Well, okay.
6 Taking a couple -- first of all, there is going to be a
7 presentation on the situation with low-income people in the
8 premium support model. I think. Is that right?

9 DR. MILLER: Yeah, and I mean, what I would say
10 about the LIS and low-income folks is we're working through
11 a set of issues here on premium support, how you set the
12 benchmark, you know, how fee-for-service is treated. We've
13 been doing that over October, November, or whatever Carlos
14 said a few minutes ago. Now we're up to this issue of
15 thinking of standardizing benefits. We need to come and
16 build and have a session on how to deal with low-income
17 folks, and that is planned for going forward. There will
18 be some discussion of it, but these plans often come out,
19 and there's not a lot of detail on how to deal with the
20 low-income folks. And I think we've got to grind through
21 that and think through it. We haven't done it for today
22 and aren't ready to talk about it, unless Carlos wants to

1 free-form it.

2 Then the other thing you were saying is how does
3 this affect, you know, overall cost and expenditures, and
4 my take on this, Carlos -- and you should, you know, jump
5 right in -- there are many other things that we've talked
6 about in terms of the role of fee-for-service, how the
7 benchmarks get set, how the bidding process works, that
8 probably have, you know, a very clear and large impact on
9 whether your total level is, you know, high, low, medium,
10 whatever the case may be.

11 What I would say about this is this can have an
12 effect in the sense that if you, you know, had a wide-open-
13 ended -- like you can set the benefit how you like, you
14 know, lots of -- or very little standardization, to the
15 extent that you could play selection games, that could have
16 an impact on what your expenditures are, and also my guess
17 is how costs would fall across plans as they try and
18 compete with each other, as I try and grab healthy patients
19 relative to you, that type of thing. But I think there are
20 some other factors we have talked about that probably have
21 first-line effect on what your total expenditures are.
22 That's my first take.

1 MR. ZARABOZO: And on this specific induced
2 demand point, if you said, for example, today induced
3 demand is a government expenditure, tomorrow it will not
4 be, then presumably you'll have savings, you know, all
5 other things being equal.

6 DR. CROSSON: Clarifying questions?

7 MS. BUTO: So just to follow on Pat's point, I
8 think the issue of whether money is saved or not really
9 falls to whether you think a competitive system is going to
10 save money over a regulated price in MA and fee-for-
11 service. And how standardization serves that strikes me as
12 it makes competition easier. So to me, the issue of saving
13 goes to whether the system itself will eventually generate
14 saving. So I just throw that out as a Round 2 answer to a
15 Round 1 question.

16 My two questions on Round 1 are -- and sorry not
17 to know this, but is it fairly common for MA plans not to
18 offer a basic benefit package? In other words, is that the
19 common practice?

20 MR. ZARABOZO: Yes, because, and it's because
21 most everybody is bidding under the benchmark. So you
22 don't have the standard benefit because within the basic

1 package you are required to have additional benefits.

2 MS. BUTO: Got it.

3 MR. ZARABOZO: So there are some plans that are
4 bidding over the benchmark, so, yes, they do have --

5 MS. BUTO: Okay, because of the current
6 structure.

7 MR. ZARABOZO: Today, current structure,
8 everybody has extra benefits.

9 MS. BUTO: And the other question I have -- and
10 this goes to the issue of how much standardization we might
11 want in premium support for supplemental packages -- is:
12 Are we confident that without some degree of
13 standardization, which I like the flexibility, but what
14 worries me about lack of standardization is selection. So
15 what's the relationship between -- or has there been enough
16 research on the ability to vary supplemental packages and
17 selection? Do we have any sense of that? Because to me
18 that would inform which direction we might want to go in
19 this regard down the road with premium support. How much
20 standardization?

21 MR. ZARABOZO: I don't -- I know there's been
22 work on standardization. I know within the exchanges, for

1 example, there was a recent Health Affairs blog about this,
2 that some states actually had more standardization than
3 others. Some states require standards -- so the point of
4 that particular study was looking at HIV/AIDS drugs and
5 what kind of cost sharing was involved. There were clear
6 indicators of, well, this is disadvantageous for this kind
7 of population. So presumably what they're trying to do is
8 avoid this kind of population.

9 I mean, it is an issue, what you do -- as we
10 mentioned, what you do with the extra benefits does create
11 selection -- possible selection issues, yeah.

12 DR. MILLER: And, Kathy, for myself -- and we can
13 go back and sort of see if there's formal studies. As I
14 think about it, I don't feel like I've run across a lot of
15 these. I feel more of it's than things like -- and I
16 suspect you've sat through some of these meetings, where a
17 plan comes in and complains about what another plan is
18 doing, and some of the stuff that Carlos hit really
19 briefly, where there was a period where people started to
20 look at the bidding, and the bids were coming in with high
21 cost sharing on cancer patients, and that's almost what
22 informs my thinking here, is where you've sort of seen

1 almost by exception behaviors that might be militating
2 against, you know, one-to-one competition.

3 DR. CROSSON: Clarifying questions? Alice.

4 DR. COOMBS: So on Slide 8, I'm trying to
5 conceptualize how things are currently with some of the
6 plans, with the highly deductible plans that are out there.
7 Does Slide 8 say that this wouldn't be a possibility under
8 the premium if we had these as our baseline? In other
9 words, if we standardize for each one of these and someone
10 has a premium, as you outline in the chapter, for X number
11 of dollars, what's to say that that given patient who
12 enters into a plan wouldn't have an evolution of a highly
13 deductible arrangement where they go into a plan expecting
14 basic benefits and wind up with cost sharing that is
15 similar to what happens in the commercial world right now?

16 MR. ZARABOZO: And that's a different slide.
17 That's the one about cost sharing and what you do with cost
18 sharing, whether or not there should be restrictions on
19 cost sharing. Now, of course, high-deductible plans is
20 sort of like a different issue, as Mark mentioned. You
21 have MSAs currently within Medicare as the one question,
22 and premium support is would those kinds of plans be

1 available in a premium support system, which is kind of
2 like a Round 2 policy issue.

3 DR. HOADLEY: So my question actually builds off
4 of Bruce's question, and it seems like implicitly -- but we
5 haven't said explicitly -- part of the answer to Bruce's
6 questions would be that if you want to have an enhancement
7 or a supplement to a Medicare Advantage plan, you have to
8 essentially get it from the same Medicare Advantage plan.
9 And I don't think you actually said that, but is that
10 implicitly part of how we're envisioning this?

11 MR. ZARABOZO: Yeah, I think I implied that in
12 the response to Bruce. I think the original question was:
13 Will there be a Medigap market, a Medigap kind of market
14 for Medicare Advantage plans? Which doesn't exist today.

15 DR. HOADLEY: For different vendors --

16 MR. ZARABOZO: Right. There's no Medigap
17 coverage for Medicare Advantage beneficiaries, I think, so
18 --

19 DR. MILLER: Yeah, I mean, I hadn't thought about
20 it the way Bruce asked and you're asking. I think, you
21 know, the way I've been thinking about is the way it seems
22 to have shaken out in C and D where, you know, the plan

1 says here's my offering, indeed here's the basic, here's
2 the enhanced, and you kind of purchase from that, I hadn't
3 thought about this notion of some new entity coming in and
4 trying to ensure across all of the plans. And I'd have to
5 pause and think about what do you do with the bidding
6 structure to make --

7 DR. HOADLEY: Right.

8 DR. MILLER: I mean, you're working off the basic
9 bid. Maybe -- I'd have to think about it. And it's not
10 hostile. It's just I hadn't thought about it that way.

11 DR. HOADLEY: I mean, my gut says that you would
12 not want to go that way. You would want to keep the sale.
13 So if I'm going to Humana to get my Medicare Advantage, you
14 know, they can offer whatever level of enhancement and
15 supplementation in multiple offerings with whatever rules
16 and restrictions we want to impose on that, whether it's --

17 DR. MILLER: And I'll tell you another reason you
18 might want to think about it that way, but, again, you
19 know, if there's other thoughts on this, I definitely don't
20 want to close them off. But the other reason people often
21 talk about -- think about the drug market, you know, having
22 a PDP separate from the medical care, people talk about

1 concern and coordination. And I know we're not necessarily
2 talking about drugs here, but the notion of if I'm going to
3 offer a suite of benefits, are they hooked to the entire,
4 you know, continuum of care for that patient, for that
5 plan, you know, in that plan's network of providers. You'd
6 have to think about whether you're creating fractures in
7 the --

8 DR. HOADLEY: Yeah, and the basic MA plan that
9 was offering it is potentially going to say, you know, this
10 other company's coming in and is messing up the design, the
11 cost containment strategies, the care management
12 strategies.

13 DR. MILLER: We've crossed the line here.

14 DR. CROSSON: Paul, do you have a comment here?

15 DR. GINSBURG: Yeah, on this point. To me, the
16 notion in insurance markets about having a separate insurer
17 supplementing an insurer's plan is really a scourge,
18 because it's really in a sense underpricing your product,
19 imposing costs on the other one. For the most part, you
20 know, it's avoided in commercial insurance by rules. I
21 think there's -- you know, in traditional Medicare, there
22 was a motivation to do it because a lot of people wanted

1 richer benefits than the Medicare package, so that was the
2 motivation. But in Medicare Advantage, they're offering
3 the richer benefits, and I really see no reason to get
4 involved in this layering of insurance.

5 DR. CROSSON: Okay.

6 MR. THOMAS: So my question is -- and I just want
7 to make sure I understand exactly what we're trying to
8 accomplish. So the idea is that because we may want to
9 move to a premium support model, that in each market -- I
10 assume this is by market -- we want to make sure we -- or
11 we're thinking about the idea of having a product that is
12 in MA that is essentially equivalent to traditional
13 Medicare so that we can do a true comparison? Is that the
14 rationale behind what we're trying to accomplish? I'm just
15 trying to understand the goal.

16 DR. MILLER: I mean, I would say yes, and true
17 comparison can mean a few things from different points of
18 view, that the beneficiary can view a product and say, "I
19 know I'm getting the basic benefit," or, "I know I'm
20 getting an enhanced benefit." But, yes, a basic benefit.
21 And I think the reason -- I think the reason in D that they
22 called for in law the notion that you had to offer a basic

1 benefit is because in that instance the benchmark is based
2 on the bids, where, as you know, in MA, as we've gone
3 through here, it's an administrative benchmark, and that,
4 you know, the rigor of the bid will be stronger if it
5 actually represents a plan that somebody could walk in the
6 door and get services.

7 And so I think, yes, there's some ability from
8 the beneficiary's perspective to know how the landscape
9 works, from the bidding process to know what bids are
10 coming in at and being able to compare them.

11 MR. ZARABOZO: And when you say equivalent, of
12 course, an MA plan, a managed care plan, can do many, many
13 things to fashion whatever -- for example, network design,
14 the way they impose cost sharing. We're using an actuarial
15 equivalent so they can have different levels of cost
16 sharing for different -- we mentioned, for example, VBID,
17 value-based insurance design, is permissible in an
18 actuarial equivalent kind of situation. So it's not, you
19 know, very strict, it has to exactly look like fee-for-
20 service. But for bidding purposes, it is your -- you are
21 bidding on a particular product. It's the fee-for-service
22 product. So what is your bid for that particular product?

1 MR. THOMAS: But going back to the MA bid --
2 maybe I've got this wrong -- I thought the administrative
3 benchmark that you bid against I thought was always a
4 traditional Medicare product or cost, what you guys
5 reference as the administrative benchmark.

6 MR. ZARABOZO: Right, a benchmark set by law, in
7 other words, so an administered -- it is specified by law
8 that it's X percent of fee-for-service in a given
9 geographic area. So it's not -- competition does not
10 determine the benchmark. In premium support, competition
11 would determine the benchmark. Right now it is determined
12 externally, if you want to --

13 MR. THOMAS: But to me -- and once again I'm
14 trying to -- this is a clarifying question. I'm trying to
15 understand. So when you are competing -- or when you're
16 bidding against the administrative benchmark, that is
17 essential a Medicare fee-for-service equivalent. Is that
18 correct? And you have to be at or better than that as an
19 MA plan?

20 MR. ZARABOZO: Yes. I mean, you can be at that,
21 and what that means, if you bid at the benchmark, that
22 means you are offering the Medicare package.

1 MR. THOMAS: Right.

2 MR. ZARABOZO: That's it.

3 MR. THOMAS: And/or you can be better, i.e., you
4 can have more benefits than the --

5 MR. ZARABOZO: Right, you come in below the
6 benchmark, yes.

7 MR. THOMAS: And then you essentially have to add
8 more benefits --

9 MR. ZARABOZO: Right.

10 MR. THOMAS: -- in order to meet the equivalent,
11 correct?

12 MR. ZARABOZO: Well, that's the requirement, yes.
13 If you come in below the benchmark -- now, it used to be
14 that you could return money to the government if you so
15 desired. That was not all that popular, but --

16 MR. THOMAS: So in this model that we're talking
17 about, if we talk about a Medicare -- let's say we have a
18 standard product that's a Medicare fee-for-service set of
19 benefits. If that bid is lower than fee-for-service
20 Medicare, then the question is: What do we do with the
21 extra dollars? Is that a policy question?

22 MR. ZARABOZO: Well, in a premium support

1 environment, for example, let's say you just have in a
2 given market fee-for-service and one plan. If you say, as
3 mentioned in the mailing material, well, the benchmark now
4 will be the weighted average -- let's say each gets half of
5 the enrollment. Essentially, the average of the two bids
6 is the benchmark now. There's no -- unrelated to fee-for-
7 service, in a sense, except that fee-for-service is the
8 bidding plan in that context. So you have a new benchmark,
9 and either a beneficiary has to pay more to be in the one
10 that was above the benchmark or they gain by choosing the
11 one that was below the benchmark.

12 DR. MILLER: I also want to zero in, because I
13 think what you said is correct. So the other conceptual
14 shift that's occurring here is not just how the benchmark
15 is structured. It's saying -- because I know -- I know I'm
16 doing some violence to this. I mean, in some ways, yeah,
17 you're bidding on an average fee-for-service person with,
18 you know, a 1.0 health risk. And in a sense, I know,
19 Carlos, you know, you'll still be bidding on an average
20 fee-for-service person with a 1.0 health risk, but what it
21 will conceptually change -- and you are picking up on this,
22 which is what if I go below that, what do I do with those

1 dollars? And I want to be really clear. The fundamental -
2 - one of the fundamental shifts here is you're saying your
3 premium's less, and you're saying to the beneficiary, you
4 come with me, you don't pay a \$100 premium, you pay an \$80
5 premium. And then you could say, by the way, if you would
6 like to purchase some, you know, additional cost-sharing
7 protection or some dental or something like that, you know,
8 you could use some of those dollars to pay for that
9 benefit. So you could get them to use those premium
10 dollars that you've just saved them to purchase additional
11 coverage if you wanted to offer that. And the difference
12 is we're saying you have to -- or in premium support, if
13 you follow the Part D model, you do have to offer the basic
14 benefit and then you go with your enhancements next to
15 that.

16 MR. THOMAS: So basically, if you're an MA plan,
17 I guess what -- I guess I'm just trying to understand this.
18 If you're an MA plan, let's say you've got whatever product
19 you got in the market today that has a richer benefit
20 structure than traditional fee-for-service Medicare.
21 You're saying you'd have another product in the market that
22 is just exactly like traditional fee-for-service Medicare

1 and that would be -- you know, and that becomes a level
2 playing field of which to bid off from.

3 DR. MILLER: You got it, and I just want to take
4 on the word "exactly" a little bit in the sense that that
5 "exactly" could be literally your cost sharing has to be
6 this, or it could be actuarial equivalent where you say,
7 you know, across all of this, within some rules, you're not
8 really distorting your cancer coverage or whatever the case
9 may be, it is actuarially equivalent. So you could think
10 of the concept actually as either literally I have to do
11 these things, which I don't know that we're really --
12 that's not what really goes on in C and D, or there's an
13 actuarial equivalence concept. But everything else, yes.

14 MR. THOMAS: Okay. And then how do you
15 contemplate in that, in the standardization, the network?
16 Does the network have to be the same as fee-for-service
17 Medicare as well? Or is the network -- I mean, and what's
18 being contemplated here?

19 DR. MILLER: I would say no, and the easiest
20 thing to get through the rest of this day -- which is
21 turning out to be really complicated, Warner.

22 [Laughter.]

1 MR. THOMAS: You put it on the agenda.

2 [Laughter.]

3 DR. MILLER: I know. I am not making this
4 mistake again.

5 So, anyway, no, the easiest thing to do, and
6 particularly for the MA folks in the room, is think about
7 it like it is today, which is you have certain network
8 requirements, but, no, you don't have to replicate the --

9 MR. THOMAS: Okay. Thanks.

10 DR. CROSSON: Okay. Brian.

11 DR. DeBUSK: Surprise, surprise, I too am hung up
12 on Chart 17, the extra benefits issue around MA. And my
13 question was: On the MA side, there are clearly certain
14 things that are going to induce utilization. But how do
15 you tease that apart from hybrids that maybe are a
16 combination of utilization enhancement or inducement but
17 also value-based insurance design?

18 A good example: Let's say I want to do a flat \$5
19 co-pay for all foot exams because I think that's going to
20 reduce my diabetic foot ulcer treatment rate. Well, I'm
21 clearly inducing utilization there, right, by going to a
22 flat \$5 co-pay. But what I may be doing is reducing my

1 overall cost. How do you tease apart VBID and utilization
2 inducement in those hybrid situations?

3 MR. ZARABOZO: You hire Bruce to figure that out.

4 [Laughter.]

5 DR. DeBUSK: That was a bank shot off you to
6 Bruce, so good call.

7 DR. GINSBURG: [off microphone] Brian, is that
8 this is a good example of why you want to have the same
9 plan providing the supplements, because then it's all
10 internal to them. You don't want to get into a situation
11 where there's another carrier that's supplementing where,
12 as in your example, it's a really good one about how do you
13 actually calculate the induced utilization. You don't want
14 to use the general rule because this is a very specific
15 reduction in cost sharing that you're hoping is actually
16 going to save you money in the long term. So I think it's
17 just an argument for leaving this internal within the
18 companies, within the carriers.

19 DR. DeBUSK: That's what I was just trying to
20 tease apart, because the idea of building on -- you bid
21 low, which would be a reduced premium. I love the example.
22 And then there would be the additional benefit that you

1 would stack on as additional premium. I could see where
2 they would offset. I just don't understand in a true VBID
3 situation where all this is in MA and happening sort of
4 underneath the hood, I don't quite understand yet how you
5 would get back to that base number.

6 MR. ZARABOZO: The reason I mentioned Bruce is I
7 think you would say that if you have overall costs that are
8 lower because of your cost structure, then you did not have
9 induced demand on net. So, again, this is like an
10 actuarial determination. Is there or is there not induced
11 demand in this particular design?

12 DR. MILLER: Or to put it differently, we've been
13 using the inducement effect, but inducement could be a plus
14 or a minus. But you have to estimate it and make sure that
15 whatever premium you're calculating takes into account. So
16 if someone like Bruce -- and, you know, he's sitting right
17 here -- says, yeah, it's \$5, I get more office visits, but
18 I avoided these hospitalizations, so on net, the inducement
19 effect is X.

20 DR. DeBUSK: So in theory, I could have a
21 negative inducement score when you try to adjust my plan.
22 I could actually induce utilization that would result in a

1 negative adjustment.

2 MR. ZARABOZO: Which would be reflected in your
3 premium, right. So it's there, yeah.

4 DR. MILLER: And you will have solved the health
5 care spending crisis.

6 DR. DeBUSK: I was going to say, once we start
7 having that problem, I think it will be greener pastures.

8 [Laughter.]

9 MR. ZARABOZO: I'm disappointed that you have no
10 more questions.

11 DR. DeBUSK: Oh, actually, I do have one more.

12 [Laughter.]

13 DR. DeBUSK: I'm really glad you brought that up.
14 You know, we talked about altering the basic fee-for-
15 service package, you know, the fundamental fee-for-service
16 package with things like out-of-pocket limits. I forget
17 which chart you mention that in. Why couldn't we just
18 package that up as one of the Medigap plans and make that
19 available and see how many people are interested?

20 MR. ZARABOZO: Well, there are Medigap plans that
21 do not fully fill in the cost sharing. The new Medigap
22 plans have partial cost-sharing fill-ins, if that's -- are

1 you talking about a government --

2 DR. DeBUSK: No, MedPAC, you know, we have --

3 MR. ZARABOZO: Oh, the MedPAC --

4 DR. DeBUSK: I mean, could there be -- well, I'm
5 just asking.

6 MR. ZARABOZO: A government supplemental --

7 DR. DeBUSK: Why wouldn't you just do a MedPAC
8 Medigap Plan L, or whatever the latest letter is? If we
9 really want those changes, why not do that?

10 DR. MILLER: All right. Move to strike.

11 [Laughter.]

12 DR. CROSSON: We have moved a little bit outside
13 of our bubble here.

14 DR. MILLER: The public will disregard all the --

15 DR. DeBUSK: Question withdrawn.

16 DR. MILLER: I actually kind of know what you're
17 getting at, and, seriously, maybe we should talk offline a
18 little bit about that. I do think that kind of takes us --
19 for today's exercise. But I do think I understand what
20 you're asking, so if you just give me a little leeway,
21 maybe Carlos and I will talk to you about that and see
22 where it goes.

1 DR. CROSSON: Are we talking about a MedPAC IPO?

2 DR. MILLER: Yeah, but actually what I think he's
3 -- what I took out of it is what if there was sort of a
4 government-offered Medigap plan, is what I took out of
5 that. Certainly not MedPAC. And, you know, that concept
6 has arisen, and people have raised that.

7 DR. DeBUSK: In the reading, though, you had some
8 of the previous Commission's ideas about things like of
9 out-of-pocket limits and restructuring the benefit, and it
10 was scary to think, oh, my gosh, we're going to completely
11 redefine fee-for-service. Could you just leave fee-for-
12 service alone and express it as a supplemental -- just the
13 delta as a supplemental policy and tee it up as a Medigap -
14 -

15 DR. MILLER: But I think another -- and now I see
16 what your question is more directed to, and my first
17 reaction to that would be I don't think you want to do that
18 because what you want is on the MA side and the fee-for-
19 service side, for the benefit structures to be relatively
20 comparable so when you get those bids, you have a common
21 basis. And so if all the managed care plans at this point,
22 just to do a simple example, are all offering catastrophic

1 coverage, then, you know, you have something that isn't
2 catastrophic, and then you have this wrap-around and you
3 have Paul's issues where he seems to be very clear about
4 how the outside insurance butts up against the basic
5 insurance.

6 And so I think what you're trying to do is create
7 a situation where the benefit structures on fee-for-service
8 and MA, which are going to be competing against each other
9 and setting the benchmark on a relatively common platform.

10 DR. DeBUSK: I accidentally became the scourge
11 that Paul was referring to earlier. My apologies.

12 [Laughter.]

13 DR. MILLER: Paul was clear on that point.

14 DR. CROSSON: Okay. We're ready -- I hesitate to
15 say it, but we're ready for Round 2, and Paul has
16 volunteered, or at least he did yesterday, to lead off.

17 DR. GINSBURG: Before I lead off, actually I
18 thought of a clarifying question for you, Jay.

19 DR. CROSSON: Yes?

20 DR. GINSBURG: On some of the slides, it's clear
21 that a particular design is good for beneficiaries, good
22 for the program. And on slides like the one here, there

1 are pros and cons, arguments for and arguments against. So
2 the question is: Is our goal to resolve what we'd prefer
3 on standardizing offerings beyond the benefits plan, or
4 just leave it as, well, you can go either way here, the
5 pros and cons?

6 DR. MILLER: What I would say is this: I think
7 what we are doing in this chapter -- and this is not going
8 to be, you know, a surprise to you. Think of some of the
9 other issues we've already talked about in this meeting,
10 where in certain circumstances we've reached a place where
11 we're saying this is what has gone into the recommendation.
12 Well, we had some very robust conversations about different
13 ways of doing things, which we're not going to lose, we're
14 going to keep in the conversation.

15 And so here's what I would say: If you'll go to
16 Slide 10 -- I think it's 10, yeah -- this is in a sense
17 what I could imagine, you know, kind of working towards in
18 the chapter and saying there are some arguments of using
19 this as your straw man point, and the arguments would be
20 the beneficiary's clear about what benefits, there's
21 flexibility in the cost sharing so you can structure
22 incentives for beneficiaries, stuff Warner and Brian were

1 saying, how do I get, you know, signals to go to the
2 beneficiary, and you got that flexibility there. And then
3 because you've really gone to a premium support system,
4 which the bids are going to drive the benchmark, you might
5 embrace the Part D structure and say there's a basic
6 benefit so that everybody is clear, the beneficiary, the
7 bid, et cetera, and then enhancements beyond that are
8 allowed, and then you just have to tie the premium to it.

9 And you might say here is a straw man to think
10 through, but then let's talk through the pros and cons.
11 You know, some people might argue they want -- and, you
12 know, I think even David started to open this. Well, what
13 about flexibility on the benefits? And you could talk
14 about in a sense almost in those three boxes what's the
15 pros and cons here.

16 And so if I had to answer Paul's question, that's
17 what I would say. You know, here's a working framework.
18 What's the toggles off of these points that might help
19 inform somebody's thinking on designing a system?

20 DR. CROSSON: That's my answer.

21 [Laughter.]

22 DR. GINSBURG: Good. Let me go into Round 2 now.

1 This was a really incisive, very clear presentation of this
2 material, and I really enjoyed reading it. I don't have
3 anything I really disagree with.

4 I think some of the edges that we might want to
5 push it on is one that David brought up about, you know,
6 accommodating a plan with a larger deductible, perhaps with
7 a savings account. Watching the Medicare population over
8 the years, I doubt there's a lot of interest in it, but
9 there's clearly a lot of political interest in it. So to
10 serve Congress, we should probably be exploring some of
11 those issues.

12 I'm intrigued at pushing more on the number of
13 offerings and even the number of carriers, that I'm
14 impressed at what has happened in Covered California, in
15 their marketplace plans, by being an active exchange and
16 basically having a two-stage thing of carriers compete to
17 offer, and then those chosen to offer are the competitors.
18 The exchange has a notion for, you know, both large urban
19 areas and for smaller areas how many competitors would be
20 optimal. I think based on its reading of behavioral
21 economics research about where consumers make better
22 choices. Everyone knows that when the consumer has 25

1 health insurance plans to choose between, that's not the
2 optimal situation.

3 And the other point I want to make is that this
4 material has a lot of applicability outside of premium
5 support, and we might want to try to find a way -- in a
6 sense, a lot of this could be done just the way we do
7 Medicare Advantage today short of premium support. I don't
8 think premium support is about to be enacted in the near
9 term, although I'm sure it will be discussed for a while.
10 But it may be that there are some things that we can do to
11 facilitate beneficiary choice of plan with the goal of
12 making the Medicare Advantage market more competitive, and
13 this will clearly benefit the beneficiaries. It won't
14 benefit the program because the benchmarks are the
15 benchmarks and they're based on the fee-for-service
16 experience. But it might be just a topic the Commission
17 wants to take up about how to take the current Medicare
18 Advantage program and make it better, make it more
19 competitive, so that it serves the beneficiaries more
20 effectively.

21 DR. CROSSON: Okay. Thank you, Paul.

22 So now we're going to go to further discussion,

1 and could I see hands for further discussants? Okay. So
2 we'll go with David and then this way and then over here.

3 DR. NERENZ: Thank you. Just a couple points.
4 One will be a question, but I think it's more than a
5 clarifying question.

6 I would like to understand a little better how
7 this whole thing we're talking about is fundamentally
8 different from what we have now with MA. You know, right
9 now as a beneficiary I can have fee-for-service, and I pay
10 a Part B premium, or I can go into the private market in
11 MA. In a premium support model, I can have fee-for-
12 service, or I can go into a private plan. So what about
13 this new thing we're talking about is fundamentally
14 different from what we currently have?

15 MR. ZARABOZO: Well, for one thing, for example,
16 if -- today you can go into fee-for-service; you do not
17 have an extra premium for going into fee-for-service. In a
18 premium support model, you might have an extra premium for
19 choosing fee-for-service, for example.

20 DR. NERENZ: Okay.

21 DR. MILLER: Or either fee-for-service or the
22 [off microphone].

1 MR. ZARABOZO: Or the plan, yeah, depending on
2 the geographic area.

3 DR. NERENZ: Okay. And that may speak then to my
4 next point. I was thinking, if there's going -- if we want
5 to have it be fundamentally different in some way, one of
6 the ways I could imagine it being different is in a premium
7 support environment, let's imagine that one can calculate
8 the cost of me receiving care in the fee-for-service
9 environment. And me, I mean as a beneficiary, age, sex,
10 HCC mix, where I live, that kind of thing. That turns into
11 a number.

12 At that point -- and I'll now personalize it to
13 Pat -- if I happen to live where Pat's plan exists, I could
14 take that amount of money, and I shop with Pat, and I work
15 with Pat for whatever Pat wants to sell me for coverage.
16 And in that model, CMS is out of the picture. CMS is not a
17 party to the transaction that Pat and I get into for my
18 coverage.

19 Now, that would seem to be a way of bringing
20 premium support to life. It would eliminate some of what
21 strike me as cumbersome features here. You don't have
22 bids, for example, because Pat and I just work out a price

1 for her covering me for any kind of plan I want. If I want
2 a very rich, expensive plan, you offer me a price; I take
3 what I get from CMS. I have to add to it. But also I
4 could go the other way, to my earlier point. If I want a
5 plan that has relatively tightly defined benefits, very
6 narrow networks, something, we do that, and I pocket the
7 difference.

8 So in that kind of model, once I've been given a
9 dollar amount that I can take into a market, I do that and
10 CMS is not party to that. Now, that's not what we're
11 talking about here, but could it be? And are there
12 fundamental reasons why this could not be done that way?

13 MS. BRICKER: It would a voucher [off
14 microphone].

15 DR. NERENZ: It would be a voucher. Maybe that's
16 a forbidden word in this topic, but that's kind of -- yeah,
17 that's what it would be.

18 DR. CROSSON: So how then would the Medicare
19 contribution be determined?

20 DR. NERENZ: By my projected cost in fee-for-
21 service, for example, my age, sex, HCC mix, where I live.

22 DR. CROSSON: You mean not based on competitive

1 bidding.

2 DR. NERENZ: No, not at all. Don't bother with
3 it.

4 DR. GINSBURG: [off microphone].

5 DR. NERENZ: Well, it is as I experienced as a
6 beneficiary. I'm given essentially a voucher -- let's call
7 it that -- with which I can go shop with Pat. Is that not--
8 -

9 DR. CROSSON: I'm not sure how that's different
10 from the current situation.

11 DR. NERENZ: Well, that was my first question.
12 Well, it would be different in the sense that my
13 interaction from the time I hold the voucher is entirely
14 with Pat. CMS is not a party to that. CMS does not
15 determine what the benefits look like. CMS does not
16 determine anything about our interaction. That's a private
17 interaction between two of us. And I'm either happy or I'm
18 unhappy.

19 DR. GINSBURG: You're talking about deregulating
20 the administered system.

21 DR. NERENZ: Yes.

22 DR. GINSBURG: As opposed to having a competitive

1 system that regulation shapes.

2 DR. NERENZ: I guess that would be a fair
3 characterization. I'm just asking: Why -- there must be
4 some fundamental problem with that.

5 MR. ZARABOZO: As Jay asked, how do you determine
6 the dollars attached to you? Because you said it would be
7 fee-for-service. Now, if in premium support your goal is
8 to say, well, let's find the most efficient plan, if you
9 want to put it that way, it might not be fee-for-service.
10 It might be Pat's plan. And the dollars would be adjusted
11 to say, well, here are the dollars for you if you go to
12 Pat's plan. If you go elsewhere, we're not going to
13 contribute at a similar level.

14 DR. NERENZ: Well, I guess I'm just thinking of a
15 simpler model. Once that dollar amount is established,
16 saying here's what it would cost to cover you in fee-for-
17 service, that's what the government owes you or you're
18 entitled to --

19 MR. ZARABOZO: Again, that's a question here. Is
20 that what the government owes you or not under premium
21 support?

22 DR. NERENZ: I'm just raising it as a question.

1 I think it's just a much simpler model, and it must have
2 some flaw; otherwise, we'd be talking about it. But --

3 DR. MILLER: Well, the first thing -- I think
4 there's a couple of things. So in that model, you're
5 abandoning the search for a more efficient delivery of
6 care. You're saying --

7 DR. NERENZ: Oh, no, no, no. I'm personally
8 searching for that. That's exactly what I'm looking for.

9 DR. MILLER: Yeah, but you're the --

10 DR. NERENZ: With intensity.

11 DR. MILLER: But you're not -- unless -- and I
12 don't understand exactly how all this would work, but
13 you're not necessarily allowing the taxpayer or the
14 beneficiaries in general to benefit from that. You are the
15 only benefactor from that.

16 Let's just say, you know, fee-for-service is
17 inefficient in some way. You're saying I'm going to
18 maintain that inefficiency, give everybody a dollar amount,
19 and you can spend that. The fundamental difference in the
20 stuff that we're talking about -- which you may be throwing
21 over, which you're entitled to do -- is well, no, actually
22 the bid is inside Miami -- let's take that -- where fee-

1 for-service is, you know, \$12,000, \$14,000 per person, and
2 there are plans that are offering it at, you know, \$10,000,
3 \$9,000 per person. You're walking away from that and
4 saying now the government could tie its payment to that
5 \$9,000. You're saying that block of dollars you're leaving
6 on the table from a taxpayer point of view.

7 DR. NERENZ: No, that would be a fair criticism,
8 but then you could amend it and just say over time if these
9 truly innovative, less expensive models come up -- and,
10 again, in that example -- you know, you can eventually
11 separate that number in part or whole from fee-for-service.

12 DR. MILLER: That's what the bidding process
13 does.

14 DR. NERENZ: Well, it is, but it just -- I mean,
15 currently it doesn't lead us in that direction.

16 MS. BUTO: Dave?

17 DR. NERENZ: -- because it's an administrative
18 baseline.

19 DR. CROSSON: Go ahead, Kathy.

20 MS. BUTO: Dave, I think this is like one of
21 those fundamentals in discussing premium support, which is,
22 you know, is it a defined benefit-based program, or is it a

1 defined contribution? And you say why aren't more people
2 talking about that. Well, people were talking about
3 defined contribution, but think of it as a block grant in
4 Medicaid. Okay? So you define the contribution at a
5 certain point in time, but budget pressures and other
6 things, especially if it's not a competitively set amount,
7 could mean that it's not updated to the extent it should be
8 to keep up with medical care costs, or there are other
9 things that intrude. And so what it becomes is a dollar
10 amount that may or may not buy you a package of benefits.

11 So that's the reason why I think most people,
12 when they talk about premium support now in Medicare, are
13 looking at more of a defined benefit model. You've got to
14 have a basic package of benefits, and you go from there and
15 figure out what that's going to cost, rather than here's a
16 block of money and let's hope it keeps up with the cost of
17 medical care inflation.

18 DR. NERENZ: I appreciate that point.

19 MS. BUTO: It's sort of the block grant idea.

20 DR. NERENZ: But I also would want to emphasize -
21 - and it was on the slides -- that going that direction
22 that you just described really cuts away from innovation,

1 true innovation and benefit design in the way services are
2 structured and what-not. If you build around standard
3 benefits, to a great extent you lock in standard benefits.

4 MS. BUTO: You know, the flexibility around that
5 I think could be debated, though.

6 DR. CROSSON: This is interesting, and perhaps we
7 could have more offline discussion about this, but we've
8 got about 15 minutes left, and I need to proceed so we can
9 get to the rest of the discussion.

10 MR. PYENSON: I just want to echo Paul's comment
11 that I think there's a lot here that could be helpfully
12 applied to other programs for Medicare Advantage, but
13 perhaps also the ACO program. So I haven't thought it
14 through, but the idea of different ways of creating
15 benchmarks might have applicability there in the relatively
16 short term. So I just wanted to note that.

17 DR. CROSSON: Thank you. Pat.

18 MS. WANG: So I really think that the chapter was
19 great, Carlos, and it's very, very thoughtful. You know, I
20 haven't thought nearly as deeply as you have about this,
21 but I would just suggest that in the chapter, and as
22 something gets really written to be published about this,

1 my preference would be to try to be clearer about what the
2 concept of premium support is. Creating a competitive
3 system to me is different from out of the box through the
4 standardization of benefits expecting that program spending
5 will decrease from where it is today with implications for
6 beneficiary spending. And, you know, you could go one way,
7 you could go the other. I just think that we need to be
8 clear about it. And I don't know enough about -- that's
9 why I asked the question before, but my instinct is
10 standardizing to fee-for-service benefits compared to the
11 way that the MA program works today would lower some sort
12 of benchmark, and that certainly kind of trying to peel out
13 induced utilization would do the same thing.

14 You know, this was Brian's point. What we're
15 calling induced utilization I call sort of flexibility to
16 meet the needs of members. We want to induce utilization,
17 particularly in certain types of beneficiaries -- duals,
18 near-duals, you know, middle-income, low-income. You know,
19 we want to induce certain kinds of utilization for primary
20 preventive services, for example. If that somehow turns
21 into like the program doesn't pay for that anymore and it
22 turns into something that has to be sort of purchased up, I

1 think we just need to kind of be clear about that, because
2 that is the way that the chapter is kind of written right
3 now.

4 I also am a bit concerned about the point that
5 others have raised about sort of however we --
6 standardization is important to the extent of being able to
7 compare. I definitely get that. You have to have
8 something out there that consumers can shop for and know
9 that this is an apple, this is an apple, that's an orange,
10 that's a pear. And there are lessons from the ACA out
11 there in that regard about standardization.

12 But the reason that MA is popular today is that
13 people don't want to buy -- they don't want Medicare fee-
14 for-service. They've been in innovative insurance designs
15 for their entire working life, and they don't really -- you
16 know, they want the same thing when they get into Medicare.
17 So, you know, there are a lot of choices available to
18 people, to go to traditional Medicare or to pick a plan
19 whose features are kind of more suited to where they are in
20 life and how they want to utilize health care. So I think
21 we need to be kind of careful about that.

22 The last two things are I think that the analogy

1 to Part D is helpful, but I would just be a little cautious
2 about that. You know, Part D is easy to standardize on a
3 national basis. It's just a drug benefit package. A/B/C
4 are far more complex, far more services, and mixture of
5 services that beneficiaries need to, you know, maintain
6 their health. And, you know, I appreciate sort of maybe a
7 separate focus on duals and low-income because it is --
8 they are treated differently right now in the bidding
9 process for MA, and I would want to make sure that we don't
10 somehow, you know, damage the ability to do more for that
11 population.

12 And the final thing I would say is as we talk
13 about this -- and I don't know whether there's more utility
14 in looking at the experience of the ACA, but you do have --
15 as you kind of tiptoe into this thing and you talk about
16 people buying up or, you know, if they want extra, there is
17 an example in the exchanges of market-driven subsidies
18 according to income level, you know, set by the market to
19 the second lowest silver. I don't think we're going to
20 have enough time to really know whether that could
21 ultimately work because it's in turmoil right now, which is
22 unfortunate. But it is interesting that that is another

1 source of kind of information or experience.

2 DR. CROSSON: Thank you.

3 MR. ZARABOZO: Could I add one point about in the
4 exchanges, if I understand correctly, the induced
5 utilization for low-income people because they have
6 subsidies is recognized as sort of valid utilization at
7 this point.

8 MS. WANG: Exactly [off microphone].

9 DR. SAMITT: So three quick things. I think
10 there's a lot of good here. Again, the chapter is
11 beautifully done. You've made a complex topic
12 understandable. But I want to tag on to Pat's comments
13 that, you know, it's going to be important here to achieve
14 a level of balance. There's an importance here of
15 standardization for comparative purposes, but I'm very
16 worried about suppressing innovation and that it's going to
17 be essential for us to assure that members, beneficiaries
18 can effectively compare for purposes of shopping. But if
19 we start to very significantly restrict the various options
20 that get created, I think we go backwards. And for that
21 exact reason, I think it is important to compare against
22 the exchanges in the ACA, both for good and bad, because

1 that level of restriction of benefits has had a negative
2 effect on the exchanges also. So I think the question is:
3 What lessons can be learned from that experience regarding
4 standardization that would apply to what we're doing with
5 premium support?

6 The other comment that I would make is I just
7 wonder whether we're trying to do too much all at once. We
8 also have to remember that while this is complex for us to
9 understand, how complex will it be for the beneficiary to
10 understand? And are we changing and modifying too much?
11 So now I have to purchase a basic MA benefit package, and
12 then as opposed to it being bundled, I have to have a
13 supplemental menu that I pick from to decide MA -- it's
14 hard enough to shop as it is for MA. And then we also talk
15 about changing fee-for-service. And to Brian's point, I
16 just wonder whether we leave fee-for-service alone and we
17 focus on sort of the core elements of why premium support
18 is important right now, without trying to modify everything
19 at once. I just think it's going to lead to significant
20 confusion. And perhaps the way we want to enter this is in
21 a series of phases. You know, there are certain things we
22 want to change to start, and maybe there are additional

1 modifications that come later. But to try to change
2 everything all at once, it feels like there will be chaos
3 in the eyes of the beneficiary.

4 DR. MILLER: And the only thing I would say here
5 is, you know, there is some flexibility around the cost
6 sharing, which is also the current circumstance that MA
7 plans are working with. And then, you know, particularly
8 on the plan offerings, at least we are not envisioning this
9 as necessarily restricting, you know, the offerings.

10 And then the way you described the choice set is
11 not quite -- it was pretty close but just to make sure, the
12 beneficiary would see, for a given organization, here is my
13 basic plan, here is my enhancement one, here is my
14 enhancement two. And you send the information out and the
15 beneficiaries use it. They do not have to choose the basic
16 plan. They can choose this plan. It is just that the plan
17 has to offer it and so that there is a benchmark.

18 And the other point I wanted to make was when the
19 benefit structure -- which we should talk about flexibility
20 there, but you also have to think about going in the other
21 direction. So if a plan enters the market and says, I am
22 not offering -- and let's do something crazy -- any post-

1 acute care, who bears that cost when the person needs post-
2 acute care? You are basically just shifting that cost to
3 an uninsured status for that provider.

4 And so I think there is some sense of why these
5 conversations end up starting with a basic package. And
6 then saying how do you go across that is some understanding
7 that this is -- it should be available for 65 and a
8 disabled person. And if it were not available, who exactly
9 in society -- if you want to get all philosophical about it
10 -- is actually going to pay when that happens? And that is
11 why those conversations around the benefit tend to start
12 there and work --

13 DR. SAMITT: Yeah, and I am very comfortable with
14 the notion of standardization with the basic package. It
15 is beyond that, sort of as we begin to think about
16 innovations that modify that or supplement that, you know,
17 for the good, that there aren't constraints, because that
18 is the type of innovative model we want to encourage.

19 DR. CROSSON: Paul, on this?

20 DR. GINSBERG: Yeah, just want to clarify that we
21 were talking about, in MA, offering an enhanced plan. It
22 is not a supplement; it is just a bigger plan so that we

1 are not going to get into this of beneficiaries having to
2 choose two products --

3 DR. MILLER: Yeah.

4 DR. GINSBERG: -- to get more benefits. It would
5 be one.

6 You know, I think we can go back and forth about,
7 say, how many options -- how many plans in an area a single
8 carrier can offer. Then I think we would want to get away
9 -- I know we want innovation but we do not want each
10 carrier offering 10, 15 plans.

11 DR. CROSSON: Okay, can I see hands for comments
12 on this side? We will start with Bill and then Jack.

13 DR. HALL: It seems to me that this has been a
14 very intense discussion, I think, as well as a tremendous
15 presentation. And I agree that this approach about
16 standardization and then applying to a lot of different
17 things.

18 In the situation that we are dealing with here,
19 now, it seems to me that if we go back a little bit when we
20 started this whole discussion, what we now call premium
21 support -- which I think was a MedPAC-defined term. Am I
22 right on that? What was the long discussion we had when

1 Glenn was here about --

2 [Simultaneous discussion.]

3 DR. MILLER: -- using different terms than
4 "premium support," because "premium support" was kind of a
5 fluid term.

6 DR. HALL: Yeah. Okay.

7 DR. CROSSON: We adopted that term in place of
8 more complicated terminology.

9 DR. HALL: Yes, I know. That is what I am --
10 right.

11 DR. CROSSON: But we did not --

12 DR. HALL: The word that shall not be used, yeah.
13 Right.

14 Okay, and we need clarification and this is a
15 wonderful start to get some of that clarification. As I
16 see it, we are talking about standardization. At some
17 point, though, we will be talking about and trying to
18 clarify what is the difference between a defined
19 contribution and a defined benefit, the pros and cons of
20 each of those, but this can get -- whoever mentioned that
21 this can get very complex very, very quickly -- I guess
22 that was you, probably, wasn't it?

1 So, recently I had to take a little trip to
2 Japan, and I was told that I could buy a voucher, or maybe
3 premium support on railroad tickets, and that this would
4 allow me to travel much less expensively and without much
5 complexity through a very sophisticated train system.

6 So I started doing that and I found out that I
7 had to apply for -- I had to apply for this, if you will,
8 insurance plan on travel. And all I had to do was to get a
9 piece of paper that would then allow me, when I got to
10 Japan, to get a voucher or a premium support.

11 So I did that, and I found out in order to do
12 that I had to find somebody who could buy this piece of
13 paper outside of the United States, preferably in Japan,
14 somehow serendipitously -- or surreptitiously get it to me,
15 and then I could then take it with me to my trip. I had to
16 have it before I got to Japan, so I had to have this before
17 I got sick, so to speak -- still sounds pretty simple,
18 except it is hard to find an agent that will provide this
19 service for you unless you are willing, in some other way,
20 to provide them with something, namely business.

21 So I figured that out, but I really could not
22 figure it out completely until I got here before this

1 meeting. And I finally went and looked up Japan travel
2 agencies in Washington, D.C., of which there are four or
3 five. I went there Wednesday and filled out all the forms
4 and applications -- it is a good thing it was not chest
5 pain that I was dealing with -- and got it. I got the
6 piece of paper and reserved a hotel room as part of the
7 requirement.

8 So now I find out that when I make this trip, I
9 get my passport stamped for another agency. Then I said,
10 you will have to go into line at Narita Airport, which
11 averages three to four hours depending on when your plane
12 lands. And then I will get a piece of paper that says I
13 can buy a ticket, or I could get a ticket for free. So the
14 balance there between -- the economic advantage I suppose
15 is still there, but these things can get very complicated.
16 It is kind of a silly example.

17 And so I think to start -- we have here more than
18 a start, obviously -- is that we are starting to help
19 people have the tools to understand these kinds of things.
20 So, Carlos, I think that is what -- well, you have done the
21 standardization. It is really very valuable.

22 But the other thing that was mentioned was how

1 complex do people want this to be? And I think we are kind
2 of going to be one of the sort of honest brokers to allow
3 us to see how we can provide people what they can
4 understand and without using the terms, necessarily, even
5 of the difference between a defined contribution and a
6 defined benefit. This is the best I think we have done so
7 far on this whole topic.

8 But it is the old Chinese curse: May your dreams
9 come true. I think this whole process here is going to get
10 very, very complex as we try to allow our consumers to
11 really figure out what kind of decisions that they want to
12 make here. But, anyway, it is a long-winded way of saying
13 I think we have some interesting challenges ahead of us and
14 this is a good start, more than a start.

15 DR. CROSSON: Well, Bill, I think the point you
16 make is a good one. And it is helpful to remind us all the
17 time, particularly as we deal with more abstruse policy
18 thinking processes such as this one that, in the end -- and
19 you and Jack and others on the Commission continually
20 remind us that not only are we here to serve the Congress
21 but we are here to serve beneficiaries as well. And to the
22 extent that we keep the beneficiary in mind as we are

1 thinking through our policy determinations, we are likely
2 to have a better product.

3 Jack?

4 DR. HOADLEY: So, thank you, and thank you for
5 doing this chapter. I mean, I think this is, as others
6 have said, going to be a helpful component of this
7 discussion.

8 You know, I am an advocate of standardization. I
9 think it is critical for a variety of reasons, and you have
10 mentioned most of these. One is mitigating some of the
11 gaming and the risk selection. Another critical one is
12 making beneficiary choices clearer, simpler, easier, and
13 also to help make some of the bidding rules work better.
14 And as Paul said, some of these principles really could be
15 translated into some of the current system in some ways,
16 and I have written about that in the past.

17 I think one thing that I would like to see a
18 little more discussion of -- you have the basics of this in
19 the chapter -- is some of the dimensions on which we are
20 not so much talking about standardization, so networks and
21 formularies and other aspects of how the benefits are
22 delivered.

1 You have made this point a little bit, but I
2 think, you know, it sort of goes to some of the discussion
3 that we have had. A number of the elements in which
4 innovation occurs is in how you design networks, is how you
5 design prior authorization or requirements to go from one
6 type of benefit to another.

7 And that has generally not been part of any of
8 the kinds of standardization discussions. I mean, you
9 could make an argument for some of those, but I think here
10 we are not generally talking about that. So I think, just
11 to be clearer in the discussion, you almost -- in this grid
12 to have -- it is a little bit implied and sort of the plan
13 offering sort of thing, but maybe even another row that
14 says other kinds of aspects of how you deliver the benefit
15 such as networks and formularies and other sets of rules
16 are not something that this pattern, or any of the other
17 sort of models we look at -- the ACA, MediGap, you know,
18 none of those kind of standardized -- that aspect. So I
19 think that would be a helpful enhancement for this
20 conversation.

21 The other thing where I think there is some
22 discussion potential -- and a lot of this does go farther

1 than we are trying to do at this moment, but it sort of is
2 this notion of the basic benefit offering. And I think
3 when we were talking about the supplemental benefits and
4 what is in the current MA program, the challenge is that,
5 generally, current MA tries to match what exists in
6 traditional Medicare with some kind of MediGap supplemental
7 coverage.

8 So it brings the cost sharing down, maybe not
9 getting rid of it completely, sort of some of the more
10 modernized versions of -- but what a typical MA offering
11 does is have flat copays, out-of-pocket maximums and
12 things. And so the reason that pretty much every MA plan
13 is enhanced is because it is enhanced relative to the un-
14 supplemented traditional Medicare.

15 You talked about how we might, in thinking
16 through this kind of system, build off of the kind of
17 reform to the basic benefit that we talked -- that the
18 Commission talked about some years ago. And I think that
19 is important, and it may even be a matter of going beyond
20 that.

21 And one of the ways to think about that could be,
22 as is done in the ACA, some kind of metal-level version.

1 And Brian kind of started on this path in thinking about,
2 should the government try to supplement? And there have
3 been discussions about how there could be government-
4 offered supplemental levels.

5 And so it would be the equivalent of, say -- you
6 know, if what we think of current Medicare is sort of
7 bronze-level or silver-level benefits, maybe the government
8 also produces a gold-level benefit that adds -- that
9 reduces some of the cost sharing or adds some extra
10 benefits or things like that. That could be a way to get
11 past some of the issues with MediGap but goes to that
12 principle of one issue or offering both the basic and the
13 supplement instead of having what we have now, which is
14 this hybrid.

15 Now, I realize this is jumping well beyond sort
16 of where we are in this current debate, but it might be to
17 sort of at least touch on that as a potential way to
18 address some of the kinds of things. I think, you know,
19 this notion that going forward without sort of an out-of-
20 pocket limit in traditional Medicare into this kind of
21 premium support world is something that will, I think,
22 cause some real problems with how this would work.

1 So, at least at some of those levels that we have
2 addressed in the previous discussion of benefit reform, but
3 maybe potentially going beyond that, which could then also
4 raise the possibility that a standardization model could
5 think about standardizing the enhanced offerings at least
6 to the level of some kind of a metal-level kind of
7 standard.

8 So you have some tiers that would not restrict
9 what a plan wants to do within that tier, allows sort of
10 all the flexibilities of types of designs the networks and
11 things that I already suggested were not part of what we
12 standardized, but again to help beneficiaries understand
13 that, I can get gold-level benefits and compare, you know,
14 what issuer A, issuer B, and issuer C offer in that, and
15 know that I am getting something like the same level of
16 benefits.

17 At least, again, we are not making
18 recommendations in this, but at least putting some of that
19 kind of notion out on the table. And we do see some of
20 these issues in Part D, where we have got companies that
21 offer enhanced benefits that are actually less expensive
22 than basic, which suggests that something is not quite

1 working about some of the things.

2 So I think there are some of those issues. And I
3 will not spend more time. I have talked about those in
4 other meetings. But that is where things like risk
5 selection probably have not been fully addressed. But I
6 think those are some thoughts about how to build from this
7 base. At least, again, I recognize we are not going to
8 have long discussions of these other issues, but at least
9 we can touch on some of these things within the current
10 context.

11 DR. SAMITT: You know, Jay, can I weigh in on
12 that?

13 DR. CROSSON: You want to counterpoint?

14 DR. SAMITT: Yeah.

15 Just one of the things that I would love for us
16 to reconcile is beyond making the benefits comparable and
17 standardized and having a level purchasing playing field is
18 whether we want to make MA and fee-for-service equally
19 attractive, so to speak.

20 We talked yesterday about the importance of
21 moving toward models that are more coordinated, more value-
22 based, driven off of the -- with the progress that has been

1 made in MA plans. And I think while I appreciate what you
2 are saying, what I am worried about is it starts making
3 fee-for-service look more attractive and more like MA
4 without all the coordination and value-based improvements
5 that we want to see.

6 DR. HOADLEY: I mean, presumably under the
7 premium support model, that is what is supposed to come out
8 in the competitive price.

9 So if what you do to add that kind of
10 coordination and -- first of all, if we can do more of that
11 in the fee-for-service world, then obviously that is a
12 plus. But if that is not the case and it takes the kind of
13 management that an MA plan provides to do that, presumably
14 that is then reflected in more efficiency and thus offering
15 the lower premium. You know, that carries with it its own
16 set of issues, but that is presumably where that should be
17 playing out.

18 DR. CROSSON: Okay, further comments?

19 Warner?

20 MR. THOMAS: I will be brief.

21 It just seems to me that we are making this
22 really complicated. And if what we want to do is try to

1 understand what a fee-for-service product would look like,
2 I guess, in the private or in the MA world, then why don't
3 we just have MA plans bid at a fee-for-service level
4 product design as well as bid with one that has increased
5 benefits?

6 And it would be interesting -- from my
7 perspective, it would actually be interesting to see how MA
8 plans would look if they had a standard fee-for-service
9 product that they bid on, because I think you would find
10 that it is a -- you know, getting back to Craig's point
11 around innovation with MA, I think we would find it is a
12 better offering for that standard set of benefits.

13 Now, I know this ties into a broader issue of
14 premium support, but the standardization, you know, I
15 actually -- I guess I thought that is what MA plans did is
16 they bid off of a flat kind of fee-for-service equivalent.
17 It sounds like you are saying now it is really an
18 administrative benchmark that they are bidding on. But, I
19 mean, let's give them specifics, say, you know, bid this
20 set of benefits, which is what fee-for-service Medicare is.
21 It would be interesting to see what that would look like as
22 they go through that process.

1 DR. CROSSON: Paul, you wanted to comment on
2 that?

3 DR. GINSBERG: I think the last thing I would
4 want to do is lock in the current Medicare benefit
5 structure, which was cutting-edge in 1965 --

6 [Laughter.]

7 DR. GINSBERG: -- and has been very difficult to
8 change.

9 So, you know, the fact that basically we are
10 talking about bidding across an actuarial equivalence, I
11 think that is the more -- you really would not want to take
12 this standard -- you know, this existing benefit package,
13 which is not at all up to the times, and make it even more
14 important -- unless I am misunderstanding you.

15 MR. THOMAS: No, I would not disagree with that,
16 but then we ought to be having that discussion, not this --
17 if that is really the key issue, that we do not like the
18 benefit design because it is the same as it was, you know,
19 50 years ago, or whatever, then let's have that discussion.

20 But I am saying if we are looking at a
21 standardization and a comparison, then let's have
22 innovative organizations like Pat and Craig's and others

1 bid that and see how they do against the fee-for-service
2 market, which I think is not innovative. And let's put --
3 let's let MA plans that are more innovative use their
4 capabilities with a fee-for-service benefit structure. And
5 it would be interesting to see how that compares to what we
6 see from traditional fee-for-service.

7 As an aside, I also would just -- and I have
8 talked to Mark about this as well. I just think it is
9 interesting in markets where fee-for-service is a more
10 expensive option that we ought to enroll everybody into the
11 most expensive option in the marketplace, which to me does
12 not make a whole heck of a lot of sense.

13 And I know that is another topic, but I do think
14 that is something that should be put on the agenda as well
15 for us to be thinking about: How do we auto-enroll people,
16 and should they be auto-enrolled into a more cost-effective
17 option, certainly having the option to opt out of it. But
18 in areas that MA is a more cost-effective option with
19 broader benefits, to me that is what we ought to be trying
20 to steer people to, to give them a better option.

21 DR. CROSSON: Okay, now we have run over time, so
22 let's -- thank you.

1 DR. REDBERG: I will be brief and just say in the
2 broad sense I support the ideas -- the details which were
3 discussed by many of my fellow commissioners of
4 standardizing the benefits package and revamping -- you
5 know, looking at value-based design both in fee-for-service
6 and in Medicare, and that I am sure we will -- this is a
7 great start -- and work this out in the future.

8 I actually could see -- and this is out of our
9 purview, but then the same idea I would love to see in the
10 pre-Medicare, the private insurance system of having
11 standard offerings for our less-than-65 and then
12 enhancements and innovations, because I think that is,
13 again, not our problem but a morass and could be much
14 improved. And I think what we are doing here could be a
15 basis for it.

16 DR. CROSSON: I like the term "pre-Medicare." I
17 think that we are going to use that more.

18 [Laughter.]

19 DR. CROSSON: I seem to remember being pre-
20 Medicare.

21 [Laughter.]

22 DR. MILLER: It is post-Medicare you want to --

1 [Laughter.]

2 DR. CROSSON: Right. As Mark points out, that is
3 better than post-Medicare.

4 [Laughter.]

5 DR. CROSSON: Okay. All right, good
6 conversation. Carlos, excellent work.

7 So let's move on to our final presentation.

8 Okay. So to continue filling in our thoughts
9 about ideas and recommendations with respect to premium
10 support, we're now going to take on some potential impacts
11 of the premium support idea, including on beneficiaries.
12 Amy, Scott, and Eric, and I think we have who beginning?
13 Scott? Amy.

14 MS. PHILLIPS: In this presentation, a
15 continuation of the discussion we've been having since the
16 fall on premium support, you will be hearing about the
17 possible impacts of premium support on beneficiaries and
18 plans.

19 The rationale behind the concept of premium
20 support is to engage beneficiaries to make efficient
21 insurance plan choices. Will beneficiaries be willing and
22 able to make rational choices under a premium support

1 system? How will these choices impact plan behavior?
2 Today we will be discussing these questions through lessons
3 learned from Medicare Advantage and Part D, hypothesized
4 plan behavior, and a study CBO did on premium support in
5 2013.

6 We will begin by taking a look at the switching
7 which occurs in the Medicare Advantage program.

8 Looking at the pie chart, you will see that the
9 Kaiser Family Foundation found that between 2013 and 2014,
10 78 percent of MA enrollees stayed in their same plans; 11
11 percent voluntarily switched to another MA plan; 2 percent
12 switched into traditional Medicare from MA; 5 percent were
13 switched involuntarily - of that, 4 percent were switched
14 to another MA plan and 1 percent were switched into
15 traditional Medicare; and lastly, 3 percent died before
16 they could make a choice.

17 To contextualize this beneficiary switching, I
18 will now go over some general characteristics and patterns
19 in the Medicare Advantage plan switching population so that
20 we can understand who switches and some of the motivating
21 factors.

22 Beneficiaries in MA plans switch at rates similar

1 to those in Part D prescription drug plans, but at lower
2 rates than those in the PPACA Marketplace. Among those
3 beneficiaries who switched plans, voluntary switching rates
4 do not vary by gender, number of plans available across
5 counties, or MA payment quartiles for the county.
6 Beneficiaries switching at higher rates tend to be younger
7 as well as higher need, higher cost.

8 When deciding if they want to switch plans, it
9 was found that beneficiaries strongly consider many factors
10 including: premiums and out-of-pocket costs, if their
11 doctors participate, if they will have access to certain
12 hospitals and treatment centers, if they will have access
13 to pharmacies and physicians closest to their homes, and
14 they also take into consideration their familiarity with
15 the plan sponsor.

16 Now that we know which beneficiaries are
17 switching plans and what they take into consideration, we
18 will discuss a major reason why some switch.

19 The cost of premiums is frequently stated as a
20 top concern for beneficiaries and a main reason for
21 deciding to switch plans. This observation is confirmed
22 through data analysis conducted by the Kaiser Family

1 Foundation where MA enrollees were found to switch plans at
2 differing rates when confronted with particular dollar
3 increases in premiums.

4 As you can see on the chart, beneficiaries faced
5 with an increase of less than \$20 switched at a rate of 11
6 percent. Those who faced a bump of \$20 or more switched at
7 increasingly higher rates.

8 MA enrollees switched at a rate of 9 percent even
9 when confronted with a premium decrease.

10 The average line is in reference to the
11 previously mentioned annual voluntary switching rate.

12 Keeping in mind the "who" and "why" of
13 beneficiary switching, we will now look at what lessons we
14 are able to glean from Medicare Advantage.

15 We can think about MA switching in two different
16 ways: beneficiaries switching between MA and fee-for-
17 service and then beneficiaries switching within MA.

18 Roughly the same percentage (2 to 3 percent) of
19 beneficiaries switch between MA and traditional Medicare
20 each year. Many beneficiaries enrolling in MA are not new
21 to Medicare and are switching from fee-for-service. We
22 previously found that these beneficiaries tended to be in

1 their late 60s, early 70s, and have experienced one or more
2 open enrollment periods.

3 The share of beneficiaries switching plans within
4 MA has been about the same every year, averaging 9 percent
5 annually. Among MA beneficiaries who switched plans, they
6 saved an average of \$210 per year.

7 The high retention we see in MA encourages
8 sponsors to strengthen their incentives to keep their
9 enrollees healthy with low medical costs since they will be
10 there for years. However, this stickiness can also signal
11 that as long as sponsors do not drastically increase prices
12 or disrupt care, they have a low risk of losing enrollees
13 which could lead to decreases in quality or the addition of
14 program benefits.

15 I will now shift to discussing experiences and
16 lessons learned from the Part D program.

17 During the first few years of the Part D program,
18 the majority of beneficiaries remained with the plan they
19 selected in the program's first year. Research suggests
20 that the complexity of the Medicare Part D drug benefit
21 might have discouraged enrollees from signing up and
22 switching plans. This initial reaction could be mimicked

1 in a premium support model without proper beneficiary
2 education.

3 After that initial hesitation, beneficiaries are
4 now found to be switching PDPs and MA-PDs at a rate of
5 about 13 percent annually. Beneficiaries who are shopping
6 and switching PDPs are, on average, saving \$32 per year.
7 The decrease in costs for PDP switchers indicates that
8 those beneficiaries choosing to switch are making rational
9 decisions taking into account their anticipated
10 prescription needs and who cover more of their medication.

11 While research has shown that beneficiaries do
12 not always maximize savings when they switch or choose to
13 remain in a plan, this does not mean that beneficiaries are
14 always making irrational decisions. As I previously
15 mentioned, beneficiaries are sensitive to non-monetary
16 switching costs, such as risk of losing a familiar
17 physician and the value of their time spent when selecting
18 a new plan.

19 With the two considerations of price and non-
20 monetary switching costs sometimes at odds with each other,
21 improving consumer choice and creating tools that allow for
22 this comparison would be important considerations in a

1 premium support model.

2 How we improve consumer choice comes down to how
3 well beneficiaries are able to receive and use information
4 for plan selection. When beneficiaries find plan selection
5 difficult, it may lead them to stay with the same plan
6 rather than search for a new one.

7 Beneficiaries would have active participation in
8 plan selection in a premium support model which many
9 current beneficiaries enrolled in traditional fee-for-
10 service Medicare have not had to do. Additionally, many
11 beneficiaries are unaware of consumer tools that can assist
12 them in selecting a plan.

13 Taking this into consideration, a similar online
14 comparison tool as Medicare Compare and Medicare Plan
15 Finder would be essential for selection of a premium
16 support system.

17 As Carlos mentioned, the number of plans offered
18 is an important consideration in premium support. Research
19 suggests that consumer ability to make rational decisions
20 when confronted with numerous choices is compromised, and
21 elderly beneficiaries have an even more difficult time when
22 comparing plans, meaning Medicare beneficiaries may

1 struggle to sort through the volume of plan options and may
2 find themselves overwhelmed with choice.

3 Within Medicare Compare and Medicare Plan Finder,
4 beneficiaries have spoken to difficulties with the language
5 used on these sites saying it is too technical and that
6 they lack standardized information between plans. These
7 comparison tools should use a common vocabulary to display
8 standardized information including provider networks, cost
9 sharing, and meaningful differences for comparison.

10 The use of State Health Insurance Assistance
11 Programs (or SHIPs) could also be helpful in guiding the
12 elderly or their caregiver through the plan selection
13 process by helping to clarify terminology and assist with
14 computer-based tasks. Please remember that in 2008 MedPAC
15 made a formal recommendation to increase the financial
16 support of SHIPs for outreach to low-income Medicare
17 beneficiaries.

18 Ultimately, beneficiary decisions eventually lead
19 to impacts on plan sponsors and how they structure their
20 premiums and coverage decisions. I will now pass things
21 off to Scott who will discuss in more detail possible
22 impacts on plans.

1 DR. HARRISON: Of course, beneficiaries must have
2 available plans to choose. The existing MA program
3 provides a good base of plans for a premium support model.
4 Currently, 99 percent of all Medicare beneficiaries have at
5 least one MA plan available. The average beneficiary has
6 18, and some places have more than 40 plans available.

7 However, plan participation could be affected by
8 new rules under premium support. Currently, plans often
9 submit one bid that covers multiple payment areas. Under
10 premium support, each plan's bid will affect the area's
11 benchmark and thus the plan's payment in that area.
12 Therefore, plans would want to pay more attention to their
13 bids in each area.

14 The Commission has suggested using new payment
15 areas, even within MA, that would result in fewer, often
16 larger payment areas than the currently used counties.
17 Plans could decide to enter or leave some areas based on
18 their perception of competition in the new payment areas.

19 Both in Amy and Carlos's presentations, there
20 were suggestions that the beneficiary ability to choose
21 might be improved if plan choices were clearer and fewer in
22 number. Therefore, plan sponsor offerings might be limited

1 to one basic plan and one enhanced plan. At the same time,
2 policymakers may not want to limit the number of insurers,
3 or sponsors, offering plans in each market. Studies have
4 found that a greater number of competitors reduced the bids
5 in the MA markets and in the Part D markets.

6 While the new rules might lead to little growth
7 in plan participation, we expect that the size of the
8 potential market under premium support would be much larger
9 than the current MA market and the new markets that have
10 opened over the past decade, namely the Part D and ACA
11 markets. Thus, we expect widespread plan interest in
12 participation. The question becomes how would we expect
13 the level of the bids to be affected.

14 Commission work, as well as the academic
15 literature, has found that the current MA market structure
16 does not focus competition on price. Studies have
17 concluded that bids are more closely related to the
18 administratively set benchmarks than they are to plan
19 costs. Plans compete more on providing extra benefits.

20 Other MedPAC work shows that fiscal pressure on
21 benchmarks can lead to lower bids. In 2011, the benchmarks
22 for MA plans averaged 113 percent of local fee-for-service

1 spending, and the bids for those plans averaged 99 percent
2 of fee-for-service spending. Legislation lowered the
3 benchmarks over the 2011 to 2017 period to an average of
4 106 percent of fee-for-service. At the same time, bids
5 came down to an average of 90 percent of fee-for-service.
6 So while there may not be perfect price competition, MA
7 plans have become more competitive with fee-for-service
8 Medicare.

9 Premium support could focus competition between
10 plans on price and thus encourage lower plan bid amounts,
11 and let me show you an example.

12 This table uses the bids from an illustrative
13 market that we have used before in our premium support
14 work. In this market, fee-for-service costs or bids \$800
15 per month, and the five MA plans submit bids ranging from
16 \$680 to \$800 per month. Assume that the benchmark is also
17 \$800. Further assume that the plans offer only extra
18 benefits that can be funded by the rebates they receive by
19 bidding below the benchmark, what we call zero premium
20 plans. In this example, we set the national Part B premium
21 at \$125, which is close to its current level.

22 If beneficiaries were to compare the five MA

1 plans on Medicare Compare, they would see the premiums
2 displayed in the third gray row there, which they're all
3 zero, despite the fact that Plan E bid \$120 more than Plan
4 A. Actually, all beneficiaries would pay the \$125 base
5 premium. But the premium will not be a factor in the
6 beneficiaries' decisions. Instead they will decide based
7 on their analysis of the benefit differences between the
8 plans.

9 The same plan bids under premium support are
10 shown on the following three rows. We assume that the
11 benchmark in this example was set at the median plan bid.
12 The beneficiaries would see and pay the premiums displayed
13 on the bottom line, which range from \$65 per month to \$185
14 per month. No doubt beneficiaries would be motivated to
15 move to lower bidding plans in order to save money on
16 premiums. And plans would expect this beneficiary behavior
17 and try to lower bids to attract enrollment.

18 In 2013, CBO issued the findings of their premium
19 support analysis and estimated that the plan bids in a
20 premium support system were likely to be somewhat lower
21 than under the MA program. The transparency of the bidding
22 process and the price-based competition I just showed an

1 example of would lower bids by a few percent. The greater
2 competition and lower bids would then likely lead to lower
3 plan margins.

4 As a result, CBO estimated that there would be a
5 significant decline in fee-for-service enrollment and that
6 decline would be greater in some geographic areas than in
7 others.

8 CBO was concerned about keeping fee-for-service
9 as a viable option and was concerned that, as the fee-for-
10 service market waned, plans might have trouble obtaining
11 provider prices that approximate fee-for-service prices
12 instead of being forced to accept higher commercial sector
13 prices.

14 Now I am turning it over to Eric who will show
15 you another way of looking at the possible impacts of
16 premium support.

17 MR. ROLLINS: Turning now to slide 13, some
18 Commissioners have expressed interest in better
19 understanding the potential distributional impacts of using
20 premium support. We can provide some impressions using the
21 illustrative framework for setting benchmarks and
22 beneficiary premiums that we discussed during the

1 Commission's November 2016 meeting. I'd like to start by
2 briefly reviewing five key elements of that framework.

3 First, the fee-for-service program would remain
4 available throughout the country, but it would be treated
5 like a competing plan for the purposes of determining
6 beneficiary premiums. Second, CMS would use a system of
7 competitive bidding between fee-for-service and managed
8 care plans to set a benchmark that would determine how much
9 the government contributes towards the cost of buying
10 Medicare coverage. Third, that bidding process would be
11 conducted using geographic areas that reflect local health
12 care markets. Fourth, the benchmark would equal the lower
13 of the fee-for-service bid or the median plan bid, although
14 the Commission also discussed using the weighted average of
15 all bids as the benchmark. Finally, beneficiary premiums
16 would equal a base amount, which would be determined
17 nationally like the Part B premium, plus the difference
18 between the plan's bid and the benchmark.

19 Under this framework, the impact of premium
20 support would depend heavily on the relationship between
21 the fee-for-service bid and the median plan bid in each
22 market area.

1 This next slide reproduces the table that appears
2 in your mailing materials. Here we have grouped market
3 areas based on the relationship between fee-for-service
4 costs and the median MA plan bid in 2016. As you can see
5 in the top line of the table, there are about 1,200 market
6 areas in our analysis, given the method that we used to
7 define them. The differences between fee-for-service costs
8 and the median plan bid are shown here as monthly amounts.
9 The table also provides total enrollment, fee-for-service
10 enrollment, and MA enrollment in each type of market area.
11 All enrollment figures are shown in millions.

12 Here I've highlighted the two groups of market
13 areas where we'd expect to see the largest shifts in fee-
14 for-service and plan enrollment under our illustrative
15 framework. The first group, highlighted on the right side
16 of the table, are market areas where the median bid exceeds
17 fee-for-service costs by more than \$50. Under our
18 illustrative framework, the benchmarks in these areas would
19 be based on fee-for-service bids, and premiums for many
20 plans would increase by \$50 or more. You'll recall from
21 earlier in the presentation that MA enrollees switch plans
22 at much higher rates when premiums increase by more than

1 \$20. We would, therefore, expect a significant portion of
2 the 1.8 million MA enrollees in these areas to switch to
3 fee-for-service coverage or a less expensive plan.

4 The second group, highlighted at the bottom of
5 the table, are market areas where fee-for-service costs
6 exceed the median bid by more than \$50. Under our
7 illustrative framework, fee-for-service premiums would
8 increase by at least \$50 in these areas, and you can see
9 that about two-thirds of the fee-for-service enrollees in
10 these areas would see their premiums increase by at least
11 \$100. The MA program has not seen premium increases of
12 this magnitude, so its experience is of limited value in
13 assessing how many fee-for-service beneficiaries in these
14 areas might switch to plans. Nevertheless, it seems
15 plausible that a majority -- and possibly a sizable
16 majority -- of the 15.7 million fee-for-service
17 beneficiaries in these areas could switch to plans. In
18 market areas where fee-for-service premiums increase by
19 particularly large amounts, the share of beneficiaries who
20 are enrolled in fee-for-service once premium support has
21 been in effect for a few years would likely be minimal.

22 Moving now to Slide 16, looking across all market

1 areas, this rough analysis suggests that approximately 15
2 million fee-for-service enrollees might ultimately switch
3 to a managed care plan and 2 million MA enrollees might
4 switch to fee-for-service coverage. If these shifts
5 occurred, more than half of Medicare beneficiaries (roughly
6 55 percent) would be enrolled in managed care plans, but a
7 significant number of beneficiaries would remain in the
8 fee-for-service program.

9 However, those figures are very rough
10 approximations at best, and they have little predictive
11 value. Even within the illustrative framework that we have
12 used here, there are simply too many other elements to
13 premium support that would still need to be specified, and
14 those details could have a significant impact on the
15 behavioral responses by beneficiaries, plans, and
16 providers.

17 Turning now to the last slide, during your
18 upcoming discussion we'd like to get your input on whether
19 the chapter on premium support that we plan to include in
20 the Commission's June 2017 report should address other
21 potential impacts beyond the ones that we have discussed
22 here today. Please keep in mind that the amount of time

1 that we would have to conduct any additional analysis at
2 this point in the annual meeting cycle is fairly limited.

3 That concludes our presentation. We will now be
4 happy to take your questions.

5 DR. CROSSON: Okay. Clarifying questions. Can I
6 see hands, roughly? So let's start here with Amy.

7 MS. BRICKER: How do we think about quality with
8 respect to this discussion? I realize this is mainly a
9 financial one, but any thoughts there, on how to weave
10 quality in?

11 MR. ROLLINS: So Ledia and Carlos had a
12 presentation, to sort of talk about some of these quality
13 issues. It now seems very long ago. And I think sort of
14 what we have taken away from those discussions was, you
15 know, some of this earlier discussion, of there are areas
16 where we have, based on sort of your conversations, a clear
17 sense of where you'd like to go in premium support. And
18 then there are other areas where we might kind of just talk
19 about, there's a couple of ways you could do it. So think
20 there were sort of two schools of thought voice in sort of
21 some of the discussions on quality.

22 The first would be sort of that you would have

1 minimum standards for plans, provider network adequacy, and
2 things like that, and that you would sort of publicly
3 disclose this data, which could be something maybe akin to
4 like the star ratings that we have now, but you wouldn't
5 necessarily tie any sort of payment adjustment to it. Then
6 there was another school of thought that said, you know,
7 yes, you could do all that stuff, but you would actually
8 sort of want to have a financial incentive to enroll in a
9 high-quality plan. And so you can envision a system where
10 the government's contribution for a high-quality plan is
11 higher than it would be for other plans, and as a result, a
12 beneficiary's premium would be lower, and they would have
13 an incentive to enroll in those plans.

14 DR. MILLER: And very simplistically, in these
15 kinds of numbers we are just assuming quality is constant,
16 and it really is a financial exercise, as you said.

17 DR. CROSSON: Questions? Bruce.

18 MR. PYENSON: Thank you very much. This is a
19 question for Amy. I think the -- I was struck by what
20 seemed to be relatively low turnover rates in the program,
21 and I'm wondering if you could guess at the impact of a
22 longer lock-in, rather than an annual cycle, a two-year

1 cycle, given those numbers.

2 MS. PHILLIPS: So a longer lock-in in terms of
3 instead of each year they decide, saying, maybe in every
4 two years, every three years? So looking at the MedPAC
5 data, the work that was in the March 2015 report, we found
6 that the beneficiaries that were switching into MA were
7 deciding to do that after so many open enrollment periods,
8 so it would make sense that even if you locked it in to two
9 or three years, you would see maybe a bigger influx,
10 because the beneficiaries have had longer to make the
11 decision. How that would impact the beneficiaries who are
12 shopping every year, unknown. So whether you locked it in
13 or didn't, I don't know if you would necessarily see a
14 different bump, because it seems that the beneficiary
15 information that they're receiving, and how they're
16 deciding to make those decisions is remaining constant.

17 DR. CROSSON: Pat.

18 MS. WANG: A follow-up on that. Do you think
19 that it would be useful, in that switching rate, if it's
20 possible to pull out folks with low-income subsidy who have
21 special enrollment periods, because they switch more
22 because they have 12-month continuous enrollment.

1 MS. PHILLIPS: Yeah, and there's also -- the
2 duals are able to switch plans every month, so that impacts
3 it. The analysis on that data isn't very available, or
4 hasn't been widely explored.

5 MS. WANG: You know, you might have kind of like
6 a higher-lower kind of [inaudible].

7 And this is just -- I should -- I'm sorry that I
8 don't know the answer to this. In the comparators of fee-
9 for-service spending, et cetera, et cetera, how are medical
10 education payments, IME and direct, treated? Are they
11 carved out on both sides, because they're not in the MA
12 now, are they, in your analyses part of the fee-for-service
13 side?

14 MR. ROLLINS: They're not. We took them out to
15 make it more of an apples-to-apples comparison with what
16 the MA plans are bidding on now.

17 MS. WANG: Okay.

18 DR. HOADLEY: [Off microphone] -- that Pat
19 raised. The work that I've done on Part D, LIS
20 beneficiaries switching, you do see some sort of small ray
21 of plan choice, plan switching, outside of open season, but
22 it stays quite low. Most of it is in the first month or

1 two, which seems like people that are either "oh, I should
2 have switched" or "I regret my switch decision" and maybe
3 switch on to yet a different plan, or something like that.
4 Once you get past sort of February it's quite minimal.

5 MS. WANG: I think that for Part C it's a
6 different story, because of extra benefits that are geared
7 towards this population. We see a lot of consumer behavior
8 of shopping all through the year, back and forth, back and
9 forth, which is another issue, I think, about --

10 DR. HOADLEY: I know there was some look, when I
11 looked at the dual demos in Virginia there was a lot of
12 anecdotal evidence of that kind of switching. It was hard
13 to sort of see, from a data point of view, that there was
14 as much as sort of the story. So I think that makes an
15 interesting question, whether it's -- there's some very
16 visible cases, or whether it really adds up to a true
17 volume.

18 MS. WANG: Probably the Stars measures for dual
19 SNPs for the voluntary disenrollment rate would provide
20 information --

21 DR. HOADLEY: Yeah.

22 MS. WANG: -- although not across the year, but

1 anecdotally I would just offer. I think Part C is very
2 different from D, which is defined benefit, that's it, and
3 C is very different.

4 DR. HOADLEY: Yeah.

5 DR. CHRISTIANSON: Paul did you have question?
6 Bill?

7 DR. SAMITT: I have two questions. Amy, the
8 first question is for you, on Slide 4. You talk about the
9 beneficiary considerations and the things that they -- that
10 matter in switching or selection. So my question is -- and
11 I probably should know this -- on Medicare Compare and
12 Medicare Plan Finder, how many of those priorities are
13 available for beneficiaries to use to select a plan? So
14 when I go to Medicare Plan Finder and Medicare Compare, how
15 easily can I assess whether certain hospitals, cancer
16 treatment centers, specific physicians, and so on and so
17 forth, are there so that I can make a good plan selection?

18 MS. PHILLIPS: I don't have as much familiarity
19 with the Medicare Compare, but within Medicare Plan Finder
20 you can do pharmacies by geographic location, so you can
21 see what's closest to you for that, and based off the
22 prescriptions you need filled, and, of course, like the

1 premiums and the out-of-cost. But the non-monetary thing,
2 not so much.

3 DR. SAMITT: We may want to call that out in the
4 chapter, because it's -- and also walking through family
5 members, through some of these tools, that the things that
6 beneficiaries need to consider are not available to use as
7 a tool when they're actually selecting a plan, and it may
8 be worthwhile to point that out in the chapter.

9 And then for Eric, on Slide 15, I'm just curious
10 on those two key groups of beneficiaries. I would be
11 interested in understanding purchasing behavior there,
12 because even in a non-premium support world, you would
13 argue that there should be incentives for those two groups
14 to shift today, and yet we don't see it. So pre-premium
15 support, what does that mean about shopping behavior?

16 MR. ROLLINS: I think the nature of the dynamic
17 now is different, so that box on the right side, up at the
18 top, the areas where fee-for-service costs less than the
19 median MA plan, right now a lot of those markets are areas
20 where the MA benchmark is higher than fee-for-service, and
21 so that's why the plans can sort of be in that market, cost
22 more than fee-for-service, but --

1 DR. SAMITT: Without consumer impact?

2 MR. ROLLINS: Right. That's correct.

3 DR. SAMITT: And how about the other group, where
4 I can get supplemental benefits, in those particular
5 settings, even though I would not have to pay more to be in
6 fee-for-service, I get supplemental benefits if I choose a
7 plan?

8 MR. ROLLINS: There, I think, what you are seeing
9 is people are moving from fee-for-service to MA. It's just
10 going on sort of fairly gradually. It's 1 to 2 percent of
11 the Medicare population year. But we are seeing them move
12 from fee-for-service to MA, and I think, in part, that's
13 because of these extra benefits.

14 DR. SAMITT: Just not as rapidly as you would
15 expect.

16 MR. ROLLINS: Right.

17 DR. SAMITT: Thank you.

18 DR. CHRISTIANSON: Brian, do you have any
19 questions? No?

20 DR. REDBERG: Thank you. I just wanted to ask a
21 question on Slide 13, and I think I understand the reason
22 for the competitive bidding and the use of geographic

1 areas, but doesn't that then kind of advantage areas that
2 are high utilize -- I'm thinking like South Florida, where
3 there's very high, you know, fee-for-service rates, and
4 then we're setting benchmarks. I think it's kind of a
5 bloated, overutilized area, and is there any other way to
6 do that, or am I right in thinking about it that way?

7 MR. ROLLINS: I think that is the implication.
8 This has been sort of a topic that the Commission has
9 discussed on a couple of occasions. The tradeoff was given
10 the geographic variation that we do see in spending, to
11 what extent do you want to sort of hold the beneficiary
12 responsible for that? You could have an alternate approach
13 that isn't sort of market by market, that uses a national
14 figure. This is what Part D does. In those cases, the
15 areas, the South Floridas that have very high spending
16 would see even larger increases in premiums that what we
17 kind of sketched out here. And I think the concern that
18 was sort of voiced in a lot of the discussions was, you
19 know, what is sort of reasonable to expect the beneficiary
20 to control?
21 And so I think there was a preference for using these local
22 market areas, which would have benchmarks that are higher

1 in high-cost areas and lower in low-cost areas, because it
2 would provide some protection for the beneficiaries who
3 live there, you know, and they're not going to easily
4 relocate to another area.

5 That being said, even with the higher benchmark
6 in like a South Florida, you would still have this dynamic
7 of within that given market area, you would have the
8 premiums for the plans that are available there differing
9 based on their underlying cost. You would still have a
10 dynamic within your area to sort of gravitate towards a
11 lower-cost plan. But it was this sort of tradeoff between,
12 you know, how do we deal with the geographic variation in
13 spending that we have now and how much sort of do we want
14 the beneficiary to be responsible for?

15 DR. REDBERG: Thanks and I do remember some of
16 those discussions. Maybe in round two we can come back if
17 there are other solutions that we could think of, that
18 wouldn't penalize the beneficiary but try to hold costs
19 better.

20 DR. CROSSON: Questions, coming up this way.
21 Jack.

22 DR. HOADLEY: So on Slide 11, I'm trying to make

1 sure I understand correctly the difference in the two gray
2 bars that you're showing. In the first case, you're -- the
3 zero excludes the Part B premium.

4 DR. HARRISON: Right.

5 DR. HOADLEY: And in the second case, it
6 effectively -- I mean, the concept of the Part B premium
7 changes --

8 DR. HARRISON: Yeah.

9 DR. HOADLEY: -- but --

10 [Simultaneous discussion.]

11 DR. HARRISON: So when you look on Medicare
12 Compare you're going to see zeros. You're still paying the
13 \$125.

14 DR. HOADLEY: Right. So this is mostly a comment
15 on how Medicare Compare displays prices as opposed to
16 purely a point about how --

17 [Simultaneous discussion.]

18 DR. HARRISON: I think if you're a beneficiary
19 and you look and you see a bunch of zeros, I don't care.
20 I'm going to pick one of the zeros.

21 DR. HOADLEY: Right.

22 DR. HARRISON: It doesn't matter which one. When

1 you drop -- you know, under premium support, you have a
2 choice on every single plan, you're going to have a
3 different premium, and it should enter your psyche as to
4 what you pick.

5 DR. HOADLEY: And that point would still be true
6 if the current Compare showed \$125 on every --

7 [Simultaneous discussion.]

8 DR. HARRISON: Right. Still no difference,
9 right.

10 DR. HOADLEY: -- they would see no difference. But it also
11 looks -- I think the problem with this is it looks like,
12 oh, everything has gone up.

13 DR. HARRISON: Oh, didn't mean to do that.

14 DR. HOADLEY: It's not like --

15 DR. HARRISON: It's just what's in the
16 beneficiary's mindset, and I think they see it as a zero
17 premium. They don't think about the \$125 that's already
18 gone in.

19 DR. HOADLEY: That's fine.

20 DR. HARRISON: Yeah.

21 DR. HOADLEY: And then on Slide 15, Eric, you
22 talked about sort of making some assumptions that, you

1 know, majority or more, particularly looking at the box on
2 the bottom, of that group might switch, and I wonder if you
3 -- if that's just a modeling assumption you're choosing, I
4 mean, because the earlier stuff that we looked at showed
5 that even with the premium increases, 70 percent stayed
6 put. So I'm just wondering on your logic for sort of --

7 MR. ROLLINS: Well, I think, and sort of Amy
8 touched on during the presentation, sort of the MA
9 experience sort of kind of tops out at like a \$30 or \$40
10 premium increase. But if you're talking about an area, for
11 example, where the premium is going to go up by \$100 or
12 more, I think you can sort of reasonably expect that the
13 switching rate is going to be much higher than what we see
14 in Medicare Advantage.

15 Another factor is I tried to convey this -- we're
16 not trying to say that everybody would switch immediately.

17 DR. HOADLEY: Right.

18 MR. ROLLINS: I think this would take time to
19 sort of work out, and there are people who might not switch
20 during the first open season, and go, "Oh, I'll try and see
21 if I can pay it," and then year two, year three might
22 decide it's time to move to a plan. So I think given the

1 MA experience we would clearly be seeing higher switch
2 rates than what we've seen in MA. Exactly what those are,
3 we don't know.

4 DR. HOADLEY: Sure. Sure.

5 MR. ROLLINS: We've not seen that occur. But it
6 seems like it would probably be much higher than what we've
7 seen, and I think once you factor in, too, how this plays
8 out after a couple of years, I think that was sort of the
9 thinking about why -- the thinking for why, in these
10 markets, after a while, your fee-for-service would probably
11 be pretty low.

12 DR. HOADLEY: So part of this is a multi-year
13 movement.

14 MR. ROLLINS: Yes.

15 DR. HOADLEY: Okay.

16 DR. CROSSON: Alice.

17 DR. COOMBS: Thank you so much. With the other
18 choices why people switch, I know there was some kind of
19 information we might have had when people age into
20 Medicare. What about network? Is that prevailing
21 decision-maker for beneficiaries, a now network or a
22 network that doesn't include certain physicians or

1 physicians' choice? What role does that play?

2 DR. HARRISON: We don't have solid data on that.
3 What we do have would come from like focus groups that
4 we've done, and yes, people pay attention to their doctor.
5 Sometimes when their doctor moves in or out of the network
6 they will follow the doctor. Sometimes they won't. That's
7 sort of the extent of what we have.

8 DR. CROSSON: Jon

9 DR. CHRISTIANSON: I guess this is a question for
10 Amy, but anybody. So in the switching decision between the
11 MA and fee-for-service, can you talk a little bit about how
12 the pricing policies in the Medigap market might influence
13 switching?

14 DR. HARRISON: Actually, could you -- what do you
15 mean about the Medigap?

16 DR. CHRISTIANSON: Well, the --

17 DR. HARRISON: Being able to give up your
18 Medigap?

19 DR. CHRISTIANSON: Yes, and then coming back in
20 at a price that changes in the Medigap policy, and that
21 sort of thing.

22 DR. HARRISON: In other words, you've lost your

1 Medigap, when you've been in MA, coming back out. Okay.

2 MS. PHILLIPS: The literature briefly touched
3 that that's a consideration, but they didn't give any idea
4 as to how much that impacts the decision.

5 DR. CHRISTIANSON: Maybe you could describe that
6 consideration for people so they understand that.

7 MS. PHILLIPS: So switching out of MA into fee-
8 for service you would lose your Medigap coverage and that
9 supplemental insurance, so some beneficiaries would have to
10 weigh how much the MA coverage mattered or if that premium
11 was a factor into going into fee-for-service, and if they
12 actually want to lose that coverage.

13 DR. CHRISTIANSON: Okay. Is the Medigap premium
14 likely to be less for the younger beneficiaries when they
15 move out of MA after a few years --

16 DR. HARRISON: So there's different ways --

17 [Simultaneous discussion.]

18 DR. CHRISTIANSON: -- premium?

19 DR. HARRISON: Yeah. It depends on the state and
20 whatnot. Some states are community rated. It doesn't
21 matter. But many states are not. Most states are not. A
22 lot of times what you have is there are two different age

1 ratings. One is issue age, so if you bought it when you
2 went there, you will be on a lower premium trajectory. So
3 then if you come back in after you've been out for a while,
4 if your issue age is like 75 instead of 65, you could
5 expect a pretty large premium increase there.

6 DR. CHRISTIANSON: That would discourage
7 switching out of the fee-for-service plus Medigap market --

8 DR. HARRISON: Right.

9 DR. CHRISTIANSON: -- once you're in it, correct?

10 DR. HARRISON: Now the other thing is that the
11 Medigap companies can underwrite you, once you're coming
12 in, if you're not 65, and again, it depends on the state.
13 And then they may give you a very high premium if you have
14 pre-existing conditions.

15 DR. CHRISTIANSON: So I think focusing just on
16 the comparison of the Medicare Advantage plans and fee-for-
17 service cost misses a potentially important consideration,
18 in terms of just the monetary implications of switching at
19 different points in the Medicare beneficiary lifecycle.

20 DR. HARRISON: Yeah. I think we agree with that.

21 DR. CROSSON: Okay. So now we're ready for
22 discussion, and I think Jack had volunteered to begin.

1 DR. HOADLEY: Thank you, Jay, and thanks for this
2 analysis and this material, that I think will go into a
3 larger chapter.

4 It seems to me that there are a number of
5 concerns that the material you brought to us raise in terms
6 of, you know -- that will have an impact on the ability of
7 premium support to go forward in a smooth way, and I think
8 there are some tools and some things we could do to
9 mitigate some of those concerns. The concerns that I sort
10 of see out of this are, number one, the sort of -- the
11 issue of suboptimal choices and the fact that people,
12 because of the complexity, because of the income, the
13 information deficits, various other factors, are not
14 necessarily making the choice that's best for them
15 financially or otherwise. And the second one is the
16 potential for volatility and churning. If we see, you
17 know, a fair amount of plan entry and exit, such as we've
18 seen in the Affordable Care Act marketplaces, then people
19 are forced to move around. If we see a lot of premium
20 volatility changing from year to year, we could potentially
21 see it, or then that goes to the -- sort of the third
22 concern, is that there's insufficient switching, and that

1 people don't respond to those cues, you know, continue to
2 pay a much higher premium because of that stickiness
3 factor. And so sort of those two things, you know, in some
4 ways are contradictory, but they're both potential issues.

5 And then that factor, in turn, goes to the fourth
6 point, which is whether there are insufficient signals to
7 the market competitors, and you brought this up briefly a
8 little more in the chapter, the extent to which if people
9 don't track those premium changes that plans have less
10 incentive to moderate premiums, and we've seen a fair
11 amount of this in Part D, where some of the older plans
12 have experienced very substantial increases in premiums,
13 hold onto their beneficiary base because people are
14 unwilling or unable to make switches.

15 And so it does appear that the market is sort of
16 thrown out of whack a bit through that, and some companies
17 seem to exploit that by keeping an old plan and collecting
18 high premiums from an older population and then putting a
19 second plan in that sort of attracts the newer
20 beneficiaries at a lower premium, which is a suggestion
21 that markets aren't working well.

22 And then I think the fifth concern, that Jon just

1 highlighted, is sort of the level playing field around
2 Medigap, and whether you have essentially sent a signal,
3 and this could be one of the reasons why you might not see
4 that switch in that one box that I highlighted a minute
5 ago, of people switching from fee-for-service to Medicare
6 Advantage. If they think they ever want to come back to
7 fee-for-service, they understand that they may not be able
8 to, and so that may be a deterrent. And if you really want
9 a smoothly functioning marketplace, we may need to change
10 the Medigap rules so that there is the ability to reacquire
11 Medigap, or, per comments I made in the last session,
12 redesign in such ways that we make the Medigap
13 supplementation appear less necessary.

14 I think there are some things, and you've
15 highlighted a number of these, that could help to improve
16 the market function. One is the potential for limiting the
17 number of choices, whether that's at a more aggressive way,
18 like some of the states have done to actually say not all
19 issuers necessarily get to enter the market. Maybe the
20 ones that have the highest bids or lower-quality bids or
21 something, you know, don't get to play. Or the simpler one
22 that we've seen in Medicare, which is to say any given

1 issuer can only offer a more limited array of choices with
2 a meaningful different standard and so forth.

3 We talked in the last session about
4 standardization. I think the tools -- you know, there was
5 some mention here about Plan Finder. I think this would be
6 an incentive that we already really need for some big
7 improvements in the way Plan Finder operates. We've raised
8 a few of these issues over the years here. Plan Finder
9 really does not allow -- this goes to, I think it was,
10 Craig's question -- to look at the provider choices. They
11 basically send you off to the plan's website, and then
12 there's all kinds of issues about the accuracy of those
13 provider directories. We really need to have better ways,
14 even under the current system, to make sure that people can
15 understand what they're getting in a particular plan.
16 Networks is the most obvious one, but to some extent, plan
17 benefit variations too. What is it that makes a plan
18 different, and CMS actually reduced some of the information
19 that is available this year compared to previous years.

20 Resources, you brought up the SHIPs, other
21 resources. It's really clear that people need -- that a
22 lot of people need person-to-person counseling, and the

1 SHIP resources are inadequate, and there's actually been
2 threats to reduce the amount of SHIP resources at a time
3 when we really should be seeing those increase. So I think
4 it's important to really continue to raise that issue. And
5 then to find ways to make sure people focus on the right
6 criteria. There's a tendency to shop on premium alone,
7 but, you know, in the Part B world, looking at total costs
8 of all your drugs, not just the premium, there are cases
9 where the low premium plan has a lot higher out-of-pocket
10 costs. The same thing is going to happen in the MA side.
11 And it's more complex and more layered there. There may be
12 all kinds of ways of providing that care coordination and
13 all those advantages. In some cases, plans do it -- they
14 need a higher premium to provide some of the resources. If
15 it works well, as Craig was suggesting, you know, maybe
16 that allows them to be more efficient and get the premium
17 down. But if people are only judging on premium signals,
18 they're not understanding both the positives and the
19 negatives of some of the other dimensions.

20 And then trying to think about better ways to use
21 nudges and others sorts of behavioral economics principles.
22 There was, however, a recent article in the most recent

1 Health Affairs in the marketplace context where they did an
2 actual randomized experiment with the Colorado marketplace,
3 and they found that additional notices to people did
4 increase their likelihood of shopping, but it did not
5 increase their likelihood of switching. Now, they can't
6 explain why. Was it that people shopped and they said,
7 "No, I'm still good with the plan I'm in"? But even where
8 they could save money, there was no increase in shopping
9 with the additional kind of nudges that were provided to
10 them. So I think that's the kind of thing that we should
11 be exploring and trying to us what is it that both
12 encourages people to do the shopping that they need to do
13 to make sure they're in the right plan and to consider --
14 again, you don't expect everybody to end up making a switch
15 or you never should see 100 percent switching, or anywhere
16 near that, but to make sure that those who can benefit by
17 switching will do so.

18 And then I already mentioned the Medigap
19 potential reforms to further level the playing field.

20 So I think there's a bunch of things that could
21 be done, and I think you've highlighted a number of these,
22 and maybe, you know, there needs to be more about sort of a

1 clear menu of steps that could be taken to make the system
2 work better, should we move in this direction.

3 DR. CROSSON: Okay. So now we'll have further
4 discussion. Can I just see roughly hands for further
5 discussion? So I think we'll start at this end this time.

6 DR. DeBUSK: I just wanted to comment. I think
7 this is a very well written chapter, and I've noticed as
8 you guys iterate through the illustrations around premium
9 support, they get better and better. I really appreciated
10 the analysis around estimating the 15 million people that
11 would switch and trying to get your hands around that,
12 because I like seeing you link the beneficiary engagement
13 mechanism to how many -- what that would translate to in
14 people. So thank you. I thought that was great. And I do
15 think this underlying effort to get away from this process
16 of administrative benchmarks and bids and rebates and extra
17 benefits and all that, and moving to something more market-
18 based, I think this is great work and I hope we continue
19 it. So thank you.

20 DR. CROSSON: Comments on this side? I did not
21 see any other hands -- sorry, Rita, and then Alice.

22 DR. REDBERG: Just briefly, to comment on Jack's

1 last comment on the Health Affairs blog, obviously I don't
2 know either why they didn't, but I can imagine -- because
3 I've gone into that to try to help people, and it's pretty
4 overwhelming. So I can imagine you've gone on -- I assume
5 that's what the shopping part was -- and then you thought,
6 oh, my God, I don't know what I'm -- you know, is it
7 better, is it worse? And you just stay with what you are.
8 So I do think, you know, you need kind of the hands-on --
9 it's very hard to sort out those plans, so I can imagine
10 why they increased shopping but not switched.

11 DR. MILLER: And that's why sometimes -- and I
12 know you have been involved in some of this. I want to be
13 really careful. Sometimes the suboptimal choice stuff, you
14 know, I read it and I get it, but then I sort of feel like
15 are we really taking in, you know, search time and that
16 stuff into account. It can be completely rational behavior
17 to say I'm going to -- you know, I thought Shinobu's work a
18 few years back in Part D, you know, people tended to save
19 some money, get the drugs they wanted, but you could
20 probably argue it wasn't optimal from an economist's point
21 of view. But I could imagine searching and saying, okay,
22 saved some money, I got the drugs I got, and I'm out. You

1 know, like I don't want to put hours more into this. So
2 the suboptimal stuff has always left me a little off.

3 DR. CHRISTIANSON: So I don't think that would be
4 the economist's point of view.

5 [Laughter.]

6 DR. CHRISTIANSON: Just to look at the dollar
7 amount. I mean, there's a whole part of economics called
8 reveal preference and attributes -- different product
9 attributes and search cost and everything you're talking
10 about. And I think the economist's point of view would be
11 you wouldn't want to say something was rational or
12 irrational just based on some projection of the dollar
13 premium difference.

14 DR. MILLER: Oh no, and I recognize that, that
15 they do take into account the search, these drugs, I need
16 these drugs. But it still left them a little bit cold even
17 at that point when people are saying it's suboptimal. And
18 I think some of it is. The complexity of having to go
19 through that process.

20 DR. CHRISTIANSON: [off microphone].

21 DR. MILLER: Yeah, right.

22 DR. HOADLEY: And I agree with that as well. I

1 look at something like the point on Slide 5 where we were
2 showing that when there's a premium increase of \$40 or more
3 -- which we're starting to get up to pretty substantial --
4 you've still got 70 percent of the folks staying put.

5 DR. MILLER: That's true [off microphone].

6 DR. HOADLEY: And I think that's part of what
7 sort of reinforces the importance of having issue.

8 DR. MILLER: That's fair [off microphone].

9 DR. HOADLEY: Now, again, there are a lot of
10 reasons why you might stay. You may be getting real value
11 from that plan. You may like the folks. There may be
12 network issues. That's the only plan that has your
13 doctors. There are plenty of reasons why you could switch,
14 but it's the magnitude of that ratio that says, you know,
15 there are probably a whole lot of people that could save a
16 bunch of money, and when you look at the Part D where,
17 again, it's a little more of a straight financial kind of
18 analysis, there's a lot of people leaving quite a bit of
19 money on the table.

20 DR. MILLER: I just want you to be clear;
21 economists don't just look at the financial [off
22 microphone].

1 [Laughter.]

2 DR. CROSSON: Okay. I think it's time to hear
3 from a doctor. Alice?

4 DR. COOMBS: I wanted to say that one of the
5 issues is this whole notion of what happens with the
6 decisionmaking of the beneficiary, which is huge because
7 this whole thing on premium support is predicated on
8 beneficiaries actually making a decision that I'm going to
9 switch because X, Y, and Z. If you have a situation where,
10 as Kahneman and Tversky say, men fear loss greater than
11 they desire gain, then it might be that the beneficiary is
12 sitting in a comfortable place with all their comorbid
13 conditions and it's just a hard heel to change. And
14 whether it means re-enrolling and getting someone in the
15 ambulance to take you to a place where only you can
16 transfer because you got the access to an ambulance to do
17 something non-medical, but, you know, the transportation to
18 get to the place, I remember there was a -- and I should
19 name the company, was enrolling seniors in a Medicare
20 Advantage program, and it was an off-beat place with no bus
21 transportation, and you had to go up a couple flights of
22 stairs. And so that was not conducive for people, you

1 know, to switch.

2 I think there's other things that become in play
3 other than the money, because the money is a signal, but
4 there are other signals, i.e., this doctor who's been
5 taking care of you understands that he's going to give a
6 script to your nephew or, you know, you have a
7 relationship. So I'm wondering if you were to look at --
8 and you probably couldn't do this, so, Mark, you don't need
9 to worry.

10 [Laughter.]

11 DR. COOMBS: But if you could actually look at
12 the behavior that we might deem as not typical, whether or
13 not things like relationship with the providers became much
14 more of a signal than the actual money. And I think that
15 my underlying thought is that there are some non-monetary
16 decisionmakers for which, if you were going to propose the
17 premium support, it may be the wrench in the whole process.
18 And so that's one area that I think this whole program, the
19 premium support, is dependent on. And if what we call
20 rational behavior or decisionmaking that we think is
21 predictable should happen and it doesn't happen, then the
22 cost savings and all the things that we think are about to

1 happen may not happen.

2 DR. CROSSON: Okay. I'm sorry. I thought you
3 said no.

4 DR. HALL: I probably did. I'm in a community
5 that has very high MA penetrance, and there's a flurry of
6 activity at enrollment time by three or four players. But
7 my sense is that people ask their friends and neighbors.
8 It's a huge influence maker. Next would be their trusted
9 health care provider, which wouldn't necessarily be a
10 physician. So, you know, it's -- the decisionmaking there
11 may not be what we would consider from an economic or a
12 sociologic standpoint rational. It's like buying the car
13 edition of a Consumer Report and then talking to your
14 friend at the garage in terms of -- I don't think this is
15 necessarily a scientific area. I feel like we ought to be
16 careful getting into it, I think.

17 DR. CROSSON: Okay. Comments on this side?

18 MR. PYENSON: Yeah, I think I disagree with
19 Jack's comments in that I see the work that you've done as
20 not identifying areas that are especially challenging. It
21 seems that many of the areas in premium support and the
22 issues are relatively technical and can be relatively

1 easily addressed. And, in particular, we're starting from
2 a standpoint with substantial standardization already in
3 Medicare Advantage and, of course, in Medicare fee-for-
4 service.

5 By contrast -- and the choice of which Medicare
6 Advantage plan to join or to stay in fee-for-service is
7 probably rarely a life or death issue. Hopefully there
8 aren't a lot of Medicare Advantage plans or fee-for-service
9 plans where there's huge differences there.

10 I would contrast that with the lack of support
11 for life and death issues in treatment, such as whether an
12 85-year-old beneficiary should get open heart surgery or
13 chemotherapy or whether the choice is to go to inpatient
14 rehab or to a skilled nursing facility or home health for
15 treatment.

16 So just on the scope of decisions, that is, I
17 think, where we need the decision support because right now
18 it's a cottage industry relative to the standardization
19 that we already have in benefits. And I support this
20 direction. It is just I see it as it works well down in
21 the -- some of the issues that have been raised are also,
22 you know, beneficiary choice, and the mystery of how people

1 make decisions is very common as well in the commercial
2 insurance world. That's part of the real world, and I'm
3 not sure we need to spend that much effort addressing it.

4 DR. CROSSON: Bruce, can you just help me for a
5 second understand, you know, within the context of the
6 Medicare program, how you would see that sort of
7 personalized clinical care advice provided in ways that
8 it's not now?

9 MR. PYENSON: Well, I think today we depend on
10 the Marcus Welby model where the physician is advising the
11 patient on what should happen to them. I think there's
12 certainly better ways to do it. I don't think that's the
13 context for this discussion.

14 DR. CROSSON: No, no, it isn't. I was just --
15 maybe we can have a conversation offline. Okay.

16 MS. WANG: If I am forgetting something, then we
17 can just move on. I don't remember whether or not in the
18 writings so far on premium support there has been a
19 specific consideration of how to treat indirect medical
20 education, direct medical education, and DSH payments. So
21 for purpose of this analysis, Eric helpfully clarified that
22 at least, you know, IME and DME were removed to make things

1 apples to apples. Is the suggestion that in order to
2 maintain that apples to apples in a premium support system,
3 these payments would continue to be made as a separate kind
4 of payment stream? And then what happens to DSH, which is
5 now embedded in the fee-for-service benchmarks that MA
6 plans bid against? It's treated differently? I have a
7 personal feeling that it shouldn't be, but it is included
8 right now. How are those -- do we need to address that?
9 Because if at the end of the day folks said let's put all
10 those sort of special kind of payments into the fee-for-
11 service, then nobody going to be able to afford it, right?
12 I mean, it creates a distortion.

13 DR. MILLER: Okay. So what I would say is -- and
14 this is mostly predicated on -- I don't think we've
15 addressed this issue directly in our analysis. I think
16 what we've dealt with our numbers is always to make sure
17 that the numbers are comparable, which is almost like
18 assuming that what goes on now continues to go on. But I
19 don't recall that we've taken a deeper discussion and said
20 how should it go on.

21 DR. STENSLAND: Moving the DSH payment out of
22 fee-for-service [off microphone].

1 DR. MILLER: I'll just repeat it in just a
2 second. Jeff is saying that -- but that discussion, Jeff,
3 was in the context of this, or it was in the discussion of
4 kind of the hospital world?

5 DR. STENSLAND: It was the hospital world [off
6 microphone].

7 DR. MILLER: Right. So just for everyone, what
8 Jeff is saying is there was some discussion in the hospital
9 world about how to deal with uncompensated care and
10 disproportionate care services and whether they're paid as
11 a separate function or whether they're a function off of
12 the formula, which is very much tied to the admissions and
13 all of that. And what he is saying -- and it's a good
14 thought -- is, you know, that thought could be imported
15 into this discussion. But you are correct. I think in the
16 context if you just read our premium support stuff, I don't
17 think we've said that very directly at all. And so maybe
18 some discussion can be exported from the stuff that Jeff
19 did, at least as a marker. I don't know that we would work
20 through solving it, but saying it needs to be there. So
21 you're right that it's not in here.

22 MS. WANG: The other comment is just a really

1 small one, and I'm not saying this just because Bruce is to
2 my side here, but in trying to think about tools that
3 beneficiaries could use, if this were a new format, is to
4 consider adding something like the actuarial value of each
5 plan design to the current out-of-pocket maximum
6 calculator. You know, it's just a benchmark. You know, if
7 fee-for-service is 70 percent, then what are you comparing
8 it -- it goes -- it's just another piece of information for
9 people.

10 DR. GINSBURG: First thing, I think Slide 11 was
11 very useful for me, just showing how the different premiums
12 are going to look different under premium support than
13 under the current system, even though the differences are
14 the same or roughly the same. So that was very valuable.

15 A bigger-picture comment is that this
16 presentation was called impacts, and it was all about
17 switching. And it was a good contribution on switching,
18 but there are other aspects of impacts that maybe you're
19 planning for a different paper. Basically, you know, how
20 are the benchmarks going to change in the different
21 markets? Because this is going to be extremely important
22 to beneficiaries. If they live in Miami, they're going to

1 have a much lower benchmark under premium support than they
2 do today. So whether they stay in fee-for-service or
3 switch to a Medicare Advantage plan, you know, things are
4 not looking up for them; whereas, there are some areas
5 where, you know, things will definitely be improved whether
6 they stay in their plan or switch. So I think that's a
7 very significant impact of premium support.

8 DR. CROSSON: Do you want to say something?

9 DR. MILLER: Yeah, and the thing I do want to say
10 -- you know, some of the complication here is we're taking
11 these issues, because you've got to organize them, come
12 into a meeting, be prepared, talk about them for an hour
13 plus, and then they're going to be booked into a single
14 chapter, which at this point is going to be about 250 pages
15 long, and I don't want a lot of complaining about that
16 because you guys are making it really long.

17 But there will be a fair amount of discussion
18 about the distributional impact on the beneficiary from the
19 shift in the benchmark, Eric, which I think harkens back to
20 some of the stuff you had presented previously, and then
21 that got appended with a conversation -- and this is a
22 quick bank shot to something Rita said -- of, well, could

1 you think about mitigating some of the effects of the
2 beneficiaries. And you may remember that we did kind of
3 crank through that, and that will be a place in the
4 chapter.

5 Then what Jack started saying, making the chapter
6 much longer, was --

7 [Laughter.]

8 DR. HOADLEY: You're welcome [off microphone].

9 DR. MILLER: Thank you. Got it. But there are
10 other considerations beyond the benchmark effect and the
11 beneficiary might be hit with a premium. And so what we
12 tried to do is scour the literature quickly on things like:
13 Well, what about plan participation? What about
14 beneficiary decisionmaking process? And you're right, this
15 is very much a switching thing, because I think our view is
16 that that is the stuff you can kind of find, and even
17 that's relatively thin. But then other stuff like will
18 plans come to this market or that market, at least from our
19 perspective we think is very thin. So we're trying to spec
20 that out.

21 But I do -- this is a long way of saying I think
22 you'll see what you want in that long chapter that will all

1 be put together shortly.

2 MR. GRADISON: Two quick thoughts. The first is
3 sort of blasphemy, I guess, but I find it difficult to
4 think that a premium support plan would be approved that
5 required people to pay extra cash to stay in fee-for-
6 service. It's such a fundamental element of the program
7 from its very beginning.

8 Now, one could counter that, well, it would be
9 phased in over time. Fair enough. It probably would have
10 to be a very long period of time, and the only reasons I
11 bring it up is I think that it might be interesting to
12 recognize that uncertainty about -- and give some thought
13 to what does that mean in terms of everything else we have
14 here, because I'm not trying to inject the political issue
15 in here. I just think as a practical matter, you put
16 yourself in the position of somebody living in South
17 Florida, and it's not a trivial sum, no matter how you
18 measure it.

19 The second thing I want to mention is -- and
20 maybe it's been mentioned and I have missed it -- is the
21 possible role and assistance that people in making these
22 decisions could get from agents. Most everybody who owns a

1 car or a house has some agent, insurance agent, or access
2 to them somewhere in their life. I appreciate people with
3 very low income would be not in that category, and I
4 recognize that. But most people have a car or a house, and
5 I realize there are problems in how agents should be
6 compensated. They may tilt towards companies or plans that
7 pay them a higher fee. There would have to be regulation.
8 I'm not saying it should be just "let loose," but there are
9 objective people out there with no help on subject.

10 And while I haven't surveyed this with great
11 care, my impression is that in the exchanges that pretty
12 limited -- in fact, maybe almost hostility towards the idea
13 of agents have any role in this thing, and I don't think
14 that we should assume that that should be the case in what
15 we're exploring. I'm not saying they should be, but I
16 think you ought to give some thought to what role they
17 might play.

18 Thank you.

19 DR. CROSSON: Thank you, Bill.

20 Seeing no further comments -- Jack? Sorry.

21 DR. HOADLEY: I am thinking about Bill's
22 comments. I think there's a good point there, but clearly,

1 they need to regulate. But we need to identify all
2 possible sources of counseling and help, and it may be that
3 brokers and agents could play a role in that.

4 Again, there are some issues, and there have been
5 some abuses, but there's been some positive experience in
6 the marketplaces.

7 The other point, I was reminded by Paul's
8 comment. One of the impacts that I think falls in the
9 category, Mark, of the things that are not easily done is
10 sort of what is the expected variation and bidding
11 behavior. I think I have raised this before. We're sort
12 of assuming a static, that plans will bid kind of the way
13 their bids are today in a system that has some pretty
14 different dynamics. I suspect there isn't much literature
15 to really say would we expect plans, given this
16 environmental, given a Miami situation, given a situation
17 in a market where fee-for-service, would some plans just
18 decide not to participate, would they raise lower bids
19 according -- as well as some of the dynamics that I talked
20 about earlier in terms of their expectations of how people
21 respond. But, unfortunately, I think it's one of those
22 areas, there is just not a literature to work from.

1 DR. MILLER: Brian, I think we do -- I am also
2 now confused of where I see things and where I don't see
3 things.

4 I think we do have the distribution of the bid
5 stuff in this chapter as well as the MA chapter.

6 DR. HARRISON: Yeah. It's in the chapter, not in
7 this particular piece. Right.

8 DR. MILLER: Okay. So, I mean, we might either
9 at least reference -- but this is the frustration with all
10 of this. What we have to look at is based on the current
11 dynamic, which is not at all like this dynamic. It's
12 administrative benchmark competing on benefits, and we can
13 put these numbers out, but they have to be extremely
14 caveated because there's going to be all kinds of
15 behavioral change here.

16 DR. CROSSON: Paul.

17 DR. GINSBURG: Yeah, it's a good point, Jack,
18 about not knowing much about the bidding behavior.

19 I think we're going to start to learn more
20 because research is starting to come out now on marketplace
21 behavior, and there was something that just came out. And
22 my reaction to reading it is that, wow, this is what a

1 really competitive insurance market looks like, and I don't
2 think Medicare Advantage will ever become as competitive as
3 many marketplace markets. But I think at least that could
4 be a source of information about real-world experience if
5 we use it right.

6 DR. CROSSON: Okay. Amy, Scott, Eric, Thank you
7 so much. Excellent work.

8 We now have the opportunity for a public comment
9 period. If there are any of our guests in the audience who
10 wish to make a comment at this time, please come to the
11 microphone.

12 [No response.]

13 DR. CROSSON: Seeing none, we are adjourned until
14 the April meeting. Thank you very much to the
15 Commissioners and staff. Great work, everybody.

16 [Whereupon, at 11:22 a.m., the meeting was
17 adjourned.]

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