

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, March 3, 2016  
10:15 a.m.

COMMISSIONERS PRESENT:

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JACK HOADLEY, PhD  
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DAVID NERENZ, PhD  
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P R O C E E D I N G S

[10:15 a.m.]

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DR. CROSSON: Okay. Why don't we sit down and we can get going.

I would like to welcome our guests who have arrived for this morning's discussion. We are going to have what I think is going to be the penultimate discussion of developing a unified payment system for post-acute care.

For the Commissioners, we are going to review again today the material that we have discussed before and that you have read in preparation for this meeting. The purpose of today's discussion particularly is to ask for suggestions for additions or changes to this policy direction.

The intent is to revisit this issue one more time, at least one more time in the recent future -- in the soon-to-come future. So we will have a vote, a formal vote, on the entire package that the paper represents at the April meeting. We will not be dividing these interrelated issues into specific bold-faced recommendations, but we will be voting on the entire report to forward it to CMS.

1           As you may remember, this is just the first phase  
2 of this work. The Secretary will then take our report, as  
3 well as other information, and prepare our own approach,  
4 and then in a few -- what is it? Five years? Four years?

5           DR. MILLER: A long time [off microphone].

6           DR. CROSSON: Some other group of Commissioners  
7 will have an opportunity to review and comment. So this is  
8 essentially getting close to launching.

9           So, Carol, I'd like to compliment you again for  
10 this body of work that you have put together. Why don't  
11 you take us through it.

12           DR. CARTER: Okay. Good morning, everybody.  
13 Before I get started, I wanted to acknowledge the work of  
14 the entire PAC team on this mandated report, and that  
15 includes Dana Kelley, Stephanie Cameron, and Evan  
16 Christman. And, again, thanks to Doug Wissoker and Bowe  
17 Garrett at the Urban Institute. Everybody has done just  
18 outstanding work.

19           The IMPACT Act of 2014 requires the Commission to  
20 prepare a report considering the design of a prospective  
21 payment system spanning the four post-acute-care settings,  
22 that is, home health agencies, skilled nursing facilities,

1 inpatient rehabilitation facilities, and long-term-care  
2 hospitals.

3           Currently, Medicare pays for these services using  
4 separate payment systems for each setting. This siloed  
5 approach can result in fragmented care that is not focused  
6 on providing coordinated care to beneficiaries. Further,  
7 while many of the patients treated in the different  
8 settings are similar, Medicare's payments can vary  
9 considerably.

10           The Commission has also been critical of the home  
11 health and SNF payment systems because they encourage  
12 providers to furnish therapy that may be unrelated to a  
13 patient's care needs. A unified payment system would span  
14 the four settings and base payments on patient  
15 characteristics. While correcting some of these  
16 shortcomings, it would not by itself improve care  
17 coordination, so we also want to discuss what other  
18 policies and broader payment reforms are needed.

19           Aware of the shortcomings in sort of the PAC  
20 space, the Congress requested the Commission to prepare two  
21 reports. The first is due in June and must recommend and  
22 evaluate features of a unified payment system and, to the

1 extent feasible, estimate impacts of moving to such a  
2 system. And as Jay mentioned, after the Secretary issues  
3 her own report in 2022, the Commission must then propose a  
4 prototype design in a second report, which we think will be  
5 due in 2023.

6 The draft report covers the topics listed on the  
7 slide, all of which have been presented and discussed at  
8 previous sessions.

9 Last month, you reviewed our findings regarding  
10 the feasibility and design of a PAC PPS and our estimates  
11 of the impacts that they would have on payments. In  
12 previous sessions, you discussed various implementation  
13 issues and possible changes to regulatory requirements that  
14 would give providers more flexibility to furnish a broader  
15 range of PAC services.

16 You discussed companion policies that need to  
17 accompany a PAC PPS to dampen the fee-for-service  
18 incentives that would remain in such a system. We also  
19 identified easily tracked outcome measures that monitor  
20 provider responses. And throughout our discussions, we've  
21 noted that in the longer term, Medicare needs to adopt  
22 broader payment reforms that encourage an efficient,

1 coordinated approach across episodes of care.

2 Today I'll present new information on outlier  
3 polices and a little bit about the discussion of the level  
4 of payments, and then I want to walk through quickly and  
5 summarize our findings on each of the topics. The mailing  
6 material is a draft of the report, and in April we'll  
7 finalize the report for publication in June.

8 Now, for new material, when we discussed the  
9 feasibility and accuracy of a PAC PPS, we noted that a  
10 stay-based payment system should have a high-cost outlier  
11 policy. To see the potential impact of a high-cost outlier  
12 policy, we modeled an illustration with the following  
13 features: the pool was set at 5 percent of payments and  
14 payments covered 80 percent of costs above a fixed loss  
15 amount. We established separate pools for home health and  
16 institutional PAC stays because, otherwise, home health  
17 episodes would be highly unlikely to ever qualify for an  
18 outlier payment.

19 As expected, for most of the 40-some types of  
20 stays that we looked at throughout all of our analyses, the  
21 outlier policy made little or no difference to their  
22 payments in aggregate. Outliers are essentially random

1 events, and we would expect them to be distributed across  
2 all of the groups. To fund the outlier pool, base rates  
3 were lowered by 5 percent for all stays, but for most  
4 groups, the additional payments for outlier stays made up  
5 most if not all of this. So in aggregate, payments changed  
6 by less or about 2 percent for each of the groups.

7           The outlier payments mattered the most for  
8 medically complex stays: those with ventilator care (for  
9 them, those stays, payments would increase by 6 percent);  
10 severe wounds, severely ill stays, and the highest acuity  
11 stays (and that is the group that Alice defined as patients  
12 with the highest severity level during the prior hospital  
13 stay, on dialysis, and with severe wounds). With an  
14 outlier policy, payments for all of these groups for these  
15 stays would be more closely aligned with these stays'  
16 costs.

17           We also looked at a short-stay outlier policy,  
18 and these prevent overpaying for stays that are unusually  
19 short. The SNF PPS doesn't include an outlier policy since  
20 it is already a day-based payment system. But the other  
21 PPSs currently have one. Our analysis of how well we  
22 predicted the cost of stays confirmed the need for such an

1 outlier policy. Without one, we found that predicted costs  
2 were far too high compared to the actual costs of these  
3 short stays.

4           We modeled an illustration that defined short  
5 stays by setting since lengths of stay vary so much by  
6 setting. Short-stay home health episodes were those with  
7 four or fewer visits, and for the other settings the short  
8 stays were defined as the shortest 10 percent. Payments  
9 were modeled on a per day or per visit basis, and we added  
10 20 percent to the cost of the first day to reflect the  
11 higher costs that are typically incurred that first day.

12           In the first column on the slide, you can see how  
13 high payments would be relative to costs if there was no  
14 such short-stay policy. For example, for short home health  
15 stays, payments would be more than three times the cost of  
16 the stay. But by switching to a visit-based payment, the  
17 ratio of payments to costs is much closer aligned with  
18 these stays' costs at 1.36. You can see from this that,  
19 though clearly needing refinement, the example illustrates  
20 the intent and the impact of a short-stay policy.

21           Policymakers will also need to consider the level  
22 of payments under a PAC PPS. Our work looking at '13 data

1 found that payments exceeded the cost of stays by 19  
2 percent. As part of the implementation of a PPS, an issue  
3 is whether the level of payments should remain at the  
4 current level or be lowered. Alternative ways to think  
5 about the level include incorporating past Commission  
6 recommendations regarding the level of payments or  
7 considering the costs of efficient providers or looking at  
8 the geographic variation in spending.

9 That's it for new material. Now I'm going to  
10 walk through kind of the whole gamut of things we've  
11 covered since last September.

12 Starting with the feasibility of a PAC PPS, we  
13 found that a unified PPS is feasible, would break down the  
14 silos between settings, and correct some of the current  
15 shortcomings of existing payment systems.

16 The design can use a common unit of service and  
17 payment (the stay, or in the case of home health, an  
18 episode) and a common risk adjustment method.

19 Payments would be based on patient  
20 characteristics, not the setting.

21 Payments for home health stays would need to be  
22 adjusted to reflect this setting's much lower costs.

1           Because coverage differs by setting, one model  
2 would be needed to establish payments for routine and  
3 therapy services and another would be needed for nontherapy  
4 ancillary services such as drugs.

5           Because the objective of a PPS is to pay for a  
6 given type of stay, regardless of setting, we focused our  
7 evaluation on how well, using patient characteristics, we  
8 could predict the average cost of stays and how much of the  
9 variation across stays we could explain. We stress-tested  
10 the model by looking at over 40 different patient groups,  
11 including 22 clinical groups, four definitions of medically  
12 complex stays, and several other groups listed in the  
13 mailing materials.

14           We found that the models using administrative  
15 data accurately predicted the average costs of stays for  
16 most of the patient groups and explained a high share of  
17 the variation across stays. We concluded that models could  
18 be used to establish payments.

19           The models were less accurate for one group, the  
20 highest acuity group, and this is a very small group of  
21 stays. However, the model was accurate for three other  
22 definitions of medical complexity. This told us that

1 further refinements to the risk adjustment should be  
2 explored in the final design to help ensure access for the  
3 very sickest patients and to make sure providers treating  
4 them are not disadvantaged by a common PPS. Outlier  
5 payments would provide some relief to providers that treat  
6 these patients.

7           As expected, there was a handful of groups where  
8 the models were not accurate, but these results illustrate  
9 the objective of a PAC PPS. Those groups included stays  
10 defined by the amount of therapy and stays treated in high-  
11 cost settings or by high-cost providers. For these groups,  
12 current therapy practices, the current designs of the home  
13 health and SNF payment systems, and the cost structures of  
14 high-cost settings and high-cost providers explain these  
15 results and should not be corrected with payment  
16 adjustments. A transition would give providers time to  
17 adjust their cost structures to the new payments.

18           Now let's review the results indicating whether  
19 payment adjusters are warranted. As I noted earlier, our  
20 findings support the inclusion of a short-stay policy to  
21 prevent large overpayments and a high-cost outlier policy  
22 to help ensure beneficiary access to care and to protect

1 providers from large losses.

2           We also tested the need for a general rural  
3 adjuster and for providers located in frontier locations  
4 and did not find strong evidence for either. Our frontier  
5 finding is a little different from what I reported in  
6 January. Since then, we have refined our prediction  
7 models, and our revised results do not indicate a clear  
8 need for a frontier adjustment.

9           That said, the Commission's general principle is  
10 that low-volume, isolated providers may need protection.  
11 The Secretary should explore this issue further. I would  
12 note that the PAC PPS would raise total payments to rural  
13 providers by 3 percent and to frontier providers by 7  
14 percent.

15           We also did not find strong evidence for an  
16 adjuster for IRF teaching facilities. It appears that a  
17 robust risk adjustment method can predict the costs of  
18 these stays reasonably well.

19           Further work needs to be done to refine the risk  
20 adjustment for the highest acuity stays. And we did not  
21 have the data to evaluate the need for an adjuster for  
22 providers treating high shares of low-income beneficiaries.

1 We had the data for IRF patients, but we did not have it  
2 for the other settings.

3           Turning to the impacts on payments, our estimates  
4 assumed spending would remain at the same levels as in  
5 2013; that is the year of the data we used. In that year,  
6 we estimate payments exceeded the cost of stays by 19  
7 percent. Our estimates do not reflect policy changes since  
8 then and should be considered as directional and relative  
9 rather than as point estimates.

10           We found that a PAC PPS would reduce the  
11 variation in profitability across the different types of  
12 stays. This would decrease the incentive to selectively  
13 admit certain types of stays and patients over others.  
14 Payments would shift from rehabilitation stays to medical  
15 care stays. In general, the average payment would increase  
16 for medical stays and for medically complex stays, while  
17 the average payments would decrease for stays that receive  
18 physical rehabilitation services that are not related to a  
19 patient's condition and for stays that are treated in a mix  
20 of settings that include lower-cost settings and lower-cost  
21 providers.

22           These results are expected and reflect the

1 objectives of a combined payment system. A high-cost  
2 outlier policy would give high-cost providers time to lower  
3 their costs in line with the new PAC PPS payments.

4           There are several implementation issues that  
5 would need to be addressed prior to the beginning of a PAC  
6 PPS. First, the Secretary will need to consider the level  
7 of payments, as mentioned earlier.

8           Another issue is the transition policy: How long  
9 should providers have to transition from setting-specific  
10 payments to PAC PPS payments? And should providers be  
11 allowed to bypass the transition and go straight to PAC PPS  
12 rates?

13           A transition could also contemplate moving ahead  
14 earlier with a PAC PPS that uses only administrative data  
15 and refine the payment system when patient assessment data  
16 become available. The Secretary could also consider a  
17 high-cost outlier policy that starts with a larger pool and  
18 transitions over time to a smaller pool.

19           Finally, the Secretary should have the authority  
20 to refine payments over time to keep them aligned with the  
21 costs of stays. This would include the authority to  
22 periodically recalibrate payments across stays and to

1 rebase payments if the changes in the cost of stays outpace  
2 the changes in payments.

3           Because a PAC PPS would eliminate payment  
4 differences across settings, Medicare should consider  
5 moving away from setting-specific regulations. Otherwise,  
6 providers in different settings would be paid the same for  
7 treating similar patients even though they incur different  
8 costs associated with their differing regulatory  
9 requirements.

10           Overhauling Medicare's conditions of  
11 participation is a complex undertaking, so we outlined a  
12 possible near-term and a longer-term strategy. In the near  
13 term, when the PPS is implemented, the Secretary could  
14 evaluate whether waiving certain setting-specific  
15 requirements is feasible and would not have unintended  
16 consequences. Waiving some requirements would give  
17 providers the flexibility to offer a range of services  
18 across the PAC continuum.

19           In the longer term, CMS could consider developing  
20 a core set of regulatory requirements for all PAC providers  
21 to ensure a common baseline competency. This common set  
22 could include things like staffing requirements, the

1 availability of physicians, the frequency and content of  
2 care plans and patient assessments, and so on. Beyond a  
3 core set, CMS could develop additional requirements for  
4 providers opting to treat patients with highly specialized  
5 care needs, such as wound or ventilator care.

6           Because a PAC PPS retains some of the undesirable  
7 features of fee-for-service, CMS should implement policies  
8 to protect both beneficiaries and the program.

9           First, a readmission policy would promote high-  
10 quality of care and encourage good care coordination that  
11 should lower unnecessary readmissions.

12           Second, a resource-use measure, such as a PAC  
13 Medicare spending per beneficiary, would counter the  
14 incentive to generate unnecessary service volume. Both  
15 policies could be organized as part of value-based  
16 purchasing. By tying a portion of payments to quality and  
17 resource use, providers would have an incentive to ensure  
18 efficient care over the course of the PAC episode, not just  
19 during the PAC stay.

20           The Secretary could also consider contracting  
21 with a third-party vendor to manage PAC services. I want  
22 to note there was a lack of consensus among Commissioners

1 about the need for and desirability of a third-party  
2 benefit manager, and I tried to capture that conversation  
3 in that section of the paper.

4           It will be important for CMS to track provider  
5 responses to the new payment system, and on this slide, I  
6 included some broad domains of what a monitoring program  
7 needs to include. Those are things like quality of care,  
8 selective admissions, generating unnecessary services, and  
9 the adequacy of Medicare payments.

10           For example, monitoring quality of care could  
11 track potentially avoidable readmissions, discharge to  
12 community, and changes in function. Mary, you asked about  
13 measures of care coordination, so in the paper we added  
14 emergency room visits and days between discharge from the  
15 hospital and follow-up care as possible measure that CMS  
16 might track. The paper focuses on possible measures that  
17 can be calculated from currently available data.

18           Given the shortcomings of service-based fee-for-  
19 service, Medicare needs to move forward with episode-based  
20 payments as soon as practicable. By focusing on the  
21 patient over an episode of care, providers would be at risk  
22 for quality and spending, and thereby encourage well-

1 coordinated, high-quality care and discouraging unnecessary  
2 services, such a serial PAC stays. Episodes would limit  
3 providers' ability to shift costs downstream onto other  
4 providers and reduce the need for companion policies.  
5 Thus, a PAC PPS should not be considered the endpoint but,  
6 by beginning to align PAC providers' payments, represents a  
7 good first step towards broader payment reforms.

8           In summary, our work confirms that it is possible  
9 to design an accurate unified PPS using a common unit of  
10 service and a common risk adjustment method. Based on our  
11 findings, the specific design features are listed here as a  
12 reference during your discussion.

13           A PAC PPS will shift payments between types of  
14 stays and reduce the variation in profitability across  
15 them. Payments based on these models would give providers  
16 less incentive to selectively admit certain types of  
17 patients over others. And the other implementation issues  
18 are listed on this slide.

19           And with that, I'm glad to answer any of your  
20 questions and look forward to your discussion.

21           DR. CROSSON: Thank you very much, Carol.

22           We'll take clarifying questions.

1 MS. UCCELLO: But I just want to confirm. So,  
2 when we talk about the outlier pool being reduced over  
3 time, it's not that we expect these extra-high-cost cases  
4 to go away. Is it that the model is going to be able to  
5 better capture them as it gets more of the assessment data  
6 and that kind of --

7 DR. CARTER: I think there are a couple of things  
8 going. One is a larger pool starts a transition that I  
9 think is a little easier, but over time, I do think  
10 providers' cost would start to narrow, and so you might  
11 need an outlier policy of a smaller size. I think practice  
12 patterns will change, and where patients are treated will  
13 change.

14 DR. CROSSON: Jack.

15 DR. HOADLEY: So this was, I think, a really  
16 well-done report, and I think it was particularly clearly  
17 written, but I just have a couple of questions.

18 First, I think I'm pretty sure I know the answer,  
19 but when you talk about, for example, the outlier policy,  
20 you're not -- the intent is not to recommend the particular  
21 example, but use it as an example to say there's  
22 potentially and likely the need for an outlier policy, and

1 here's an example that illustrates that it really could  
2 work and could improve things. Is that the right way to  
3 read that?

4 DR. CARTER: Yes. I mean, we pick sort of a mid-  
5 core size. I mean, the pools right now range from 2.5  
6 percent to 8 percent, depending on the setting, so we pick  
7 something sort of in the middle, but it's really just meant  
8 as an illustration of what kinds of impacts you would  
9 expect from designing a policy.

10 DR. HOADLEY: Right.

11 DR. MILLER: And that's the way I would think  
12 about the report generally.

13 DR. HOADLEY: Right.

14 DR. MILLER: I mean, we're trying to set  
15 guideposts for a process that the Secretary has to start  
16 going through herself.

17 DR. HOADLEY: And that's really what I just  
18 wanted to make very clear.

19 The other, much more narrow question, on Slide  
20 13, you talked about the outlier pool potentially starting  
21 larger and then make it smaller over time, and I was  
22 wondering if there is any precedent in some of the other

1 PPS developments for that kind of a transition, or is this  
2 the kind of thing where once you've set it larger, it  
3 becomes hard sort of politically to make it smaller? Have  
4 we been able to do that on other systems?

5 DR. CARTER: I think outlier pools have changed,  
6 but I don't know that they were part of an explicit  
7 transition policy, and I could be wrong, but that's my kind  
8 of recollection.

9 DR. HOADLEY: Just something to think about over  
10 time.

11 DR. CARTER: Yeah.

12 DR. MILLER: Yeah. I think the politics of  
13 changing it go in two directions. There's the people who  
14 benefit who say keep it big and the people who have it  
15 taken out of their base rate who say let's get it down to  
16 small. So I think you can have pressure in both  
17 directions.

18 And I almost think -- feel like the size of the  
19 outlier pool -- and I could be wrong about this -- is less  
20 about it changing within a given provider. As you've seen  
21 different PPSs come on in different years, different sizes  
22 have happened that way. But that's all just off the top of

1 my head, but I did get one nod from the staff, so --

2 [Laughter.]

3 DR. CROSSON: On this? Yes, Cori.

4 MS. UCCELLO: Yeah. This is completely  
5 different, but the reinsurance program under the ACA  
6 marketplace plans started higher, and it did decline over  
7 three years. And then it completely goes away. So that is  
8 somewhat of a precedent, even though it's completely plan  
9 based versus provider based.

10 DR. CROSSON: Thank you. Alice?

11 DR. COOMBS: One of the charts on page 43, I was  
12 looking at the LTCH. That's from 2013, a minus 17, and  
13 just, you know, dealing with the fact that the high acuity  
14 happens to be at the LTCH and what that means in terms of  
15 issues -- and just speak to that.

16 And then the second thing is, with the LIS, do  
17 you have some kind of projections that you might just kind  
18 of noddle around going forward if we were to include them  
19 in the model?

20 DR. CARTER: So we did look at where we have the  
21 data, which was for IRF patients, because that is part of  
22 the LIS adjustment, is a graduated.

1 DR. COOMBS: Right.

2 DR. CARTER: And so we had the data to do that,  
3 and we did see no reason for an adjustor, except for the  
4 highest share. But we really don't have the data for the  
5 other settings, so we didn't want to venture into  
6 speculating about what that would be like for the others.

7 DR. COOMBS: Okay.

8 DR. CARTER: We really just don't have that  
9 information.

10 DR. CARTER: But, again, we've pointed it out for  
11 the Secretary --

12 DR. CARTER: Yes.

13 DR. MILLER: -- as someplace that as she thinks  
14 through it -- and we can, of course, come back to it when  
15 it's our turn to come back to it.

16 DR. CARTER: Right.

17 And the other thing you asked about are sort of  
18 the LTCH and high-acuity patients, and the thing about  
19 LTCHs is about half their -- the types of stays are also  
20 treated in lower-cost settings, and so they're affected by  
21 a payment system that's looking at the average cost of  
22 these stays across all four settings.

1           That also is true for the highest-acuity  
2 patients, where over half of those patients are treated in  
3 other settings, and so, again, the group that has the most  
4 impact of sort of the different patient groups that we  
5 looked at -- and, in part, it's because there are other  
6 setting -- lower-cost settings that are treating those  
7 patients.

8           DR. CROSSON: David.

9           DR. NERENZ: Yeah. Thanks, Carol. This is great  
10 work.

11           Slide 7, please. Just to clarify, the short-stay  
12 model that you used says based on cost, including cost plus  
13 20 percent. I'm a little curious how in the lower right  
14 here, we get payments less than cost at the .8 and the .72.  
15 Is that because the cost estimate here is pooled across the  
16 settings rather than being site-specific? How does a model  
17 based on cost get you under cost?

18           DR. CARTER: Yeah.

19           DR. NERENZ: How does that work?

20           DR. CARTER: Right. So we ran -- for all of our  
21 analysis, we were always using the same kind of prediction  
22 models. This just happens to be who did we report on, and

1 so, yes, you're seeing kind of that lower end because of  
2 the pooling of stays across settings. And I want to  
3 double-check that, and I'll get back to you, but I think  
4 that's right.

5 But, also, I mean, I look at these results, and  
6 I'm, like, that directionally, they're better, but it's  
7 obviously a place where I think you would want to refine  
8 this if you were actually designing the policy.

9 DR. NERENZ: And in the spirit of Phase 1, I'm  
10 not so interested in is it good or bad. I just want to  
11 know how you get there.

12 DR. CARTER: Yeah, yeah. Yeah, I'll get back to  
13 you on that.

14 DR. CROSSON: Other clarifying questions?

15 [No response.]

16 DR. CROSSON: Okay. So we'll move on to  
17 discussion. What I think we'd like to achieve here is a  
18 general sense of whether we have support for this report in  
19 your comments. If not, do you have suggestions as to  
20 something added or changed? I'd like to have a sense at  
21 the end of the discussion whether we're kind of prepared  
22 for this to come to a vote in April or not.

1           So, Mary, would you like to lead off?

2           DR. NAYLOR: Great. So let me lead off in the  
3 way that I've done in the past, which is this is really  
4 terrific work, so congratulations to you and your team and  
5 all that have been involved.

6           My comments really are in the spirit of trying to  
7 think about ways that the chapter and the work might be  
8 easier to absorb because one thing that happened when you  
9 read now all of the work put together is you really  
10 appreciate the complexity of this. We've looked at  
11 different dimensions and so on.

12           So one of the things that I thought might be  
13 helpful is to really kind of map out in a table what are  
14 the key design issues here that in a transition policy I  
15 think give us two options. One, as you suggested  
16 throughout the chapter, the opportunity, for example, to  
17 earlier move to adoption of a unified payment, but maybe  
18 what we might think about is kind of the opportunity and  
19 the pros and cons of each of those options.

20           So, for example, measurement of functional  
21 status, you recognized throughout is a very central issue  
22 in getting to models that accurately predict cost, and so

1 then there's an opportunity to say, "Well, should we really  
2 focus on that first in the next couple of years or think  
3 about implementation and refinement as we go?"

4           The whole issue around risk adjustment and the  
5 critical need for refinement of that for the high-acuity  
6 patients is a really central one, as you've pointed out,  
7 and so does that become an opportunity we work on first  
8 versus later?

9           So these are the ways that I was thinking about  
10 these, the waiver requirements. In the area of outcomes,  
11 one -- just recommendation is that to think about whether  
12 or not even a suggested outcome, that -- and you just put -  
13 - you do posit them as suggestions, but whether or not 30-  
14 day readmissions makes sense, even with looking at the  
15 impact of a post-acute payment system. I mean, you know,  
16 it may make sense for short hospital stays, but now for 60  
17 days or X number of days in a post-acute episode, maybe we  
18 should have higher expectations, 90-day readmissions or  
19 something like that. But it doesn't seem to me to be  
20 exactly.

21           I really appreciate your attention to care  
22 coordination but wonder whether or not the way -- that

1 opportunity isn't better to really push the kind of  
2 patient-reported outcomes that I really feel that my care  
3 was coordinated throughout this entire experience makes  
4 sense.

5           The issue of hospitals, so we have people who are  
6 community admitted currently, and so rehospitalization  
7 might not make sense. It might be hospital admission  
8 that's the outcome that becomes important.

9           The issue of benefit cost sharing, I really think  
10 that's central, but wondered about language. Should we be  
11 talking about uniform benefits cost sharing or standardized  
12 or some kind of way in which we acknowledge the centrality  
13 of it as a principle? That may need to be adopted,  
14 depending on what the episode is.

15           I was one of those that did not -- so now we'll  
16 move from that kind of table of thinking through what are  
17 these key issues. The implementation using a benefits  
18 manager -- and I appreciate the way in which you framed  
19 that, but I would really think that you may want to suggest  
20 that the pros and cons of third-party vendors might be  
21 explored as part of this transition.

22           There is tremendous concern about fragmentation.

1 There is concern about how well this will align with what  
2 you articulated very well as the ultimate goal here, post-  
3 acute as one step toward getting to an episode of care,  
4 where we can move people quickly, maybe even more quickly  
5 from hospital stays to a post-acute environment and through  
6 multiple options in that environment.

7           So I think if you keep it, I would keep it out of  
8 the Executive Summary, but put it in the frame of "There  
9 are these benefits associated with this, and these are the  
10 cons." I mean, you've articulated that, but I would --  
11 rather than recommend it as possible, say, for  
12 consideration, here's a possibility you need to think  
13 about, the pros and cons of that.

14           Ultimately, in the beginning of the chapter, I  
15 think placing in context what you put at the end, which is  
16 this is a path toward getting us to understand how to pay  
17 for episodes of care with post-acute being a part of that  
18 episode, post-acute episode, if you will.

19           So those are my recommendations.

20           DR. CROSSON: Thank you, Mary.

21           DR. NAYLOR: Oh. And I totally support.

22           [Laughter.]

1 DR. CROSSON: Thank you for that. I might have  
2 missed it.

3 [Laughter.]

4 DR. CROSSON: Bill.

5 DR. HALL: Well, I would join Mary in really  
6 complimenting you, Carol, and all the staff that worked on  
7 this. This is a monumental project and one that could have  
8 tremendous implications for improving care of older adults.

9 I wonder, as you go forward with this, whether we  
10 have given enough consideration to the overall sort of  
11 global impact on sites of care, the venues that would be --  
12 that are now, in many cases, for different payment streams,  
13 but there's a lot of sort of real estate and architecture  
14 involved in this. Some of these services are provided in  
15 hospital, attached to hospital, freestanding, and then home  
16 health agencies, which are scattered all over the country,  
17 probably are the most homogenous in nature.

18 So this has the potential for really changing the  
19 entire way we look at episodes of care, as Mary has said,  
20 but it's going to take some time to pull all this out. Has  
21 there been any thought about how the structure would look  
22 like when this really came online? Would we have to

1 eliminate certain types of community-based entities? It  
2 just seems to me that it has enormous, enormous  
3 implications for a change.

4 DR. CARTER: We did talk a little bit in the  
5 chapter about what down the road -- and I would say longer  
6 term. For entities that are opting to provide a continuum  
7 of care, that would be their choice. Some providers may  
8 choose not to do that and sort of specialize in something,  
9 but I think that's a long process. And figuring out what  
10 regulations would dictate what those entities look like  
11 really need to be thought through, and that's complicated.  
12 That part is really complicated.

13 So I think we try to discuss, at least lay out  
14 here are the issues that need to be thought through, but I  
15 think we're just sort of developing. I don't feel like  
16 we've done a lot of work in that area, and it is very  
17 complicated.

18 Particularly from the conversations that you all  
19 have had, I think we want to create an environment where  
20 providers have the flexibility to do that if they want to,  
21 and we wouldn't want the payment system to impede that, but  
22 to support that.

1 DR. CROSSON: Warner.

2 MR. THOMAS: Just to comment on Bill's -- because  
3 I think this is an important one, and the comment I would  
4 make -- and perhaps we captured somewhere in the chapter --  
5 is I think there could be some benefits to provide  
6 incentives early on for organizations that want to go in  
7 this direction, especially in a single facility type of  
8 model, because I think we will find that from a cost  
9 structure perspective, they will have a much better cost  
10 structure, be able to deliver care more cost effectively,  
11 because right now, for the most part, most of these  
12 facilities are in different types of facilities and  
13 different types of location.

14 So, if there could be some thought put to early  
15 demonstration projects to get some organizations that want  
16 to be innovators in this area, they could work with,  
17 whether it's CMMI or some other demonstration project, I  
18 think that can be a real learning lab, which would then  
19 inform, later, policy and regulatory changes in the future.

20 DR. CROSSON: Herb.

21 MR. KUHN: So Carol, I want to join the chorus of  
22 others. Really nice work for you and the team here and

1 ultimately the consultants that you had at Urban Institute  
2 to help you with this work. This is a complex undertaking,  
3 and you've all done a great job.

4           What I liked about the report we have before us  
5 now is you updated the estimates and the model, but also  
6 you presented -- and I think Mark put it in good context  
7 that here's kind of the guidepost, but you looked at  
8 beneficiary cost payment sharing. You looked at regulatory  
9 changes, transition, the need for periodic refinements, and  
10 it's probably kind of a silly way for me to think of it,  
11 but I kept thinking about aspirationally what we want is  
12 like looking at a pond with a duck floating on it.  
13 Everything is nice and smooth, but below the surface,  
14 there's all this paddling going on. And I think what this  
15 report shows is all the paddling that has to go on under  
16 the surface as we go forward.

17           But there's two things I wanted to highlight, and  
18 one had to do with the high-acuity patients and on that and  
19 the regulatory reform. So, on page 58, you lay out a  
20 scenario of providers facing specific set of regulatory  
21 requirements that might have to go after or deal with high-  
22 acuity patients. And, as I read this, I thought are we

1 coming -- I know this is not the intent, but when I read  
2 it, it seems like we're coming back to silos again, that  
3 we're saying here's this system out here, but for some of  
4 these high-acuity patient, we do need to create silos  
5 because of just the nature of who they are.

6           So two questions on this part, and then I have a  
7 second thing I want to raise, is, do we think the risk  
8 adjustment model as we talk about the refinements would  
9 capture this, or do we think that because of the  
10 development or the requirement of specialty equipment to  
11 deal with these high-acuity patients and the sunk cost  
12 these facilities are going to have -- are they going to  
13 need a special payment in order to make sure that we have  
14 access for these patients? This part kind of bothered me,  
15 and I'm just curious of your thoughts on that.

16           DR. CARTER: So the model did pretty well for  
17 some kinds of high-acuity patients, but not the highest  
18 acuity. So things like ventilator patients, the model was  
19 fine with those. You can predict who those are, and they  
20 get their share of costs, and their payments come out all  
21 right.

22           It's for the patients who have kind of multiply

1 occurring, and we did have -- in one of our medical  
2 complexity groups, we had patients who had five or more  
3 different body systems, and the model predicted cost for  
4 those pretty accurately. But it's for these -- we didn't  
5 model every combination, and Alice's group is an example of  
6 that, where there are probably many combinations of very  
7 expensive conditions that we may not be capturing  
8 accurately. With more time, you might be able to refine  
9 the risk adjustment that does a better job with the -- if  
10 you want, the tail of the distribution, right, because  
11 that's at that point who we're sort of talking about.

12 MR. KUHN: I mean, to me, as I think about it,  
13 the reason CMS or Congress created LTCHs and IRFs was for  
14 these unique patients --

15 DR. CARTER: Right.

16 MR. KUHN: -- and by kind of doing some of the  
17 specificity we have here on page 58, are we kind of re-  
18 creating those kind of entities again as part --

19 DR. CARTER: Well, I guess I see it as, if you  
20 have a payment system that's paying fairly for those cases,  
21 then you might actually encourage SNFs to take them,  
22 whereas right now SNFs typically don't -- some do, but it's

1 not a common place where they're talking very medically  
2 complex cases.

3           For SNFs, their payments might actually increase  
4 for those types of cases, and so you might see a broader  
5 set of providers, not just LTCHs, going after -- I mean,  
6 wanting to treat those medically complicated cases.

7           Now, what you've said is right. Some of those,  
8 you can't just decide tomorrow you want to go into that  
9 business. It takes staffing and equipment, and so the  
10 payments need to be adequate to allow for that kind of  
11 investment.

12           MR. KUHN: Thank you.

13           DR. MILLER: We spent a fair amount of time  
14 talking about this both internally and, you know,  
15 externally with groups and also, to some extent, with CMS.  
16 And I think about it two ways. You know, one is, can you  
17 get your payment system to track this kind of patient and  
18 your payment cover their cost in some reasonable way, and  
19 we're saying, mostly, when you stress test it by groups,  
20 you can and it looks like there are some that you're  
21 probably going to need further refinement. And, of course,  
22 the functional status data is supposed to help with some of

1 that, which we're working with very paltry versions of it  
2 or no versions of it in some of our impact models. So, the  
3 first thing is the very exercise of the impact act is to  
4 collect this data, which is supposed to help you with  
5 details of the distribution.

6 Two, you probably always are going to have some  
7 sets of patients in which that's why you have an outlier  
8 policy, that, you know, you probably won't ever get them  
9 100 percent correct. You'll have some reinsurance.

10 Then the regulatory environment is the way it's  
11 gone, as people said, well, an IRF looks like this, an LTCH  
12 looks like this, you know, have gone at it by silos, and  
13 you have to turn that on its side and say, if you want to  
14 take vent patients -- assuming now that the payment is all  
15 fine, which I realize is a gigantic assumption, but if you  
16 want to take vent patients, there are certain requirements.  
17 You know, you have to have a machine, you have to have  
18 staff, whatever the case may be, and you're sort of  
19 changing the regulatory framework this way, by category of  
20 patient, instead of this way, by silo. Now, I think that's  
21 a very easy conceptual thing to say. I think it is much  
22 more complicated to execute. And that, in the report, is

1 what we're trying to say, that CMS needs to now start  
2 thinking about categories of patients.

3           And I think your last exchange with Carol is  
4 really right. I mean, you may get different patients at  
5 different times, but if you're going to take certain levels  
6 of patients, you probably have to anticipate it, have those  
7 requirements present. It's not just from day to day that  
8 you're going to say, oh, suddenly, we'll enter the vent  
9 market tomorrow. I think you probably have to put some  
10 work into it.

11           MR. KUHN: Your explanation of kind of turning it  
12 on its side really, I think, is very helpful, because, I  
13 think as I said at the outset, when I read this part on 58  
14 about, oh, gosh, here we go back to silos --

15           DR. MILLER: [Off microphone.] Right.

16           MR. KUHN: -- I think maybe some different ways  
17 to characterize it or get that as part of that would help  
18 explain kind of what we're trying to talk about here.

19           DR. MILLER: [Off microphone.] The duck.

20           MR. KUHN: Yeah. Yeah.

21           [Laughter.]

22           MR. KUHN: Let's make sure the duck and the

1 churning under the water looks right.

2 DR. MILLER: [Off microphone.] I wasn't going to  
3 do the duck thing.

4 MR. KUHN: So, my second issue had to do with on  
5 page 35, and we talk in two sentences here about those  
6 patients that live in poverty, and we all know there's a  
7 disease of poverty out there and we talked about it here in  
8 terms of star ratings and socio-demographic status, et  
9 cetera.

10 I just think if there's a way we could kind of  
11 fill this section out and have a little bit more  
12 conversation about the impacts here and things that CMS  
13 ought to be looking at, I think would be helpful.

14 DR. CROSSON: I have Alice and then Warner and  
15 then Kathy. Craig, did I see you? No. Kathy and David.

16 DR. COOMBS: Thank you very much, Carol. This is  
17 excellent, a very nice novel.

18 I'd like to say a couple of things. About the  
19 high acuity, I think that Carol is right. If you were  
20 paying people to take care of high acuity, that's where we  
21 should be, and if the model does a great job of that, I  
22 think it's one of the things that's most important to me.

1 As we have talked about, the combination of the ventilator,  
2 the wound vac, and the dialysis patient, which are very,  
3 very high resource in terms of requirements in an  
4 institution.

5 One thing I do want to mention is that an LTCH is  
6 very good at weaning vents, and that's where ventilator  
7 patients should go preferentially. If IRFs and SNFs become  
8 better at some of these other things that LTCHs do, then so  
9 be it.

10 I would speak to -- I know Warner said something  
11 about demonstration, but I would even speak to early  
12 adopters, especially of the high acuity. They may actually  
13 leap at an experience, or leap at this as an experience to  
14 help cover their sicker patients, because it may be a  
15 system now where it's not basically covering the costs in  
16 the same way as the new system would. So, I'm thinking  
17 that a high acuity, high percentage institution with a lot  
18 of high acuity patients might find this a lot more  
19 attractive than the current system.

20 So, I support the outlier policy specifically for  
21 the fact that there may be disproportionate percentages  
22 within the community of the PAC, so that if you're in a

1 region where you might have more of the high acuity in your  
2 institution, then this would be very attractive.

3 I agree with Mary about this whole notion of  
4 having someone in an institution for 60 days and saying,  
5 okay, you're only liable for 30 days afterwards. I think  
6 that maybe there should be some consideration for  
7 lengthening that period to 90 days or 60 days. I mean, it  
8 doesn't have to be 90, but certainly longer than 30,  
9 somewhere in between.

10 And, in terms of the readmission rate, I am  
11 concerned about how that looks in terms of actually getting  
12 down into the weeds. We talk about readmission to, what,  
13 to the hospital, to one of the other entities. So, I know  
14 that for me, that becomes very important, because it tells  
15 you that there's no, you know, just chairs being moved  
16 around on the deck.

17 And then, lastly, the low-income subsidy. I am  
18 really concerned about what that looks like for  
19 impoverished under the system. You did a nice job with the  
20 chart. I mean, this is one of the most comprehensive  
21 things.

22 But, really, the last thing is right, site

1 neutral cost sharing. And, I know this is a very different  
2 thought, but if we're changing site neutral for patients in  
3 terms of the PACs, what are we doing for the beneficiary  
4 with their cost sharing? And, so, the regulatory has got  
5 to address that in some fashion.

6 DR. CROSSON: So, let me just ask one question  
7 here, because, Alice, you brought up something similar to  
8 the same point that Warner brought up about there being an  
9 opportunity. Warner, I thought I heard you saying  
10 something about like demos for institutions who either like  
11 this idea or are anxious to prepare for it to be given the  
12 opportunity to do that. It sounds reasonable.

13 However, we've got this statute that gives a  
14 timeline for the evolution of this policy, which is, you  
15 know, I mean, I think we were talking about 2023 for the  
16 final report. So, I mean, there's a pretty long period of  
17 time before we were to get there. Is the suggestion -- and  
18 I'd ask Mark to comment on this -- is the suggestion that  
19 we suggest that between now and the evolution of the final  
20 approach that CMS comes to, that there be some opportunity  
21 -- because I think that was inherent in what Warner was  
22 saying. Is that, within the context of the statute we're

1 dealing with, is that possible or not?

2 DR. MILLER: [Off microphone.] Some opportunity

3 --

4 DR. CROSSON: Some opportunity to -- so, for  
5 example, for CMS to say, you know, in order to help us  
6 learn what we want to do by 2022 or 2023, we're going to  
7 offer an opportunity for organizations to kind of --

8 DR. MILLER: [Off microphone.] Oh, the demo --

9 DR. CROSSON: Yeah, the demo idea --

10 DR. MILLER: [Off microphone.] I see.

11 DR. CROSSON: Be paid or regulated in this way.

12 DR. MILLER: [Off microphone.] Okay. So --  
13 actually, I'd like this answer not to be on --

14 [Laughter.]

15 DR. MILLER: -- since I'm making it up. I  
16 wouldn't expect, given -- I wouldn't see why, given their  
17 authorities, if they thought there was a targeted way to  
18 move ahead on this, they would be prevented from doing  
19 that. That would be a first reaction. You know, when I  
20 look at sort of demo, general demo authority or CMMI  
21 authority. So, I wouldn't see a reason why that couldn't  
22 happen. I'd have to think a little more out of public and

1 give you a really straight answer to that.

2 DR. CROSSON: Okay, thanks. Sorry to put you on  
3 the spot.

4 DR. MILLER: [Off microphone.] No, that's quite  
5 all right. It's what I'm doing here. But, Rita seems to -  
6 -

7 DR. CROSSON: Rita, on this issue?

8 DR. REDBERG: Yes. My only concern about doing  
9 that is you might get a very skewed view. I mean, it might  
10 be -- you know, the facilities that were doing the best  
11 under the current system and would not be, for example,  
12 overpaid over a PPS system, wouldn't be the ones that would  
13 go for a pilot, and we wouldn't really -- I mean, because  
14 it's encompassing, you know, so many different types of  
15 post-acute care facilities, I think without having a  
16 comprehensive pilot, we would not really learn a lot from  
17 having some started earlier.

18 DR. CROSSON: Okay. Thank you. I'm sorry.

19 DR. MILLER: Well, I'm sorry. I mean, to that  
20 end, for example, in the CMMI world, and Carol, you'll want  
21 to watch this carefully, you know, so for example, CMS went  
22 ahead with the joint replacement episode payment and it

1 wasn't voluntary. They identified geographic areas of the  
2 country it was going to happen. And, I think, in some  
3 ways, your concern was what drove some of that thinking,  
4 that if you get volunteers, you get a different group than  
5 if you said, okay, this is how it's going to work. That  
6 would still be a demo, although whether it's what you guys  
7 meant when you were saying, I'm not --

8 DR. CARTER: So, I actually meant more of early  
9 adopters that become a part of it spontaneously, not like  
10 the demo.

11 DR. MILLER: [Off microphone.] Then I think you  
12 do run into Rita's --

13 DR. CROSSON: So, these are good points. They  
14 speak to whether CMS would want to do this. What I was  
15 basically trying to establish was whether there was  
16 something in statute that would not have CMS able to do  
17 that, and it sounds like, at least on a preliminary  
18 analysis, it would be possible. Whether or not it's  
19 something that CMS wants to do is a second question.

20 Warner, I have you next.

21 MR. THOMAS: Just to build on that, and I think  
22 one of the challenges that we face, I think we will face as

1 an industry, is if we keep referring to patients as a SNF  
2 patient or a rehab patient or an LTCH patient versus a  
3 post-acute patient, because I really think that we need to  
4 change the mindset of, you know, you've got to have these  
5 different types of facilities to care for the patients  
6 versus, you know, facilities that want to extend to rehab,  
7 that want to extend to take care of a more acute patient  
8 and wants to get into the vent world because they feel like  
9 they could do a better job there.

10           So, I know there's regulatory challenges in doing  
11 that, which, I think, need to be addressed and ought to be  
12 referenced in the article. I still think this idea of just  
13 waiting until 2022 or 2023 to have a next report is  
14 extremely conservative and I would just encourage us that  
15 there's a lot of opportunity in the post-acute world to  
16 create a lot of benefit and value for patients, and I think  
17 this chapter, which, first, is excellent and I think it's  
18 great directionally, I would just encourage us to try to  
19 expedite some of the changes and that I think there's a  
20 real opportunity for patients here.

21           And, I think there's a real opportunity for folks  
22 that want to innovate in the post-acute world to do some

1 really interesting and creative things that could be  
2 different. Now, whether it's a demonstration project that  
3 is directed at specific regions, because we feel that's  
4 going to -- we're going to avoid bias in doing that, I  
5 mean, I think that would be a great idea. Perhaps it could  
6 be that and -- versus or -- it could be that and if there's  
7 folks that want to innovate on their own, we give them the  
8 opportunities to do that because they feel like there's an  
9 opportunity to do something different and better.

10           So, I don't think they're mutually exclusive, but  
11 I do think we ought to, in the chapter, try to create  
12 language that incents or guides the direction of this to  
13 move quicker than the timing that's outlined in the  
14 statute.

15           DR. CROSSON: I've got Kathy, David, Jack, and  
16 Sue. Kathy.

17           MS. BUTO: Okay. So, picking up a little bit on  
18 what Warner was saying, I recall Carol asking a question at  
19 the last meeting -- first of all, I support the chapter. I  
20 think it's wonderful. It's one of the best things I've  
21 seen on the topic and I think it will lead to comprehensive  
22 change in the post-acute care payment space and, I hope, in

1 the way that, eventually, those payments get bundled into  
2 episodes of care. So, I think it's just tremendous work.

3 I remember asking at the last session whether  
4 this approach, if taken, would sort of reduce the need to  
5 proceed with some of the refinements in PPS, and I was  
6 specifically thinking about SNFs and the payment that's  
7 driven by the amount of therapy that's provided and so on,  
8 and I know in the paper you deal with the level of payment,  
9 payment reductions that the Commission has recommended, but  
10 I wonder if we really -- if we do believe, because I think  
11 you said at the time, oh, no, those refinements would make  
12 it actually easier as a transition to something like this,  
13 than leaving everything in place until a final  
14 recommendation is adopted.

15 We're talking ten years before there will be  
16 anything new, because 2023 means that there will have to be  
17 legislation. Then there will have to be implementation.  
18 It's going to be 2026 or 2027 before they could actually  
19 begin a transition.

20 So, I'm wondering whether we want to, in a way,  
21 beef up our discussion of the kind of the glide path,  
22 whether it's a demo, which I think could be possible, you

1 could figure out ways to sort of take current payments and  
2 give some provider entities or health systems the  
3 incentives to manage the payments they're already getting  
4 across these various settings using some of the work that  
5 you've done, but at a minimum, CMS has been reluctant or  
6 hasn't moved ahead yet with some of these other changes  
7 that we've all talked about, and I'm wondering if there's  
8 some way to build a little bit more into this to say that  
9 would really actually make it easier to move into this  
10 system and then, ultimately, to an episode-based approach.

11 DR. CROSSON: David.

12 DR. NERENZ: Thanks, and again, great work on  
13 this.

14 I just have a couple of questions about the  
15 general issue of length of stay and the distributions of  
16 that and -- I have actually got a lot of questions. I  
17 don't want to ask them all here. But -- and I have to jump  
18 back by analogy to hospital and then I'll get right back to  
19 here, because it's all about prospective payment.

20 In the hospital arena, I think there's a general  
21 sense of when a patient is ready to go home. It has to do  
22 with free of infection. It has to do with maybe

1 ambulatory. It has to do with physiological stable. But,  
2 when you do a prospective payment system, you're basically  
3 trying to come up with a fair payment that would allow the  
4 hospital to get the patient to that point, and then you  
5 understand that there's a distribution of length of stay  
6 around that.

7           Now, in this arena, and maybe I just don't  
8 understand it as well, I'm less clear about when that point  
9 of readiness for discharge has occurred, and I also know in  
10 a lot of the background run-up to this, when we've looked  
11 at empirical distributions of length of stay, we see,  
12 frankly, goofy things, and they're clearly distorted by the  
13 current payment structure.

14           So, for example, you look at a distribution -- I  
15 forget which setting exactly -- you see it running along  
16 flat and all of a sudden there's a huge peak at 28 days.  
17 So, what's that? Everybody gets better at 28 days? How  
18 does that work?

19           [Laughter.]

20           DR. NERENZ: Now, clearly, this moves away from  
21 that, and this says, we're not going to link payment to a  
22 fixed interval like 28 days. But now I wonder, well, what

1 will the distribution of length of stay look like? What  
2 should it look like? And is there a way, other than purely  
3 mathematically, of saying, what is a long stay outlier?  
4 What is a short stay outlier?

5           So, again, I've -- why don't I just pause there  
6 for a minute and let you talk a little bit, because I guess  
7 where I think I'm going is that the chapter might include  
8 at least some discussion of what in a new environment we  
9 think the distribution should look like and what should be  
10 the appropriate marker of ready for discharge, and then  
11 I'll just come back to one more after that.

12           DR. CARTER: I don't know.

13           [Laughter.]

14           DR. NERENZ: Okay. That's good. That's good.

15           DR. CARTER: That would be my first answer. I  
16 don't know what's the right length of stay. I do agree  
17 with you that the current lengths of stay that we see are  
18 very unlikely to reflect what is the most appropriate care.  
19 We have SNFs that are paid on a per day basis. People,  
20 when I look at the data, are not magically discharged on  
21 day 21 when their copays kick in. You see a tiny blip, but  
22 it's not like a cliff. And LTCH length of stay

1 requirements obviously have an incentive for longer stays.

2 I mean, IRF and home health are already an  
3 episode basis, discharge basis, and so those lengths of  
4 stay, if anything, might be on the short end, right,  
5 because you're getting paid your set rate regardless of how  
6 long they're there or how many visits they get. Does that  
7 mean they're right or are they short? I don't know.

8 I do agree with you that it might be easier in  
9 the hospital world to say when somebody kind of is  
10 clinically ready to go home. I think there are clinical  
11 markers for that. I think when you're rehabbing somebody,  
12 particularly for a condition that's going to take a long  
13 time to recover from and maybe the patient is at a new  
14 normal, when somebody is ready to transition home may be as  
15 much a function of when is the family ready to take them  
16 home? Is the home set up for them to be ever to go home?  
17 I mean, I think there are other factors and I think that  
18 the continuum of post-acute care as people recover, rehab,  
19 may never recover to the prior functioning, I think does  
20 make it difficult to know when somebody's ready for the  
21 next setting, except to say that most benes would like to  
22 go home if they can.

1 DR. NERENZ: My only suggestion -- and it is  
2 quite vague -- is that as we move from what we currently  
3 have into this territory, we are clearly moving away, say,  
4 from paying for a day of care in this setting. But it  
5 would be nice to be able to say that what we think we are  
6 paying for is, say, an achievement of a certain clinical  
7 state or a certain functional state, and that's what this  
8 form of payment is about.

9 And then the only other question just on short  
10 stay, but it's just an extension of that, that what you did  
11 in modeling I thought was absolutely reasonable, and I  
12 don't know a specific way to do it better. But, again, it  
13 would be useful, if we possibly could, to be able to say  
14 rather than you just saying four or fewer visits on the one  
15 hand or the lowest 10 percent, which is kind of arbitrary,  
16 we say there's some other way of declaring a short stay,  
17 and particularly -- and this may be pie in the sky -- if we  
18 could distinguish a bad short stay from a good short stay.

19 So, for example, if in a given setting the proper  
20 state of function and independent ability can be achieved  
21 in a short period of time, we may say that's fine, and if  
22 you can do that under the basic prospective payment model,

1 great, go for it, do more of it. But that is different  
2 from saying let us just park somebody in one of these  
3 settings for two days, generate a full payment, and then  
4 move on. That is bad.

5 And I'm looking for a way to try to distinguish  
6 in some way between what might be an acceptable short stay  
7 and what is a bad short stay. And it may not be possible.

8 DR. HOADLEY: So I do support what we're doing  
9 here, and I think, as I said before, it's a really good  
10 report chapter. And I think somebody used the phrase, you  
11 know, this sort of creates a whole lot of guide posts that,  
12 you know, CMS and the policy community more generally can  
13 use to sort of shape this policy over the period of time.

14 I think the other point that a lot of people have  
15 spoken to is sort of the impatience that we have of, you  
16 know, these dates of 2023 and even later by the time you'd  
17 actually see that. And I think, you know, you did put in  
18 the chapter this time for our last discussion the notions  
19 of some transitional steps that could move to, you know,  
20 because we have seen some of the things you have modeled  
21 work as well as they do, that there's the potential to --  
22 and that's in there now.

1           I think the other way we can speak to that is in  
2 our annual discussions of our updates. Once we've got this  
3 out there, then that's kind of our -- somebody used the  
4 term "glide path" that we have established. Then we can  
5 say, well, in doing our update for, you know, whatever,  
6 2018, we can think about both levels, which, you know, we  
7 mostly aren't addressing here, but also about some of the  
8 changes we've already spoken to or that we would come to  
9 speak to, to say there are ways that the current system  
10 could be modified to get us closer to that glide path. And  
11 I think this can become a marker we use, you know, next  
12 December and January and the following Decembers and  
13 Januarys to sort of think about how we talk about this and  
14 reinforce what we're doing here.

15           The other specific thing on that -- and I know  
16 Mary and Alice both talked about the beneficiary cost  
17 sharing. I mean, right now, as you point out, there are  
18 some really wacky ways that cost sharing is set up in some  
19 of these different sectors, and they're so completely  
20 different, and maybe that's something that obviously you've  
21 made -- you've put the marker in here that that's an issue  
22 that needs to be thought about. Maybe that's something

1 that we could come back to, you know, a year from now or  
2 something to sort of -- and I know we've said some about it  
3 in past years, but it's something that at least could be on  
4 the agenda to begin to talk more about and think through  
5 those issues a little more than we've had time to do in  
6 this particular cycle. And maybe that's in conjunction  
7 with some of the other broader issues about benefit design  
8 that, you know, we may continue to come back to. But it's  
9 something that we could speak to, having put our market in  
10 it within this report.

11 DR. CROSSON: Thank you.

12 MS. THOMPSON: I, too, thought it was a great set  
13 of work, so thank you, Carol.

14 This is to go back to some of the comments Warner  
15 made about innovation. Within the alternative payment  
16 models that we have had to date, whether it be the Pioneer  
17 or now Next Gen, I think there's likely some learning that  
18 we could capture around particularly some of the regulatory  
19 relief given those models, three-day waivers around SNF.  
20 And to respond also to some of the issues that David  
21 raised, these sorts of models create all kinds of  
22 incentives for unrelated partners to suddenly become very

1 interested in becoming partners and understanding what  
2 costs are driving the overall spend. So I think it just  
3 sets a great foundation for all of that work. But I do  
4 think if we could get our hands on some of the learnings  
5 that occurred within Pioneer, we might be well served.

6 Also, on the rural front, I'm curious, because a  
7 number of the critical access hospitals run swing beds,  
8 which are SNF, and our experience has been they're some of  
9 the highest-cost SNF beds, creating stress. And so I'm  
10 reflecting also some of our discussion around the rural  
11 hospital issues that we have and wondering what's the glide  
12 path for those, because there's a lot of SNF beds in those  
13 settings, and yet I'm not sure how that in that cost space  
14 environment will transition to this PPS world.

15 DR. CARTER: Right, so we haven't specific -- I  
16 mean, this is mostly looking at who's on the PPSs, so we  
17 haven't really addressed that.

18 MS. THOMPSON: I know.

19 DR. CARTER: But I know -- the way that we talked  
20 about it a little -- it was an issue that Bill actually  
21 raised early on -- was it's kind of a model for a provider  
22 to use one bed in a couple of different ways. But in terms

1 of specific modeling, we haven't looked at that.

2 DR. CROSSON: Okay. Thank you very much, Carol,  
3 again, for an excellent report, but also the Commissioners  
4 for, I think led by Mary, a number of helpful suggestions  
5 to improve what is already a terrific piece of work.

6 As I mentioned before, our anticipation is that  
7 Carol will take these comments under advisement and we'll  
8 have a final paper to take a look at for the April meeting.  
9 And then we will be calling for a formal vote on the entire  
10 report so that it can be forwarded to CMS.

11 So what I'm going to ask right now -- and I  
12 haven't heard anything, but I just want to -- and this is a  
13 little unfair, I guess. But is there anybody, are there  
14 any Commissioners who foresee difficulty at this point,  
15 assuming what we have said about making adjustments, who  
16 foresee difficulty in support this report?

17 [No response.]

18 DR. CROSSON: Okay. Thank you very much, Carol.

19 We will now proceed to the public session -- I'm  
20 sorry. Where are we?

21 DR. COOMBS: Telehealth.

22 DR. MILLER: Telehealth.

1 DR. CROSSON: Oh, my gosh. Sorry about that.  
2 You guys tricked me.

3 [Laughter.]

4 DR. CROSSON: That means lunch is going to be  
5 late? Is that it? Okay.

6 [Pause.]

7 DR. CROSSON: So there is an agenda.

8 [Pause.]

9 DR. CROSSON: Okay. So, just so we can remember,  
10 one of the things we discussed at our July strategic  
11 planning session was the fact that there's a broad interest  
12 right now in the industry, in the policy community, among  
13 legislators and regulators around the issue of telehealth,  
14 which, again, is a term that encompasses a lot of different  
15 types of services.

16 So we are going to spend some time on telehealth.  
17 We've got Zach Gaumer, Ariel Winter, and Amy Phillips, who  
18 prepared a nice report for us, and then we'll have a  
19 discussion. Take it away.

20 MR. GAUMER: Okay. thanks very much. Good  
21 morning, everybody. Before we begin, I want to thank a  
22 couple of folks that worked on this: Jeff Stensland; Anna

1 Harty; and the MA crew, Carlos and Scott and Andy. This  
2 was a big team effort.

3           This presentation is a follow-up to our November  
4 discussion about telehealth services. Many of you have  
5 expressed interest in the topic, and we have also seen an  
6 increase in congressional interest in the last year. We  
7 anticipate this material will appear in an informational  
8 chapter in MedPAC's June 2016 report, and in that chapter,  
9 we will not make formal recommendations. However, a draft  
10 of the chapter will be circulated to you for review in the  
11 coming weeks, as Jim indicated.

12           Our goal today is to update you on new  
13 information and gather your thoughts on our principles and  
14 potential policy directions. As a part of this, we will  
15 remind you of our key points from November, identify what  
16 we have done to gather more information, update you on our  
17 new findings, and lead you to a couple of key discussion  
18 questions.

19           In November, we described telehealth as a multi-  
20 dimensional set of services. We described Medicare's  
21 coverage of telehealth under the fee schedule for  
22 physicians and other clinicians and specified that this

1 coverage is limited to rural locations and a specific set  
2 of services.

3 We also concluded that the use of telehealth was  
4 very low within Medicare but has been growing recently. We  
5 described how some employers and insurers were using  
6 telehealth outside of Medicare, and that the VA uses  
7 telehealth a bit more widely. We also concluded at that  
8 time that the evidence of telehealth's ability to expand  
9 access, improve quality, and reduce cost was mixed.

10 Since November, we have updated our Medicare  
11 claims data analysis, expanded our analysis of MA and  
12 bundled payment models. We've conducted a set of semi-  
13 structured interviews with several insurers and the VA. We  
14 traveled to Missouri to observe telehealth firsthand,  
15 expanded our literature search, conducted meetings with  
16 several vendors and advocates, and evaluated state and  
17 Medicaid telehealth programs.

18 Before we get into the meat of the raw material,  
19 I want to frame for you what we are talking about so that  
20 we are all speaking the same language here. We have  
21 updated how we define telehealth by grouping these services  
22 into six distinct forms. The first three categories on the

1 screen above pertain to basic medical care and the three  
2 lines of communication that occur. The fourth involves the  
3 remote monitoring of patients while the patient is in the  
4 hospital. The fifth involves remote monitoring of patients  
5 in their homes. And, finally, the sixth is store-and-  
6 forward telehealth, which is the electronic transfer of  
7 saved-patient images or video to a clinician.

8           Now, based on your questions, we expanded our  
9 analysis of Medicare claims data. Different providers are  
10 using telehealth for different types of services.  
11 Physician offices and health centers typically provide E&M  
12 visits via telehealth, and inpatient hospitals typically  
13 provide inpatient follow-up visits and ED consults via  
14 telehealth. A relatively small group of providers are  
15 using telehealth, and among this group, 1 percent of  
16 providers, or about 60 providers, accounted for 22 percent  
17 of all telehealth visits.

18           We also have new information on beneficiaries.  
19 Among the 69,000 beneficiaries that received telehealth in  
20 2014, they averaged three visits and \$182 per user.  
21 Roughly, 60 percent of these beneficiaries were dual-  
22 eligibles, and only 2 percent used more than one telehealth

1 visit per month.

2 We also identified that roughly 55 percent of all  
3 the telehealth episodes were missing originating site  
4 claims.

5 And, finally, we also observed that only 6  
6 percent of visits crossed state lines.

7 Telehealth is covered under other parts of the  
8 Medicare program. Under the MA program, plans must include  
9 coverage for all services covered under Medicare fee-for-  
10 service. Plans can cover additional telehealth services  
11 but must cover them as supplemental benefits. This is an  
12 important dynamic to understand. Fee-for-service telehealth  
13 services are included in the plan's bid amount, but  
14 supplemental benefits are not. This means that the cost of  
15 supplemental benefits are financed through rebate dollars  
16 or by charging an additional premium to beneficiaries.

17 While some insurers have expressed concern about  
18 the structure of payment for supplemental benefits, some  
19 plans are also offering telehealth services as supplemental  
20 benefits. This is discussed in more detail in the mailing  
21 materials.

22 CMMI permits the use of telehealth services,

1 beyond what is covered under the fee schedule, for some of  
2 their programs. To do so, CMMI provides a waiver to  
3 participants, and this waiver does vary from program to  
4 program. For example, the Next-Gen ACOs have a waiver to  
5 use the fee schedule telehealth services in the home and in  
6 the urban settings, and while one of the bundled payment  
7 programs, the BPCI, has an expansion waiver for urban --  
8 expansion of telehealth use in the urban setting.

9           Finally, we also want to make you aware of  
10 services such as remote interpretation of images and the  
11 monitoring of cardiac patients and devices. This was  
12 something you asked about in November. These services are  
13 widely used under the fee schedule.

14           Amy will now discuss our findings related to the  
15 non-Medicare setting.

16           MS. PHILLIPS: Thank you Zach.

17           Our interviews and site visit gave us insight  
18 into telehealth outside of Medicare. We talked to 12  
19 insurers and systems and 4 hospitals whose findings I'll  
20 now discuss.

21           Across the board, the reasons for wanting to use  
22 telehealth were similar: increasing quality, access, and

1 convenience with the hopes of cost savings. We also found  
2 among the major players that cost-sharing varied greatly.

3           Several large commercial insurers have been using  
4 telehealth services more regularly. Their rationale for  
5 doing so is that the clinicians and employers are  
6 requesting it be offered so they can increase enrollee  
7 convenience.

8           In general, insurers tend to focus their coverage  
9 of telehealth on primary care, especially after-hours care  
10 since they believe using telehealth for primary care is  
11 likely to result in keeping their enrollees out of the ED.  
12 Some said that the impact of these services on costs is  
13 currently inconclusive, but they also anticipate that the  
14 utilization will increase and more data will become  
15 available in the next year.

16           To provide basic primary care services, many  
17 insurers either contract with telehealth vendors or hire  
18 health systems or even staff their own clinician call  
19 centers.

20           Many insurers said that they don't pay telehealth  
21 services differently from face-to-face visits.  
22 Additionally, several insurers said that they sometimes

1 restrict telehealth services that are reimbursable under  
2 fee-for-service models because they believe these services  
3 are more compatible with capitated payment models.

4           Numerous large health systems are also advancing  
5 telehealth by producing products to distribute within their  
6 systems as well as to sell outside.

7           Many systems have implemented hospital-based  
8 telehealth service because they intend to link their  
9 various facilities, clinics, and physician groups with one  
10 another to share resources.

11           The services typically come in two forms,  
12 hospital-based telehealth which includes stroke care, ICU  
13 care, and hospitalist care, and then telehealth services  
14 including basic medical care such as case management and  
15 primary care.

16           Most systems are not currently receiving any  
17 reimbursements for these activities from private insurers  
18 because they said that this might be because telehealth is  
19 more compatible with a capitated payment model.

20           Health systems said that developing telehealth  
21 networks within their own systems requires capital  
22 investment.

1 However, they have also said that rural hospitals seeking  
2 to develop their telehealth infrastructure have been able  
3 to turn to federal grants.

4           As we told you in November, the VA has been  
5 experimenting with telehealth programs for over a decade,  
6 and in 2015, the VA's telehealth program served more than  
7 736,000 veterans. VA staff stated they implemented  
8 telehealth programs for two particular reasons. First,  
9 individual clinicians were interested in exploring new  
10 technology options, and second, they wanted to broaden  
11 access and convenience for veterans.

12           The VA currently has several nationwide  
13 telehealth programs, and further detail can be found on  
14 your slide and in your mailing materials.

15           It's worth noting that the VA's program has  
16 utilized cost-sharing as a mechanism to incent utilization  
17 of telehealth services by waiving or lowering copayments  
18 for certain telehealth programs. It's also important to  
19 consider the VA's unique characteristics that may have  
20 allowed them to implement telehealth.

21           The VA is a global payment system as well as an  
22 integrated system of facilities and clinicians, and under

1 the VA, the medical licensure of clinicians is federally  
2 administered and not beholden to state border limitations  
3 of practice. Despite the self-reported successes, there  
4 has yet to be a robust study showing the costs and quality  
5 of the VA's telehealth programs.

6 State-level policy related to the parity of  
7 telehealth services as well as Medicaid coverage of  
8 telehealth vary considerably from state to state.  
9 Telehealth parity laws are those that require equal payment  
10 for telehealth visits as for their face-to-face  
11 counterpart.

12 In 2016, 28 states have telehealth payment parity  
13 with commercial insurance in effect. This number doubled  
14 over the last four years.

15 The majority of Medicaid programs cover some form  
16 of telehealth services in 2016, but there is wide variation  
17 in the extent to which telehealth is covered, including  
18 states that have cover none and others that have no  
19 restrictions.

20 State Medicaid programs that do choose to cover  
21 telehealth services are still held to state licensure  
22 requirements which vary from state to state.

1           At our last presentation in November, we went  
2 over the evidence of the efficacy of telehealth services.  
3 After further study, we have arrived at the same place with  
4 more evidence, which was detailed in your mailing  
5 materials.

6           Several studies and discussions with stakeholders  
7 have reinforced that telehealth services do appear to  
8 improve access and convenience for both the patients and  
9 the providers. This applies to both urban and rural  
10 patients who have limited access to specialists or  
11 facilities and face travel inconveniences.

12           A report released for comment by the Agency for  
13 Healthcare Research and Quality this past December  
14 concluded that among the 44 of studies they reviewed,  
15 telehealth interventions aimed at patients with chronic  
16 conditions and behavioral health needs produced some  
17 successes. However, they also said that more studies are  
18 needed, especially those aimed at hospital-based  
19 telehealth, pediatrics, primary care, and in payment models  
20 where risk is shared.

21           More targeted research from unbiased sources  
22 needs to be conducted to determine efficacy and, in

1 particular, cost savings.

2 I will now pass things off to Ariel.

3 MR. WINTER: Over the next few slides, we will  
4 review Medicare's coverage of telehealth services under  
5 different payment systems and explore some principles for  
6 expanding coverage.

7 Under fee-for-service, as Zach described earlier,  
8 Medicare pays separately for each discrete telehealth  
9 service.

10 As with any other service under fee-for-service, providers  
11 have an incentive to increase use of telehealth, regardless  
12 of the impact on total spending.

13 CBO has stated that expanding coverage for  
14 telehealth could increase or decrease spending, depending  
15 in part on whether telehealth services would reduce the use  
16 of other Medicare services or would be used in addition to  
17 currently-covered services.

18 If policymakers want to expand telehealth  
19 coverage under fee-for-service, it might make sense to  
20 focus on services with low potential for unnecessary use.  
21 One example is tele-stroke services in which a neurologist  
22 in a remote location evaluates a patient using two-way

1 video to determine if they've had a stroke and whether the  
2 stroke can be treated, can be treated with tPA, a clot-  
3 busting drug.

4           Because tele-stroke services are limited to a  
5 specific condition and a small window of time, they are  
6 less likely to be overused. In addition, the Commission  
7 discussed in November the idea of a per-member per-month  
8 partial-capitation payment for primary care visits. This  
9 payment would give providers more flexibility to structure  
10 care, such as allowing them to use telehealth services.

11           Next, we will talk about bundled payment models  
12 and ACOs.

13           CMMI has developed new bundled payment models  
14 that allow for expanded use of telehealth. In these  
15 models, providers are at risk if total spending per episode  
16 exceeds the target price set by Medicare. Therefore,  
17 providers have an incentive to use telehealth services if  
18 they reduce episode spending or improve quality of care.

19           The Next Generation ACO model is a new model in  
20 which ACOs accept two-sided risk. As Zach described  
21 earlier, Medicare will pay for telehealth services provided  
22 by these ACOs to patients living in both rural and urban

1 areas, in their home or place of residence. Other ACOs do  
2 not have this waiver. They may choose to provide extra  
3 telehealth services not covered by Medicare, but Medicare  
4 will not pay for them separately.

5 Next, we'll discuss Medicare Advantage.

6 As we described earlier, telehealth services  
7 covered by fee-for-service Medicare are included in each  
8 plan's bid amount for Part A and B services. But if plans  
9 want to offer additional telehealth services not covered by  
10 Medicare, they must be financed with rebate dollars or  
11 additional premiums.

12 An important question is whether to allow plans  
13 to include these additional services in their bid amounts.  
14 It is unclear if this would cause the net bid to go up or  
15 down. This would depend on whether telehealth would  
16 increase or decrease overall spending represented by the  
17 plan's bid. If telehealth increases overall spending and  
18 the bid goes up, this would reduce the amount of rebate  
19 dollars and Medicare savings. Conversely, if the bid goes  
20 down, this would increase rebate dollars and Medicare  
21 savings.

22 Another implication is that the MA benefit would

1 no longer be comparable to fee-for-service benefit because  
2 the MA benefit would include additional telehealth  
3 services, and this could set a precedent for including  
4 other services in MA but not fee-for-service.

5 One option to think about would be to give the  
6 Secretary discretion to allow MA plans to include  
7 additional telehealth services in their bids.

8 As we said at the beginning, we are aiming for a  
9 chapter in June, in the June report, with no  
10 recommendations. However, you may want to lay out policy  
11 principles for a possible expansion of telehealth coverage.

12 Here, we gave listed some potential principles  
13 for your discussion. In context of fee-for-service, should  
14 Medicare cover services that expand access to timely care  
15 and have low potential for unnecessary use? Should  
16 Medicare allow primary care providers to deliver additional  
17 telehealth services under a PMPM partial-capitation model?  
18 In context of bundled payment models and ACOs, should  
19 Medicare expand coverage of telehealth if providers are at  
20 risk for total spending for an episode of care or a  
21 population? And, in terms of Medicare Advantage, should  
22 Medicare allow MA plans to include additional telehealth

1 services in their bid amounts?

2 Thank you, and we'd be happy to take any  
3 questions.

4 DR. CROSSON: Thank you very much. I want to  
5 start with one comment and one question for Amy on Slide  
6 12. The cost-of-care bullet, evidence is mixed, I would  
7 guess that the evidence would be mixed. I'm making this  
8 up, of course. You actually have facts. I would guess  
9 that the evidence would be mixed at least with respect to  
10 the payment system involved, right? I mean, so roughly on  
11 the fee-for-service side, as you've mentioned in the  
12 presentation, there might be an incentive to provide extra  
13 services, but in the presence of capitation or some other  
14 form of risk-based prepayment, population payment, the cost  
15 experience might be different.

16 So did you find that, or is there simply not  
17 enough observations at the moments?

18 MS. PHILLIPS: So we did see that there were  
19 different cost variations, depending on the size of -- if  
20 it's a health system integrating it, if it's an insurer.  
21 So where it's coming from, there is variation, who is  
22 paying and what type of technologies they were using and

1 the cost of those technologies and the infrastructure they  
2 needed to develop around them. And then most people we  
3 talked to when we asked, "Do you have results yet?" they  
4 said they're coming. They're still gathering the data.  
5 They're still trying to calculate those. So that will be  
6 coming, hopefully, in the next year or two.

7 DR. CROSSON: Thanks very much.

8 So just to kind of reinforce the last slide and  
9 then to be clear what we're doing here, we are reviewing  
10 telehealth. As noted, we've done that now the second time,  
11 and we are evolving some ideas. But the chapter is not  
12 going to contain recommendations around telehealth, per se.  
13 That doesn't mean that as we approach a particular payment  
14 sector, Medicare Advantage, physician payment under fee-  
15 for-service, et cetera, we may very well -- that we would  
16 and may very well elaborate a recommendation later on that  
17 relates to telehealth. So the notion here is we're not  
18 going to be elaborating recommendations on telehealth as an  
19 isolated policy arena, but using this information in our  
20 discussions, we may very well gravitate over time to  
21 telehealth-related recommendations related to specific  
22 payment sectors within the Medicare program.

1 All right. So clarifying questions. I see  
2 David, Bill, Mary, Kathy, Scott.

3 DR. NERENZ: Thanks. If we could go to Slide 7,  
4 please, just a question about the MA context. The framing  
5 of this suggests that we're still in an environment where  
6 the providers are being paid on fee-for-service or some  
7 sort of similar basis. So there's a question of whether  
8 the thing is a covered benefit because there's a  
9 transaction, there's a bill.

10 If the providers are paid on capitation and  
11 they're not billing the MA plan, in that environment can a  
12 provider do basically whatever he/she/it wants regardless  
13 of whether it's a covered A/B benefit or regardless of  
14 anything?

15 MR. GAUMER: Yes. So MA plans have the broad  
16 ability to do what they want.

17 DR. NERENZ: But in this case, I'm thinking about  
18 does the provider have the ability to do what he or she or  
19 it wants if the provider is paid on capitation.

20 MR. GAUMER: That is my understanding, yes.

21 DR. CROSSON: I guess I would wonder, though,  
22 David, whether or not that's a function of the relationship

1 between the plan and the providers and what rules are set  
2 up there or not.

3 DR. NERENZ: That's exactly what I'm asking but--

4 DR. CROSSON: Okay. All right.

5 DR. NERENZ: The whole large context here is that  
6 there are some restrictions, and I'm just trying to say is  
7 there a particular kind of contractual and payment  
8 environment in which there are no restrictions, and I was  
9 just imagining that might be one.

10 MR. GRADISON: I recognize your caveat that some  
11 of these things are for later, but what I'm wondering about  
12 is this: Obviously, the cost concern is a big one,  
13 particularly in the fee-for-service context. And I've been  
14 trying to think about how that concern could be dealt with  
15 by requiring this be on a revenue-neutral basis. Have you  
16 given any thought to that and how, if one did want to go  
17 that way, how it could be structured? That is to say,  
18 budget neutral against what, is the one that I got a little  
19 bit hung up on in my own thinking. But a way to reassure  
20 people this is not going to get out of hand because it is  
21 all coming out of the same pot, folks.

22 MR. WINTER: I think that would be a task for CBO

1 to estimate whether any particular fee-for-service  
2 expansion would be budget neutral or save money or cost  
3 money. And they've laid out the principles, and one of  
4 them I touched on, which is with the particular new  
5 telehealth service, would it substitute for an existing  
6 service or be supplemental to additional -- would it be  
7 used in addition to currently covered services? And then  
8 the other factor they would consider is what would be the  
9 payment rate for these new telehealth services. So these  
10 are the factors they would consider, but they have not, you  
11 know, to my knowledge, estimated the cost of specific bills  
12 that have been introduced recently.

13 MR. GRADISON: What I'm really wondering is could  
14 we almost bypass that question by saying we really don't  
15 know but we'll protect the trust fund by requiring it be  
16 revenue neutral.

17 MR. WINTER: One option there to think about  
18 would be in the context of bundled payment where the  
19 providers or organizations are at risk if spending is above  
20 some kind of target price, then, yeah, in that case the  
21 trust fund would be protected. And in a couple of models  
22 that we've talked about, CMMI has given waivers to

1 providers that are participating in those models to have  
2 more flexibility to provide telehealth than currently  
3 exists.

4 MR. GRADISON: But coming back to what really  
5 where my thinking kind of runs up against a brick wall is  
6 how to make that work in traditional fee-for-service.

7 DR. MILLER: Right, and so --

8 MR. GRADISON: And I don't have an answer, but --  
9 and I'm not saying this is the right time to approach it,  
10 but I hope you give some thought to that because the way  
11 it's been going on, I don't know when we'll get information  
12 that would provide a sufficient comfort level that this  
13 won't blow the budget apart to permit moving ahead in a  
14 more -- in a broader manner.

15 DR. MILLER: All we can offer you at this point  
16 is, you know -- and this is what we were trying to say in  
17 the fee-for-service part of the conversation. If there's  
18 an urge -- and you immediately pick up on in a bundled  
19 environment, an ACO, you know your population, you know  
20 your top line, so you can begin to give flexibility and say  
21 keep your top line in mind and give the provider  
22 flexibility.

1           I think what we're trying to say to the  
2 Commissioners on fee-for-service is if there's an urge here  
3 to do something, then think about it two ways: one, are  
4 there populations and services where you're pretty clear  
5 that the risk isn't there? People aren't trying to have  
6 strokes, and so telestroke may not be a place where you're  
7 going to see a ton of unnecessary services. You know,  
8 somebody who takes home hemodialysis, you know, again,  
9 maybe that's a population that they were doing telehealth  
10 visits, again, that's a population that, you know, you're  
11 not going to see explode overnight.

12           And then the other thought is as you -- and this  
13 is what Jay was saying. As you move through other parts of  
14 the work and you create in a sense almost little safe  
15 harbors, so you go to PMPM for primary care, and you say I  
16 have a new way of paying, by the way, I just drew a  
17 boundary around a block of dollars, so now maybe  
18 telemedicine could go on there because the program is  
19 indemnified.

20           But it's definitely kind of retail work as  
21 opposed to your question, which is, can I just put a global  
22 limit on it, which I haven't thought through.

1 DR. CROSSON: Right, and although we're drifting  
2 a little bit into Round 2 here, one could imagine, you  
3 know, at least retroactively, looking at the escalation of  
4 telehealth services and using that information to inform  
5 update recommendations for physician services or  
6 institutional services as one factor. It's imperfect, but  
7 that's a possibility.

8 DR. NAYLOR: So I'm going to try to, in Round 1,  
9 the AHRQ work, and building on your comment about what CBO  
10 is looking for, of those 44 studies how many were looking  
11 at telehealth and its multiple dimensions and modalities as  
12 supplement to face-to-face visits versus in addition to?

13 MS. PHILLIPS: So most of the studies that they  
14 narrowed it down to -- so they started with over 1,000  
15 citations for telehealth mentioned, and then they put it  
16 through what they considered what are the good studies,  
17 what has the appropriate sample size, what has a randomized  
18 controlled trial style, and that's how they got to the 44.

19 As far as looking at how it applied to costs and  
20 that sort of topic, they kind of mostly focused on the  
21 efficacy and the outcomes. So they were looking at what  
22 technology did they use, what clinical group did they work

1 with, and were the outcomes better for that population. So  
2 there wasn't much mentioned within those studies on if it  
3 was a supplement or a substitute.

4 DR. NAYLOR: Historically, the work has been  
5 studying something plus -- using telehealth in addition to,  
6 so--

7 MS. PHILLIPS: Usually. In addition.

8 DR. NAYLOR: So I just wanted to know the quality  
9 of the evidence about its full substitutional capacity.

10 MR. GAUMER: And I'll just add on to that. So in  
11 our November mailing materials, there was a little bit of a  
12 description about specific studies that are talking about  
13 exactly what you're describing. Great studies that -- you  
14 know, they're well constructed. They may show positive  
15 outcomes, but there's all kinds of things going on there,  
16 where there's case management and telehealth and maybe a  
17 small population, and it's real specific.

18 And so, you know, our paper coming up, we will  
19 put that back in so you can see how it's itemized, so you  
20 can see the variation. And I think this maybe was also  
21 your question. None of these studies really individually  
22 looked at the big, broad scope of all six kinds of

1 telehealth and said, you know, voila, here's the answer.

2 DR. NAYLOR: Thank you.

3 MS. BUTO: Two questions. One, how much can the  
4 Secretary do to address these issues? I realize that PMPM  
5 payment is not something that the Secretary, I think, has  
6 the authority to do unless there's additional legislation.  
7 I'm not sure about that one. So that's one question. How  
8 much could already be done within discretion?

9 The second one is MA, which mystifies me, why MA  
10 plans can't -- since they are at risk, can't simply  
11 substitute telehealth where they think it's appropriate  
12 without having to charge a supplemental premium or use  
13 savings dollars to fund that added benefit. I mean, they  
14 decide they'd rather have a telehealth visit than a face-  
15 to-face visit, they've already priced out in their premium  
16 bids the face-to-face visits that they expect to have. Why  
17 wouldn't Medicare allow that when under bullet two in a  
18 bundled payment environment we might suggest broader  
19 coverage as possible? I mean, it's the ultimate bundled  
20 payment environment. I'm just trying to understand why,  
21 unless there's a restriction in the statute.

22 So, you know, question one is: How much

1 discretion? Question two is: Why is MA more restrictive  
2 than bundled payment?

3 MR. GAUMER: So I can take -- I see you want to  
4 get in, maybe, but I can take -- okay.

5 First question, the answer is a lot of the rules  
6 here around telehealth are written into statute, and so the  
7 rural, the types of services, originating sites, a lot of  
8 that is written into statute. So a lot of it's covered,  
9 and the Secretary does not have a ton of discretion.

10 However, there have been some services over the  
11 years that have been added by the Secretary, so there's  
12 some wiggle room there, and this is maybe an answer to  
13 question 1(b), getting us to part two, which is under MA,  
14 you know, we've heard from CMS that they don't have the  
15 discretion to allow telehealth to be included as -- to  
16 waive telehealth into the fee-for-service benefit. They  
17 would need Congress to do that.

18 MR. WINTER: With the exception of CMMI, which  
19 has authority to waive restrictions for their team and  
20 models.

21 DR. MILLER: I just want to parse through your  
22 comment a little bit, because I think there's an issue of

1 whether they can include it in the bid versus whether they  
2 can do it. And so I want to be sure that it's clear in  
3 your mind.

4           To the extent that an MA plan bids on the  
5 traditional fee-for-service benefit and they come in, blow  
6 the benefit, they get the difference between their bid and  
7 some portion of the difference between their bid. And with  
8 all of that block of dollars, they can do telemedicine.  
9 There's nothing that restricts them from doing it. Well,  
10 you used the term of like why is it more restricted, and I  
11 want to make sure. They can do that. But what the managed  
12 care plans, some of them at least, are saying is they don't  
13 want to bid on the traditional fee-for-service and pay for  
14 that with the -- or use the traditional fee-for-service bid  
15 and have to use their bid dollars and their rebate dollars.  
16 They want to just build it into the bid. That is at least  
17 one of the issues that's floated, and that's what he's  
18 talking about, the Secretary is saying, well, wait a  
19 second, the bid is supposed to be traditional A/B. And, on  
20 the one hand, you might say, okay, what's the big deal? In  
21 theory, if telemedicine saves money, that bid should, you  
22 know, in some ways not even change or go down. But to the

1 extent the bid costs money, like it doesn't actually save  
2 money, then what you're doing -- and I'm sorry for this  
3 highly scientific graph that you have to work with here --  
4 then the bid goes up, and the difference between the  
5 benchmark means that what you're getting in rebate dollars  
6 or other extra benefits goes down. And you're also making  
7 a comparison between a traditional fee-for-service benefit  
8 and a not traditional one. And that's the issue that some  
9 people are talking --

10 MS. BUTO: Okay. I totally get that. You don't  
11 want to have them bidding on a different benefit --

12 DR. MILLER: Well, maybe [off microphone].

13 MS. BUTO: What I'm trying to say, Mark, is if  
14 you're a plan and you're bidding on traditional Medicare  
15 and this is your bid, why do you have to use supplemental  
16 dollars to cover telehealth if you think it's going to save  
17 you money to deliver -- and, by the way, you've got to meet  
18 all kinds of quality benchmarks -- if you think you're  
19 going to be able to deliver the same package but use more  
20 cost-effective methods? You can use more nurse  
21 practitioners. You can do a whole lot of other things.  
22 Why can't -- why don't you have the flexibility to use

1 telehealth if that makes sense and you can meet and exceed  
2 quality expectations? Why do you have to use supplemental  
3 dollars? That's my question

4 DR. MILLER: Remember [off microphone] -- sorry,  
5 and, Carlos, I need line of sight here so get out from  
6 behind Carol. In fact, you might drift over towards one of  
7 the tables. You know, just start to shamble on over.

8 Okay. So back to this discussion. I'm sorry  
9 this is complicated. As I understand it, Carlos, they are  
10 not required to do supplemental dollars. If it has an  
11 additional cost above what they can get from the bid and  
12 the rebate dollars, then they have to, as I understand it.

13 MR. ZARABOZO: Yes, and part of the reason we're  
14 having this discussion is plans have said, "We need to be  
15 reimbursed for this." So to the extent that they say, "We  
16 need to be paid for this," or "We need extra revenue for  
17 this," that kind of suggests that it's costing them money.  
18 But as Mark pointed out, when you do the bid-to-benchmark  
19 comparison, it is strictly the Medicare benefit package,  
20 the A/B benefit package.

21 MS. BUTO: So what you're saying is they do have  
22 the flexibility, if they want to, to use telehealth as long

1 as they're only bidding on the Medicare benefit package and  
2 they don't think it's going to cost them money. So, in  
3 other words, if they think it's going to be a saver, they  
4 can do the substitution.

5 MR. ZARABOZO: Well, to get to David's question,  
6 if, for example, even in the capitation model, physicians  
7 say, "Well, at the end of the day I spent half an hour  
8 emailing with my patients," and so in capitation they're  
9 getting a salary, let's say, then they say, "Well, you know  
10 what? It's now expanded to an hour, it's expanded to two  
11 hours. I, in fact, look like I think I need an adjustment  
12 to my compensation." So there is a way in which, well,  
13 this actually turned out to be an extra service and it cost  
14 more. So even in that sort of protected capitation  
15 environment, there may be a result where now you've gone  
16 beyond the Medicare benefit package. So, yes, it's costing  
17 you money.

18 What happens underneath, it's kind of hard to say  
19 what happens underneath.

20 DR. MILLER: But the direct answer to her last  
21 comment is yes, as long as they are, you know, within their  
22 bid and within their extra dollars, they're free -- I mean

1 rebate dollars. I'm sorry. They're free to do it. If it  
2 starts to run into, "Well, I need to get compensated for  
3 it," the current rule is you have to go to a supplemental  
4 dollar -- or supplemental premium. And some plans are  
5 saying, "But I want to build that in" -- and, again, I  
6 don't have a complete -- I think this -- you know, if you  
7 want to, we can -- or you may never want to speak of this  
8 again. I could understand that reaction as well.

9 [Laughter.]

10 DR. MILLER: If you want to discuss it, there are  
11 some puts and takes, and it's sort of like why this benefit  
12 relative to some other extra benefit built into the bid.  
13 And you guys could have that conversation, and we would  
14 guide you through that.

15 Are you okay, Carlos? And no damage done here?

16 MR. ZARABOZO: No [off microphone].

17 DR. MILLER: All right. Then let's give Zach his  
18 seat back.

19 DR. CROSSON: Let me just mention -- can I bring  
20 this up?

21 DR. MILLER: Oh, no.

22 DR. CROSSON: Don't bring it up?

1 [Laughter.]

2 DR. CROSSON: There's some discussion about  
3 whether or not the basis for risk adjustment in MA should  
4 be changed from just the diagnostic coding to a combination  
5 of diagnostic coding and encounters.

6 DR. MILLER: Right.

7 DR. CROSSON: And so at least if I've got this  
8 right in my head, that raises another issue then as to  
9 whether or not these telehealth visits on the MA side are  
10 going to be counted as encounters or not. Right? So is  
11 that --

12 [Laughter.]

13 DR. MILLER: I'm really sorry -- yeah, I'm sorry  
14 about this, Zach. So, yeah, we heard that that question  
15 was floating around, and, Andrew, you and I had, what, a  
16 five-, seven-minute conversation about this?

17 DR. JOHNSON: Yes.

18 DR. MILLER: Do you want to run that tape?

19 DR. JOHNSON: So there is an explicit description  
20 in the encounter data that says that telehealth services  
21 are included in the types of physician services that are  
22 used as the source of diagnoses for risk adjustment, under

1 the current risk adjustment model, so that's going forward,  
2 and CMS is transitioning more and more to that. Under the  
3 current risk adjustment model, there isn't an explicit  
4 definition, but it is under the services that are covered  
5 under the A/B benefit in the MA setting. They're included  
6 in the risk adjustment model, by the way, that the plans  
7 submit their diagnostic information.

8 DR. CROSSON: Great. Thanks very much. We were  
9 at Scott.

10 MR. ARMSTRONG: My question was asked.

11 DR. CROSSON: Asked and answered.

12 DR. HOADLEY: So this one's probably going to be  
13 a question that doesn't have an answer, but I'll ask it  
14 anyway.

15 On one slide -- I think it was Slide 6 -- you  
16 talk about 69,000 beneficiaries who received a telehealth  
17 service, which is like a tiny tenth of a percent kind of  
18 share of Medicare. When you talked about the VA, it was  
19 like some 700,000, which I think is maybe 10 percent or  
20 something like that, a much, much higher share, whatever  
21 the right denominator is for the VA.

22 Did you get any sense from the privacy insurers

1 or anything from Medicaid of sort of what share -- I mean,  
2 I know you talked a lot about the different nature of how  
3 they're offering benefits, but of what share of their  
4 business or their enrollees are using these services?

5 MR. GAUMER: So, our view on what's going on in  
6 the insurance, commercial insurance market, is that more  
7 and more insurers are beginning to offer telehealth to  
8 enrollees, but the use is generally still quite low, not  
9 that there isn't interest. I think there's a data lag  
10 issue that's going on here, too.

11 There has been some work by the Health Care Cost  
12 Institute, HCCI. They are showing low use, like in the  
13 thousands of visits, which is quite, quite low. We've also  
14 looked at some of that data which shows similar data, maybe  
15 10,000 visits in a later year. But, there's really not a  
16 lot of evidence and what we have is that it's low right  
17 now, and just anecdotally, it sounds like it's low use, but  
18 growing.

19 DR. NERENZ: And, does it seem like it's low at  
20 sort of that tenth of a percent of people kind of level  
21 that we're at at Medicare, or is that too precise?

22 MR. GAUMER: I don't know that I can say. Do you

1 guys?

2 DR. HOADLEY: Yeah.

3 MR. GAUMER: But, it's probably beneath VA.

4 DR. HOADLEY: Yeah.

5 MR. GAUMER: Lower than VA, I would say.

6 DR. CROSSON: Cori.

7 MS. UCCELLO: I can't believe I'm going to do  
8 this.

9 [Laughter.]

10 DR. MILLER: [Off microphone.] Don't do it,  
11 then.

12 MS. UCCELLO: Get ready, Carlos.

13 DR. MILLER: [Off microphone.] Don't do it.

14 [Laughter.]

15 MS. UCCELLO: It was kind of asked and answered  
16 with the Kathy-Mark exchange, but just so I make sure I got  
17 it right --

18 DR. MILLER: Oh no --

19 MS. UCCELLO: If an MA plan includes supplemental  
20 telehealth benefits, we are not seeing evidence that the  
21 A/B bid goes down to reflect those benefits.

22 MR. GAUMER: I don't think we know the answer to

1 that question, and --

2 DR. MILLER: I'm going to go with we haven't  
3 looked at that to know the answer to that.

4 MR. GAUMER: So, one thing we have seen is that  
5 there are MA plans that are offering this as a supplemental  
6 benefit. I think in the paper we say 200 are using remote  
7 patient monitoring, or offering remote patient monitoring,  
8 and some -- to some very broad degree, something like 1,700  
9 plans are offering what's called remote access, which could  
10 be anything from, you know, the two-way video that we're  
11 talking about or nurse help lines. And, we kind of think  
12 that it's more of the nurse help lines that are going on  
13 here, maybe e-mails, too. But, you know, one shred of  
14 evidence here is that CMS has said that they're seeing a  
15 change in that remote access category and it's -- plans are  
16 becoming more sophisticated in moving from the nurse call-  
17 in lines, to the e-mails, to the two-way video.

18 DR. BAICKER: But, I would imagine, even if you  
19 looked at correlations between the bid and those services,  
20 it would be virtually impossible to tease out causal  
21 effects unless they really muck around with it now and then  
22 use that as an event study.

1 DR. MILLER: [Off microphone.]

2 DR. CROSSON: But, let me point out something  
3 else here that's sort of buried in here but may not be  
4 obvious, maybe or not. But, one of the variables is also  
5 how the plan pays the physicians, because it's the  
6 physicians who are deciding often, anyway, the modality of  
7 treatment. And if the physicians are paid fee-for-service,  
8 you've got one dynamic. And if the physicians are on  
9 salary or part of a capitated payment arrangement, you've  
10 got a different dynamic. So, looking at those all combined  
11 would be very difficult to tease it out.

12 Warner, I've got Rita first and then you.

13 DR. REDBERG: I have just some quick clarifying  
14 questions. On page 16 of the mailing material, it's  
15 talking about the waiver that allows originating sites to  
16 be in urban areas and says there's not information yet on  
17 how it's been used. Do we have any ideas on the take-up  
18 and when we would have information on that, because I could  
19 see that it could be applicable. I mean, there are urban  
20 areas that have, you know, lack of access for various  
21 reasons, particularly primary care.

22 MR. WINTER: Yeah. So, this relates to the --

1 that statement relates to the VPCI models, of which there  
2 are many.

3 DR. REDBERG: Right.

4 MR. WINTER: So, they came out with the report --  
5 the first evaluation report came out in February of last  
6 year, so I think we'll see another report sometime in 2016.  
7 I can't say when, and Carol is nodding her head, which is a  
8 good sign. So, sometime this year, and as soon as we get  
9 that, if it's in time for the chapter, we'll build it in,  
10 but I'm not convinced it will be in time for the chapter,  
11 in which case we'll come back to you with more information  
12 the next time we talk about this.

13 DR. REDBERG: And sort of on that same theme, but  
14 on the next page, talking about the next gen ACOs and their  
15 including telehealth, do we know when we'll get some --

16 MR. WINTER: Well, since that -- that model just  
17 got up and running in January, so I don't -- it's going to  
18 be a while before we have information. But, again, we'll  
19 keep track of it. As soon as we get any data, we'll come  
20 back to you.

21 DR. REDBERG: Because I'm certainly thinking we  
22 need more evidence before we can make any kind of informed

1 determination.

2           And my last question is on page 25 in the mailing  
3 materials. It was impressive that most of the telehealth  
4 visits, it seems, are for the younger and disabled Medicare  
5 beneficiaries, and is that because they're mostly mental  
6 illness visits, or do we know why there's such a -- because  
7 I notice in the previous a lot of the telehealth is used  
8 for psychiatric --

9           MR. GAUMER: Yeah. We don't have a connection  
10 between the two to speak of, but a lot of the visits are  
11 E&M visits that we're seeing, and a lot of these folks are  
12 also duals, as you probably read in the paper, as well.  
13 But, there is a large share of psych care going on and  
14 that's part of it. You know, often on a claim you'll see  
15 both E&M and psych care happening at the same time, and  
16 it's just that the E&M services far outnumber the psych  
17 care visits. Yeah.

18           DR. COOMBS: Zach, you mentioned about the  
19 disabled, too, and that was an overlap, so it might be that  
20 there's an overlap between the disabled and --

21           MR. GAUMER: Yeah. I think there probably is,  
22 although it's probably not exact. Yeah, because it's --

1 you know, all three of those groups are about 60 percent of  
2 the telehealth claims. So, they don't all overlap exactly,  
3 but mostly.

4 DR. CROSSON: Okay. Warner, and then Jon, I  
5 think, for the last question.

6 MR. THOMAS: So, mine is more of a, not  
7 necessarily a clarifying question. It is more of a round  
8 two. Is that okay to -- it's more of a comment versus a  
9 question.

10 DR. CROSSON: Let's hold that for round two.

11 MR. THOMAS: Okay.

12 DR. CROSSON: You can go first.

13 Jon has a question.

14 DR. CHRISTIANSON: Zach, you talked about,  
15 briefly, Walmart and the telehealth visit stuff and a very  
16 small copay for their employees and a much bigger copay for  
17 the customers. Did you get any sense of how these copays  
18 vary in the private sector? I'm just thinking about my own  
19 personal experience. It's set high enough to discourage me  
20 from using a telehealth visit. So, the plan I'm in  
21 apparently thinks this is going to overburden their  
22 providers and will add to their cost and something they

1 don't really want me to do, but they need to sort of have  
2 it out there. Did you get any sense in your visits and so  
3 forth how the copay structure might look in these?

4 MR. GAUMER: So, there is wide variation, and it  
5 seems as though some insurers and employers are jumping in  
6 with two feet and even offering this with zero cost  
7 sharing. I think some of the members of our staff have  
8 that option on their insurance plans. But, so, it varies  
9 widely, and we also see that when we did our kind of  
10 employer analysis, that the employers that use the vendors  
11 that have a flat fee for their service often pass that flat  
12 fee directly along to the consumer or to the patient, \$40,  
13 \$50, in that range. So, there's wide variation, and it  
14 looks as though some of the insurers and employers are  
15 using this as a convenience benefit and these low or zero  
16 dollar cost sharings are an incentive to get beneficiaries  
17 excited, you know.

18 DR. MILLER: [Off microphone.] And when we  
19 initially did this, Jon, our first round kind of ended up  
20 running into plans that were doing what you said, either  
21 full freight or kind of a large add-on. And then as we did  
22 more work, we started to see a lot of different variants on

1 that.

2 MS. PHILLIPS: And, additionally, with the VA,  
3 what we saw when we talked to them is that they even  
4 eliminated the copay when they were starting out with a lot  
5 of these programs to incentivize use and to get uptake in  
6 the population.

7 DR. CROSSON: Round one question. Question.

8 DR. SAMITT: A question. I promise it's round  
9 one. And I don't think this kind of question has come up  
10 often, because we usually do comparators within U.S. But,  
11 my sense is that there are some countries that are far more  
12 advanced in the use of telehealth than even the U.S. Have  
13 we looked at utility in other nations? You know, we don't  
14 have a lot of evidence within U.S., but have we looked at  
15 utility in other nations to see if there's evidence of  
16 effectiveness and utility of these services?

17 MS. PHILLIPS: I can say that while reading a lot  
18 of literature, I'd start reading and then realize it was  
19 talking about the U.K. So, they have been using it, but a  
20 lot of what I was reading by accident seemed to overlap  
21 with a lot of the same issues in terms of knowing the  
22 outcomes and knowing the actual quality and costs and

1 effectiveness, but --

2 MR. GAUMER: Yeah. I think some of the things  
3 that I've seen say that it's happening in other countries,  
4 the U.K. in particular, but there's not a lot of definitive  
5 evidence on this.

6 DR. CROSSON: Yeah. Amy, you can often tell,  
7 because they spell words funny in the articles.

8 [Laughter.]

9 DR. CROSSON: All right. So, I'm sorry I  
10 neglected to, Warner, neglected to remember that Alice and  
11 Herb had asked to go first, so we'll take Alice and Herb  
12 and then Warner, and then we'll have general discussion.  
13 We've got about 15 minutes.

14 DR. COOMBS: Okay. I can be brief. So, first of  
15 all, telemedicine is where it's at. I kind of brought this  
16 up because of tele-ICU and e-ICU, where it is very -- it's  
17 increasing dramatically.

18 And, some of the issues that might be challenging  
19 going forth is this whole notion of primary care and  
20 establishing a baseline physical examination. You can't do  
21 a physical examination baseline. So, I'm wondering if we  
22 need to have guidelines and frameworks for how telemedicine

1 is done in terms of primary care with the Medicare  
2 beneficiaries.

3           The specialties, I don't have a problem with  
4 psychiatry. There's a number of studies with nurses  
5 actually running COPD management, comorbid conditions.

6           The monitoring is really huge. I mean, there's  
7 too many studies in the literature -- I have some quotes  
8 here from different journals -- where monitoring has made a  
9 difference in terms of mortality, especially with the  
10 congestive heart failure patients.

11           And, just in reviewing some of the stuff you said  
12 about the Medicaid state policy, I looked up another  
13 Medicaid state which has a policy. It's Idaho, which was  
14 kind of interesting. You might take a look at that. And  
15 then the whole notion of the tele-doc and the vendors.

16           So, this is an area that is very prevalent in a  
17 big state in the Southwest and it is growing very rapidly.  
18 I just spoke to someone who's in primary care there and  
19 they were offered a job to make \$23 per patient when the  
20 patients are being asked to pay a copay of \$40 plus  
21 whatever the privates are paying the doc in the box, which  
22 they don't see, really. It's the business.

1           So, I mean, I think that it's going to grow, and  
2 if we have regulations that actually kind of prevent the  
3 kind of perverse incentives that might exist.

4           The other piece of it is that what we talk about  
5 access, I think it improves access in the sense that you're  
6 able to access the system. What it does for quality, I  
7 don't see a lot of strong -- especially in the primary care  
8 sector, I don't see overwhelming support yet. Maybe it's  
9 out there and I haven't seen it yet.

10           The patient experience is the other thing. So, I  
11 think that there are going to be a myriad of experiences  
12 based on the patient, but I'm also concerned with patients  
13 who have linguistic -- they have discordance. In other  
14 words, they, you know, Spanish-speaking patients in Texas  
15 is huge and what kind of access do they have for  
16 telemedicine and how do we deal with that.

17           The workforce dynamics are very interesting, and  
18 I'm only thinking about the Walmart issue, because if you  
19 put a program out there that takes all of the healthy  
20 patients to be seen at Walmart with a copay of \$4 and they  
21 might be part of another health care system where they're  
22 reluctant to get certain types of care, it might result in

1 some kind of fragmentation because there's not  
2 communications, there's not interoperability with systems  
3 in terms of the information that's seen at maybe a Minute  
4 Clinic or Walmart. So, I think that might impact  
5 continuity of care and care continuity, patient  
6 satisfaction, as well.

7           So, I like the low potential, being able for us  
8 to establish low potential for abuse, kind of where  
9 telemedicine should rein. There's probably a list of  
10 things like that, including the things that you mentioned,  
11 monitoring with code stroke, all in there.

12           DR. CROSSON: Thank you, Alice.

13           Herb.

14           MR. KUHN: So, let me make a couple quick  
15 observations, talk a little bit about the evidence, and  
16 then come back to these principles, because I think that's  
17 a good set-up on Slide 16.

18           So, on the observations, and I think Bill  
19 Gradison started this conversation, that if we add  
20 something here and it doesn't display something over here  
21 and people over here keep doing the same thing over and  
22 over again, we're just layering on. We haven't

1 accomplished anything. So, I absolutely agree with that  
2 line of thinking that we've had here today.

3           The second thing is, how do we create a set of  
4 incentives that we really incent and move forward the  
5 positive aspects of telehealth and call out the fancy  
6 things that really aren't effective, and, in fact, get away  
7 from the whole notion that everybody's trying to chase the  
8 latest shiny object, and, so, we're really focusing on the  
9 effectiveness here.

10           So, those would be the two kind of goals I would  
11 set up as I look at this.

12           So, when I look at evidence, I had a chance to  
13 talk to a number of the telehealth providers in our state,  
14 and let me just give you some of the things that they're  
15 seeing out there. So, when it comes to the issue of tele-  
16 stroke and the administration of TPA, the time of less than  
17 60 minutes from door to administration has improved  
18 dramatically as a result of that, and that's saving lives  
19 and I think that's a good thing and I think that's what we  
20 heard in the report.

21           When it comes to their engagement on sepsis, let  
22 me just share with you three numbers that they shared with

1 me. A 68 percent decrease in severe sepsis mortality, a 44  
2 percent decrease in septic shock mortality, and a 91  
3 percent decrease in progression to septic shock from severe  
4 sepsis. That's real improvement out there.

5           When you look at the areas of EICU and  
6 monitoring, you know, for every dollar spent, they're  
7 saving \$3.70 on the back end. I mean, it goes on and on.  
8 So, I think there is some growing evidence out there.

9           And, I guess what I would ask is when we talked a  
10 little bit earlier about the AHRQ report -- and AHRQ does  
11 great work, I'm not -- but there is a line of thinking that  
12 I've heard from others is that the work that AHRQ put into  
13 this came out of their Evidence-Based Practice Center, and  
14 that there is some -- there is a narrative that they use a  
15 very narrow standard for telehealth and to this extent that  
16 they're throwing out the good in the search of the perfect.

17           So, what I would ask, if there's people in the  
18 audience here today who are familiar with this AHRQ work  
19 and familiar with that narrative, if they could share that  
20 with us in the public comment section, I think that would  
21 be helpful, just to understand that side of the dynamic out  
22 there as we go forward.

1           So, having said all that, again, trying to make  
2 sure that if we're displacing something we're getting  
3 something on the -- the return on the other side, when we  
4 look at Slide 16, on the fee-for-service side, I absolutely  
5 agree. I think there are covered services, tele-stroke,  
6 the sepsis, the ICU. I think there are some opportunities  
7 that are very limited that you don't create problems in the  
8 fee-for-service world that's worth looking at.

9           I'm not sure where I am yet on allowing primary  
10 care providers to offer more telehealth under a PMPM  
11 payment. It's interesting. I think there are some  
12 opportunities there. I'm just not -- I want to think about  
13 that more and understand that.

14           But, the other one I would add under fee-for-  
15 service is in rural health care. It's already covered in  
16 many aspects already, but we know it's an important access  
17 issue. It's a way to know about a deterioration before it  
18 happens with a patient with that kind of access. And we  
19 know from our work last year and published in our June  
20 report last year of the growing number of demographic  
21 changes and the number of elderly, particularly those in  
22 rural areas. I think making sure that we can maintain that

1 access in rural areas and looking at refinements makes  
2 sense to me.

3           On the bundled payment ACO, I think that  
4 principle makes absolute sense and anything we can do to  
5 encourage that in our conversation and this report would be  
6 helpful.

7           And then, ultimately, in the MA -- don't want to  
8 repeat this stuff, but I think the questioning that Kathy  
9 put on the table was very instructive and that seems to  
10 make a lot of sense to me, as well. But, I would be  
11 curious to others that are more familiar with MA on that  
12 one. But, that sounds like a very sound principle to me.

13           DR. CROSSON: Thank you, Herb.

14           Warner.

15           MR. THOMAS: Just maybe to build on Herb's  
16 comments, and I think it's important, we're talking about  
17 telehealth, but as Herb just went through, I think breaking  
18 it into the different components of telehealth is really  
19 important, because I think we're missing an opportunity on  
20 this -- the area where we talk about, you know, patient at  
21 home talking to a clinician, patient in a medical facility  
22 talking to a clinician, you know, such as the stroke

1 telemed, psychiatric services to patients that are sitting  
2 in ERs that don't have psychiatric services. I mean, these  
3 are opportunities that are huge quality opportunities to  
4 improve on that, and I think -- to me, I have no discomfort  
5 with including that in fee-for-service because I think  
6 there is a quality opportunity and there is a cost  
7 opportunity by being able to care for these patients in a  
8 more effective way.

9           As it gets into primary care, I could see where  
10 there would be concern on a fee-for-service basis, and a  
11 lot more of this is being dealt with on a retail basis  
12 anyway. But, I think it's really important that we  
13 bifurcate telemedicine into the different components of  
14 telemedicine, and there is the outreach to rural areas, the  
15 outreach to hospitals that don't have these types of  
16 services is critically important. And, we do save lives.  
17 We do improve quality. And, we do improve costs at the end  
18 of the day by providing services that a lot of facilities  
19 don't have. So, I would just encourage us to look at those  
20 a little bit separately in our analysis.

21           DR. CROSSON: Thank you. I have Rita and Bill  
22 Gradison, Craig, Kathy, Scott, and Jack.

1 DR. REDBERG: It was an excellent chapter. I  
2 really appreciated the review and the attempt to define  
3 telehealth because I think it is very difficult to define.

4 You know, after I do it, because treadmills tests  
5 on a patient I offer them, they can come back in, or we can  
6 communicate by the electronic health record. Is that  
7 telehealth? I mean, there's so many things that --

8 And then the other issue that came up in the  
9 chapter was about licensing and the issue of state, and  
10 it's kind of a funny issue because, clearly, we're all --  
11 you know, I'm licensed in California, but I can see  
12 patients from any state. I mean, they will come. Some of  
13 them will make a trip to California because they want a  
14 second opinion from me, and that's not a problem. But I  
15 couldn't go to New York and see that same patient. So, I  
16 mean, that's not an issue that is in our purview, but it's  
17 a peculiarity that could be a limit on telehealth that's  
18 unfortunate, I think.

19 The other issue is what we've got with regard to  
20 the tele-stroke. So, in cardiology, I think we also like  
21 to diagnose heart attacks very quickly, and so I looked,  
22 before this meeting, because -- well, you could take an EKG

1 from the ambulance and send it or whatever -- at what we're  
2 currently doing. And we do have an electronic transmission  
3 so that someone can send us an EKG to look at before the  
4 patient comes, but because of HIPAA regulations, they can't  
5 -- like, I could take a picture of it and send it to  
6 someone, and it looks really clear. But we use this system  
7 -- it's through a fax. I won't say the proprietary name.  
8 And the images are terrible, and so we're not actually able  
9 to use it, just because -- and I said -- and what we're not  
10 allowed, for reasons I don't understand, but it's a HIPAA  
11 violation to send the photo to another doctor, but we can  
12 receive these fax images of EKGs. So it's a problem with  
13 the telehealth system.

14           And the last thing I wanted to comment, Herb, was  
15 on his looking for evidence to support it because I think  
16 we really do need more evidence, and certainly, for now, I  
17 think we should be looking at value-based payment models  
18 because otherwise it's very unclear how -- you know,  
19 whether it's going to add to cost or decrease cost. But if  
20 it is truly increasing value, then it's going to work best,  
21 I think, in a value-based payment model, and if you can  
22 share the references that you've cited from these people

1 that participate, that would be great. Thank you.

2 DR. CROSSON: Bill Gradison.

3 MR. GRADISON: A suggestion. In our annual  
4 survey, so from beneficiaries, it might be helpful to take  
5 a look at from a beneficiary's point of view of what's  
6 available to them right now. And we do ask, "Have you been  
7 able to see a physician within a reasonable period of time?  
8 Can you get a new doctor if you need one?" and all that,  
9 which is very important.

10 I would ask some -- really start with a really  
11 fundamental question: Can you reach your doctor by  
12 telephone, your doctor by telephone, if you wish to do so?  
13 Can you send an email to your doctor and get a -- or have  
14 you sent emails to your doctor and received a response? As  
15 well as some of these things, more what we mean by  
16 telemedicine. I think it's really sort of getting back to  
17 fundamentals here because my sense is there are a lot of  
18 doctors. You have to go in to see them. It would be a  
19 rare case where they would accept a phone call. They might  
20 turn it over to somebody else. And with email, while many  
21 doctors have websites and all of that, I think it's a rare  
22 one where you can actually type in a message and hope to,

1 say, within 24 hours or something, get an emailed response.

2 DR. CROSSON: Thank you. I've got Craig, Kathy,  
3 Scott, Jack, and Mary.

4 DR. SAMITT: So I sense that we're being overly  
5 cautious in our pursuit of telehealth. We're definitely  
6 seeing in the commercial side, a much more accelerated  
7 willingness to adopt telehealth. I think we need to bring  
8 health care's use of technology to the contemporary age,  
9 and our payment system shouldn't suppress progress, which I  
10 sense that we're doing here.

11 I actually, wholeheartedly, support all of the  
12 elements on this slide. I think we need to do them all,  
13 and part of my concern is I am not sure we're sort of  
14 seeing clearly the potential risks associated with  
15 telehealth use.

16 To counter Herb's view, I don't think that  
17 inappropriate use or unnecessary use is very constrained.  
18 I actually think there are a lot of different scenarios  
19 where telehealth should replace existing services. There  
20 is clearly a view that a substantive portion of what occurs  
21 in the primary care setting probably doesn't ever need to  
22 be seen within a clinic environment, and that retail or

1 virtual or telehealth solutions are as effective as an on-  
2 site environment.

3 I also think that if our concern is very much  
4 about driving up cost, that this is a supplemental service,  
5 not a replacement service. I don't fully understand  
6 because where we would see incremental costs don't, to me,  
7 appear to be the core drivers of escalating cost in our  
8 industry, so those would be inpatient hospital, outpatient  
9 hospital, ER, imaging, lab, pharmacy. Those are where the  
10 costs are really rising, and if telehealth actually  
11 suppresses some of those major cost drivers, which is where  
12 I believe and where people feel that it will make an  
13 impact, then incremental cost in a telehealth space may  
14 actually be a good incremental cost.

15 We talk about this in other settings. Maybe we  
16 need to be doing more things in certain areas that incur  
17 greater costs as a means of cost avoidance in some of the  
18 areas that are driving up costs more quickly.

19 So I can't strongly enough sort of underscore the  
20 fact, I think we're being too conservative. I think we  
21 should be embracing telehealth faster than we are in the  
22 industry.

1 DR. CROSSON: Before we go on, I just want to add  
2 something to what Craig had said because I agree with it,  
3 and this is not part of our normal considerations here at  
4 the Commission.

5 But I receive my health care from an organization  
6 that uses telehealth extensively, and it's very popular  
7 with me, as well as other patients, and also increasingly  
8 so with employers. And the reason has nothing to do with  
9 any of the things we've talked about so far. It has to do  
10 with the fact that it has a strong impact on the  
11 productivity of patients in their work, right? I mean, the  
12 notion of being able to communicate quickly with a  
13 physician through telephone, email, whatever -- and that  
14 replaces a half-day off from work -- that would otherwise  
15 be the only way they can receive care has a gigantic  
16 economic impact on the lives of patients and in many cases  
17 their employers, not that -- again, this is not something  
18 we normally consider, but it is important.

19 Kathy.

20 MS. BUTO: So, back to the point I raised earlier  
21 on page 14 of the paper, we say, "If MA plans wish to  
22 include telehealth services beyond what is included in the

1 Medicare Part A and B benefit," which by the way is rural  
2 focused, in fact, restricted to rural relationships, "they  
3 can do so by including these services as supplemental  
4 benefits." My point was if a plan wants to provide  
5 telehealth services as a substitute and can meet quality  
6 standards, why wouldn't we let them do that? I mean, it  
7 just strikes me that on this slide and the last bullet,  
8 we're only focusing on the supplemental issue that the  
9 plans apparently have raised about getting paid more to do  
10 it and being able to bid on it. But at least our language  
11 sounds like -- and maybe it's also CMS rules sound like --  
12 they are forced down the supplemental route if they want to  
13 go beyond any kind of use of telehealth in rural areas,  
14 which is the Medicare A and B benefit.

15           So, if that's not true, I just wanted to point  
16 that out and ask that it be clarified in the write-up  
17 because I think it's all right to substitute, but it didn't  
18 come across that way.

19           DR. MILLER: Unless I'm missing something, I  
20 think that needs to be rewritten.

21           DR. CROSSON: Okay. We are running over now. We  
22 have Scott, Jack, and Mary, and that will be the last

1 contribution.

2 MR. ARMSTRONG: So I will be brief. This is the  
3 second time this morning that Craig pretty much took the  
4 words out of my mouth.

5 [Laughter.]

6 MR. ARMSTRONG: But I bring a point of view to  
7 this conversation that telehealth is not a separate,  
8 distinct service. It's a modality or it's a tool to  
9 deliver the same services that are already covered, and you  
10 want to apply it appropriately in far more effective ways.

11 I worry that we are being far too conservative.  
12 Even the tone of this conversation is far more cautious  
13 about this. I think the technology and our patient  
14 expectations are moving far faster than our payment policy  
15 is right now.

16 In a system like group health, just as one  
17 example, we have many of our primary care practices where  
18 60 to 70 percent of their patient encounters are telehealth  
19 encounters, and this is the home base for Microsoft,  
20 Amazon, Expedia. If we're going to be relevant to the  
21 customers who will age into Medicare one day, we need to be  
22 offering these kinds of alternatives.

1           And, by the way, our experience has been that  
2 they improve access, they improve quality, and they lower  
3 cost at the same time. I would just say in fee-for-service  
4 and bundled payment models and through the MA plan, we  
5 should be looking for ways of encouraging and accelerating  
6 the application of this set of tools.

7           DR. CROSSON: I agree completely. Jack.

8           DR. HOADLEY: So, going into this issue, my  
9 original sort of gut feeling was that Medicare was being  
10 quite restrictive and sort of in the lines that Craig and  
11 Scott -- I guess I'm not quite as bullish about sort of  
12 where we should go as I was then.

13           Partly, on this notion -- I mean, again, part of  
14 my notion was Medicare was so far behind what private  
15 insurance was doing, and I think we're getting a difference  
16 between what's sort of going on inside the best integrated  
17 practices and maybe what they found in the research in  
18 terms of what's going on in more traditional private  
19 insurance.

20           On the other hand, the things on this page are  
21 not the kind of aggressive steps like remove the rural  
22 restriction and remove the at-home and some of the kinds of

1 things that we might at some point want to see happen, but  
2 they are sort of pretty modest steps. And I think part of  
3 the point is let's continue to use the demonstrations, the  
4 ACOs, the bundled payment kinds of issues to learn more.  
5 Let's hope that there's more to learn from the private  
6 sector, the kind of stuff that Herb was talking about and  
7 build that evidence.

8 I mean, a lot of this in the end is going to come  
9 down to how CBO would score. If we were to say remove all  
10 the restrictions, make it a completely covered benefit, is  
11 that going to get scored as a cost, and CBO is going to  
12 figure that out by looking at what's the evidence out  
13 there. And so the more we sort of encouraging the smaller  
14 experiments, whether it's the first couple of bullets here  
15 or inside the bundled payments, then that evidence base  
16 would get created that would allow this to be done someday,  
17 potentially, without a score cost from CBO, because if it  
18 comes with a big price tag, obviously it's not going to  
19 happen.

20 DR. CROSSON: Last word, Mary.

21 DR. NAYLOR: Briefly, I think all of this cries  
22 for a kind of taxonomy of telehealth. An email does not

1 equate to a face-to-face visit, and so understanding how to  
2 do that.

3           Secondly, I sit on AHRQ's National Advisory  
4 Committee, and I think we will want to pay attention to the  
5 kinds of reviews of evidence as setting a framework for us  
6 in terms of, especially from a beneficiary's perspective,  
7 knowing what we should be measuring in quality and how it  
8 is that we can create this as a real value-based  
9 proposition. So I think evidence matters.

10           And, lastly, I worry about the copay variation  
11 and wonder if, as we pursue this, that we really pay  
12 attention to the burden we're going to be placing on  
13 beneficiaries relative to the quality. If we go forward  
14 with a bullish effort, I would really want to make sure  
15 that we distinguish quality metric performance using  
16 telehealth versus face-to-face and/or the combinations.

17           DR. CROSSON: Thank you so much, Mary and the  
18 rest of the Commission. It's been a good discussion and I  
19 think very helpful as we advance our thinking here.

20           So now it's time for the public comment session.  
21 Those of you who would like to make a comment, please come  
22 to the microphone so we can see how many individuals we

1 have.

2           Since many of you may be new to MedPAC, I will  
3 make the comment I make often, which is that you are  
4 welcome here to make comments. This is not the only  
5 mechanism, however, that exists to provide feedback to the  
6 Commission. You can do that through the MedPAC website as  
7 well as contact with Mark and his staff ahead of time.

8           We would invite you to make your comments and  
9 limit them to two minutes. When this light comes back on,  
10 that means the two minutes have expired.

11           Please introduce yourself and what organization  
12 you represent.

13           DR. RECHTSCHAFFEN: I am Dr. Thomas Rechtschaffen  
14 with the American Urological Association. This is an  
15 excellent discussion.

16           We also have a committee working on telemedicine,  
17 which is co-chaired by two urologists who are part of a  
18 large system in California.

19           I haven't heard anything today about tele-  
20 surgery, and I think, as the comments have been made, we  
21 have to stratify different parts of telemedicine,  
22 telehealth. Tele-surgery has to be addressed.

1           One of their problems is an increasing 90-day  
2 wait time for outpatient non-urgent cystoscopy, so they  
3 have to play with the idea of having non-urologists do the  
4 cystoscopy as remote clinics, to transmit and store the  
5 video, and have them remotely review them, so these  
6 patients aren't waiting three months or more for this care.

7           Outpatient endoscopic management of stones is  
8 another good example. Not all hospitals, especially remote  
9 hospitals, have urologists on staff. We're the second  
10 oldest specialty in terms of age of provider, and we have a  
11 huge shortage coming up. So I think any discussion in the  
12 future should include tele-surgery as well.

13           DR. CROSSON: Thank you very much.

14           MR. JARRIN: Hi, there. My name is Robert  
15 Jarrin, and I'm with Qualcomm Incorporated. Thank you to  
16 the MedPAC for considering telehealth and remote patient  
17 monitoring.

18           On the IRFs question about the AHRQ study, which  
19 we all love AHRQ -- they do wonderful work --  
20 unfortunately, on this study, they did not really consider  
21 remote patient monitoring at all, and that's a big part of  
22 the different modalities of telehealth, remote patient

1 monitoring being, in my opinion, a little more  
2 comprehensive, a little more up to date.

3           If you look at the original telehealth statutory  
4 definition, it includes live voice and video. ON the  
5 market today, you will find a myriad of medical devices  
6 that are not live voice and video, but do remotely monitor  
7 patients.

8           Also, it did not include evidence from federal  
9 studies, like a study done of the VA of over 600,000  
10 patients and 1.8 million episodes of telehealth. It was  
11 also a literature review of other literature reviews.

12           So I think that the AHRQ study needs a little bit  
13 more. They were taking public comments. I know that a  
14 variety of different organizations did comment publicly  
15 about this.

16           Also, I would like to offer for your  
17 consideration, telehealth remote patient monitoring is also  
18 a part of care coordination. When you are discussing  
19 value-based models, including things like what's being now  
20 considered for MACRA via APM and MIPS, merit-based  
21 incentive payment systems, particularly with MIPS, now that  
22 MIPS includes a clinical practice improvement activity that

1 specifically call out telehealth and remote patient  
2 monitoring in the law, I think that's really important for  
3 your determination.

4 I'd also call to your attention that the Chronic  
5 Care Management codes that went into effect a year and a  
6 half ago, which is a non-face-to-face management code, I  
7 don't know what the utilization has been. Purely,  
8 anecdotally, my understanding is it's not being utilized  
9 because it's also very restrictive, but that's something  
10 for you to consider.

11 And then, finally, I think Rita brought up the  
12 issue of these new waivers for originating sites, and  
13 you've all discussed that this morning, but those all came  
14 into being just over the last four months. Those were  
15 final rules that were finalized, I think starting in  
16 November, so they're really just too new.

17 Thank you.

18 DR. CROSSON: Thank you very much. Good  
19 discussion. We are adjourned until 1:30.

20 [Whereupon, at 12:44 p.m., the meeting was  
21 recessed for lunch, to reconvene at 1:30 p.m. this same  
22 day.]



1 MS. SUZUKI: Good afternoon. Today, we'll pick  
2 up our discussion from last November about how to ensure  
3 Part D continues to meet the goals of providing  
4 beneficiaries with access to needed medications while  
5 remaining financially sustainable in the changing health  
6 care environment.

7 The Part D program was originally designed to  
8 encourage broad participation by plans and beneficiaries.  
9 It's now in its 11th year and the program continues to have  
10 broad participation with high satisfaction among enrollees.  
11 Policy makers consciously designed Part D to be different  
12 from fee-for-service Medicare in that it uses private plans  
13 to deliver the benefits. Those plans negotiate with  
14 pharmacies and drug manufacturers over prices. Medicare  
15 subsidizes about 74.5 percent of the basic benefit costs  
16 and has risk sharing arrangements that we've discussed in  
17 our previous meetings. And for about 30 percent of Part D  
18 enrollees with low incomes, Medicare's low-income subsidy  
19 pays for most or all of their premiums and cost sharing.

20 But, there are challenges ahead with a growing  
21 Medicare population and growth in program spending that's  
22 increasingly driven by rising prices of drugs and more

1 enrollees reaching the out-of-pocket threshold. Those  
2 factors make it difficult to maintain financial  
3 sustainability for taxpayers. Eleven years into the  
4 program, now is the time to prepare Part D for these  
5 challenges.

6           This slide is to remind you of the basic features  
7 of Part D. There are two things I want to point out to you  
8 on this slide. One is the coverage gap, in light green.  
9 Before 2011, non-LIS enrollees were responsible for the  
10 full cost of the drugs in the coverage gap. Most LIS  
11 enrollees don't have a coverage gap. The Patient  
12 Protection and Affordable Care Act of 2010 called for a  
13 phase-out of this coverage gap by 2020. Now, non-LIS  
14 enrollees pay reduced cost sharing for both brand and  
15 generic drugs in the coverage gap.

16           One component of the phase-out is a 50 percent  
17 discount on brand name drugs. These manufacturer discounts  
18 are added to enrollee cost sharing, with both credited  
19 towards the out-of-pocket threshold. So, more non-LIS  
20 beneficiaries are reaching the catastrophic phase earlier  
21 than they otherwise would have.

22           The second feature is the 80 percent reinsurance

1 Medicare pays for spending above the out-of-pocket  
2 threshold. That's shown at the top in white, where plans  
3 pay 15 percent and enrollees pay five percent. More people  
4 are reaching this catastrophic phase often earlier than  
5 they otherwise would have without the discount, means more  
6 spending by Medicare for reinsurance.

7           The manufacturer discount and the risk sharing  
8 provided by Medicare in the catastrophic phase both have  
9 significant implications for incentives faced by plan  
10 sponsors and beneficiaries.

11           While spending for high-cost enrollees has been  
12 growing rapidly, we haven't seen the full effect of this on  
13 the premium side. We've discussed in previous meetings the  
14 patterns of reconciliation payments and bidding incentives  
15 that are largely driven by Part D's risk sharing structure.  
16 Here, I'll quickly review some of the key points.

17           Plan sponsors, on average, are bidding too low on  
18 catastrophic benefits and bidding too high on the rest of  
19 the benefit. That results in Medicare paying an overall  
20 Part D subsidy higher than the 74.5 percent specified in  
21 law. That also means the share paid by beneficiaries is  
22 lower than it would be otherwise, which has kept the

1 premiums stable, on average. Bidding too high on the non-  
2 catastrophic portion of the benefit where plan sponsors are  
3 at risk has, on average, allowed them to earn profits above  
4 those already included in their bids.

5           In November, we began to discuss policy changes  
6 that would better align plan and beneficiary incentives  
7 with the program goals. One set of changes relate to the  
8 plan and beneficiary incentives around the out-of-pocket  
9 threshold: Providing plans stronger incentives to manage  
10 high-cost enrollees, changing the treatment of manufacturer  
11 discounts that currently count towards the out-of-pocket  
12 threshold, providing more complete protection at the out-  
13 of-pocket cap, and making modest changes to LIS cost  
14 sharing to encourage the use of lower-cost medicines.  
15 Another set of changes relate to providing plans greater  
16 flexibility to use formulary tools.

17           DR. SCHMIDT: Now, we'll go over each of the  
18 issues Shinobu mentioned as well as three draft  
19 recommendations that aim to improve incentives within Part  
20 D's market-based approach.

21           Let's start by considering three issues related  
22 to Part D's out-of-pocket threshold. The first issue is

1 that when Medicare pays 80 percent of benefit costs above  
2 the out-of-pocket threshold. Such a large percentage of  
3 reinsurance takes away some of the incentive and urgency  
4 plans would otherwise feel to manage benefits and negotiate  
5 for lower drug prices.

6           At previous meetings, we've discussed one way to  
7 address this. Medicare could keep its overall subsidy the  
8 same, at about 74.5 percent, but provide less of that  
9 subsidy through reinsurance and more of it through  
10 capitated payments. Making such a change would put more of  
11 the insurance risk for Part D benefits on the private  
12 plans, and this would have mixed effects. On the one hand,  
13 it would give them greater incentive to manage spending and  
14 negotiate better prices. On the other hand, some plans  
15 might need to purchase private reinsurance, which would be  
16 a new expense. It's also important to point out that plan  
17 sponsors might not have leverage to bargain for lower  
18 prices for all drugs. That leverage depends on whether a  
19 specific drug class has competing therapies.

20           We think most Part D plan sponsors could handle  
21 the higher levels of risk. In your mailing materials, we  
22 show that the majority of Part D enrollees are in plans

1 operated by large insurers. Consulting actuaries have told  
2 us that large insurers who are involved in markets other  
3 than just Medicare probably have enough capital to reinsure  
4 themselves.

5           It is the smaller insurers that would be more  
6 likely to purchase private reinsurance. It turns out that  
7 most of the smaller insurers in Part D offer Medicare  
8 Advantage drug plans, where they're already bearing  
9 insurance risk on medical benefits. Some smaller insurers  
10 already buy private reinsurance for their Medicare  
11 Advantage business. And our conversations with reinsurers  
12 suggest it may be possible to modify those existing  
13 contracts to include drug spending.

14           Another thing to note is that there is a lot of  
15 persistence in high-cost enrollees. We found that 60 to 70  
16 percent remain high-cost from one year to the next. We  
17 estimate that in 2013, more than three-quarters of spending  
18 above the out-of-pocket threshold was for beneficiaries who  
19 also had high costs in 2012.

20           Private reinsurers say that when enrollees have  
21 predictably high costs, plans should build those costs into  
22 their premiums, not rely on reinsurance. You could argue

1 that the same is true in Part D, that Medicare shouldn't  
2 reinsure predictable spending. It should be reflected in  
3 plan bids. CMS would recalibrate the Part D risk adjustors  
4 to reflect that predictably high spending to counter  
5 incentives for selection.

6 A second issue related to Part D's out-of-pocket  
7 threshold is the manufacturer's brand discount and the  
8 coverage gap. Manufacturers are required by law to provide  
9 a 50 percent discount as a condition of having their drugs  
10 covered in Part D. That discount and the enrollees' out-  
11 of-pocket spending get counted together for purposes of  
12 deciding when the enrollee reaches the out-of-pocket  
13 threshold. So, this quickens the pace at which  
14 beneficiaries reach that cap.

15 A third issue related to the out-of-pocket  
16 threshold is that it does not offer complete insurance  
17 protection. High-cost enrollees who don't receive the low-  
18 income subsidy pay five percent coinsurance above the out-  
19 of-pocket threshold on top of what they've already paid in  
20 the initial coverage phase and in the coverage gap. For  
21 certain conditions, like cancer, multiple sclerosis, and  
22 rheumatoid arthritis that tend to be treated with high-cost

1 drugs, five percent can be a real financial burden.

2           Ways to address this would be to either charge  
3 fixed-dollar copays above the out-of-pocket cap, which  
4 would at least be more predictable for the beneficiary, or  
5 to provide a hard out-of-pocket cap in Part D as there is  
6 in the Medicare Advantage program.

7           In November, we told you that when we tried to  
8 get a sense of the cost of a hard cap, we estimated that in  
9 2013, the costs were relatively small. It would have been  
10 a few hundred million dollars. The main reason our  
11 estimate was relatively small was that most people hitting  
12 the cap that year got the low-income subsidy, so Medicare  
13 was already paying for their five percent cost sharing.

14           However, we see this as a lower bound on costs  
15 for a couple of reasons. First, the numbers of non-low-  
16 income subsidy enrollees who reach the out-of-pocket  
17 threshold is growing quickly. Second, the pipeline of new  
18 therapies includes many of what are likely to be very  
19 expensive drugs. And even when high-priced drugs have a  
20 competing therapy, and hopefully some price competition,  
21 say, 20 to 40 percent reduction off the price of a high  
22 price, still leaves you with a pretty high price.

1           Now, we move forward to the Chairman's first  
2 draft recommendation. It reads as follows. The Congress  
3 should change Part D to lower Medicare's individual  
4 reinsurance subsidy from 80 percent to 20 percent while  
5 maintaining Medicare's overall 74.5 percent subsidy of  
6 basic benefits; exclude manufacturers' discounts in the  
7 coverage gap from enrollees' true out-of-pocket spending;  
8 and eliminate enrollee cost sharing above the out-of-pocket  
9 threshold.

10           The implications of this first draft  
11 recommendation, in terms of spending, the combination of  
12 draft recommendations one, two, and three, would lead to  
13 program savings relative to baseline spending, but an  
14 estimate of the magnitude of savings is not available yet.  
15 So, as you can see, we don't have a separate estimate of  
16 the spending implications of each draft recommendation on  
17 its own. We just have this statement as a package.

18           In terms of the effects on beneficiaries and  
19 providers, lowering Medicare reinsurance would -- the  
20 effects on plan sponsors and average enrollee premiums are  
21 indeterminate. Some plan sponsors might need private  
22 reinsurance, which would raise costs. But sponsors might

1 also more effectively manage benefit spending and negotiate  
2 lower prices.

3           In terms of the impact of the brand discount,  
4 some non-low-income subsidy enrollees would no longer reach  
5 the out-of-pocket threshold and would pay higher cost  
6 sharing.

7           And in terms of the out-of-pocket cap, all non-  
8 low-income subsidy enrollees would benefit from more  
9 complete insurance protection. All Part D enrollees would  
10 pay slightly higher premiums because the Part D benefit  
11 would become more generous.

12           In 2012, the Commission recommended giving the  
13 Secretary authority to change low-income subsidy copays to  
14 encourage more use of generics. The issue requires  
15 balance. We think low-income individuals are responsive to  
16 financial incentives, just like everyone else. At the same  
17 time, we don't want copays to discourage low-income  
18 beneficiaries from getting appropriate medications. We  
19 think a key lever may be to not charge for generics in drug  
20 classes that have a generic.

21           To date, full subsidy dual eligible enrollees pay  
22 \$1.20 for a generic prescription and \$3.60 for a brand name

1 drug. Other categories of LIS enrollees pay copays that  
2 are a little bit higher and some pay no copays. Plans  
3 build much larger cost sharing differences across formulary  
4 tiers into their benefit designs to encourage enrollees to  
5 use generics and preferred brands. For low-income subsidy  
6 enrollees, the plan's benefit design doesn't apply and  
7 Medicare pays for the difference between the plan's cost  
8 sharing and the LIS copay.

9           We've seen that LIS enrollees tend to use fewer  
10 generics. Some of that is for clinical reasons, but some  
11 of it may also be their limited financial incentives to use  
12 lower-cost drugs.

13           A few studies, including one by Jack Hoadley,  
14 have shown that when Part D plans do not charge anything  
15 for generics, it can lead to greater use of generics.  
16 Getting something for free seems to lead to a greater  
17 behavioral change. Now, Jack's study didn't look at LIS  
18 enrollees, but CMS just released a study that did and they  
19 found that both LIS enrollees and non-LIS enrollees use  
20 more generics when they're free.

21           The current low-income subsidy copay structure  
22 doesn't prepare us for a world in which there are more

1 biosimilars. Our understanding is that the LIS cost  
2 sharing for a biosimilar would be the same as for the  
3 referenced product. They would both have the same brand  
4 name copay. The introduction of biosimilars may lead to  
5 lower prices over time, so we may want to encourage their  
6 use when clinically appropriate to help keep the Part D  
7 program financially sustainable.

8           This brings us to the second Chairman's draft  
9 recommendation. It reads, the Congress should change Part  
10 D to modify low-income subsidy copayments for Medicare  
11 beneficiaries with incomes at or below 135 percent of  
12 poverty to encourage the use of generic drugs, preferred  
13 multi-source drugs, or biosimilars, when available in  
14 selected therapeutic classes; direct the Secretary to  
15 reduce or eliminate cost sharing for generic drugs,  
16 preferred multi-source drugs, and biosimilars; and direct  
17 the Secretary to determine appropriate therapeutic  
18 classifications for the purposes of implementing this  
19 policy and review the therapeutic classes at least every  
20 three years.

21           Here are the implications of draft recommendation  
22 number two. Again, the combination of draft

1 recommendations one, two, and three would lead to program  
2 savings relative to baseline spending, but we don't have an  
3 estimate of the magnitude of savings yet.

4

5           The draft recommendation number two would reduce  
6 program spending for the low-income subsidy and for  
7 insurance. Now, CBO estimated savings for a similar policy  
8 that was in last year's President's budget and the savings  
9 in that estimate were \$7 billion over five years and \$17.7  
10 billion over ten years.

11           In terms of the effects of beneficiaries and  
12 providers, greater use of generics could lower copay  
13 amounts for LIS enrollees, particularly if copays were  
14 reduced or eliminated for generics. LIS enrollees who  
15 chose not to switch to generics may pay higher copays for  
16 brand name drugs or might not be as adherent to treatment.

17           The final set of issues we'll talk about relates  
18 to Part D formularies. A formulary is the key tool plans  
19 use to manage benefit spending through decisions about what  
20 drugs are on it, which cost sharing tier a drug is on, and  
21 whether there's prior authorization and so forth.

22           Part D has more restrictions on plan formularies

1 than what insurers and PBMs use in many commercial plans.

2 CMS reviews plan formularies to make sure they're  
3 not designed in a way that would discourage people who have  
4 certain diseases from enrolling in the plan. Under Part D  
5 law, plans have to cover two distinct drugs in each  
6 therapeutic class and plans must cover all or substantially  
7 all drugs in six protected classes. Law allows CMS to  
8 review which classes should be protected, and in 2012, CMS  
9 proposed removing two classes, antidepressants and  
10 immunosuppressants for transplant rejection, from projected  
11 status. This was never implemented, though, because of  
12 stakeholder concerns.

13 Plans are also subject to rules about mid-year  
14 changes to their formularies. CMS wants plans to maintain  
15 continuity in their formularies so it's not a bait-and-  
16 switch situation for the beneficiary. Plans can enhance  
17 their formulary without prior CMS approval, but they must  
18 obtain approval for negative changes, and they have to  
19 provide affected beneficiaries with 60 days' notice.

20 There are some situations that could warrant  
21 these kinds of formulary changes mid-year, such as if new  
22 clinical information came out about a drug that leads to a

1 plan's pharmacy and therapeutics committee to want to add  
2 prior authorization to it.

3           We have heard from plan sponsors that this  
4 process is long and that there are limited opportunities to  
5 apply for changes in the year.

6           Part D plans are required to have certain  
7 protections for beneficiaries, including an exceptions and  
8 appeals process and a process for transition fills that's  
9 used, for example, when a beneficiary first joins a plan.  
10 I won't go over all of these requirements now, but I'm  
11 happy to take them on question.

12           We've heard from stakeholders about these  
13 processes and no one seems particularly happy. Many  
14 beneficiaries do not understand that they have rights to  
15 these protections and they find the process confusing.  
16 Some prescribers find the process of supporting patient  
17 requests for exceptions or appeals burdensome, especially  
18 across multiple plan sponsors. Meanwhile, some plan  
19 sponsors believe their coverage determinations are reversed  
20 routinely, even if a prescriber gives a supporting  
21 statement that is extremely general. And CMS has said that  
22 some plans are not fully compliant in carrying out these

1 processes.

2           It is not clear that we can address this whole  
3 situation, but maybe one way forward would be to lay out  
4 some clear expectations about the clinical rigor that  
5 prescribers would need to provide on behalf of a patient to  
6 support exceptions. CMS already has a model coverage  
7 determination request form that would be easy to use, but  
8 plans are not permitted to require prescribers to make  
9 their supporting statements in writing or to use a  
10 particular form.

11           Going forward, more and more specialty drugs will  
12 be used to treat diseases prevalent in the Medicare  
13 population. There is no one definition of a specialty  
14 drug, but they tend to have high costs. Medicare defines  
15 them now as costing \$600 or more per month. Because of  
16 their high costs and the effects of those costs on  
17 everyone's premiums, commercial plans and some private  
18 Medicaid plans use additional tools to manage those  
19 medicines. For example, commercial plans may provide an  
20 initial 15-day supply rather than a full 30 days to make  
21 sure that a patient doesn't have side effects that leads  
22 them to quit the treatment, so this avoids waste.

1           Many commercial plans use credentialed specialty  
2 pharmacies that can work with the patients to help them be  
3 adherent to treatments and that can sometimes negotiate  
4 better rebates or discounts on specialty drugs.

5           We've also heard that some plans, as more  
6 biosimilars come out onto the market, are moving towards  
7 using two specialty tiers, a preferred one and a non-  
8 preferred one, so that they can encourage enrollees to use  
9 lower-cost biosimilars. These tools are not now permitted  
10 in Part D, but given the cost of specialty drugs and the  
11 goal of keeping the program financially sustainable, it may  
12 be time to move towards using similar tools in Part D.

13           Which brings us to the Chairman's draft  
14 recommendation number three. The Secretary should change  
15 Part D to remove antidepressants and immunosuppressants for  
16 transplant rejection from the classes of clinical concern;  
17 streamline the process for midyear formulary changes;  
18 require prescribers to provide supporting statements with  
19 more clinical rigor when applying for exceptions; and  
20 permit plan sponsors to use certain tools to manage  
21 specialty drug benefits.

22           In terms of the implications of Draft

1 Recommendation 3, again, the combination of Draft  
2 Recommendations 1, 2, and 3 would lead to program savings  
3 relative to baseline spending, but we don't know the  
4 magnitude of those savings yet.

5 In terms of effects on beneficiaries and  
6 providers, for the protected classes, plan sponsors may be  
7 able to negotiate lower prices which could reduce premiums.  
8 Some beneficiaries may need to switch medications or seek  
9 formulary exceptions.

10 And in terms of the other formulary tools,  
11 increased formulary management would reduce costs of  
12 providing Part D benefits and constrain enrollee premiums  
13 and cost sharing. Some beneficiaries may need to apply for  
14 exceptions, redeterminations, and appeals. Some  
15 prescribers may find providing more clinical rigor in  
16 supporting statements burdensome.

17 This final slide provides a summary of all of the  
18 Chairman's draft recommendations. The recommendations make  
19 up an interrelated package that's designed to improve Part  
20 D's market-based approach for the challenges that lie ahead  
21 for the program. And with that, we'll take your questions.

22 DR. CROSSON: Thank you very much, Rachel and

1 Shinobu. Excellent work and presentation as usual.

2           We're going to proceed with the discussion in a  
3 moment. Just for the purpose of understanding for our  
4 guests, many of whom may not have been here before at  
5 MedPAC, it is our custom when we are making formal  
6 recommendations to the Secretary or to the Congress, or  
7 both, for us to discuss and review and potentially amend  
8 those recommendations and vote on them at the subsequent  
9 meeting. So the recommendations you see or some version of  
10 those are likely to come back in April, at which time we  
11 will take a formal vote.

12           So to begin the discussion, I think what we'll do  
13 is take clarifying questions across the board here. Then  
14 I'll ask Jack to make some introductory comments. And then  
15 we will have discussions on each recommendation  
16 individually, and the reason is there are enough pieces to  
17 each recommendation that, were we to take all three in one  
18 discussion, I think we would get ourselves a little tied up  
19 in knots.

20           MS. UCCELLO: Can you go to Slide 3? Can you  
21 just remind me how the progression to the coverage gap  
22 changing over time? Because eventually it is supposed to

1 go away, but now I can't remember if that's solely just  
2 because of the discounted prices or if it's something else.

3 MS. SUZUKI: So I don't remember the actual  
4 percentages, but it's a gradual phase-out. But for brand-  
5 name drugs, it started out with 50 percent being paid by  
6 the manufacturers, and initially I believe plans paid 2.5  
7 percent of the remainder, and the beneficiary paid the rest  
8 in cost sharing. And gradually that percentage is being  
9 increased, and right now I think it's 5 percent. And by  
10 2020, beneficiaries' share will be 25 percent for brand-  
11 name drugs and 25 percent paid by plans and 50 percent by  
12 the brand manufacturer discount.

13 MS. UCCELLO: Okay. So current law is that even  
14 when the beneficiary cost sharing gets to 25 percent, that  
15 50 percent that's the drug company's is still going to  
16 count toward the true out-of-pocket.

17 MS. SUZUKI: [Nodding yes.]

18 MS. UCCELLO: Thank you.

19 DR. CROSSON: Clarifying questions.

20 DR. REDBERG: Thanks for a very informative  
21 chapter. On page 9 in the mailing materials, you refer to  
22 that CMS recalibrated the prescription drug hierarchical

1 conditions category for 2017. So you have any details  
2 about how they recalibrated it?

3 DR. SCHMIDT: So when they go about  
4 recalibrating, this most recent year they put out the  
5 advanced notice, they said that they used more recent year  
6 of claims data for the expenses, so that would be 2014  
7 data, and a more recent year of diagnosis information, so  
8 that was for 2013 diagnoses. And one advantage of having  
9 2014 data was particularly associated with the hepatitis C  
10 spending that did show up in those claims.

11 DR. REDBERG: Sure.

12 DR. SCHMIDT: And in the prior year, they had  
13 made a manual adjustment to the risk adjuster to reflect  
14 what they thought the spending might look like, but they  
15 actually had claims to build a risk adjuster this time.

16 DR. REDBERG: Great. Two more questions, very  
17 quick.

18 On Table 3, page 14 in the mailing materials --  
19 and you can get back to me on it, but I'm interested if you  
20 could specify some of the top drugs in the categories there  
21 that were responsible for the high-cost-enrollee spending,  
22 the specific prescriptions.

1

2 DR. SCHMIDT: You mean among the non-LIS or the -  
3 -

4 DR. REDBERG: Yes.

5 DR. SCHMIDT: Okay.

6 DR. REDBERG: And then last was, on page 17, you  
7 say differences in health status may limit the opportunity  
8 for clinically appropriate therapeutic substitutions for  
9 some beneficiaries. I wasn't sure what you were referring  
10 to.

11 DR. SCHMIDT: An example that we hear from  
12 beneficiary advocates might be that, you know, people with  
13 mental illness may be stably managed on a certain  
14 medication that is brand name, and it may be more difficult  
15 in some cases to substitute, like generic substitutions. I  
16 think it's just because it's been a stable treatment, I  
17 think is the key thing.

18 DR. HOADLEY: So on 13 and 14, on Recommendation  
19 2, the language is not specific when it says modify the LIS  
20 co-pays in terms of what's happening on the brand side.  
21 The second bullet says reduce or eliminate cost sharing for  
22 generics. Are we necessarily speaking to whether the brand

1 co-pays go up or are we just staying silent on that as the  
2 current --

3 DR. SCHMIDT: I think we are envisioning that --  
4 well, I guess that's ultimately for you to decide, but I  
5 think, yes, we're envisioning the brand co-pays would go  
6 up. And in classes where there is a generic, it would try  
7 to aim for zero.

8 DR. HOADLEY: Okay. We can come back to that on  
9 discussion.

10 And then on 15, when you're talking about the  
11 midyear formulary changes, is the thought that it would be  
12 a different range of changes that might be allowed, or is  
13 it more purely in the process for considering -- I mean, I  
14 know there's issues about the length of time it takes, and  
15 since a midyear -- you know, the whole issue of how the  
16 timing -- you go into more of this with the 60 days' prior  
17 notice that's on this bullet. But sort of what's the  
18 intent in terms of process versus the actually sort of  
19 standards by which the approval would be --

20 DR. SCHMIDT: I think we are envisioning process  
21 more so than anything else. What we're hearing is that  
22 it's kind of a call-and-response approach, if you will.

1 There's two sets of formulary review processes going on,  
2 one for the benefit year ahead and one for the benefit year  
3 underway. And there's kind of fixed points in time at  
4 which you can adjust the formulary submission for the year  
5 to come, and that can be constraining from the plans' point  
6 of view. They would like to maybe make some changes,  
7 although there's also the desire to keep things stable as  
8 beneficiaries are enrolling.

9 But they use a formulary reference file approach  
10 where CMS sends out this file and plans come back with, you  
11 know, their suggestions on the types of coverage they would  
12 provide, the restrictions on that coverage, the criteria  
13 they might use for deciding prior auth and so forth. And  
14 the timing of that process I think some plans find  
15 cumbersome or clunky, if you will, and so I think what we  
16 had in mind was streamlining that particular process. And,  
17 yeah, I'll leave it there.

18 DR. HOADLEY: Thank you.

19 MS. BUTO: Just two quick questions. One is, so  
20 in the coverage gap, the additional 25 percent that the  
21 plan is going to be contributing ultimately, I guess by  
22 2020, that's actually subsidized by the federal government,

1 right? I mean entirely or partially?

2 MS. SUZUKI: It's just like the other parts of  
3 the benefit, so it will --

4 MS. BUTO: So it will be paid up front,  
5 basically.

6 MS. SUZUKI: Yes.

7 MS. BUTO: Okay. And the second question is, in  
8 the coverage gap in the paper, I guess on page 26, you talk  
9 about some plan enrollee sources of supplemental coverage  
10 do not get to count toward the out-of-pocket threshold.  
11 But I thought Medigap couldn't cover co-pays in the  
12 coverage gap. Is that not right? Medigap plans can cover  
13 co-pays?

14 MS. SUZUKI: That is correct, so Medigap -- my  
15 understanding is Medigap -- if they have any coverage  
16 through Medigap for drugs, that would not be counted  
17 towards the out-of-pocket threshold. The things that are  
18 counted towards the out-of-pocket threshold are very  
19 specifically specified. For example, I believe ADAP, a --  
20 what is --

21 MS. BUTO: Low-income drug coverage, right, by  
22 the states.

1 MS. SUZUKI: That is specifically counted towards  
2 the out-of-pocket.

3 MS. BUTO: I actually thought -- I mean, this is  
4 something we could just check -- that Medigap is not  
5 allowed to cover co-pays in the coverage gap, but maybe  
6 that's not correct. Anyway, I think we could check that  
7 pretty easily.

8 DR. SCHMIDT: Your first question about the 25  
9 percent, I just want to make sure we have a common  
10 understanding of -- you said something about it being paid  
11 up front, and it's just that it's part of the overall  
12 benefit that Medicare's subsidizing by 74.5 percent.

13 MS. BUTO: That's what I'm thinking.

14 DR. SCHMIDT: Okay.

15 MS. BUTO: Right. Thank you.

16 MR. THOMAS: So my question is clarifying on the  
17 -- and I might have missed this. On the transplant  
18 patients, what is the rationale again for excluding  
19 antidepressants and immunosuppressants?

20 DR. SCHMIDT: I think the original thought was  
21 that you needed a wide variety of drugs available for  
22 patient care in that particular class, and I think that

1 there have been a number of generics that have entered that  
2 particular class. And CMS, when they laid out some  
3 objective criteria for how to evaluate those six protected  
4 classes, one of the criteria had to do with whether it was  
5 going to lead to hospitalization or death or risk of that  
6 nature, extreme results, obviously, if there wasn't quick  
7 access to a wide variety of drugs. And they decided in  
8 that 2014 proposed rule that this no longer applied to that  
9 particular class.

10 MR. THOMAS: So is the thinking that -- so would  
11 generics -- is it just excluding brand and would generics  
12 be covered? Or it would --

13 DR. BAICKER: Just to clarify, it's not that the  
14 drugs are excluded from coverage. It's that it's not a  
15 special protected class in this way.

16 DR. SCHMIDT: Thanks, Kate. So now as a  
17 protected class, the plans have to cover all of the drugs -  
18 -

19 MR. THOMAS: I got it. Okay.

20 DR. SCHMIDT: Right. So a plan could still  
21 decide -- they still have to cover two for the class, at  
22 least, but it would be them deciding which.

1 MR. THOMAS: I got it. Okay. Thank you.

2 DR. MILLER: Can I just tack back to Kathy for a  
3 second, the reason why (off microphone) we're all confused  
4 is that any newly issued Medigap can't pay in the coverage  
5 gap, and the old ones are a little murky, and we're going  
6 to come back to you on that. Okay? That's why I think  
7 we're all confused.

8 DR. CROSSON: Other clarifying questions?

9 [No response.]

10 DR. CROSSON: If not, Jack, we'll ask you to make  
11 some introductory remarks.

12 DR. HOADLEY: So most of my comments go more to  
13 specific items on the list of recommendations, but I think  
14 overall we've got a really good package of recommendations  
15 to work with. I think we're trying to address several  
16 things here which have to do with trying to make some  
17 changes in Part D that will allow better management of  
18 overall program costs as well as better protection for  
19 beneficiaries and out-of-pocket costs. And I think when we  
20 get to the individual items, you know, some of these things  
21 -- most of these things go to one of those purposes or  
22 another. And then the last set kind of goes to trying to

1 provide some additional tools for the plans to try to sort  
2 of speak to the fact that they're going to be on the hook  
3 more with spending.

4 I guess the one thing that strikes me as sort of  
5 a missing piece -- and it's something that we've talked  
6 about in previous years, or I think maybe it was last year  
7 -- was more generally some of the appeals and exceptions  
8 and redetermination processes, and it comes up in a number  
9 of these because a number of these are pretty reliant on  
10 having a process that really works well for the  
11 beneficiary, several of the things here will potentially  
12 put somewhat more reliance on those processes. And our  
13 discussion of that when we last looked at it was that,  
14 first of all, there weren't really enough data to give us a  
15 good sense of how well those processes are working, but  
16 there were some flags. And I think at the very least, we  
17 should make sure to comment on -- refer back to that  
18 earlier discussion and sort of draw that comment in. And I  
19 wish I had something specific I could suggest about sort of  
20 strengthening that process. There is some work underway.  
21 CMS has been working with stakeholders trying to come up  
22 with some improvements in the process, and that's underway,

1 so not necessarily something we want to jump in the middle  
2 of while that process is going on. But maybe even that is  
3 something that's worth at least taking note of in this.

4 But I think it's something we should keep in mind  
5 as we're sort of going through this list of items and  
6 thinking about that. Otherwise, I think I'll hold my  
7 comments until we get to specific items.

8 DR. CROSSON: Okay. So then we will start with a  
9 discussion of Recommendation 1, which is on Slide 10, and,  
10 Jack, you can begin as well.

11 DR. HOADLEY: So there are three pieces to this  
12 recommendation, and I'm enthusiastically in support of the  
13 first and the third, and I want to talk a little more about  
14 some of the nuances on the second of these.

15 I think the first one is something that we've  
16 been sort of setting up in our discussions in last year's  
17 chapter and the notion that Medicare pays such a large  
18 share of reinsurance really -- and doesn't have any tools  
19 to address those costs, and the plans are the ones that are  
20 responsible for managing the costs. It just is kind of  
21 illogical as the program -- and we've watched -- you know,  
22 I don't need to repeat all the data that we've seen in this

1 chapter and previous discussions about how much more the  
2 spending is falling in this thing. So I think that makes a  
3 lot of sense.

4 I think one thing that we don't necessarily --  
5 well, two points that we don't necessarily make: one is  
6 this may well require some kind of a transition rather than  
7 go all at one point, and I don't know whether that was  
8 already sort of assumed, but there is no discussion at this  
9 point. And I think -- I know the President's budget has a  
10 comparable proposal but it proposes to do it sort of 10  
11 percentage points at a time over a period of six years,  
12 whether that's the right length or whatever. But it  
13 probably makes sense to create some transition around this,  
14 and we should -- whether it goes formally in a  
15 recommendation or in the discussion to follow, we should  
16 probably raise that.

17 I also think that we should in the discussion  
18 around this take note of the fact that we're not proposing  
19 any changes to the risk corridors and that that still  
20 remains a protection for the plans against a slightly  
21 different kind of risk but, nonetheless, it is something  
22 that is protection, and so I think we should just be

1 explicit to sort of remind people of that, that that's  
2 going on.

3           And the second one, I guess one of the questions  
4 I have is whether we could get a sense of sort of the  
5 combined impact of Item 2 and Item 3, the second two pieces  
6 of this recommendation on beneficiary cost. So obviously  
7 beneficiaries are going to save -- or at least a small set  
8 of beneficiaries who are in catastrophic are going to save  
9 from the cap on out-of-pocket costs. Beneficiaries, as you  
10 noted in the impact, some of them won't reach the  
11 catastrophic cap, so there will be some higher cost  
12 sharing, sort of thinking about the balance and sort of how  
13 many people are affected in both ways would give a sense.

14           So, you know, I could be comfortable with that  
15 second point, but I'd like to understand a little better  
16 where the impact is going to fall. In some ways, it's a  
17 step backward from what Congress tried to do when they  
18 closed the gap and tried to reduce the total out-of-pocket  
19 hit on beneficiaries. So we're taking a little bit of a  
20 slide back from that in doing this. And I think sort of  
21 trying to think through particularly what this looks like  
22 in 2020 when the phase-out is complete and sort of how this

1 would play out in terms of impact would be helpful in sort  
2 of thinking about this a little bit further.

3 DR. CROSSON: So can I just ask Rachel and  
4 Shinobu, is that something that can be modeled, say, in the  
5 next month?

6 DR. MILLER: First of all --

7 DR. CROSSON: It's only work, right?

8 DR. MILLER: -- I know you guys aren't doing  
9 anything nights and weekends, so --

10 But the other way to size this -- I'll just give  
11 you a second to think about his question while I give you a  
12 different way to think about it. One way to size this --  
13 and I suspect you know this, but I just want to say it out  
14 loud, just in case it helps. I mean, we're talking about  
15 the non-LIS population, and we did know, when we were  
16 thinking about the hard -- and you're right. There's like  
17 a little bit of back step in your words or whatever you  
18 were saying in the gap, but then they get stronger  
19 insurance, an enhanced insurance benefit with they actually  
20 hit the cap, so there's a little bit of give-and-take,  
21 which is what you're getting at. But I need you guys now.

22 We had some sense of how many people were kind of

1 affected by the cap, right? And it's a relatively -- can  
2 you remind everybody of that?

3 DR. SCHMIDT: So there were 700,000 non-LIS  
4 enrollees. They hit the cap in 2013, and it was around 2  
5 million, I believe, 2.1 million low-income subsidy  
6 enrollees. So that the vast majority or LIS. So we're  
7 talking about a subset of the 700,000.

8 DR. MILLER: I wanted to at least give you that.

9 MR. GRADISON: And I guess the other piece that  
10 you might be able to do -- and I would be totally  
11 comfortable with doing this just in the sort of 2013 data  
12 kind of sense. I realize we've got all kinds of questions  
13 about the future, but sort of how many people might fall in  
14 that position where they hit the gap based on the current  
15 rules, but would no longer hit the gap, and sort of just  
16 trying to think that through. I mean, it's probably not a  
17 lot of people is what I'm thinking and so that may help in  
18 this conversation.

19 MS. BUTO: Can I just, on a related -- on the  
20 same issue -- and I think this question I raised about  
21 Medigap coverage -- so, if those beneficiaries who are  
22 affected actually do get Medigap coverage for their copays,

1 it seems to me to be less of a concern than if they are  
2 facing a 50 percent exposure, virtually 50 percent exposure  
3 for a longer period of time. So it just seems to me that  
4 we need to kind of -- it would be good to know more about  
5 the answer to that question.

6 DR. HOADLEY: I believe -- and I haven't  
7 specifically looked at this -- that, I mean, Mark clarified  
8 part of it. So anybody that's sort of new can't be in that  
9 situation. People who have -- first of all, there were  
10 never a lot of people who bought Medigap with those INJ or  
11 whatever they were that had the drug coverage. It was  
12 always a very small share. I think some of the people in  
13 that situation kept their Medigap but did not buy Part D,  
14 and others probably dropped their old Medigap in favor of  
15 Part D or switched to a different kind of med. So I think  
16 that number is likely to be quite tiny.

17 MS. BUTO: Again, I'd like to know because I  
18 think it could be bigger than we think.

19 DR. CROSSON: Kate, on this?

20 DR. BAICKER: Yeah. I just want to be sure I  
21 understand Mark's supposition that this is likely to be a  
22 small group that's in the situation of Bullet 2 in that.

1 Unless I'm -- I think I might be misunderstanding, but I  
2 would think that there are a whole bunch of people who are  
3 pushed out of the gap under the current rule because the  
4 subsidy counts who would then be pulled back into the gap  
5 and then have more cost sharing in that realm.

6 I'm surprised that that's a small number because  
7 I would think that that's in the meat of the distribution.

8 DR. HOADLEY: But the total that are in the gap  
9 is the 700,000 that they just talked about --

10 DR. SCHMIDT: That's the number that are hitting  
11 the cap.

12 DR. HOADLEY: -- of the non-LIS.

13 DR. BAICKER: That's the number that are hitting  
14 the cap.

15 DR. SCHMIDT: Yeah.

16 DR. BAICKER: Yeah.

17 DR. HOADLEY: Cap.

18 DR. BAICKER: But there should be more people --

19 DR. HOADLEY: Oh, I'm sorry. Right.

20 DR. BAICKER: -- to whom this applies, right? Or  
21 am I misunderstanding?

22 DR. HOADLEY: But what matters -- so if they're

1 counter on out-of-pocket spending, the only ones that are  
2 going to be hurt by this are the ones that made it to  
3 catastrophic.

4 DR. BAICKER: Right.

5 DR. MILLER: The other ones would be baseline  
6 effects from the current law.

7 DR. HOADLEY: Right.

8 DR. BAICKER: Right. So anybody who --

9 DR. HOADLEY: So some of those 700,000 --

10 DR. BAICKER: It's everybody --

11 DR. HOADLEY: -- won't make it anymore.

12 DR. BAICKER: Right. But there are other people

13 --

14 DR. HOADLEY: The people on the other side aren't  
15 going to be hurt by this.

16 DR. BAICKER: -- who aren't going to actually  
17 have to pay anymore.

18 DR. HOADLEY: Right.

19 DR. BAICKER: They'll still be in that zone, but  
20 their payment will --

21 DR. HOADLEY: Their counter will be at a  
22 different point.

1 DR. BAICKER: Right, right.

2 DR. HOADLEY: But it's not going to affect.

3 DR. BAICKER: But a bunch of people should be in  
4 that total range.

5 DR. HOADLEY: But it's out of that 750, so it's  
6 some subset of 750.

7 DR. BAICKER: And we can --

8 MS. BUTO: Isn't that the fastest-growing group?

9 DR. HOADLEY: It will get bigger.

10 MS. BUTO: The non-LIS group that hits the cap is  
11 the fastest-growing group.

12 DR. HOADLEY: It will get bigger, but that's the  
13 part that's hard to project.

14 DR. REDBERG: But that's really the problem. You  
15 know, with that kind of artificial Medicare subsidizing the  
16 pharmaceutical companies, you're encouraging high drug  
17 prices because then it's shifting people out of that gap  
18 and into the area where there's no copayment and no out-of-  
19 pocket.

20 And we know that there are less expensive  
21 alternatives for a lot of these drugs that could be used  
22 with the same therapeutic efficacy, but the way it's

1 structured currently, it doesn't -- there's no incentive.  
2 In fact, there's more incentive to use very expensive  
3 drugs, so you can get out of the path in Medicare that  
4 fills in that 50 percent of the artificially not-paid money  
5 --

6 DR. BAICKER: Right. So --

7 DR. REDBERG: -- from the artificial high prices.

8 DR. BAICKER: Yeah. So I guess what I was  
9 thinking is that you need think about --

10 DR. HOADLEY: You need a behavioral effect.

11 DR. BAICKER: Yeah. You need to think about  
12 everybody whose marginal consequence of spending more is  
13 changed, that the out-of-pocket costs are only going to  
14 change for people who actually made it out of the gap, but  
15 the marginal incentives on spending might be different. If  
16 it would affect quantity of use, it would apply to  
17 everybody whose presence in that whole range changes.

18 DR. HOADLEY: I think that's right. I think the  
19 question is how strong an incentive is that, and I think to  
20 Rita's point, it's still cheaper for them to use -- much  
21 cheaper for them to use the generic alternative, which may  
22 be costing them \$5 or \$10, and even the discounted brand

1 could be a lot more than that. So I've always questioned  
2 how strong an incentive that is in the first place, but  
3 even if I grant that, then there's the question, right, of  
4 what's the -- there is a behavioral effect that makes it  
5 more complicated than just looking at the number of people  
6 who fell in, in that so-many-dollars range.

7 DR. BAICKER: Right. And your work is suggesting  
8 that the difference between zero and a small amount may  
9 make a bigger difference than --

10 DR. HOADLEY: A small amount.

11 DR. BAICKER: -- a medium amount, in a medium  
12 large amount. The behavioral effects might be small.

13 DR. HOADLEY: Right.

14 DR. BAICKER: I have no sense about how big  
15 they'd be, but they would apply to that whole range.

16 DR. CROSSON: Okay. We will endeavor --

17 [Laughter.]

18 DR. CROSSON: You got a result?

19 We will endeavor in April to bring a little bit  
20 more to this question.

21 Jack, have you finished your comments on  
22 Recommendation 1?

1 DR. HOADLEY: Yes.

2 DR. CROSSON: Okay. Other comments on  
3 Recommendation 1? Scott, Kathy, I think. Scott, Kathy,  
4 Craig, Cori.

5 MR. ARMSTRONG: Just briefly to add a point to  
6 Jack's comments, on the first bullet, it's a significant  
7 shift, obviously. I would acknowledge this is where  
8 Recommendations 1, 2, and 3, in a way, are kind of a  
9 package deal. Simply shifting the risk to the plans does  
10 not necessarily mean the costs will be lower. I think we  
11 really do need to look at what tools do we give the plans  
12 to do a better job of managing those costs than, you know,  
13 the Medicare program otherwise would be able to do that.

14 And then, second, Jack mentioned the need for a  
15 thoughtful transition process, and I would really endorse  
16 that.

17 DR. CROSSON: So, Scott, in partial answer to  
18 that, anyway, one of the things we could discuss, if you  
19 wanted to, was whether or not when we come to vote in  
20 April, we should take the three recommendations as a voting  
21 package or not, because I think I heard an implication in  
22 what you said that you would like to see it done that way.

1 MR. ARMSTRONG: Well, maybe we should put that  
2 question on the table after we've gone through these, this  
3 discussion today.

4 DR. CROSSON: All right.

5 MR. ARMSTRONG: But I think it's hard not to look  
6 at all three of them as related to one another. So I don't  
7 know exactly what the implications for voting would be.

8 DR. CROSSON: And, again, I was assuming that we  
9 end up in April with something that looks like what we have  
10 now, but we haven't finished the discussion. You're right.

11 Okay. Kathy.

12 MS. BUTO: So I am a big fan of Recommendation 1,  
13 and I actually think it has spillover effect to  
14 Recommendation 2 in the sense that once the plans are more  
15 at risk for reinsurance, I think they will have a greater  
16 skin in the game to manage use of generic drugs in the  
17 coverage gap because, if they can encourage more use of  
18 generic drugs in the coverage gaps, fewer people will end  
19 up in that reinsurance bucket. So I think it has actual  
20 positive effects down the line.

21 I would like to know more about the discounts in  
22 the coverage, and I know what Rita said about the

1 manufacturers are -- the federal government is subsidizing  
2 them. I think they think they're subsidizing the federal  
3 government forever at 50 percent of whatever we think the  
4 price is.

5           So, you know, I think it's important just to know  
6 what the dimensions of the impact are -- is on  
7 beneficiaries there, so we know who is going to really have  
8 to be paying more. But I would point out, I think more  
9 beneficiaries are going to find generics attractive once  
10 the plans are more actively engaged.

11           DR. CROSSON: Craig.

12           DR. SAMITT: So, in terms of Draft Recommendation  
13 1, the first bullet is what I am actually most concerned  
14 about. That we certainly want higher plan accountability,  
15 but what I'd be interested in understanding is not so much  
16 the impacts to plans on average, but whether there is risk  
17 of instability to certain plans that may have higher-acuity  
18 patients or that may have a predominant use of specialty  
19 drug.

20           On Slide 7, you talk about the fact that much of  
21 the spending above Part D's out-of-pocket threshold is, for  
22 enrollees with predictably high cost, better addressed

1 through risk adjustment. I guess I would ask whether risk  
2 adjustment will actually address the potential volatility  
3 of costs that rise above the threshold. So I don't know if  
4 I've seen that.

5 At a minimum, if we do want to make a change, I  
6 agree completely with the notion that it should transition  
7 over time to avoid the risk of instability, but I am  
8 worried at a plan-by-plan level about the implications of  
9 this dramatic change.

10 DR. CROSSON: So let me ask -- sorry -- again,  
11 Rachel and Shinobu: Do we have information on the efficacy  
12 of risk adjustment in Part D that could be applied to that  
13 question?

14 MS. SUZUKI: In general, the predictability of  
15 spending for drugs is higher than for medical spend, and so  
16 the drug model has had higher R-squared. And the way CMS  
17 has been adjusting the model over time to account for the  
18 more generous benefit that's occurring as the gap is phased  
19 out, that's happening too. So we kind of consider it  
20 similar to that sort of changed in that the plans portion  
21 of that benefit is just becoming more generous.

22 DR. MILLER: And the other thing I would add

1 here, because I think it was said -- there's a set of  
2 troublemakers who generally sit over here, and the one, in  
3 particular, I don't want to really say Cori's name -- is --

4 [Laughter.]

5 DR. MILLER: Cori, you were making the point, you  
6 know, the -- right? Do you want to make it?

7 MS. UCCELLO: So, when it eventually got to me, I  
8 was going to talk about the risk adjustment part of this,  
9 and by taking away this reinsurance or reducing it  
10 substantially, it is going to put more pressure on the risk  
11 adjustment program to get it right, because part of the  
12 reason, I think, that the risk adjustment did so well is in  
13 part, in effect, because they were -- there was a threshold  
14 of cost over which the risk adjustment program didn't have  
15 to take care of because the reinsurance program was taken  
16 care of.

17 But my point here would be not that this isn't  
18 worth doing because of that. I don't think the risk is  
19 overwhelming here. I just think it's something that we  
20 need to monitor, and my perspective on this would be there  
21 might be more of a need for some of these ad hoc  
22 adjustments, or it could come out in the risk corridor

1 program, as Jack mentioned.

2 DR. MILLER: That's what I was looking for.

3 MS. UCCELLO: Yeah.

4 DR. MILLER: His point is -- I think what he's  
5 saying is there could be a plan that disproportionately  
6 gets something. That's going to be much more of a corridor  
7 issue, and that's the point I was -- like, that's all I was  
8 looking for, Cori, just one simple --

9 [Laughter.]

10 MS. UCCELLO: Well, you know, I didn't talk a lot  
11 this morning.

12 DR. SAMITT: And so do we believe that the risk  
13 adjustment model will be predictable enough as it has with  
14 the emergence of new high-cost specialty drugs, or do we  
15 envision it will be increasingly less predictable over  
16 time?

17 DR. HOADLEY: Well, keep in mind -- and I think  
18 they point out this in the paper -- CMS, with the hepatitis  
19 C drug as being a big shock to the system, went in and made  
20 an ad hoc adjustment to the adjustors. Now, it lagged  
21 essentially by a year, but that year was, to a great  
22 extent, covered by the risk corridors.

1           So, again, it's this belt-and-suspenders kind of  
2 protection. They can make an adjustment to the risk today.  
3 If there suddenly are new drugs for something else in 2018,  
4 the first line of protection becomes the risk corridors  
5 that says if you lose too much money, the government is  
6 going to help compensate that. If you make too much, you  
7 are going to pay some back. And then they can make an  
8 early adjustment, which is essentially what they did. They  
9 didn't wait for the data to come in, in detail on hep C.  
10 They looked at it and said, "We're going to go in and  
11 manipulate that coefficient so that it gives better  
12 protection for this category of illness, this diagnosis,  
13 which we don't even have the claims yet to show. But we  
14 know in the aggregate, this is happening, and so we're  
15 going to up the risk adjustor for people with hep C."

16           DR. SAMITT: The only other point that I would  
17 make on Draft Recommendation 1 is, in the category of  
18 eliminating cost sharing above the out-of-pocket threshold,  
19 so the third part, we haven't had discussion about the  
20 distinction between eliminating and nominal. And so, while  
21 I recognize the potential benefits of eliminating  
22 altogether, the question is, wouldn't we prefer something

1 nominal in terms of cost sharing so that there is some  
2 accountability at the beneficiary level for costs above  
3 that threshold? And even if you say that it's eliminated  
4 for generics above the threshold, but not for others, that  
5 may be a better modification to this.

6 DR. CROSSON: Jack, is that the area that you've  
7 done research in? Do you want to comment?

8 DR. HOADLEY: Well, in part, yeah. I mean, I  
9 guess the point I made the last time we had this discussion  
10 were a couple. One is we've said in Medicare Advantage  
11 that there should be a hard out-of-pocket cost in spending,  
12 so the same logic, you know, in a sense would have said,  
13 well, even on Medicare Advantage, if you're using health  
14 care services, you've hit the cap. We do it in the ACA on  
15 the exchanges, say there should be a hard out-of-pocket  
16 cap. And I think for the kinds of -- the people that are  
17 in this kind of territory, they're in it because either  
18 they're taking a whole lot of drugs -- and that ought to be  
19 maybe addressed in other mechanisms, but if the cost  
20 sharing hasn't slowed them down all the way up to this  
21 catastrophic limit, there's no reason to me to think that  
22 it's going to slow them down on an ongoing basis. And for

1 the people who are up in the catastrophic, which is a lot  
2 of them because they're taking one very expensive drug,  
3 putting a nominal copay on a \$1,000-a-month drug seems  
4 like, you know, not really going to -- you know, if there's  
5 value in that drug and you manage to do the 33 percent  
6 coinsurance the first month you took it and some other  
7 amount the second or third month, then you're hitting the  
8 third, fourth, fifth month, and you're being told, well,  
9 they're going to charge you another \$5 just to make sure  
10 you really want to take that drug. It just doesn't seem to  
11 me to be a real behavioral kind of thing.

12 MS. UCCELLO: Or way more than \$5, and people are  
13 then lacking the hard backstop on total out-of-pocket  
14 spending. You know, another \$1,000 a month for people,  
15 month after month --

16 DR. HOADLEY: Which is exactly what the 5 percent  
17 does.

18 MS. UCCELLO: -- is still a burden.

19 DR. CROSSON: Cori, I had your name, but did you  
20 get your point in?

21 MS. UCCELLO: I'm not done.

22 [Laughter.]

1 DR. CROSSON: Why did I think that?

2 MS. UCCELLO: So just back to risk adjustment, so  
3 to kind of just complete this thought that because there's  
4 more pressure in risk adjustment and risk adjustment isn't  
5 perfect, that we're just going to have to monitor plans to  
6 make sure they don't engage in other behaviors that will  
7 have them avoiding some of these high-cost people, just  
8 something we need to keep in mind.

9 And in terms of the predictability of this stuff  
10 -- and you talked about reinsurance in the paper -- you did  
11 a really great job of talking about the lasering issue and  
12 how reinsurers aren't going to want to reinsure the folks  
13 who are already known to have predictably high cost. So  
14 that can somewhat limit the usefulness of some of this  
15 private insurance if we think it's just to get at this high  
16 cost problem. It's the unpredictable high cost issue that  
17 the reinsurance will be able to address, so I just wanted  
18 to make that clear. I think I'm done.

19 DR. CROSSON: Okay. We're on discussion on  
20 Recommendation 1. Rita.

21 DR. REDBERG: I wanted to pick up on Kate's  
22 comment on the \$1,000-a-month and it's a burden. I mean, I

1 think we should be clear that \$1,000-a-month drug is a  
2 burden, full stop. Okay. And we're just talking about who  
3 it's burden on, but it's a burden because that's a lot of  
4 money to be paying for drugs, and we're just talking about  
5 should the Medicare program have that burden, should the  
6 plans have that burden, should the beneficiaries have that  
7 burden. It's a burden, and that's what we have to really  
8 talk about, you know, not just shifting it from one place  
9 to another, but those are very expensive drugs and is that  
10 the value and sort of look at it from that point of view,  
11 what is anyone getting for those, because otherwise we're  
12 just talking about shifting high-cost drugs that we don't  
13 really know what we're getting for those costs, so that's  
14 what I would suggest.

15 DR. CROSSON: Okay. Thank you.

16 Seeing no further comments on Recommendation 1,  
17 we are going to move to Slide 13, Recommendation 2, and I  
18 will start again with Jack.

19 DR. HOADLEY: So this recommendation is a  
20 refinement of one that we've already got on the books,  
21 which was done the year before I came on the Commission.  
22 If I were the Part B czar, I would probably suggest a

1 modification that reduced to zero the cost sharing for  
2 generics, maybe preferred multisource drugs and maybe  
3 biosimilars, and not raise the cost sharing for the brand  
4 drugs. I can be comfortable with the way this is  
5 structured, and I think the one change I guess I would like  
6 to suggest on this is to direct the -- to maybe on the  
7 second bullet go to specifying the zero cost sharing for  
8 the generics, maybe not on the preferred multisource --  
9 well, preferred multisource, I guess that's the -- yeah, I  
10 guess I would do it for all three of these categories. I  
11 was thinking that was saying brand drugs. But I think I  
12 would go to eliminate the cost sharing for the generics,  
13 the preferred multisource drugs, which really means  
14 preferred drugs among -- you know, if there's multiple  
15 brands available, and biosimilars, and then, you know, what  
16 is implied, to my question earlier, is that we might be  
17 upping somewhat the brands in categories where there are  
18 therapeutic alternatives, which is, of course, the  
19 implications of the third bullet. And that's the  
20 combination of circumstances, it seems to me, that will get  
21 the largest behavioral response.

22           So I am comfortable with this recommendation, but

1 the suggestion that we just change it to say "eliminate"  
2 instead of "reduce or eliminate."

3 DR. CROSSON: Anyone want to comment on that  
4 comment?

5 [No response.]

6 [Comments off microphone.]

7 DR. CROSSON: Any comments on Recommendation No.  
8 2 [off microphone]?

9 DR. BAICKER: Just a very small one. I'm  
10 supportive of this. I'm more comfortable with the "reduce  
11 or eliminate," because I can see a rationale for at least  
12 some of these for maintaining some cost sharing if we think  
13 the incentives line up better for monitoring use. The  
14 classes that we're describing are broad enough. The  
15 "reduce or eliminate" I feel adds some flexibility and  
16 speaks to the general idea that we want these groups of  
17 drugs to be more affordable. So I'd vote for leaving it  
18 the way it is.

19 MS. BUTO: I agree with that point, especially  
20 since I think we haven't talked about some of the increases  
21 in the prices of generic drugs. So if we go to a zero co-  
22 pay for generic drugs and we see behavior where generic

1 pricing is sort of out of control or continues to escalate,  
2 I think that's a problem. So I would leave it flexibility  
3 also.

4 I go back to Jack's point -- two points,  
5 actually, two different comments. One is the issue of not  
6 raising the cost of the brand drug, the co-pay, because  
7 there will be some patients who need the brand-name drug.  
8 And to have them in a sense have to be the funding source  
9 to subsidize the use of generics bothers me, and  
10 particularly since the other comment you made about I don't  
11 think we've yet figured out how to make the appeals process  
12 more speedy. So that's going to create hardship in some  
13 places, and particularly, again, if there's a Medigap  
14 issue. So I would just like to see --

15 DR. SCHMIDT: Could I add something on --  
16 information on that?

17 MS. BUTO: Sure.

18 DR. SCHMIDT: So there is a process -- it's an  
19 imperfect process, but beneficiaries can apply for tiering  
20 exception, so lower cost sharing, even if it's something  
21 that wasn't preferred.

22 MS. BUTO: We might want to mention that

1 somewhere in the text, or maybe you already have. But I  
2 think that's helpful.

3 DR. SAMITT: So what I haven't seen mentioned in  
4 this recommendation and I wonder if it should be included  
5 is any incentives regarding use of preferred pharmacies and  
6 whether this is the right category to consider beyond just  
7 the cost sharing related to generic versus brand, but  
8 whether there should also be an incentive for enhanced use  
9 of preferred versus non-preferred.

10 DR. SCHMIDT: So we did bat that around a bit,  
11 and I think -- Mark, you can jump in here, too, but the  
12 thought was that, you know, even if you, say, doubled the  
13 brand co-pays, it's -- one thing we heard from beneficiary  
14 advocates is that, first of all, it's can be difficult to  
15 find information about what is a preferred pharmacy. The  
16 plan finder tool is not necessarily well geared for  
17 figuring that out right away. You have to kind of jump  
18 through some hoops to figure that out. And the dollar  
19 amounts involved might not be enough. You know, you have  
20 many different categories of incentive to use generic  
21 versus brand versus preferred versus non-preferred  
22 pharmacies. We were starting to think it might be a bit

1 confusing, and we thought that trying to encourage more of  
2 the generic use was kind of the primary thing to pursue.

3 DR. CROSSON: Craig, can I ask you, then, on that  
4 note, in your own organization is this identification and  
5 communication of access to preferred pharmacies easy or  
6 complicated?

7 DR. SAMITT: I guess the way I'd address it is  
8 that this should be a solvable issue, and so I don't think  
9 that this would be a barrier. You know, we've reviewed in  
10 multiple reports before the implications of preferred  
11 versus non-preferred as another driver of cost. So I  
12 think, you know, the ability to enhance finder capability  
13 should be a solvable issue, as well as making an  
14 understandable and somewhat simplified incentive for use of  
15 preferred once it's found.

16 So I don't -- I would say those wouldn't be  
17 reasons why we should not consider it. Or maybe it's an  
18 immediate subsequent phase of these recommendations. But I  
19 would want to bake it in.

20 DR. CROSSON: I think it's reasonable. I think  
21 also that I get the sense that we don't have enough  
22 information, and that was one of the reasons that maybe we

1 don't really have enough information yet to have added that  
2 here. And as you say, perhaps we can come back to that  
3 issue. That would be my sense.

4 DR. HOADLEY: Just to follow up on that point, I  
5 think the other piece beyond what Rachel mentioned -- and I  
6 think the confusion issues, you know, are -- I've been  
7 listening to some beneficiary advocates talk about these  
8 issues, and the counselors who talk to beneficiaries really  
9 do find it very hard to sort through the options. But  
10 there's also an access issue, and CMS has been trying to  
11 address that and has made some progress between 2015 and  
12 2016 in addressing the adequacy of these preferred pharmacy  
13 segments of the pharmacy networks. But there's still quite  
14 a few outlier plans. But when you add to that for a low-  
15 income population, their transportation flexibility is a  
16 lot less. So, whereas, to tell one of us that we need to  
17 drive an extra mile to get the better price, you know,  
18 fine, that's not that big a deal. I'll either pay the  
19 extra or I'll drive -- the choices are quite clear. But to  
20 a person who's limited to public transportation and maybe  
21 the preferred pharmacies are not on the public  
22 transportation routes or they've got a particular pharmacy

1 in the neighborhood that's been very good for working with  
2 them and it's an independent, which are generally not among  
3 the preferred pharmacies. So I think the access issues are  
4 a pretty serious part of this as well.

5 DR. CROSSON: I'm just going to suggest that we  
6 keep this on the list, and as we get more information about  
7 Jack's points, or perhaps you could add some as well, as to  
8 how this works in your own organization, and whether it's  
9 easy or complex, then we could come back to it, if that's  
10 okay.

11 DR. MILLER: And it sounds like whichever way the  
12 recommendation comes out, it sounds like this at least gets  
13 a discussion in whatever the write-up is, because, again, I  
14 think we had a lot of the same reaction that you had as  
15 were discussing it internally. And then it comes to "but  
16 for this population" is where we sort of hung up.

17 DR. CROSSON: On Recommendation No. 2, Rita.

18 DR. REDBERG: I just wanted to comment on the  
19 previous comment about generics and brand name. For a  
20 generic to get on FDA approval, it has to be  
21 therapeutically equivalent to the brand name. So I think  
22 there's really very few circumstances where you couldn't

1 have generic substitution. You know, the few studies that  
2 have been done looking at that usually find that generics  
3 are equivalent to brand-name drugs. So I think it's less  
4 of a concern than --

5 DR. HOADLEY: I think here we're talking about  
6 substitution across a class, not for the same product. So  
7 it might be that one drug in the class that's available  
8 generically doesn't have the same clinical properties as  
9 some of the other things in the class, and that's where the  
10 issue would come up.

11 DR. REDBERG: I think it's as poorly studied  
12 area.

13 DR. HOADLEY: That I agree with [off microphone].

14 DR. REDBERG: And the other comments I would make  
15 just in general when we look at sort of making changes, we  
16 usually look at the capital and the margins of the  
17 industry, but we haven't done that for the pharmaceutical.  
18 You think we should --

19 DR. MILLER: That's true.

20 DR. REDBERG: -- be doing that, too?

21 DR. MILLER: And Warner has raised this point a  
22 couple times, and we have some work going in the back room

1 that we're trying to, you know, work through. It's a  
2 little more difficult than you might think. And, you know  
3 --

4 DR. REDBERG: Those nights and weekends.

5 DR. MILLER: Yeah -- no, my nights and weekends  
6 are spoken for. I said theirs were open.

7 [Laughter.]

8 DR. MILLER: It is a little more difficult. Of  
9 course, when we talk about margins elsewhere, we have  
10 arrays of data that come in through Medicare. In order to  
11 do it here, it's a little more searching.

12 DR. CROSSON: Thank you very much. We're going  
13 to now show Slide 18, and we'll entertain discussion on  
14 Draft Recommendation No. 3.

15 DR. HOADLEY: So, you know, I think this is kind  
16 of what Scott had in mind when he talked about sort of the  
17 linkage of the different recommendations, and I take that  
18 point very seriously. I think my concerns on some of the  
19 items here are more about trying to make sure I completely  
20 understand what we're trying to address.

21 I think the first one is pretty clear. That has  
22 been addressed by CMS. And I think the -- I mean, I do

1 kind of look back to the data that we presented, that you  
2 guys presented in the March chapter, and, you know, the  
3 track for some of the protected classes wasn't really all  
4 that different from the other classes. So that does raise  
5 the question of how important this is.

6 But, on the other hand, the antidepressant class  
7 in particular is mostly generics now, so I think the need  
8 for the protection does seem a lot less than it once was.  
9 So I'm okay with that.

10 And I think as long as we clarify what the  
11 procedural changes are on the midyear formulary changes, I  
12 don't have any problem with that. I think what I want to  
13 make sure is that we're not sort of loosening the notion  
14 that there's got to be a good reason for the negative  
15 changes that are made, and the good reason usually has to  
16 do with there's a new product that's gone generic, and so  
17 the brands that were previously in the preferred tier now  
18 sort of appropriately could go to a non-preferred tier or  
19 even off formulary because there's other generics available  
20 that -- and I think that's the kind of situation that it  
21 probably does make sense. So, again, as long as we just  
22 say very clearly what sort of process changes we have in

1 mind.

2           On the third one, I guess, you know, in your set  
3 of points that sort of created the issues, I guess it was  
4 back on Slide 16, the different concerns about this  
5 process, I guess my concern here is we've sort of addressed  
6 the prescribers find it -- well, we've addressed the  
7 sponsors feel like they're not able to really enforce their  
8 things, and yet there's also issues of prescribers finding  
9 processes burdensome and beneficiaries not understanding  
10 their rights. So I wonder if there aren't some things we  
11 could do. It just feels like it's solving one piece of the  
12 issue and not the other pieces. And I just try to think  
13 about whether there's anything else we could add to this to  
14 -- and, you know, maybe the standard form, I don't know if  
15 that's one of the things you have in mind here, but that's  
16 something that presumably is helpful to prescribers, that  
17 they have the same paperwork regardless of the plan they're  
18 in. The beneficiaries sort of better noticing of what  
19 their rights are has been some of the issues there, and  
20 maybe there's something -- and I know we've sort of talked  
21 in text in some pass, and maybe there's something we could  
22 add there.

1           On the management of specialty process, some of  
2 these are kind of new issues to me. The designated  
3 specialty pharmacies in particular make me wonder whether  
4 there are going to be access implications and sort of how  
5 widely available are those pharmacies and does this become  
6 an access barrier. And I just don't have the information  
7 to speak to that. I don't know if you have better  
8 information that can become convincing on that, or whether  
9 the statement needs to be much more about, you know, as  
10 long as access concerns are resolved. And I know some of  
11 that is probably in the text.

12           The two specialty tiers is something else I  
13 hadn't thought much about, and I could get into a much  
14 longer discussion of that that we don't really have time  
15 for. But one of the things that starts to occur to me is,  
16 you know, we watched the tiering structure go from, you  
17 know, a single generic tier, two brand tiers, and a  
18 specialty tier. Now we've got pretty much all plans going  
19 two generic tiers. Now we're looking at a day when there  
20 would be two specialty tiers. So we'd be going up to, you  
21 know, like a six-tier system. And one of the things that  
22 struck me is maybe the way this should be evolving in the

1 future is not towards the continued splitting off of  
2 specialty tiers from brand tiers. Most brand tiers now are  
3 doing coinsurance. They don't really look all that  
4 different than the specialty tiers except if the specialty  
5 tier denies the beneficiary the right to ask for a tiering  
6 exception.

7           So would we be better off -- and I don't know how  
8 the plans would react to this -- to actually consolidate  
9 back the other direction, put all brand drugs on a pair of  
10 tiers with coinsurance without drawing the distinction  
11 between the specialty and other kinds of brands, allow  
12 exceptions across the board, because what I worry about is  
13 the amount of sort of complexity that we already are  
14 developing in terms of the tiering structure for  
15 beneficiaries, and would that have -- that would still  
16 allow that sort of dual choice between putting some  
17 specialty drugs in a higher tier and some in a lower tier,  
18 but without the complexity of what would then become a six-  
19 tier system.

20           So that's just some of what I wanted to throw out  
21 to think about.

22           DR. CROSSON: Okay, on Recommendation 3.

1 MS. BUTO: I just have a question. Maybe Jack  
2 could answer this, actually, or Rachel or Shinobu, and  
3 that's on the tiering issue. Is it tiering just based on  
4 price, or is it -- let's say you've got an individual, and  
5 that person needs something that is an expensive drug, and  
6 for whatever reason there's no good alternative. Is the  
7 tier based just on price or is it based on, you know, a  
8 limited sort of patient selection criteria? Could that be  
9 a tier? In other words, you can't get to that drug no  
10 matter how much you're willing to pay out-of-pocket unless  
11 you meet certain patient criteria? Because I'm fearful  
12 that we're getting to the point where if you're that person  
13 who needs that expensive drug, you're in an expensive tier  
14 just because it's expensive as opposed to whether you have  
15 any alternatives therapeutically.

16 DR. SCHMIDT: Well, plans are, as Jack said,  
17 allowed to designate a specialty tier now, and it is based  
18 on the price of the drug. But it's pretty common or pretty  
19 uniform, I would say, for most plans to apply prior  
20 authorization on those drugs, even though it's on a  
21 specialty tier, to make sure that at least the person has  
22 the indication for which that drug applies.

1 MS. BUTO: So you're basically -- so that person,  
2 even if they really don't have good alternatives, will have  
3 to pay the highest or a potentially very high co-pay.

4 DR. SCHMIDT: That's right. It's generally 25 to  
5 33 percent.

6 MS. BUTO: Thanks.

7 DR. HOADLEY: And if there were two specialty  
8 tiers, I mean, if the second of the specialty tier became  
9 an even higher percentage, you know, again, maybe that's  
10 part of what your question implies. Does that just become  
11 -- well, when they get really expensive, we're going to --  
12 I mean, they're already -- you know, it's a coinsurance, so  
13 a \$1,000 drug at 33 percent is \$330, and a \$500 drug at 33  
14 percent is \$160. So, you know, you've already got that  
15 sort of price-related thing. You know, would it be used  
16 for sort of biosimilars versus other specialty -- what  
17 you're really proposing is to allow them to have a  
18 biosimilar, a lower -- you know, I think some of the  
19 details of how this might be used and what the rules  
20 associated with this would be, would they be allowed to  
21 have the top tier be more expensive than is allowed today?  
22 Or is it that it could be a cheaper one to create an

1 incentive to use, say, a biosimilar?

2 MS. BUTO: I think we sometimes forget that price  
3 isn't the only issue. Sometimes it's a matter of what the  
4 appropriate medicine is for the person.

5 DR. MILLER: I thought the thinking here for [off  
6 microphone] allowing two tiers, one of the specialty drugs  
7 could find its way down to something less. That was the  
8 thinking.

9 DR. HOADLEY: At the very least, that should be  
10 more explicit.

11 DR. MILLER: Absolutely. And, you know, that's  
12 always true, and we'll always take that and make the text  
13 more clear.

14 The other thing, I can't tell from your exchange,  
15 I think our general posture has been, you know, the plans  
16 in the market tries to innovate, you know, from year to  
17 year as new drugs and new indications come on, and over  
18 time they have pushed this process of kind of  
19 differentiating. Now you have a tier between, you know,  
20 preferred generics and non-preferred generics because, you  
21 know, some of the prices are even rising there. And I  
22 couldn't tell from your comment and then your exchange, are

1 we saying we would then go back to plans and say, okay, now  
2 here is how you have to do your tiering? Whereas, I think  
3 we've generally taken a posture of unless we see a tiering  
4 that's really abusive, we tend to let the plans kind of  
5 figure out how they want to structure some of this stuff.

6 DR. HOADLEY: Certainly, the status quo has been  
7 a lot of flexibility, and what CMS has done in several  
8 stages over the years is tried to put some discipline on  
9 it, so they've got now ranges of allowable copays or  
10 coinsurance in certain tiers. They've got more labeling  
11 requirements. This year's call letter says, "Well, because  
12 we've seen this phenomenon where there's a lot more  
13 generics on the so-called brand tiers, that plans could  
14 switch and just call it a non-preferred tier without  
15 designating a non-preferred brand."

16 But what I keep hearing on the beneficiary  
17 community side is this is just getting more and more  
18 confusing. So, when beneficiaries are trying to figure out  
19 how to pick a plan and then how to use their plan once they  
20 pick it, you know, they can obviously go to the plan finder  
21 and just say, "Forget what all the tiers are called, and  
22 just tell me what it's going to cost me." But there was a

1 time when we thought about the tiers were sending signals  
2 to people, that we really do prefer you to use certain  
3 drugs over others. But the complexity has gotten to the  
4 point where it's like overwhelming to most people, and I  
5 think that's part of what I'm saying, is we're continuing  
6 to just split it up.

7 I get the notion of having a less expensive tier.  
8 I think that's a good thing, but I'm just wondering whether  
9 there's a different way to get at it and whether all the  
10 amount of sort of planning, experimentation is sometimes at  
11 the expense of beneficiary comprehension of what's going  
12 on. DR. CROSSON: Mary.

13 DR. NAYLOR: So I support the recommendation,  
14 except for the last bullet. Really stimulated by this last  
15 conversation. I think that -- and especially, I think in  
16 the body of the work, you talked about the management plans  
17 that commercial plans are using, and that these would need  
18 to be carefully monitored by CMS to make sure we weren't  
19 restricting access.

20 But if you -- the list of options of 15-day  
21 fills, refills, and specialty pharmacy designations and  
22 this tiering, I mean, if all of those tools were applied,

1 it could dramatically restrict access, I think, to Medicare  
2 beneficiaries.

3           So I would be very concerned to just say permit  
4 plans to use certain tools without real understanding of  
5 the implications it would have on access for this  
6 population.

7           DR. CROSSON: So, Mary, I think one of the  
8 reasons it was worded this way was not just for simplicity  
9 and lack of complexity, but also to provide CMS with some  
10 latitude in terms of which among these tools they decided  
11 to use.

12           We could -- I'm trying to understand whether  
13 you're suggesting that we actually, in the next version,  
14 list those that we think should be included or what.

15           DR. NAYLOR: I'm just trying to make sure that we  
16 don't impose -- well, I mean, I would want to make sure  
17 maybe in the write-up that the suggesting -- enabling the  
18 Secretary to permit plans to use tools to manage specialty  
19 drugs does not result in severely restricting access to  
20 people that need it.

21           DR. CROSSON: So this is a point that could be  
22 made in the text; is that right?

1 DR. NAYLOR: It is. And it is made in the text.  
2 There is a comment that that could happen and that CMS will  
3 need to carefully monitor it. So I'm just trying to figure  
4 out what's the right language, I guess, that would enable  
5 management tools, but that would not -- you know, that are  
6 really paying attention to this population.

7 I mean, I'm thinking of the 75-year-old who will  
8 have to go to a pharmacy for specialty drugs, who would  
9 have to go every 15 days. So I'm just thinking of the  
10 combination of what might be made available and use that  
11 could restrict access. So I guess I am looking for more  
12 assurance that, on the one hand, it provides plans with the  
13 flexibility that they need, on the other hand, does not  
14 severely create access issues for the beneficiary. So  
15 that's -- maybe it's a language.

16 DR. CROSSON: In the way the recommendation is  
17 worded or the comprehensiveness with which the point is  
18 made in the text?

19 DR. NAYLOR: I don't know, to tell you the truth.  
20 Maybe it's the comprehensiveness with which it's in the  
21 text, but, you know, a real caution around how application  
22 of multiple tools simultaneously could really create access

1 issues for the population, so something like that.

2 DR. CROSSON: Okay, thanks. Kathy. Kathy and  
3 Scott.

4 MS. BUTO: Yeah. Just a quick comment on Mary's  
5 comment. I share her concern and think that maybe one way  
6 to deal with this is to have the Secretary -- because it  
7 isn't just this recommendation. We've got two others, one  
8 of which is actually going to probably increase the plan's  
9 risk on the reinsurance end, which I think is going to put  
10 more pressure on the plan, you know, from the get-go. So  
11 we could see, with a recommendation like this, the use of  
12 multiple tools that will make access difficult.

13 I think another way to deal with it is to have  
14 our recommendation also sort of suggest that the Secretary  
15 needs to do an impact assessment really of all of the  
16 recommendations and the impact they might have collectively  
17 on beneficiary access and to develop ways of monitoring  
18 that access over time, something like that, because we  
19 can't just take them individually. All three of them are  
20 going to have an impact on beneficiaries.

21 DR. MILLER: The only other thing I would suggest  
22 -- and I haven't cleared this with the Chairman -- is we

1 may also be able to get at least a few words into the reg  
2 itself that imply the intent of what we're trying to pull  
3 off here. You've sort of made two tiers, maybe not so bad  
4 if it does this, whatever other things. If our concern is  
5 some balance between flexibility and access, maybe there's  
6 at least a few words where that pointer is in there, and  
7 then we can go into the text and say this is the kinds of  
8 things we're talking about. And then it's at least visible  
9 enough to all view as you vote that it has been taken into  
10 account, and then the text can try and go after the issue.

11 DR. CROSSON: Including Kathy's idea in the text.

12 DR. MILLER: And I don't have any objection to  
13 what Kathy said, so that could get in there as well.

14 DR. CROSSON: Yeah, okay. Scott.

15 MR. ARMSTRONG: So, on the one hand, I want to  
16 agree, Mary, with your concern that these policies  
17 shouldn't limit people who need help from getting the care  
18 they should be getting, but I really disagree that if --  
19 particularly, Kathy, it reminds us we're looking at all  
20 three of these recommendations, and if we're going to shift  
21 a whole lot of responsibility to the health plans for a lot  
22 of really good reasons, then we need to allow the health

1 plans to apply tools to pharmacy drugs that they've been  
2 applying for decades to all sorts of other kinds of care  
3 with, you know, responsibility for assuring access and  
4 clinical quality and all the other things that we hold them  
5 accountable to.

6           And I would just say that split fills as an  
7 example has saved my system tens of millions of dollars and  
8 our patients tremendous improvement in quality of care  
9 because we're engaged short order after very expensive  
10 prescriptions and finding out was it really the right drug  
11 or not.

12           Specialty pharmacies give our beneficiaries the  
13 opportunity to engage clinical pharmacists who have  
14 specialty knowledge around their prescription in a much  
15 higher quality kind of course of care, and so I think we  
16 need to be careful about this. But these are exactly the  
17 kinds of interventions and tools that, in a broad sense,  
18 we've been advancing through payment policy for the five,  
19 six years that I've been part of MedPAC. I wouldn't be too  
20 cautious about applying this to our medical drug cost as  
21 we're starting to move into that neighborhood.

22           DR. CROSSON: Okay. Well, Rachel and Shinobu

1 will work this all out.

2 Oh, sorry. Jack, one more.

3 DR. HOADLEY: Just to follow on, I mean, this is  
4 the challenge, then, sort of this mix of comments. Because  
5 we're just seeing the recommendations, we're not able to  
6 look at it in the context of the text that will be written,  
7 and so, obviously, part of the test will be how we put this  
8 together.

9 But, I mean, I think I take Scott's comments --  
10 or I think these are the techniques that could really work.  
11 They've got to be done, and I trust Scott's plans to do  
12 this really well. I'm not sure I trust every plan to do  
13 this well, to make sure that they've got specialty  
14 pharmacies contracted that are convenient to where  
15 beneficiaries live, to make sure that they are handling a  
16 split fill in a way that somebody who is frail and can't  
17 always get out can get it delivered to them instead of  
18 having to go down and pick it up.

19 I mean, I think coming up with some of the -- and  
20 maybe this, again, writing this into the text when we raise  
21 these kinds of issues, on the one hand, a split fill does  
22 these good things. On the other hand, if it's done in a

1 way that makes it hard for people to get those drugs, they  
2 need to be -- consideration about delivery or other kinds  
3 of things. And then we can put that all together.

4 I also would wonder which of these things the  
5 Secretary already has the authority for. I mean,  
6 certainly, the specialty tiers, the Secretary created them  
7 in the first place. They're not in law. The Secretary  
8 could do that today, so we may -- it's something, I know,  
9 Kathy sometimes brings up is which are these things does  
10 the Secretary already have the authority to do and which of  
11 these things -- and maybe the specialty pharmacy is an  
12 example of something the Secretary could not do today, but  
13 maybe she could. And so that just probably is a useful  
14 thing to mention as well.

15 DR. CROSSON: Okay. Very good discussion. Thank  
16 you, everyone. I think we have exhausted our time for this  
17 topic. Thank you, Rachel and Shinobu. Very good work, as  
18 usual.

19 And now we're going to move from Part D to Part  
20 B.

21 [Pause.]

22 DR. CROSSON: Okay. So, now we're going to have

1 a discussion about Part B. We're going to have, based on  
2 prior discussions we've had at the Commission, we're going  
3 to have one recommendation as it applies to dispensing and  
4 supplying fees. But, the majority of the discussion, I  
5 think, is going to be to take us through some potential  
6 avenues that we could explore, some of which we've referred  
7 to before, some of which may be a little new, and in the  
8 process of discussing the presentation, or we're going to  
9 try to focus in or prioritize those areas that we think  
10 have the most potential benefit as well as feasibility.

11 So, we have Kim Neuman, and it looks like Kim has  
12 got a shotgun there. Joan Sokolovsky has joined us again.

13 DR. SOKOLOVSKY: Silent partner.

14 [Laughter.]

15 DR. CROSSON: Silent partner. I thought maybe  
16 the shotgun was under the table.

17 Kim, go ahead.

18 MS. NEUMAN: So, as Jay said, today, we're going  
19 to continue our discussion of Part B drug payment policy  
20 issues that we began last spring and that we discussed most  
21 recently at the November meeting.

22 Today, we'll focus on three types of issues.

1 We'll first talk about the six percent add-on to the  
2 average sales price and a policy option to restructure it,  
3 a topic we've discussed previously.

4           Then we'll discuss some broader policies beyond  
5 the add-on payment that could have the potential to  
6 increase price competition among Part B drugs or put  
7 downward pressure on ASP. These are ideas we could develop  
8 further over the next cycle if there's interest.

9           Lastly, we'll revisit the issue of the Part B  
10 dispensing and supplying fees and we'll have a draft  
11 recommendation from the Chairman for your consideration.

12           One last thing to note. As far as going forward,  
13 the idea is that the topics we discuss today would be  
14 included in a June report chapter with the potential for  
15 these issues to be developed further in the future,  
16 depending on your guidance.

17           You've seen this slide with background on the ASP  
18 payment system before. I'll just highlight a couple of  
19 quick points. As you know, Medicare pays for most Part B  
20 at a prospective rate equal to 106 percent of the average  
21 sales price. ASP is the drug's price from the perspective  
22 of the manufacturer. ASP is defined as the price realized

1 by the manufacturer for sales to all types of purchasers,  
2 with some exceptions, net of rebates, discounts, and price  
3 concessions. The price an individual provider pays for a  
4 drug may differ from ASP for a variety of reasons, such as  
5 price variation across purchasers.

6 As we've discussed previously, concern has been  
7 expressed that the six percent add-on to ASP gives  
8 providers a financial incentive to prescribe higher-priced  
9 drugs. However, few studies have looked at whether the six  
10 percent add-on is influencing prescribing behavior.

11 In November, we modeled two budget neutral  
12 options to restructure the six percent add-on. We took a  
13 hybrid approach where we reduced the percentage add-on and  
14 added a flat fee. Commissioners had several reactions to  
15 this. Some Commissioners expressed concern about whether  
16 providers would be able to purchase drugs within the  
17 Medicare payment amount. Some Commissioners felt the  
18 policy changes were modest and suggested we consider models  
19 that generate savings. And several Commissioners urged  
20 further work to consider broader approaches.

21 So, with that feedback, we've done additional  
22 work on all of these points. First, to get a sense of how

1 the prices providers pay for Part B drugs compare to  
2 Medicare's payment rate, we obtained proprietary invoice  
3 price data from IMS Health Incorporated. These data break  
4 out prices for the clinic channel of purchasers, which  
5 includes physician offices, hospital outpatient  
6 departments, and non-hospital surgery centers and dialysis  
7 facilities. We analyzed data for 34 Part B drugs that  
8 accounted for about two-thirds of Part B spending in 2014.

9           Because our contract with IMS Health does not  
10 allow us to report actual prices, we focused on the ratio  
11 of the invoice price to the average sales price and  
12 summarized our results across the 34 drugs.

13           This chart shows the trend in the median 75th  
14 percentile invoice price as a percent of ASP between first  
15 quarter 2012 and second quarter 2015. So, here's how to  
16 interpret this measure. If the median 75th percentile  
17 invoice price is 103 percent of ASP, that would mean that  
18 for half of the 34 drugs, at least 75 percent of the volume  
19 was sold to clinics at an invoice price at or below 103  
20 percent of ASP.

21           Now, looking at the trend line, what we can see  
22 is that this measure of invoice prices as a percent of ASP

1 declined in second quarter 2013, the same quarter the  
2 sequester went into effect. As you know, Medicare's  
3 payment rate is ASP plus six, but the sequester reduces it  
4 to effectively ASP plus 4.3 percent. So, this chart  
5 suggests that some manufacturers may have responded to the  
6 sequester by changing their pricing patterns in a way that  
7 mitigated the effect of the sequester on some providers.

8           Next, we look more closely at the distribution of  
9 invoice prices as a percent of ASP across the 34 drugs for  
10 one quarter. Here, we have data for first quarter 2015.  
11 Looking at the first two lines in the chart, we can see  
12 that for about two-thirds of the 34 drugs, at least 75  
13 percent of the volume was at an invoice price less than 102  
14 percent of ASP.

15           In summary, these data suggest that for a  
16 substantial portion of the volume for many of the drugs in  
17 our analysis, there is still headroom between providers'  
18 acquisition costs and the Medicare payment rates, even with  
19 the sequester.

20           Now, turning back to our work modeling  
21 alternatives to the six percent add-on to ASP, we've  
22 modeled a new policy option that generates savings. The

1 option is 103.5 percent of ASP plus a flat fee of \$5 per  
2 drug administered per day. Overall, this approach is  
3 estimated to save about 1.3 percent, or about \$270 million  
4 annually, and that's based on 2014 data, assuming no shifts  
5 in utilization. These savings would be split 80/20 between  
6 the program and beneficiaries.

7           The policy has the effect of increasing the add-  
8 on payments for drugs with an ASP per administration of  
9 less than \$200 and decreasing the add-ons for higher-priced  
10 drugs. The policy option would reduce, but not eliminate,  
11 the difference in add-on payments between higher-priced and  
12 lower-priced drugs. Specifically, it reduces the  
13 difference in add-ons between two such products by about 40  
14 percent.

15           Jon, you had asked for a real world example of  
16 how this would change the add-on payments for two products  
17 that were therapeutic alternatives and we've added a table  
18 showing that in the paper.

19           Next, we have the revenue effect of the policy  
20 option on different types of providers. Hospitals and  
21 physicians that tend to prescribe higher-priced drugs, like  
22 oncologists, ophthalmologists, and rheumatologists, would

1 see reductions in their Part B drug revenues in the range  
2 of 1.5 percent to 2.1 percent, and you can see that in the  
3 middle column on the chart. As a share of these providers'  
4 total Medicare revenues, the effect is smaller,  
5 particularly for hospitals, and that's the far right  
6 column. Also note that payments would increase modestly  
7 for primary care physicians, who tend to use more  
8 inexpensive drugs, and would be virtually unchanged for  
9 suppliers.

10 In addition to concerns about the six percent  
11 add-on, there are also concerns about the overall prices  
12 Medicare Part B pays for drugs. The largest component of  
13 Medicare's payment for Part B drugs is the ASP. The six  
14 percent add-on is a relatively small share of the total  
15 payment. If the Commission wishes to influence Part B drug  
16 payments to a larger degree than possible through the add-  
17 on payments, we could consider Medicare payment policies  
18 that create more incentives for price competition among  
19 drugs or that put downward pressure on ASP.

20 Today, we'll explore three options. First, an  
21 ASP inflation cap. Second, consolidated billing codes for  
22 Part B drugs. And, third, restructuring the competitive

1 acquisition program for Part B drugs.

2           The growth in ASP plus six payment rates for  
3 individual drugs is driven by manufacturer pricing  
4 decisions. In theory, there's no limit on how much  
5 Medicare's ASP plus six payment rate for an individual drug  
6 can increase over time.

7           In your paper, we included a table showing ASP  
8 growth from 2005 to 2016 for the 20 highest expenditure  
9 drugs. This shows that the median ASP growth across the 20  
10 highest expenditure drugs was slower than inflation from  
11 2005 to 2010, but has exceeded inflation since 2010. For  
12 example, in the last year, ten out of the 20 highest  
13 expenditure drugs have had an increase in their ASP of at  
14 least five percent.

15           A policy option that could be considered would be  
16 to place a cap on how much Medicare's ASP plus six payments  
17 for an individual drug can grow over time. This could  
18 potentially be operationalized through a manufacturer  
19 rebate to Medicare when the ASP for its drug increases  
20 faster than a specified inflation benchmark. One possible  
21 model for this type of policy is the inflation portion of  
22 the Medicaid rebate. Other approaches are possible, as

1 well.

2           If Medicare had an ASP inflation cap, it would  
3 protect against the potential for a dramatic increase in  
4 the Medicare payment rate for a product and it would also  
5 potentially generate savings for drugs with ASP growth  
6 exceeding the inflation benchmark.

7           Next, we consider incentives for price  
8 competition under the ASP payment system. Single-source  
9 drugs and biologics receive their own billing codes and are  
10 paid based on their own ASP. Having drugs with similar  
11 health effects in separate billing codes does not promote  
12 price competition. There are examples of high-expenditure  
13 competitor drugs with relatively stable or increasing ASPs,  
14 which demonstrates that price competition among non-generic  
15 drugs is limited under the ASP payment system.

16           Also related to this is coding policy for  
17 biosimilars and reference products. CMS finalized a policy  
18 to group all biosimilars associated with the same reference  
19 product in one billing code. But even though all  
20 biosimilars will be in one billing code, the reference  
21 biologic will remain in a separate code and paid its own  
22 ASP plus six rate per the statute.

1           In other work, the Commission has held that  
2 Medicare should pay similar rates for similar care. Given  
3 that principle, a policy option that could be considered is  
4 to give the Secretary the authority to put drugs with  
5 similar health effects in the same billing code. With two  
6 or more similar products in the same billing code and paid  
7 at a rate that's based on the average ASP for the products,  
8 drug manufacturers would have more of an incentive to lower  
9 their price below their competitors to make their products  
10 more attractive and garner market share. This would  
11 promote price competition and generate savings for  
12 beneficiaries and taxpayers.

13           Another approach that could be considered to spur  
14 price competition for Part B drugs is a competitive  
15 acquisition program. Medicare's initial experience with  
16 this type of model for Part B drugs was not successful, but  
17 we can explore whether there are ways to restructure it.

18           So, first, this slide has some background on how  
19 the original program worked. The MMA required Medicare to  
20 implement a competitive acquisition program called CAP for  
21 Part B drugs furnished by physicians. It operated from  
22 July 2006 to December 2008. The idea was to take

1 physicians out of the business of buying and billing for  
2 drugs and eliminate any financial incentives associated  
3 with furnishing drugs. With this program, the physician  
4 could choose to enroll or could choose to remain in the  
5 regular buy and bill fee-for-service system.

6           Those physicians that participated obtained drugs  
7 for fee-for-service beneficiaries from a vendor. The  
8 physician would submit a prescription to the vendor for an  
9 individual patient before the patient's office visit. The  
10 patient would ship the drug to the physician. The  
11 physician would then administer the drug and bill Medicare  
12 for the drug administration service only. Medicare would  
13 pay the vendor for the drug and the vendor would collect  
14 the beneficiary cost sharing for the drug. Competitive  
15 bidding was used to select the vendor and to set the prices  
16 Medicare paid the vendor. Although Medicare offered vendor  
17 contracts to more than one organization, only one company,  
18 Bioscript, chose to participate.

19           The original CAP program faced several  
20 challenges. Physician enrollment was low; about 1,000  
21 practices participated each year. The vendor had little  
22 leverage to negotiate discounts. For single-source drugs

1 and biologics, the vendor was required to offer each  
2 product and, therefore, had little leverage to negotiate.  
3 Medicare paid the vendor more than ASP plus six for the  
4 drugs. There were several reasons for this, including a  
5 flawed process for updating the bids. The vendor,  
6 Bioscript, declined to sign a contract to continue serving  
7 as the CAP vendor for 2009 and the program has been  
8 suspended since that time.

9           While the original CAP program faced a number of  
10 challenges, we could consider options to restructure it to  
11 encourage physician enrollment and give the vendor more  
12 negotiating leverage. Your paper walks through some  
13 different approaches that could be considered for doing  
14 this. For discussion purposes, here's an example of a  
15 possible approach.

16           First, several steps could be taken to encourage  
17 physician enrollment. Physicians could be offered the  
18 opportunity to share in any savings from the CAP program.  
19 At the same time, the ASP add-on percentage could be  
20 reduced or eliminated in the traditional buy and bill  
21 system, making it less attractive. And to reduce  
22 administrative burden on physicians as well as the vendor,

1 the program could be changed to a stock replacement model  
2 instead of physicians having to pre-order drugs for each  
3 individual patient.

4           Second, the vendor could be permitted to operate  
5 a formulary and, like physicians, could share in any  
6 savings generated by the program.

7           Finally, to the extent that the program led to  
8 lower prices, the savings could be shared with  
9 beneficiaries through lower cost sharing.

10           To make this more concrete, let's talk through an  
11 example of applying this approach to a specialty. We'll  
12 use ophthalmology as our example. I want to note, though,  
13 that using ophthalmology as an example does not mean the  
14 CAP program would necessarily be limited to only a few  
15 drugs. A restructured CAP program could also be applied  
16 broadly across specialties, like, for example, the original  
17 CAP program applied to about 180 drug billing codes.

18           We've picked ophthalmology because there's a  
19 sizeable amount of drug spending, but a limited number of  
20 drugs, and spending is concentrated among just a few  
21 competitor drugs. So, there may be opportunities to garner  
22 price competition and get savings. So, here is how this

1 might work.

2           As noted previously, ophthalmologists would be  
3 encouraged to enroll in the CAP program in several ways.  
4 The ASP add-on in the traditional buy and bill system would  
5 be reduced or eliminated. At the same time, physicians who  
6 chose to enroll in the CAP program would have opportunities  
7 to share in any savings generated by the program.  
8 Organizations that wanted to become CAP vendors would  
9 submit bids to Medicare on the price at which they could  
10 offer each drug. Organizations that could offer the lowest  
11 prices would be selected as vendors. Vendors' leverage to  
12 negotiate discounts would come from their ability to  
13 construct a formulary and from physicians having shared  
14 savings opportunities. Both ophthalmologists and the  
15 vendor would be eligible for shared savings, in other  
16 words, extra payments, if the program saved money.  
17 Beneficiaries would also share in savings by paying 20  
18 percent of a lower price.

19           So, last, we have the issue of the dispensing and  
20 supplying fees. You will recall we discussed this in  
21 November and there was general agreement on the issue. In  
22 2014, Medicare and beneficiaries spent about \$155 million

1 on the Part B dispensing and supplying fees. The  
2 dispensing fee is \$33 per 30-day supply, or \$66 per 90-day  
3 supply of inhalation drugs. The supplying fee is \$24 for  
4 the first prescription in a 30-day period and \$16 for each  
5 additional prescription in that period for three categories  
6 of Part B-covered pharmacy furnished drugs. These  
7 dispensing and supplying fee rates were established in 2006  
8 based on limited data. OIG has reported that Medicare Part  
9 B and Medicaid paid dispensing fees of less than \$5 per  
10 script for these categories of drugs in 2011.

11 In light of this, the Chairman's draft  
12 recommendation reads, the Secretary should reduce the  
13 Medicare Part B dispensing and supplying fees to rates  
14 similar to other payers.

15 The implications of this draft recommendation is  
16 that it would reduce Medicare program spending and  
17 beneficiary cost sharing, and we would expect no adverse  
18 impact on beneficiary access or providers' willingness or  
19 ability to serve beneficiaries.

20 So, that concludes the presentation. We'd be  
21 happy to answer any questions and look forward to your  
22 discussion.

1 DR. CROSSON: Thank you, Kim. A very nice job.

2 Let's do clarifying questions, and we'll take the  
3 whole report. Alice, Herb, Kathy.

4 DR. COOMBS: Thank, Kim. The graph on page 6,  
5 you talk about the sequester having an effect. What would  
6 the graph look like without the sequester? I was trying --  
7 I had a hard time understanding. You said that the  
8 industry responded to the sequester. If they didn't  
9 respond, what would the graph look like?

10 MS. NEUMAN: So this graph, just to clarify, is  
11 the invoice price, the 75th percentile invoice price,  
12 divided by 100 percent of the ASP. So, if nothing changed,  
13 you might expect a flat graph, but we see this marked  
14 change at the same time that the sequester occurred.

15 DR. COOMBS: And just help me to understand the  
16 reasoning behind the -- I'm looking at the drop, thinking  
17 that it was appropriate, but it's not?

18 MS. NEUMAN: It's not -- there's no judgment  
19 about appropriate or inappropriate. The idea is that when  
20 the sequester happened, Medicare's payment rate to  
21 providers effectively went down from 106 percent of ASP to  
22 104 percent of ASP. So, under that situation, you might

1 think that the spread that a provider gets between what  
2 Medicare pays them and what they pay for the drugs would  
3 shrink, but what appears to have happened in this chart is  
4 that at the same time that the Medicare payment rate went  
5 down, the provider's price, as a percent of that payment  
6 rate, also went down. And so it seems to have mitigated  
7 the shrinkage of the spread for the providers.

8 DR. MILLER: Maybe another way to say this, in  
9 this case, there's always a bit of a tension of Medicare  
10 saying is it 106 or 103 or whatever the case may be, and  
11 what's the manufacturer going to do? Because a lot of  
12 initial reaction from the physician community would be "You  
13 can't do this because they won't change their prices, and  
14 then I'll get sunk." And so it's very hard to judge, and  
15 it's also very hard to judge drug by drug. And we're not  
16 asserting this happens in all instance, but there was a  
17 little moment of a -- I don't call it a natural experiment.  
18 Kate will get all over me. But, you know, where we could  
19 kind of look at the data.

20 As someone who has done real ones, I just didn't  
21 want to get cross-wise with you.

22 [Laughter.]

1           MR. KUHN: So two questions, Kim. First, on the  
2 dispensing and supplying fees, so whether it's the  
3 inhalation drugs or the anti-emetics, presses those, are  
4 they traditionally mail order, or are these actual  
5 visitations to a pharmacy to get these drugs?

6           MS. NEUMAN: So the inhalation drugs may be  
7 supplied by the same company --

8           MR. KUHN: The DME.

9           MS. NEUMAN: -- that supplies the DME, and so it  
10 may go directly to the patient's home.

11           With the pharmacy-prescribed drugs, it could go  
12 either way.

13           MR. KUHN: Okay. And just on the question on the  
14 inhalation drugs, so a person gets their nebulizer and gets  
15 their drugs. That may come in the mail. It may be  
16 delivered by the DME supplier, but they already have a  
17 billing code that gives them the instructions on  
18 instructing the beneficiary how to use the product. This  
19 is just an additional payment for just supplying this drug?  
20 Am I understanding that correctly?

21           MS. NEUMAN: So the dispensing fee covers getting  
22 the drug to the beneficiary, so what you sort of commonly

1 think about the services of a pharmacy dispense a drug to a  
2 beneficiary.

3           There is this issue of training the beneficiary  
4 in how to use the nebulizer. CMS, in their final rule on  
5 the fees, said that the training of the beneficiary is part  
6 of the DME, responsibility of the DME supplier, not the  
7 part of the drug supplier.

8           MR. KUHN: Right. Thank you.

9           And the second question had to do with the  
10 competitive acquisition program. So you laid out a series  
11 of issues of maybe how to restructure it. RTI was the  
12 evaluation contractor. As part of their evaluation, I  
13 assume they interviewed BioScript, who was the vendor at  
14 the time. Do the recommendations or the information you  
15 have in the report and then up on these slide decks comport  
16 with what RTI found from the vendor in terms of reforms  
17 that would be necessary to make this program work in the  
18 future?

19           DR. CROSSON: Can I help? Because I actually  
20 read the report, and I didn't see any recommendations at  
21 all.

22           MR. KUHN: Okay. Thank you.

1 DR. CROSSON: If I'm wrong, go ahead. Sorry.

2 DR. SOKOLOVSKY: No, you're not wrong, but at the  
3 time, we also met with BioScript, and the things that they  
4 told us, the things that were the biggest problem for them,  
5 was the way in which ASP was updated or not updated, and  
6 also this -- well, that was their biggest problem, that  
7 they were making a lot of money on some drugs, but there  
8 were some drugs that particular specialties were going to  
9 BioScript for because the price had gone up a lot, and it  
10 was not being updated. So they were losing money on that  
11 particular -- those particular drugs, and that was a big  
12 problem for them. The update process didn't reflect ASP  
13 changes.

14 DR. MILLER: And that was in part because there  
15 was an indexing in this, too, right? The way this works,  
16 it wasn't like an interactive thing where the vendor was  
17 extracting prices. There was sort of a negotiated price,  
18 and then that got indexed, which was also another kind of  
19 odd feature.

20 DR. CROSSON: Kathy.

21 MS. BUTO: So my question is around Slide 12, the  
22 ASP inflation cap. My understanding, Kim, is that,

1 although we lay out the issue as possibly being  
2 operationalized through the rebate, in the paper, page 26,  
3 we talk about it could also be operationalized through a  
4 payment rate limit sort of a la what we do with other  
5 payment systems where we apply some sort of a Medicare  
6 increase that could limit what the increase is. So it  
7 could be done either way, as I understand it.

8           And the difference is that if you do it through a  
9 rebate, the provider, in a sense, gets ASP plus 6, and then  
10 the program later will get a rebate if that -- the price  
11 increase is above inflation, right?

12           The other difference is, as I understand it, the  
13 beneficiary would pay more under this option than under the  
14 Medicare puts a limit on the increase in the payment rate  
15 option because, if Medicare puts a limit on the payment  
16 rate, the beneficiary will pay 20 percent of that limited  
17 payment rate, where under a rebate, the beneficiary is  
18 paying the copay based on the inflated, if you will, rate,  
19 as I understand it. Is that right?

20           MS. NEUMAN: So, if you limited the Medicare  
21 payment rates to providers, then the beneficiary's cost  
22 sharing at the point of care would be lower than it would

1 be through a rebate.

2           On the flip side, if you go for a rebate, then  
3 the money comes back to the program, which then will filter  
4 back to the beneficiary through the Part B premium. It  
5 will get spread across more beneficiaries, smaller amount  
6 of effect on a larger number of beneficiaries, or with  
7 limiting the payment rates, it will be a bigger effect on a  
8 smaller group.

9           DR. CROSSON: Okay. Clarifying questions?  
10 Warner.

11           MR. THOMAS: On page 7, I just want to make sure  
12 I understand the chart. So if the pricing is limited to  
13 ASP plus 106 percent, then how on the 34 drugs are they  
14 charging above the 106? They're charging the provider  
15 above 106, and then the provider is just being reimbursed  
16 the 106? Is that how it works?

17           MS. NEUMAN: So this says that 12 percent of the  
18 drugs had an invoice price that was greater than 106  
19 percent of APS --

20           MR. THOMAS: Right.

21           MS. NEUMAN: -- among our 34. There's a couple  
22 of things that could explain that. One thing is that these

1 prices do not reflect off-invoice rebates. So some of the  
2 prices in our analysis may be overstated for that reason,  
3 so that could be one thing. It may not be 106 when you  
4 took that into account.

5 The second thing is that there is variation in  
6 prices across purchasers, and so some of this could be, you  
7 know, the certain segment of the purchasing group is not  
8 getting as good a price as others. It could be both or a  
9 combination.

10 MR. THOMAS: So the ASP --

11 DR. BAICKER: It's the "A" in the ASP. It's an  
12 average, but any individual person --

13 DR. MILLER: So what you said is correct, but  
14 there's also another explanation of what might be going on.  
15 Somebody could be buying a drug above 106 percent, or it  
16 could be that what we're -- the acquisition cost we're  
17 measuring here could not reflect fully some of the rebating  
18 or discounts that somebody is getting.

19 MR. THOMAS: How confident are we in the ASP  
20 calculation?

21 DR. MILLER: As confident as the manufacturer's  
22 numbers that they submit. I mean, these are supposed to be

1 market transactions. I mean, they're supposed to --

2 MR. THOMAS: But we're really not sure.

3 DR. MILLER: Is there any auditing that's done of  
4 this?

5 MS. BUTO: I'll just speak for my former company.  
6 That's one of the most rigorous audits that went on because  
7 you're subject to all kinds of federal penalties, criminal  
8 penalties, et cetera, if you misreport the data, so yes.

9 And it was, on just a side note, very difficult  
10 because until ASP came in and the requirement for reporting  
11 came in, different parts of the company had different  
12 definitions of what these different rebates, free goods, et  
13 cetera, et cetera, were. So they had to go through a whole  
14 level-setting exercise, so that the definitions that could  
15 be audited were the same. So, yeah, I'd say at least for  
16 that company, it was a rigorous process.

17 MR. THOMAS: Do we know what the range of pricing  
18 is on the 34 drugs? We're kind of comparing to the average  
19 price, but do we know the range of pricing? Is it from 50  
20 percent to 100 percent? Is it tight? Do we have any idea?

21 MS. NEUMAN: So you can kind of get a sense of  
22 that. In the paper, there's Table 4 that shows you the

1 50th percentile and the 90th percentile as well, and so you  
2 can kind of get a sense from that that -- how tight it is  
3 depends on how you define that, but it's a pretty narrow  
4 range. If you look at the median across the 34 drugs at  
5 the 50th percentile, you're at 99.7 percent of ASP. The  
6 median at the 75th percentile is 101.6, and the median at  
7 the 90th is 100.4, so yeah.

8 DR. REDBERG: Related to that, when you gave us  
9 that date, you said you can't report the actual prices.  
10 Why can't we report the actual prices?

11 MS. NEUMAN: We purchased this data. It's  
12 proprietary, and part of our contract, we agreed not to  
13 report the prices.

14 DR. MILLER: Kim will go to jail.

15 [Laughter.]

16 DR. CROSSON: Clarifying questions? Alice.

17 DR. COOMBS: I just had another question. It  
18 would be helpful if you could march out an example of what  
19 it would look like for the average sale price and then what  
20 kind of impact a prompt pay has versus a rebate and the end  
21 result, what's the end-result number of the actual cost,  
22 because I'm just kind of interested in all of the variables

1 that affect the end point.

2           So prompt payment may be something that they  
3 don't consider. Is it considered a piece of this average  
4 sale price in the end in terms of the end point?

5           MS. NEUMAN: The regulations on calculating the  
6 APS say that they have to subtract out prompt-pay discounts  
7 that the manufacturer gives to the wholesaler, but we don't  
8 have a window on how much that is because the manufacturer  
9 is reporting a single number for each NDC. So we have no  
10 idea, the components or anything like that.

11           DR. COOMBS: Okay. So the prompt pay is pre, and  
12 the rebate comes after, obviously, but you don't have any  
13 kind of cumulative effect?

14           MS. NEUMAN: No. We just have the final ASP  
15 number that the manufacturer reports.

16           DR. CROSSON: Okay. So here's what I think. I  
17 have a sense, mostly from our previous discussion of the  
18 dispensing and supplying fees, that we're not going to have  
19 a lot of discussion there. Maybe I might be wrong, but I  
20 don't think so. So we will separate these issues and  
21 spend, hopefully, the bulk of our time talking about the  
22 four, you know, Part B options that we have here.

1           I have to say that I don't know that we need to  
2 winnow these down because I think, in many cases, we're  
3 just getting into them for the first time.

4           I also know from having talked to Kim and John  
5 and I and Mark and thought through these that there's  
6 nothing perfect here. These vary a lot in terms of  
7 potential impact, feasibility, complexity, and the like.  
8 And what I hope we can do in the discussion is pull out  
9 some of those issue and kind of illuminate us collectively  
10 about that and then see where we want to go.

11           So, Jack, you are working very hard today. You  
12 are on the hook again.

13           DR. HOADLEY: So, first of all, I think this was  
14 a really great analysis, and I think the new information  
15 you brought to us really helps inform this discussion a  
16 lot, so I really appreciate that. Thanks.

17           I think the -- I was one of the people that had  
18 encouraged us to look at an option that was actually saving  
19 money to the program as opposed to the budget-neutral  
20 options, and I think what I saw here sort of convinced me  
21 that that makes sense as a good direction. I mean, I could  
22 even imagine going more aggressively. I think the biggest

1 deterrent in going more aggressively is sort of where the  
2 sequester fits in, and we've always said that we try to  
3 make policy pretending the sequester doesn't exist. If you  
4 think about the sequester coming off, 103.5 plus \$5, then  
5 you're getting a lot closer to the actual ASP. If we don't  
6 think of it in those terms, then there's no reason we  
7 couldn't sort of bring it down by kind of like the  
8 sequester is already doing. So there is that sort of  
9 conundrum of how to think about the sequester. But that  
10 aside, I mean, I think this gets us in the kind of  
11 territory to try to create some savings.

12 I also like the inflation cap option. I'm glad  
13 Kathy raised the cost-sharing implications, and I think  
14 that's an important -- and I guess I would prefer, among  
15 the two approaches, to -- I mean, I think you're right.  
16 The cost sharing would go to the beneficiaries, indirectly  
17 to everybody or directly, but these are the people that are  
18 facing the cost sharing for this drug, Medigap coverage  
19 aside. So I would probably prefer to see it done in a way  
20 that would protect those beneficiaries who are using those  
21 drugs. I think that's a relatively minor issue in the  
22 scheme of things when you assume that not a lot of people

1 are going without their Medigap protection.

2 I also like the consolidated billing codes  
3 approach. I think one of the things that we're really  
4 going to face in the future is how to make sure that we  
5 achieve the savings that is promised by the availability of  
6 biosimilars, and this wouldn't obviously have to be just in  
7 the biosimilar versus original manufacturer situations, but  
8 certainly, in those situations, forcing the competition  
9 even more strictly than under the current statutory rules  
10 would help. So I do like that option as well.

11 The restructuring the cap program, I guess I'm  
12 just more of a skeptic on whether it will get anywhere.  
13 Having paid a fair amount of attention back on the original  
14 one and watching the total lack of enthusiasm from the  
15 provider community and then ultimately from the vendor, I  
16 think the kind of rethinking of it makes a lot of sense.

17 I'm just sitting here thinking I'm not sure that  
18 even with the redesign of it that we necessarily get a big  
19 response to it, so I wonder how much of that is worth it.  
20 On the other hand, since we're mostly in the business right  
21 now of sort of laying out some potential options to put on  
22 the table, I think it's a perfectly good option to have out

1 there, and maybe if we wanted to get more serious about it  
2 down the road, getting some sense of response from both the  
3 provider community and the potential vendor community on  
4 whether this -- some of the issues about inventory stocking  
5 or some of the issues that got in the way the last time,  
6 and you've got ideas here on the table to try to do that  
7 better. But whether that works from the point of view of  
8 the providers involved, I think is an open question.

9           So I think we're really putting some good ideas  
10 on the table. In some ways, it would be nice to be moving  
11 forward with a recommendation. There's a lot of talk from  
12 a lot of different sources about trying to make some  
13 adjustments on the 106 percent, and this might be a good  
14 window to weigh into that. If we feel like there's just  
15 too much, it's too much of a moving target in terms of  
16 where we are and where our discussion is, then I can  
17 appreciate that.

18           And then, last, I have no problems with the  
19 dispensing and supplying. I think that's a good  
20 recommendation as well.

21           DR. CROSSON: Okay. Discussions. Kate, Warner,  
22 Bill.

1 DR. BAICKER: So I think we've come in a really  
2 productive direction in thinking about modifying the ASP,  
3 and I'm a little of two minds about whether it should be a  
4 revenue-neutral package or a revenue-saving/generating  
5 package in that -- the point is nicely illustrated with the  
6 revenue-neutral one, but I'm not clear which one is better,  
7 but I like the direction a lot.

8 The reason I like that one and thinking about the  
9 consolidated billing codes is that they both encourage  
10 focusing on the highest-value care for the patient, what  
11 the patient really needs, not using care that's of  
12 questionable value when better-value care is available.  
13 They both move in that direction on a chassis of ideally  
14 competitively based prices.

15 I'm much less comfortable with the inflation cap  
16 idea, which really sounds a lot like just straight price  
17 controls and maybe undermines the competition towards  
18 higher-value care that we're trying to embed in a lot of  
19 the other things that we're doing. So I'm not so  
20 enthusiastic about that one.

21 The restructured CAP program, I hadn't known much  
22 about it until I read the chapter, and it really sounded

1 kind of cool on paper and really didn't work at all. And  
2 so I share Jack's skepticism about that, which doesn't mean  
3 that it isn't worth thinking about why it didn't work and  
4 whether it would work better in a system that had a  
5 restructured ASP, as you highlight in the chapter. But I'm  
6 not sure how much energy to sink into trying the same not  
7 so successful tactic again.

8           So that's my feeling about those four.

9           DR. CROSSON: I'm going to jump in here a little  
10 bit on the restructured CAP. You know, in the context of  
11 what I said in the beginning, this is one of the approaches  
12 that is complicated, may have feasibility issues, but down  
13 the line could be extremely impactful, because it's  
14 essentially restructuring the market that is created  
15 between the physicians and the drug manufacturers.

16           It may have escaped notice, but one of the design  
17 features that Kim presented here was essentially  
18 reintroducing the CAP program as an option, but at the same  
19 time reducing the ASP much more dramatically than we're  
20 talking about. And that, you know, by itself produces a  
21 rather significant net savings of somewhere -- if we had a  
22 model that was similar to the original cap that included

1 180 or 70 percent of the prescription cost, if I remember  
2 that correctly, that would represent a savings of somewhere  
3 around \$800 million a year to start with, as well as  
4 whatever incentives then were created for the physicians  
5 who chose this in consultation with the patients to manage  
6 the cost of drugs, much in the way that they're managed in  
7 integrated delivery systems who are in a prepaid  
8 environment.

9           So that's the promise. Of course, getting there,  
10 you know, is another question, I mean both from a design  
11 perspective and politically as well.

12           DR. BAICKER: And getting the physician out of  
13 the business of, you know, potentially making money based  
14 on the different choices of drugs sounds like a great idea,  
15 but the "C" in the CAP, I didn't quite understand how that  
16 was playing out with just the one vendor. So it all makes  
17 much more sense to me if there are multiple vendors, and  
18 without some guarantee of competition there, I'm not sure  
19 how well it would work.

20           DR. CROSSON: And, again, it's sort of -- I mean,  
21 this is a modeling exercise because there's about six or  
22 eight moving parts here, and depending on which one you

1 pull, you could get something that's viable or something  
2 that's not viable at all. And I think we'll have an  
3 opportunity to spend more time on that.

4           But I think your observation is one that I have  
5 as well, which goes something like this: The add-on to  
6 ASP, at least the way I think about it, is essentially kind  
7 of like sort of a reinsurance payment. I mean, it's  
8 basically providing money to make up for the fact that not  
9 every provider can negotiate the average sales price. So  
10 at least half of that money -- if I'm wrong, Kate, you're  
11 the economist. At least half of that money is going to  
12 providers who have been able to negotiate the average sales  
13 price or better. And so the question is: Of what utility  
14 is that money? And, you know, I think a model that gets  
15 the physicians essentially out of being a drug vendor with  
16 the attendant costs to the Medicare program, but in  
17 addition provides real incentives for the physicians  
18 through selection of drugs, through utilization management,  
19 through the volume of drugs prescribed, all the mechanisms  
20 that I think some of us are familiar with, has some  
21 promise.

22           It also requires -- and one of the

1 characteristics that Kim brought to the table was the  
2 ability to use a formulary of some sort. And as we said  
3 earlier today, there's a whole range of formularies that  
4 one could design.

5 So, anyway, I just wanted to add to what you  
6 said.

7 DR. BAICKER: Okay. Now we both want to respond  
8 to what you said, you know, like debate rule style.

9 DR. CROSSON: Right, right.

10 DR. BAICKER: You mentioned economist, so I get  
11 to say something.

12 [Laughter.]

13 DR. CROSSON: I also mentioned physicians.

14 DR. BAICKER: You guys jump right in. How about  
15 you just talk right over me?

16 [Laughter.]

17 DR. BAICKER: So we had been concerned in  
18 previous discussions that that insurance policy was really  
19 important if there were a lot of people who weren't being  
20 able to purchase under that, and the extra information that  
21 you brought to the table in terms of the distribution of  
22 prices that are currently paid, and that sequester graph,

1 which I find pretty telling, suggests that it's not so  
2 necessary to fulfill that function and really is just a  
3 bonus payment for prescribing a drug.

4 DR. HOADLEY: And I think, you know, again, the  
5 concept of this feels like it should have worked, but it  
6 felt that way ten years ago. And I think the question is  
7 the ability to make the practical sides of it work as well.  
8 I think a lot of the physicians would love to be out of the  
9 business, a lot of physicians have gotten out of the  
10 business in exchange for moving to the OPD side already.  
11 So we've got that trend going on in the background.

12 One of the things, I think -- and Joan may  
13 remember this better than I -- when we looked at those  
14 things a long time ago, was the sort of different response  
15 from the oncologists whose need for these drugs was a lot  
16 more likely to be determined on the day of providing the  
17 drug versus, say, the rheumatologist who's given the RA  
18 drug who knows, you know, weeks in advance exactly what  
19 drug and what dosage is going to be provided. And, again,  
20 this reconceived thing does come up with an inventory  
21 system that should handle that better, but one of the  
22 questions is, again, will it work?

1           We've also got a discussion coming up on the  
2 oncology side of maybe rethinking oncology in yet other  
3 ways, and that would leave this maybe to handle the  
4 rheumatologist and some of the other specialists who use  
5 more predictable drugs.

6           So, yeah, I mean, there's a lot of potential  
7 promise.

8           DR. CROSSON: Okay. So the moderator inserted  
9 himself. Sorry about that.

10          MR. THOMAS: So I would just say that I think the  
11 analysis has been great. I think placing the cap on the  
12 ASP going forward makes a lot of sense. I think if you  
13 were to place this same rigor and analysis on this part of  
14 the industry that we have on the rest of the industry where  
15 we look at access, where we look at profitability, where we  
16 look at availability to invest, I think we would find that  
17 we probably would keep flat or even decrease payments based  
18 upon the performance of this part of the industry. So I  
19 think the cap on the inflator makes a lot of sense.

20          I would challenge us to look at the proposed  
21 reductions, 1.3 percent. I would actually challenge us to  
22 potentially look at being more aggressive there. You know,

1 if you think about the percentage change, it's relatively  
2 small in the scheme of the industry. And, once again, I  
3 think it's an opportunity to think about whether ASP should  
4 be the average or whether it should be the cap. So I think  
5 that would be another concept to think about going forward.

6           The consolidation of billing codes I think makes  
7 a lot of sense. I think it certainly would create a  
8 situation where, you know, if we have similar drugs, they  
9 kind of go in similar categories. I think that absolutely  
10 makes a lot of sense to consolidate those billing codes.

11           On the competitive acquisition, I would agree, it  
12 seems like that has been a challenge. I think we ought to  
13 actually look at the first couple recommendations, see if  
14 we can make significant progress there, and once again  
15 then, you know, continue to watch the change as we move  
16 forward.

17           MS. BUTO: The first recommendation, which is the  
18 ASP+ add-on plus flat fee, I would -- and we didn't get  
19 into this, but there's some drugs that are very low cost  
20 where, when you do that, they get a big increase. It  
21 struck me that we could look at the lower of that or ASP  
22 plus 6 percent if they're a drug that's such a low cost

1 that would actually boost payments for that drug without  
2 any rationale, really.

3           On the inflation cap issue, I share some of  
4 Kate's concern about price controls, which is why if we did  
5 something like that, I would much prefer looking at  
6 limiting the payment rate Medicare pays. I think that's  
7 totally within our purview. And it also has the  
8 additional, to my mind, benefit of reducing the beneficiary  
9 out-of-pocket, not just bringing rebates back to the  
10 government. So that's the way I would prefer it.

11           I'm not a fan of consolidated codes. I think  
12 this is really very similar to least costly alternative,  
13 which I have issues with, and I just boil them down to say  
14 that I think, oddly enough, this is even potentially more  
15 difficult for the beneficiary than LCA because under LCA I  
16 think we imagined that if they needed a higher-cost drug,  
17 they could at least appeal it. But if you're setting the  
18 rate on an average, I don't see any basis for appeal there.  
19 I mean, I think the beneficiary just pays out-of-pocket a  
20 higher co-pay for the more expensive drug. So I'm  
21 concerned about it driving prescribing when we don't know a  
22 whole lot about it.

1           Secondly -- so I'm worried about that, but, on  
2 the other hand, I don't think it actually applies to very  
3 many drugs where you've got multiples that would gain the  
4 Medicare program a lot from applying the policy.

5           And, lastly, I think it's going to reduce  
6 research in the category, so if it's a category that's in  
7 this consolidated code bucket, I don't think there's going  
8 to be much more invested in research in that category based  
9 on what I've seen, just the way research investment is  
10 made.

11           On the restructured CAP, I actually think that  
12 this should work. There ought to be a way to make it work  
13 because the issue of having the physician be the buyer and  
14 then the recipient of payments having to do with drugs I  
15 think has just really got to be sort of dealt with. And if  
16 we could think about what works in the private sector,  
17 whether it's specialty pharmacy or other things that  
18 provide the right tools, I think we ought to think more  
19 broadly about this. And maybe it's a longer-term option.

20           I also think it is more consistent with our  
21 interest in ACOs and managed and coordinated care than  
22 continuing to have physicians be the buyers and billers for

1 drugs. So to have an entity that specializes in this makes  
2 sense to me.

3 And then, lastly, I don't have an issue with the  
4 dispensing and supplying fees. I think that's fine.

5 MR. GRADISON: With regard to the ASP, I'm  
6 comfortable with Kathy's suggestion. It's certainly worth  
7 considering.

8 With regard to the inflation cap, there's some  
9 problems here. First of all, a new product comes out. If  
10 you know that you're going to be limited with that new  
11 product to an inflation cap, there is a powerful incentive  
12 to have a very high launch price. Now, you say, well,  
13 we're going to -- we want to deal with that. Then you --  
14 that's how you get back into the price-fixing thing -- or  
15 price control thing.

16 Another situation that could easily happen in  
17 this field, FDA comes in, they say you've got to stop  
18 production, there's some issues here. You've got to  
19 completely change your manufacturing process. The company  
20 salutes and moves ahead to do it, but in the process incurs  
21 a lot of costs, or at least they do calculations which  
22 suggest they're going to incur a lot of costs, and then

1 they have to decide whether they really want to stay in  
2 that market with that particular product because -- or in  
3 that situation you have to have some kind of an exceptions  
4 process. It gets very complicated, and I'm not sure it  
5 would work very well.

6           With regard to the CAP program, the previous  
7 attempt with the voluntary process probably poisoned the  
8 well in the sense it may discourage people from  
9 participating the next time around. But aside from that, I  
10 think it's almost too exquisite a design. It's something  
11 that works beautifully in principle, but I'm not sure it  
12 works in practice. And to be more specific about it, if I  
13 were a provider, I'm not so sure I'd want to be a part of  
14 this. It would change a lot about the way I keep my  
15 inventory and the way I do my billing and the way I even  
16 deal with my patients, co-pay arrangements are changing.  
17 But more than that, from the provider's point of view, they  
18 would be moving from something that's reasonably fixed and  
19 determinable to something that's contingent on a savings.  
20 That's something we may want to encourage but in -- and  
21 that could well work with a mandatory program. But with a  
22 voluntary program, it might not -- you might not really

1 learn very much. The people who might choose to  
2 participate might not reflect the larger universe with a  
3 mandatory program.

4           With regard finally to dispensing fees, I'd like  
5 to know a little bit more -- and maybe I should have asked  
6 this earlier, but how much money are we talking about there  
7 in aggregate for individual providers? Because the reason  
8 I ask that, if it's not a whole lot, fine, and that's a  
9 judgment call to be sure. But if it's a substantial  
10 amount, it might create an incentive for the providers to  
11 look somewhere else to make up for that, and that somewhere  
12 else could be higher-priced drugs, if it's 3.5 percent,  
13 it's still more, 3.5 percent of a higher number than if it  
14 were a lower number. I don't know what the behavioral  
15 effects might be outside of the payment for the dispensing  
16 fees.

17           My recollection, which I admit is not as clear as  
18 I'd like in commenting upon this, from some earlier work I  
19 had done which had to do with Medicaid was that some of the  
20 states had driven the -- now, this is not the same kind of  
21 -- I guess it is the same kind of dispensing fee. They had  
22 driven the dispensing fees down to a point where it was

1 having some behavioral effects, significant behavioral  
2 effects. As I recall, it had to do with choices of  
3 generics -- and you're nodding. You know a lot more about  
4 this than I ever will, Jack. But I think there's some  
5 experience here that we can learn from in the Medicaid  
6 program, particularly in certain states.

7 Thank you.

8 DR. HOADLEY: Just a quick follow-up. I think  
9 the issues with the dispensing fees in Medicaid, Bill, were  
10 more with sort of standard drugs as opposed to the sort of  
11 supplier -- that's where I'm not sure if they're  
12 necessarily comparable, but your right about your  
13 recollection.

14 DR. CROSSON: Okay. Thank you.

15 DR. NERENZ: Just a thought about the first  
16 bullet, which seems relatively straightforward, and I know  
17 we've talked about it a lot. But I was very struck by  
18 Table 6 in the materials, and I appreciate it's not on the  
19 slide so it's a little tough for others to follow. But I'm  
20 just trying to understand, and my question fundamentally  
21 gets to we don't talk a lot about the influence of the co-  
22 pays as a restraining force. And I'm just curious, using

1 this example, why that would be so.

2           Basically what you've got here are two different  
3 drugs, both of which are somewhat expensive, but one  
4 clearly more expensive than the other, that at least  
5 according to the background are equally effective as part  
6 of a cancer care regimen -- no health benefit, no survival  
7 benefit, nothing, but different price.

8           Now, the illustration says that because of the  
9 different price, if a physician prescribes the more  
10 expensive one, he or she will get \$540 more through the  
11 plus-6-percent mechanism, and a lot of this is -- we're  
12 concerned about that that's driving the choice of the more  
13 expensive drug. Okay. And then if we change the policy,  
14 that \$540 difference drops to \$315, and we think, okay,  
15 well, that will make it better than. And it might.

16           But what seems to be, I will call it, the  
17 elephant in the room, there's a \$9,000 difference in the  
18 actual drug cost in the regimen, and presumably  
19 beneficiaries are seeing at least some of that in the form  
20 of a co-pay unless it's all covered by Medigap or  
21 something.

22           So here then is the question: Why is the co-pay

1 tied to that \$9,000 difference, not restraining what the  
2 physician's doing for \$500? Why isn't that working now?

3 MS. NEUMAN: So one argument that people make  
4 that the 6 percent add-on does not influence prescribing  
5 behavior is the point that you're making, that providers  
6 will take into account cost sharing, and the fact that the  
7 cost sharing is higher for the more expensive drug would  
8 result in them picking the cheaper drug. And I think as  
9 we've talked about here, there's a lot of uncertainty about  
10 what in the end happens and what's driving these choices.  
11 And so I don't think that there is a clear body of  
12 knowledge about sort of which forces are dictating what's  
13 happening.

14 DR. NERENZ: It may just be a minor semantic  
15 thing, just to test it, the way you just phrased it, the  
16 clinician tries to take into account the patient ability to  
17 pay a co-pay. But I'm also curious why the patient is not  
18 more active in this. Why don't we see dynamics where the  
19 clinician says, "I think we want to use this drug, but  
20 actually it's going to cost you \$20,000 more, and it has no  
21 benefit." Why doesn't the patient say, "No, we're not  
22 going to do that"? Why does that not happen?

1 DR. MILLER: Remember some of what's going on in  
2 -- this example is -- is this an oncology example?

3 DR. NERENZ: Yes [off microphone].

4 DR. MILLER: I mean, you know, I think there's  
5 sort of the dynamic of what's going on at that particular  
6 moment for the patient, and, you know, having been through  
7 it, I get some of that.

8 I also think way back in the day, Joan -- it's  
9 good you're here. Way back in the day, the provider might  
10 sort their patients to whether they do it in the office or  
11 whether they send the patients who can't afford it to a  
12 hospital. So I think -- and then Jay has made this point  
13 elsewhere, that to the extent that there are pathways, you  
14 know, a physician may be following those and saying this is  
15 the right combination here.

16 And so there's been this whole conversation about  
17 the 106. There's a lot of assertions and some early-on  
18 evidence that suggested it might drive more expensive  
19 prescribing. But then there's also these conversations.  
20 Is that true of all drugs? Is oncology different? What's  
21 the evidence these days? And it's very hard to do an  
22 antecedent because you don't have a natural experiment,

1 which Kate ought to get on. You know, those types of  
2 things. Exactly what is driving these prescribing  
3 patterns?

4 DR. CROSSON: Alice, did you want to make a  
5 comment on this?

6 DR. COOMBS: Yes. I think, David, you kind of --  
7 you stole this thought from me, because as long as you have  
8 that three or two or the one -- anything above that 100  
9 percent, as long as you have that, you have this gradient  
10 that's created. And so for a physician to make those  
11 choices, I think, there's not much difference in my mind  
12 with adding the \$5 versus a differential of \$315. I think  
13 you're always going to have the higher-priced drug that  
14 leads people to maybe make that decision without  
15 consideration of the co-pay for the patient.

16 Is there data that says that one drug is better  
17 than the other? And sometimes there might be. There might  
18 be some kind of preferential treatment by a physician. But  
19 I think the problem is really the way it's put together.  
20 As long as you've got 103, you can have 102, you can have  
21 102.5. No matter what you do, when you add this little  
22 measly \$5 on the end and you think that's going to make a

1 difference with a decision, that table actually points to  
2 the crux of the matter, because you have created a  
3 gradient, and the gradient is fairly significant.

4           The real question -- Mark, you kind of alluded to  
5 it -- is that physicians might make decisions based on them  
6 having to keep this drug on the shelf. I mean, it was  
7 mentioned in the paper about the vendor not being able to  
8 supply the drug in an expeditious fashion. The patient  
9 comes into the office. You might want to do something.  
10 And all of a sudden the physician's stuck there  
11 inconveniencing the patient because a vendor failed to meet  
12 his requirement of getting something to the doc. That is  
13 really burdensome for a beneficiary. Okay? How about  
14 showing up for chemotherapy and you don't have  
15 chemotherapy?

16           And then there was the other proposal of how do  
17 we correct the CAP system, and that was the replacement on  
18 the shelf so that if you use it, you get it replaced by --  
19 you get a replacement by the vendor. That's problematic  
20 too because some of the shelf life is very short, so I  
21 think that's an issue as well.

22           It is fraught with a lot of different problems.

1 I'm not sure we're really getting to the crux of the matter  
2 in terms of deciding -- I talked at Jack earlier about  
3 desegregating, some sort of way put the vendor over here,  
4 if we're going to do a vendor, put the vendor over here,  
5 and put the dispensing or acquisition all in one category  
6 for the provider. I don't know if that's possible, but it  
7 has to be something where the provider sees that it's  
8 important for them to make the right decision and the most  
9 appropriate decision for the patient, as well as shared  
10 decisionmaking. And inculcated in this is the fact that  
11 there must be shared decisionmaking, some sort of shared  
12 decisionmaking. But to be honest with you, there's not an  
13 incentive here for you to talk about, well, do you want to  
14 take this drug versus that drug? There's not an incentive  
15 to say that I want this patient to really understand the  
16 differential between the two drugs. And I think that's  
17 problematic.

18           So, I mean, when I look at this, the  
19 restructuring of the cap program, something has to be done  
20 where the provider is actually incentivized to do due  
21 diligence with your decision-making. And all of the rest,  
22 I think, is kind of window-dressing until you get to the

1 real crux of the matter.

2 DR. CROSSON: Thank you. Rita.

3 DR. REDBERG: Thanks. I wanted to talk a little  
4 bit. You know, we have been concentrating on the 6 percent  
5 of ASP, but I think we should talk a little bit about ASP  
6 because that's 100 percent, and I'd like to have mechanisms  
7 for downward pressure on average sales price. I find it  
8 disturbing that these prices are secret because you can't  
9 have a market and competition when prices are secret.

10 We know that we have very high prices, and so  
11 certainly, we can look at the 6 percent, but the program is  
12 paying a lot of money on 100 percent of the average sales  
13 price.

14 DR. MILLER: Let me give one clarification. What  
15 we couldn't disaggregate and tell you was the acquisition  
16 cost, which is different than the average sales price that  
17 Medicare constructs and pays out of a series of  
18 acquisitions cost, because we had purchased the data  
19 proprietary.

20 I mean, the ASP is known.

21 MS. NEUMAN: Right. It's --

22 DR. MILLER: Right. And you may want to shift

1 your comments and say, well, I'm talking about acquisition  
2 stuff, in which case, you know, then back on track, but the  
3 ASP is known.

4 DR. REDBERG: Well, the ASP has to be known or  
5 you can't pay the 6 percent.

6 DR. MILLER: Exactly.

7 DR. REDBERG: But how about how do you calculate  
8 the ASP? Do we know the range that goes into the ASP?

9 MS. NEUMAN: So CMS has instructions about how to  
10 calculate and what kind of things count as a discount and  
11 what don't and how to handle various things. So there is  
12 guidelines, but the raw ingredients of what they use to  
13 calculate the ASP, no. That's proprietary to the drug  
14 manufacturers, and we don't see that.

15 DR. REDBERG: But what I mean is for any  
16 particular drug. If you know the average sales price --  
17 but do you know what the range is that got to that average?

18 MS. NEUMAN: No.

19 DR. MILLER: To that end, that information is not  
20 easily obtainable and is proprietary.

21 DR. REDBERG: Okay. So that is my point that  
22 it's hard to have a market when you don't know the average

1 sales price. You don't know the prices that everyone is  
2 paying. People are in a difficult position for negotiating  
3 -- or plans are in a --

4 DR. MILLER: So I think where you're headed --  
5 and you're talking about a transparency argument and  
6 whether the transaction data is more transparent, I think  
7 is where you're headed. At least on the staff level, we  
8 just kind of got hung up on ASP in your opening comment.  
9 Right.

10 DR. REDBERG: So, for example, with the inflation  
11 cap, I understand the idea, but I think -- and I think  
12 maybe Bill said this too. It's the launch price I'm  
13 worried about. That's the really high -- then you're  
14 talking about inflation, and we can -- there are certainly  
15 concerns about it.

16 I do support the consolidated billing codes. I  
17 think that's our principle of similar prices for similar  
18 care. The instance, the idea that there's a different  
19 reference code for the original than for the biosimilars, I  
20 don't think is a good idea. That's not the idea of having  
21 biosimilars. It's to drive down prices and their similar  
22 therapeutic effects.

1 I think that was it. Thanks.

2 DR. CROSSON: Kate, one second. On this point?  
3 Yeah, go ahead.

4 DR. BAICKER: I just wanted to note that in --  
5 there's a counter-argument to the very persuasive  
6 transparency points that you're making. In lots of private  
7 markets, the negotiations are proprietary. We don't know  
8 what health plans pay hospitals. We don't know what  
9 hospitals pay doctors. And there's an argument to be made  
10 that in a world where everybody knows those, that actually  
11 drives prices up because then nobody gives a discount,  
12 because if I give you a discount then and you know that I  
13 gave you a discount, then you demand the same discount.  
14 And so this is -- it does -- I think that you're making a  
15 very good argument about transparency and one that could  
16 very well result in lower prices, but it's less clear than  
17 it might seem ahead of time, and it's much more common in  
18 private markets than one might think. Hospitals and  
19 doctors and health plans hold that information very close  
20 too.

21 DR. REDBERG: It's very hard to know, without  
22 looking at the data, who is getting a discount and who

1 isn't, and you're really talking about private health care  
2 markets because it's not very common not to know prices in  
3 any other kind of markets.

4 DR. MILLER: And there is pressure even in those  
5 markets to start to make that transparent. If you really  
6 want to get geeked out, you should come to our lunch  
7 sessions. This is what we have raging arguments about when  
8 people get put in headlocks and all that kind of thing --

9 [Laughter.]

10 DR. MILLER: -- about whether transparency or  
11 price discrimination, which I think is to your point, Kate,  
12 results in the lowest price, so we should continue this.

13 DR. CROSSON: This is all documented on film.

14 [Laughter.]

15 DR. CROSSON: You know, in April, we'll have a  
16 little show or film festival.

17 MS. BUTO: I promise I'll keep it short. Oh, I'm  
18 sorry.

19 DR. CROSSON: Hang on. Alice, you were on the  
20 list. Did you finish your point?

21 DR. COOMBS: Yeah.

22 DR. CROSSON: Okay. All right. So, then Kathy

1 and then Warner.

2 MS. BUTO: And the short is that at least when  
3 the Medicare drug benefit was enacted, the initial proposal  
4 was to make PBM discounts transparent, and I believe -- and  
5 I don't know if they would stand by this today -- that CBO  
6 estimated the cost of the benefit would go way up because  
7 of the very thing that Kate was talking about.

8 What happened, based on Medicaid best price, was  
9 rebates flattened out, and prices across the board in total  
10 ended up costing more than savings. So I don't know if  
11 they'd stand by that analysis today, but it ended up coming  
12 out of the legislation for that very reason.

13 DR. CROSSON: Warner.

14 MR. THOMAS: I just wanted to comment on the  
15 launch price. I guess what I get a little confused with is  
16 that, in the delivery side, we're constantly coming up with  
17 new procedures or new things that we're doing, and somehow  
18 we figure out how a price gets set of what's going to be  
19 paid for that procedure, whether it's a new type of  
20 surgery, whether it's a new approach, and so -- but yet we  
21 don't use that when we look at launch prices of new drugs.  
22 So I just kind of raise it as something to be thought about

1 as we think about pricing of drugs and especially new drugs  
2 and their launch prices because it sounds like we're  
3 worried about where that initial launch price is going to  
4 be set, but yet in other areas when we set Medicare fees,  
5 we come up with a price and we set it.

6 DR. CROSSON: Okay. This has been very helpful.  
7 I think Kim and some of the rest of the staff will -- don't  
8 go yet. We haven't -- we've got to do the recommendation.

9 So we have a recommendation. Can we show Slide  
10 20? I've heard some discussion about this already. I  
11 haven't heard any objections or queries about it, but I  
12 want to give everybody an opportunity now. We're not  
13 voting on it until next month. Comments? Questions about  
14 the recommendation on page 20?

15 [No response.]

16 DR. CROSSON: Seeing none, thank you very much,  
17 Kim and Joan, and we will move on to the final presentation  
18 of the day, oncology bundling.

19 MS. RAY: Good afternoon. This is the second of  
20 two sessions on Part B drugs. We are going to look at four  
21 approaches that attempt to improve the value of drug  
22 spending and the delivery of health care services. In

1 contrast to the approaches that you discussed at Kim's  
2 sessions, these four approaches that we are going to  
3 discuss would generally take longer to implement. Also, we  
4 are going to focus on anti-cancer drugs.

5           We focus on anti-cancer drugs, chemotherapy, and  
6 their supportive drugs administered in a physician's office  
7 of hospital outpatient department because Medicare spending  
8 is substantial, about \$11 billion in 2014. Last spring, I  
9 presented findings from our analysis that showed in 180  
10 days following the administration of an anti-cancer drug  
11 for newly diagnosed cancer patients, anti-cancer drugs and  
12 their associated administration services accounted for more  
13 than half of total spending. In our June 2015 report, we  
14 began to explore approaches for bundling oncology services.

15           So, today's presentation is based on your  
16 interest in looking at different models. Last spring, when  
17 we were discussing the idea of oncology bundling,  
18 Commissioners also were interested in learning about other  
19 approaches, so we have brought back some new ideas that are  
20 used by payers and providers. The first two approaches are  
21 relatively narrow and they focus on the drug price and drug  
22 selection, risk sharing agreements and clinical pathways.

1 The last two approaches are broader, attempting to affect  
2 the use of drugs and other services, CMS's oncology medical  
3 home, and episodes of care. There are more approaches and  
4 ideas in your briefing paper and I'm happy to take  
5 questions about these other ideas at the end of the  
6 presentation.

7           So, let's move to the first approach, risk  
8 sharing agreements. From the payer's perspective, these  
9 agreements are intended to improve the value of drug  
10 spending by linking the price of a drug to its  
11 effectiveness. It reduces uncertainty for the payer in  
12 paying for drugs, particularly new and costly drugs whose  
13 effectiveness in clinical practice might be unclear.

14           In your briefing paper, we summarize an  
15 arrangement in the United Kingdom between the National  
16 Health Service and the product developer for bortezomib,  
17 Velcade. That is an anti-cancer product, anti-cancer drug,  
18 that's used to treat multiple myeloma administered in the  
19 clinician's office or hospital. Under this agreement,  
20 established in 2007, the product developer refunds the full  
21 cost of the product or provides replacement product to the  
22 payer for patients who, after four cycles of treatment,

1 have less than a partial response. The response is based  
2 on a biomarker for disease progression.

3           There are examples of risk sharing agreements for  
4 oral drugs in the United States and these include anti-  
5 cholesterol drugs, a drug that treats diabetes, and a drug  
6 that treats osteoporosis.

7           So, this slide raises some issues in implementing  
8 these agreements in Medicare. These agreements are not  
9 always easy to implement, but there is increasing interest  
10 by commercial payers and PBMs to put them into effect.  
11 There are high transaction costs to develop and adjudicate  
12 the agreement on the part of both the payer and the product  
13 developer.

14           Agreements are very data intensive to administer  
15 and track. Measurement is a key issue to finding a  
16 clinically relevant outcome that occurs in a reasonable  
17 time period. Longer-term outcomes that occur years out  
18 might be more challenging. The more successful  
19 arrangements have been ones with easily measured and  
20 reliable outcomes.

21           Another issue is having the infrastructure to  
22 easily track outcomes, for example, using administrative

1 data versus chart review.

2           Defining the financial agreement, for example,  
3 whether a discount or refund is provided or replacement  
4 product, is another key issue.

5           Medicare would need statutory authority to  
6 implement these agreements for Part B drugs and would also  
7 need to create the necessary infrastructure to implement  
8 such approaches.

9           Moving to clinical pathways, our second approach,  
10 they attempt to reduce prescribing variability, maintain or  
11 improve quality of care, and reduce costs of care.

12 Pathways are evidence-based treatment protocols used by  
13 payers and providers that identify specific treatment  
14 options based on efficacy, toxicity, and then cost.

15 Pathways are more specific than guidelines, but are often  
16 based on guidelines. Some providers have developed their  
17 own pathways while others use pathways developed by third-  
18 party vendors.

19           There is some limited evidence showing that  
20 pathways reduce treatment variation and decrease costs. On  
21 the other hand, some have raised concerns that some  
22 pathways are too rigid, do not include non-drug components

1 of care, and may discourage appropriate off-label use.

2           So, here are some issues to consider if Medicare  
3 were to implement pathways. A key issue for Medicare would  
4 be how to develop and update clinical pathways. One option  
5 would be for Medicare to invest the resources for pathway  
6 development, which could be costly and challenging.  
7 Alternatively, the Secretary could evaluate existing  
8 pathways for use. However, some existing pathways are  
9 proprietary. Another issue is that some practices are  
10 already using multiple pathways from different programs.  
11 Some providers have linked financial incentives to the use  
12 of pathways and have adjusted payment based on pathway  
13 adherence.

14           Medicare would need statutory authority to  
15 implement pathways under Part B or could test such an  
16 approach under CMMI's authority. The practices  
17 participating in CMMI's oncology care model, which is  
18 expected to begin this spring, will be required to report  
19 if the care they furnish is consistent with a pathway or a  
20 national guideline.

21           So, now, let's discuss a broader approach. The  
22 first is CMS's oncology medical home. Its goal is to

1 improve health outcomes through improvements in access and  
2 coordination of care, reduce admissions and ED visits, and  
3 reduce total cost of care. The oncology medical home  
4 builds on the concept of patient-centered care under which  
5 a designated provider is responsible for complying with  
6 requirements for integrated care, evidence-based medicine,  
7 performance measurement, and enhanced access.

8 CMS provided a grant to test the community  
9 oncology medical home, COME HOME model. Seven practices  
10 participated, treated Medicare, Medicaid, and commercially  
11 insured patients with seven cancer types. Enhanced  
12 capabilities on the part of the practices included the use  
13 of triage pathways and extended access. The three-year  
14 grant ended in 2015 and we are waiting for the final  
15 evaluation of the program's effect on quality of care and  
16 total costs.

17 So, here are some issues that Medicare would need  
18 to decide on to implement the oncology medical home.  
19 Defining the trigger event, diagnosis or treatment, and the  
20 patient population is certainly one. Determining practice  
21 requirements, such as enhanced access, patient education,  
22 and shared decision making. How to pay providers is

1 another issue, including the idea of risk sharing in the  
2 longer term. With additional evidence on the effect of the  
3 COME HOME model on quality and spending, CMS under CMMI  
4 authority could test this approach nationally.

5           So, moving to the last approach for today's  
6 session is an episode of care approach implemented by  
7 United Healthcare. The goal of United Healthcare's pilot  
8 was to reduce potential financial incentives to prescribe  
9 one drug versus another. We discussed this approach during  
10 our April 2015 meeting and in our June 2015 report. The  
11 pilot paid participating practices ASP plus zero percent.  
12 It removed the add-on and converted the add-on into an  
13 episode fee. There was an opportunity for shared savings  
14 in this pilot that was linked to improving the survival  
15 rate or decreasing total costs.

16           According to the peer reviewed publication under  
17 the three-year pilot, total spending was reduced by 34  
18 percent. However, drug spending increased. While it is  
19 not clear what drove the increase in drug spending, the  
20 larger scope of the episode means if a more costly drug or  
21 longer chemotherapy regimen is appropriate, oncologists  
22 have the opportunity to do so without necessarily

1    jeopardizing overall savings.

2                    So, here are some of the issues to consider if  
3 Medicare were to implement oncology episodes or bundles.  
4 This list comes from our June 25 report. I'm going to  
5 highlight two of the design features, but we'll be happy to  
6 take questions that you might have about other design  
7 aspects.

8                    The first element is the services included in the  
9 bundle. Bundles or episodes that include more services  
10 require providers to be accountable for a wide range,  
11 thereby creating greater incentives for care coordination  
12 than narrowly defined bundles.

13                   Another key element is the type of payment. One  
14 option is to pay providers prospectively, while another  
15 option is to maintain fee-for-service payments and adjust  
16 net payments retrospectively.

17                   CMMI could test an episode of care approach,  
18 which it is doing. The oncology care model is described in  
19 your briefing paper and it is a six-month episode that is  
20 triggered by chemotherapy administration.

21                   So, to summarize, the narrow approaches that I've  
22 discussed attempt to improve the value of drug spending

1 while the broader approaches attempt to improve health care  
2 delivery. Providers would have somewhat greater  
3 flexibility under the broader approaches, and the broader  
4 approaches give more opportunity for providers to decide on  
5 the value of services.

6 We are seeking guidance from you about which  
7 direction, which approach you would like us to further  
8 pursue.

9 That concludes my presentation and I'm happy to  
10 take questions.

11 DR. CHRISTIANSON: Okay. Thank you, Nancy.

12 I think we'll do just a general set of questions  
13 for Nancy on this and just -- so, don't worry about whether  
14 your question is clarification or something else. And,  
15 Jack, were you going to take the lead on this? David, you  
16 were going to. Okay. Go ahead.

17 DR. NERENZ: Nancy, this is good work.

18 Let me just start -- well, a couple of very quick  
19 observations, but I think I'll try to focus on the first  
20 point that you have up here and we'll see where we go.

21 The very first minor point is that I think as you  
22 appropriately labeled it in your own introduction, most of

1 the content here is about chemotherapy and about drug costs  
2 as opposed to oncology more generally. The title of the  
3 thing says "oncology," but I think we just observed that  
4 we're not talking about surgery here in any significant  
5 amount. We're not talking about radiation therapy. So,  
6 just -- you said that, and I agree with it, but that's just  
7 so we understand, because there are areas of discussion we  
8 could get into that I presume we are not going to get into,  
9 or at least you have not led us into.

10 MS. RAY: No, not yet, but --

11 [Laughter.]

12 MS. RAY: But -- oh, I'm getting myself in  
13 trouble, but certainly, some of the concepts that we've  
14 presented here could certainly be applied to other aspects  
15 of oncology care, and there are examples of surgery-based  
16 episodes and radiation oncology is another area that could  
17 be looked at.

18 DR. NERENZ: All right. Well, then I presumed  
19 all we needed to do was clarify that the scope of this  
20 discussion was chemotherapy and we just hadn't said so.  
21 Now, if that's not it, well, then --

22 DR. MILLER: That's the way. Yes.

1 DR. NERENZ: Okay. Well, then -- all right.  
2 Then, that still takes me to where I was going to go next  
3 anyway.

4 [Laughter.]

5 DR. NERENZ: Just to reinforce the point that you  
6 have up there, in the examples we've been given, I think  
7 there are some very distinct differences that you've  
8 captured by the phrase "narrower and broader." I was  
9 thinking of them perhaps in some slightly different terms.  
10 Some of the projects are very specifically and very  
11 directly about drug costs and drug use. The pathway  
12 things, for example, are quite tightly focused about that.

13 The oncology care model is not. It's about the  
14 specific thing being done that's novel is this per patient  
15 per month care coordination payment, and its effects are  
16 presumably in areas like unplanned and unwanted ED visits,  
17 readmissions, what not. Although there certainly can be  
18 attention to drug costs in the context of that program or  
19 that model, I would have to say its essence is not drug  
20 costs.

21 So, again, I just want to emphasize for those  
22 following along here that the examples we have here really

1 are different, as the point is made here, in their focus,  
2 their scope, and the range of their potential effects, and  
3 the bundling projects, of which the oncology care model is  
4 an example, is really about more than drug use, drug costs,  
5 okay. So, I wanted to go with that.

6           Then the only other thing I wanted to get into a  
7 little bit, and this probably ties back into the discussion  
8 we had in the previous session about Part B in general, in  
9 that chapter, as I brought up in the question, there's this  
10 very nicely crafted example about two drug alternatives  
11 that are in that example identical in their clinical  
12 effects but different in their costs. And, I think as we -  
13 - and we talked about that.

14           Now, in this discussion, I think the scenario  
15 shifts just a little bit, but in an interesting way. It's  
16 very unusual, I think, in oncology to have two things that  
17 are precisely identical in terms of their clinical effects,  
18 but it's fairly common to have things that are close. And,  
19 it seems to me, but I'd be interested in other discussion,  
20 particularly among the clinicians here, how the choices and  
21 how the eventual costs of care really get crafted.

22           What I'm thinking is that as research goes on and

1 as clinical trials are done, in any one cancer domain, we  
2 get new things coming that are a little bit better than  
3 what we had before, and these new things that are a little  
4 bit better than what we had are often way more expensive  
5 than what we had. And the issue of price and drug use  
6 comes down to this question of how much are we in the  
7 Medicare program willing to pay, and through the copays  
8 beneficiaries, how much are we willing to pay for a little  
9 bit of benefit, and that -- whether that's driven by this  
10 plus six percent, I think, now sort of fades a little more  
11 in the background.

12 I think this is a little more about how do we as  
13 patients, how do we as a society think about this tough  
14 question of how do you pay for more benefit, and I'm  
15 thinking the framing of it is frequently significant, that  
16 if you look at a published clinical trial or you look at a  
17 summary of some aggregates, you may say that a particular  
18 drug might increase average life expectancy, say, by four  
19 weeks. And, so, now as a policy thing you say, okay,  
20 what's four weeks worth.

21 But, I don't know that that's exactly how it's  
22 captured in the mind of the patient or even in the

1 clinician, because in oncology specifically, it is  
2 literally a life and death thing. Often, you're talking  
3 about the probability of cure, which is measured in a  
4 different way, and maybe these two different drugs have  
5 marginally different probabilities of cure. But, the  
6 decision when it finally comes down to it may not be about  
7 one month additional. You know, that's a statistical  
8 average. It may be about what are the chances that I will  
9 survive or not survive this horrible disease.

10           And, so, I think as we think about these options  
11 and how they play out, we have to carefully think, how does  
12 this decision of this drug or that drug, this regimen, that  
13 regimen, how is it framed in the patient's mind and how is  
14 it framed together in the clinician's mind and in the  
15 patient's mind, and eventually, how do we come up with  
16 something where sort of clinically and ethically we do the  
17 right things for patients but we don't waste money.

18           So, I'm not sure quite where that takes us, but  
19 this is deep, deep water because of the specific nature of  
20 this disease.

21           DR. CHRISTIANSON: So, not wasting money is a  
22 good thing, right.

1 DR. NERENZ: [Off microphone.] I think we can  
2 settle that --

3 DR. CHRISTIANSON: Yeah.

4 DR. NERENZ: -- but it's all the rest of it --

5 DR. CHRISTIANSON: Okay. So, just before we go  
6 into individual comments, just sort of remember that the  
7 notion here is to provide the staff with some general  
8 guidance about if we really feel that one of these  
9 directions versus another is the right way to go, not sort  
10 of, gee, I didn't like this part of the United Healthcare  
11 model, right. So, do we want broader stuff? Do we want  
12 narrower stuff? What do we think the most promise is? So,  
13 who's --

14 DR. MILLER: Can I say one thing?

15 DR. CHRISTIANSON: Yes.

16 DR. MILLER: Obviously, I agree with that, and in  
17 the larger context of what's gone on today, at least as we  
18 move from B to oncology, the way your guys' conversation  
19 went last time was -- or several times ago, I can't  
20 remember, but there is the stuff of, like, oh, is there  
21 something we can do about the price of Part B drugs. Then  
22 there were sets of comments about, well, maybe there are

1 differences in these drugs and can we construct different  
2 ways to think about utilization of the drugs, because  
3 you're right, a lot of this now isn't about the price, and,  
4 so, it's really about how you control and make decisions  
5 about which drugs you use, and then broader scopes of  
6 services.

7           And, so, there's B, as we did in the last  
8 session, then we're taking half of the book of business in  
9 B, \$10 billion, and asking a different question, which is  
10 do you want to think about utilization strategies as it  
11 relates to those.

12           DR. CHRISTIANSON: It looks like a lot of people  
13 want to talk, and so just to keep it easy, let's just start  
14 with Alice and go around the room.

15           DR. COOMBS: Thank you, Nancy.

16           So, in the chapter, on 23, it talks about the  
17 overall spending in the UnitedHealthcare model was  
18 decreased from 98 to 64, something like that, not including  
19 drugs, right? And then the drug spending went from --

20           MS. BUTO: Including drugs.

21           DR. COOMBS: Including drugs?

22           DR. MILLER: Yeah. Drugs went up, but --

1 DR. COOMBS: Drugs went up, but does that 98 to  
2 64 include --

3 MS. RAY: Right. Total spending, the net went  
4 down --

5 DR. COOMBS: Right.

6 MS. RAY: -- even though the drug component went  
7 up.

8 DR. COOMBS: Okay. So that's actually a very  
9 good thing, with the ASP of 100 percent. Okay.

10 DR. HOADLEY: I'm not sure I got much to add on  
11 the core question of sort of the different approaches. I  
12 mean, one of the things that this brings me back to is the  
13 drug launch prices. I mean, a lot of this is driven by --  
14 I mean, the way we're trying to -- because that these drugs  
15 are launched at high prices, which is not really the  
16 conversation we're having right now, but I think David put  
17 all this out very clearly that this is a bigger set of  
18 issues because most of the decision-making is not around  
19 price.

20 I mean, I guess I just generally would encourage  
21 us to continue to look at this range of options. I think  
22 things like CMS demos will be -- should be informative, and

1 I don't have in my head right now how quickly we started to  
2 get more of those kinds of results, but trying to figure  
3 out what we can learn from the different things that have  
4 been tried, which is what you sort of laid out to this  
5 point, and continuing to see what's happening seems like a  
6 very helpful exercise.

7 DR. CROSSON: Herb.

8 MR. KUHN: Nancy, two quick questions. One is,  
9 if you look at the medical home, the oncology medical home  
10 CMS is working on how, how do local coverage determinations  
11 impact how that might work in different parts of the  
12 country? So say there's an LCS that makes a change in  
13 terms of the use of a particular drug, does that impact how  
14 CMS would configure these things differently around the  
15 country, or is it going to be the same around the country?  
16 Will they override LCDs? How might that work?

17 MS. RAY: So you're talking about LCDs specific  
18 to the anti-cancer drugs?

19 MR. KUHN: Yes.

20 MS. RAY: You know, I'll have to get back to you  
21 on that. That's a good question.

22 To my recollection, I would want to look at the

1 RFA for the oncology care model to see if that's dealt with  
2 or not addressed.

3 MR. KUHN: Okay, thank you.

4 And then the second thing, in the paper, there  
5 was a discussion a little bit of this initiative that  
6 Express Scripts has launched into that is looking at  
7 differential pricing on impacts on different tumors. Any  
8 indication how effective that has been in terms of  
9 controlling prices or managing the process so far?

10 MS. RAY: Can you just say a little bit more  
11 about --

12 MR. KUHN: Yeah. So I --

13 MS. RAY: Oh. what page are you on?

14 MR. KUHN: There's an Express Scripts program  
15 that was mentioned in the paper, and I'm just curious when  
16 did it start. What have they learned from it? Have they  
17 published any information on it so far?

18 MS. RAY: So these arrangements are proprietary.  
19 It's often very difficult to get specific information about  
20 them.

21 The one that we focus more on was the anti-cancer  
22 drug arrangement in the UK, because that is infused in a

1 doctor's office or a hospital outpatient department. The  
2 paper did provide other examples of what commercial payers  
3 and PBMs are interested in doing, but I don't have  
4 specifics yet on how these agreements have materialized.

5 MR. KUHN: Thank you.

6 DR. SCHMIDT: You're referring to the indication-  
7 specific pricing, the Peter mock idea?

8 MR. KUHN: I don't know if he did that. It might  
9 similar to what Peter had done, but it was specifically  
10 cited on page 17 on this Express Scripts initiative, but if  
11 it's similar to what Peter had recommended, I'd be  
12 interested in hearing about it.

13 DR. SCHMIDT: That is brand-new, so I don't think  
14 that there is much to report yet.

15 MR. KUHN: Thanks.

16 DR. CROSSON: Cori.

17 MS. UCCELLO: So this presentation was framed in  
18 terms of narrow approaches and broader approaches. Do  
19 these necessarily have to be mutually exclusive? I mean, I  
20 could envision a risk-sharing arrangement within an episode  
21 of care. I think that might be really interesting to think  
22 about.

1 MS. RAY: Right. And clinical pathways, where  
2 are being used -- were used in the episode of care, can be  
3 used in the episode of care, as well as the oncology  
4 medical home.

5 DR. CROSSON: Warner.

6 MR. THOMAS: I think the approach that United  
7 used should be further studied and considered to be  
8 expanded. I mean, certainly, there's a lot of  
9 hospitalization and rehospitalization that goes on with  
10 oncology patients that probably could be managed -- have  
11 improved management in an oncology medical home-type model.  
12 So I think thinking about how you wrap all the services  
13 together -- the hospital component, in- and outpatient; the  
14 actual treatment, radiation, infusion -- I think there is  
15 probably a lot of improvement that could be done there with  
16 multidisciplinary teams to impact cost. So I think trying  
17 to build upon this model is a really attractive approach.

18 DR. CROSSON: Rita.

19 DR. REDBERG: Nancy, I have a question and then  
20 some comments. Do we know what costs went down in the  
21 United model, if drugs went up?

22 MS. RAY: So, in the publication, they mentioned,

1 first of all, that it wasn't set up to statistically  
2 analyze that, but they did see a drop in admissions and  
3 radiology.

4 DR. REDBERG: Thanks.

5 So, in further discussion, in general, I think  
6 broader approaches to improve health care delivery are  
7 good, but I wanted to start with sort of first looking at  
8 whether the drugs or the treatment was indicated in the  
9 first place because the example on the Executive Summary  
10 page 1 of that proton beam therapy is more costly than  
11 IMRT. Well, IMRT has never been studied in a randomized  
12 controlled trial for prostate cancer. So, I mean, to  
13 compare something very expensive to something a little  
14 expensive, that never worked anyway. We don't really know  
15 if you would have been better off with nothing, which is  
16 certainly preferable for the beneficiary and much cheaper  
17 for the program.

18 You know, we're talking about all this treatment  
19 for prostate cancer when we don't -- the task force  
20 recommendation, the part of Health and Human Services, says  
21 we shouldn't even have been screening for prostate cancer  
22 because men would be better off if we left them alone, and

1 they wouldn't have all this chemotherapy and surgery and  
2 radiation therapy.

3           And so I think when we're talking about  
4 treatments, we first have to look at should we be doing  
5 anything and is it appropriate, and that's the first step I  
6 think in the pathway, is to look at the value, because  
7 we're doing some cancer treatments that people would  
8 definitely be better off without.

9           And then you had mentioned about looking at if  
10 you got a month of life, would that be better, but that  
11 really brings up another problem with oncology drugs, is  
12 that most of them are now being approved on surrogate  
13 markers, and they're not getting approved on "Would you  
14 live?" They're getting approved on "Do your biomarkers get  
15 better? Does your imaging get better? Does your  
16 progression-free survival get better?" None of that  
17 correlates to "Do you live longer?" So now we're getting  
18 very expensive drugs on the market, and we don't know if  
19 they're helping patients to live longer, even when they are  
20 indicated.

21           And then the last thing I wanted to comment on  
22 was on page 15. It says, for example, that if the drug is

1 used for an off-label indication, but that's another area,  
2 I think, of concern, is that Medicare is obligated to pay  
3 for off-label indications if they're listed in the NCCN.  
4 But the evidence behind that compendium is often not there,  
5 and so, again, maybe we're paying for very expensive drugs  
6 that people would be better off without. And I'd like to  
7 relook at that as well.

8 DR. HALL: I guess I have a little bit of  
9 dissidence here. You mentioned at the very beginning that  
10 -- in the very first paragraph, the expense involved with  
11 covering drugs and just looking at that in the abstract.  
12 Does the data include comprehensive cancer centers, or is  
13 this just looking at all chemotherapeutic agents given in a  
14 doctor's office that falls into fee-for-service payment?

15 MS. RAY: The analysis that we included in the  
16 June 2015 report looked at all providers, all sites of  
17 care.

18 DR. HALL: Okay.

19 MS. RAY: Including comprehensive cancer centers.

20 DR. HALL: Okay. I think we may be lumping  
21 things that are somewhat unrelated or true and unrelated,  
22 and just very simply, if it turns out that a lot of private

1 oncologists in their office are prescribing drugs kind of  
2 independent of a more comprehensive approach, that  
3 definitely needs to be looked at. And any alternative to  
4 that might be very fruitful.

5           But I don't think that's really the direction we  
6 should be going in. I think that if we're going to improve  
7 cancer care, it's probably going to be in an  
8 interdisciplinary mode, and so chemotherapy is certainly an  
9 important and expensive part of that. But it's taken out  
10 of context with what else is going forward. I don't really  
11 have a solution, how we dissect that out, but I think if we  
12 spend a lot of time just individually looking at fee-for-  
13 service payments, what we're going to conclude is a better  
14 way of prescribing medication is an interdisciplinary  
15 cancer center where you have a lot of different resources  
16 for the total care of the patient.

17           DR. CROSSON: This way. Mary.

18           DR. NAYLOR: So I think it was Cori who said I  
19 think we should be looking at these both, not an "and."  
20 The cancer in a Medicare population is often one of  
21 multiple health problems, and so thinking about the  
22 critical role of care management and what the oncology

1 medical home was attempting to do was to really link with  
2 not just all of the people involved in cancer, but the  
3 primary care providers and others to deliver comprehensive  
4 care. And I think the evidence is pretty compelling here  
5 that comprehensive care is very important. GI cancer is  
6 one in five of the admissions, your wonderful report says  
7 are avoidable, hospitalizations are avoidable, and for  
8 symptoms, for treatment, adverse events, for not having  
9 access to care, those kinds of issues, and it seems to me  
10 all of that, UnitedHealthcare pointed to the value of a  
11 comprehensive approach.

12           At the same token, I think the issues around  
13 clinical pathways and risk-sharing agreements make a great  
14 deal of sense in terms of thinking about the drug component  
15 of this. So my recommendation is that these are both  
16 approaches. The comprehensive approach should be both  
17 narrow and broad in scope.

18           DR. CROSSON: Craig.

19           DR. SAMITT: So I would echo that as well. I  
20 would see these as nested opportunities where you want to  
21 have both a narrower incentive as well as a broader one.  
22 If you were to have me pick, I would actually be more in

1 favor of the oncology medical home because for the reasons  
2 that we've talked about, Rita has talked about in terms of  
3 the episodes themselves, some of these episodes may not  
4 actually be necessary, or we may not be doing good for the  
5 beneficiary in thinking of it as an episode level. But if  
6 we think of it from an oncology medical home perspective,  
7 thinking all of the various options, episodes or not, that  
8 that would be the way that I would want to think about  
9 cancer care.

10           But within the medical home, we would want to  
11 assure that should episodes occur that there is protocol  
12 that is being followed, and that's why in addition to  
13 medical home, the one I would pick would be pathways. Are  
14 we adhering to pathways and guidelines when episodes are  
15 required within the context of a broader population health  
16 view of cancer care in the medical home?

17           DR. CROSSON: Nancy, correct me if I am wrong,  
18 but I think this summer, we are going to get more  
19 information about the medical homes, the COME HOME project,  
20 rather, and how well that's performed. Is that right?

21           MS. RAY: We are awaiting the final evaluation of  
22 it, yes. Yes. Hopefully, this summer.

1 DR. CROSSON: Kathy.

2 MS. BUTO: I just wanted to make the point that  
3 on the Velcade project that I actually think that's a  
4 really good example of something else, which is this issue  
5 that both Rita and Warner have brought up about high launch  
6 prices. So there is a category, and I would add coverage  
7 with evidence development is another. What do you do about  
8 a new potentially breakthrough drug that comes along? And  
9 this was that case, and that's the reason the company got  
10 into a negotiation with NICE to essentially guarantee the  
11 outcome, which is very unusual.

12 So more than a cancer example, I think it  
13 actually falls into a bucket of potential "What do you do  
14 about new, potentially very promising drugs?" and that we  
15 could look at that set of tools as a whole category.

16 And, as part of that, I was saying to Mark  
17 earlier that it's helpful -- looking for Rachel and Kim and  
18 others, but it's probably helpful for us to get the  
19 background on what happens when a new drug doesn't have ASP  
20 because there haven't been enough sales in the commercial  
21 sector, how does Medicare set the rate, so that we start  
22 with an understanding of how that's done initially and I've

1 forgotten, and then look at various tools that we might  
2 want to encourage that would do a better job of paying for  
3 the right care for these new drugs.

4 DR. CROSSON: Okay. Other questions, comments on  
5 the report?

6 [No response.]

7 DR. CROSSON: Nancy, thank you so much. We shall  
8 return to this topic.

9 [Pause.]

10 DR. CROSSON: Now we have the opportunity for the  
11 public comment period. For those of you who want to make a  
12 comment, please come to the microphone so we can see who  
13 you are.

14 A comment for particularly newcomers, this is not  
15 the only or the best way to provide input, to MedPAC staff  
16 particularly. You can do that online or in person.

17 We'd ask you to state your name and your  
18 affiliation and limit your comments to two minutes. And  
19 when this red light comes back on, the two minutes will  
20 have expired.

21 I see Sharon at the microphone. Go ahead.

22 MS. McILRATH: So for those who don't know, I'm

1 Sharon McIlrath with the AMA. I wanted to raise the  
2 question of the difference between what happens when you  
3 reduce ASP in the hospital outpatient setting versus what  
4 happens when you reduce it in the physician setting. I  
5 don't know if the data that you looked at would look at the  
6 prices that the physicians are buying it at versus what the  
7 hospitals are buying it at or what a small practice can buy  
8 it at versus what a large practice could buy it at.

9           A fear in the physician community is that you  
10 will drive the little guys -- and there is already, as you  
11 can see in your June report from last year, a much higher  
12 increase, four times as big an increase in the -- sorry, my  
13 throat's all -- in the hospital outpatient department as in  
14 the physician setting. So a fear is that you're going to  
15 drive it all into the hospital where the facility fee and  
16 the 340B discount make it much easier for somebody to  
17 subsidize the lower price that they're getting on the drug  
18 now.

19           So it would be interesting, I think, to look at  
20 some simulations of what happens if it all moves into the  
21 hospital and various percentages of difference that would  
22 occur that way.

1 DR. CROSSON: Thank you.

2 Seeing no one else at the microphone, we are  
3 adjourned until 8:30 tomorrow morning. Thank you.

4 [Whereupon, at 5:00 p.m., the meeting was  
5 adjourned, to reconvene at 8:30 a.m. on Friday, March 4,  
6 2016.]

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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 4, 2016  
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair  
JON B. CHRISTIANSON, PhD, Vice Chair  
SCOTT ARMSTRONG, MBA, FACHE  
KATHERINE BAICKER, PhD  
KATHY BUTO, MPA  
ALICE COOMBS, MD  
WILLIS D. GRADISON, JR., MBA, DCS  
WILLIAM J. HALL, MD, MACP  
JACK HOADLEY, PhD  
HERB B. KUHN  
MARY NAYLOR, PhD, FAAN, RN  
DAVID NERENZ, PhD  
RITA REDBERG, MD, MSc  
CRAIG SAMITT, MD, MBA  
WARNER THOMAS, MBA  
SUSAN THOMPSON, MS, RN  
CORI UCCELLO, FSA, MAAA, MPP

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Public Comment.....	140

P R O C E E D I N G S

[8:30 a.m.]

1  
2  
3 DR. CROSSON: Good morning. We are going to  
4 spend the morning on a topic that we have been working on  
5 in different versions over the last two years or so. We've  
6 had a number of different names -- synchronization, some  
7 other names I won't mention. But it fundamentally is  
8 predicated on the notion that we have had in front of us  
9 that, at least from the perspective of the Medicare program  
10 and the beneficiaries, Medicare fee-for-service, Medicare  
11 Advantage, and fee-for-service incorporating different  
12 payment mechanisms ought to be on something like a level  
13 playing field. I think we're discussing it from the  
14 perspective of competitive pricing, but that's the  
15 underlying notion that we've been working on. And so we're  
16 going to take that on again, take a little bit of a  
17 different look at it, with the expectation that we can  
18 advance this process along.

19 So we have plenty of time for the discussion. It  
20 is a complex issue. So we're going to have a presentation  
21 by Eric Rollins, Carlos Zarabozo, and Scott Harrison.  
22 Eric, I'm not sure, but is this your maiden voyage in front

1 of the Commission?

2 MR. ROLLINS: Second.

3 DR. CROSSON: Second time, okay. Then it's okay  
4 that we don't have any champagne for you.

5 [Laughter.]

6 DR. CROSSON: But you can start out.

7 MR. ROLLINS: After, we can talk.

8 DR. MILLER: Because there's sort of two topics  
9 here, the way we were thinking we would do this is Eric  
10 will do his, we'll get clarifying questions. Then we'll do  
11 the second topic, and then we'll do the whole shebang. And  
12 so that's the game plan, just break it up in pieces so you  
13 can kind of absorb it.

14 [Pause.]

15 DR. MILLER: And if I wasn't clear, Eric will  
16 stop, clarifying questions on Eric; then we'll do the other  
17 things; you'll get clarifying questions there. And then  
18 you just do the whole deal. So there will be a little  
19 break in which you'll be asking questions.

20 DR. CROSSON: Okay, Eric.

21 MR. ROLLINS: Good morning. Today Carlos, Scott,  
22 and I are going to discuss ways that Medicare could use

1 competitive pricing to determine beneficiary premiums in  
2 the fee-for-service and Medicare Advantage programs. Our  
3 discussion today builds on the analyses that we presented  
4 to the Commission last spring on synchronizing various  
5 aspects of Medicare policy across the fee-for-service, MA,  
6 and ACO sectors.

7 I'd like to start by giving you a quick overview  
8 of the presentation. As Mark noted, we're going to cover a  
9 fair amount of material in this presentation, and as a  
10 result we've decided to break it into two parts. I'll  
11 start by reviewing our analytic framework for comparing  
12 fee-for-service and MA costs in different areas of the  
13 country and present updated figures for the three  
14 illustrative examples that we used last year to explore how  
15 Medicare could change the way it determines beneficiary  
16 premiums. I will also discuss some options for mitigating  
17 the potential increases in premiums that could occur under  
18 some of these examples, and then we'll have a round of  
19 clarifying questions on Part 1.

20 After that, we'll move on to Part 2, where Carlos  
21 and Scott will discuss how competitive pricing could be  
22 used just within the MA program to achieve savings. There

1 will then be a round of clarifying questions on Part 2  
2 followed by the normal Round 2 of policy discussion, which  
3 will cover this entire presentation.

4           Moving now to Slide 3, the Commission has made  
5 numerous recommendations over the years that would  
6 strengthen the incentives for both fee-for-service  
7 providers and MA plans to provide good-quality care in an  
8 efficient manner. The incentives that Medicare  
9 beneficiaries face can play an important role in  
10 reinforcing those efforts. In particular, policymakers  
11 could create financial incentives that encourage  
12 beneficiaries to use more efficient delivery models. If  
13 those efforts help lower Medicare spending, the savings  
14 could be shared between taxpayers and beneficiaries and  
15 could thus benefit both groups.

16           The next slide summarizes the framework we used  
17 to compare fee-for-service and MA costs in different parts  
18 of the country. First, we began by grouping counties  
19 together to approximate the insurance markets served by  
20 private plans. Using a combination of core-based  
21 statistical areas and health service areas, we created a  
22 total of about 1,200 market areas in the 50 states and the

1 District of Columbia. Our market areas are thus often  
2 bigger than the service areas that MA now uses, which are  
3 usually based on individual counties.

4 Second, we calculated average fee-for-service  
5 spending for 2016 in each market area and did so in a way  
6 that made fee-for-service spending comparable to the  
7 spending included in MA plan bids. This effectively  
8 allowed us to approximate a fee-for-service "bid" in each  
9 market area.

10 Third, we recalculated MA bids for 2016 to  
11 reflect the use of our market areas instead of the existing  
12 MA service areas.

13 Finally, we assumed that the quality of care is  
14 the same in both the fee-for-service and MA sectors.

15 Moving on now to Slide 5, here's an overview of  
16 the three market areas -- Portland, Oregon; Columbus, Ohio;  
17 and Miami, Florida -- that we used for last year's analyses  
18 and will return to in this presentation. All three areas  
19 have a large number of Medicare beneficiaries, many MA  
20 plans available, and high MA enrollment rates.

21 For 2016, the national monthly average for fee-  
22 for-service spending is \$784 per beneficiary. With that as

1 a yardstick, you can see from the figures highlighted in  
2 yellow that fee-for-service spending is well below average  
3 in Portland, slightly below average in Columbus, and well  
4 above average in Miami. Finally, the median and average MA  
5 plan bids are higher than average fee-for-service spending  
6 in Portland, but lower in both Columbus and Miami.

7           In our analysis, we looked at three different  
8 ways for calculating premiums that would encourage  
9 beneficiaries to use the more efficient delivery model.  
10 Under the first illustrative example, there is a base  
11 premium that equals a fixed percentage of national average  
12 fee-for-service spending and buys fee-for-service Medicare  
13 in every market. This approach is similar to how Medicare  
14 currently calculates the Part B premium.

15           Under the second example, the base premium is  
16 also calculated using the national average for fee-for-  
17 service spending. However, in this example, the base  
18 premium buys either fee-for-service Medicare or the  
19 reference MA plan -- whichever costs less in a given  
20 market. In other words, if fee-for-service is lower than  
21 MA, then the base premium buys fee-for-service Medicare.  
22 And if fee-for-service is higher than MA, then the base

1 premium buys the reference MA plan. Therefore, what people  
2 can buy at the base premium will vary across markets  
3 depending on how fee-for-service compares with the  
4 reference MA plan.

5 Under the third example, the base premium is  
6 calculated in a different way. Here it's a fixed  
7 percentage of either local average fee-for-service spending  
8 or the cost of the reference MA plan -- whichever is lower  
9 in that market. As in the second example, the base premium  
10 buys either fee-for-service Medicare or the reference MA  
11 plan -- again, whichever costs less in that market.

12 In all three examples, the base premium pays for  
13 a specific delivery model. If beneficiaries enroll in  
14 something else, their premiums are increased or decreased  
15 by the full difference in cost.

16 Slide 7 lays out two key considerations to keep  
17 in mind when you're comparing these illustrative examples.  
18 First, the examples differ significantly in their impact on  
19 existing premiums. Under Example 1, most Medicare  
20 beneficiaries do not see their premiums go up: the fee-  
21 for-service premium is the same, and many MA enrollees see  
22 lower premiums because their plans are less expensive than

1 fee-for-service. However, MA enrollees in plans that are  
2 more expensive than fee-for-service do face higher  
3 premiums.

4           In contrast, under Examples 2 and 3, a majority  
5 of beneficiaries face higher premiums because the base  
6 premium now buys the lower of fee-for-service or the  
7 reference MA plan in each area. In areas where MA is less  
8 expensive, this means that fee-for-service premiums  
9 increase, and MA enrollees in plans with bids that are  
10 higher than the reference plan pay more as well. And in  
11 areas where fee-for-service is less expensive, most MA  
12 enrollees pay higher premiums. So you can think of Example  
13 1 as an approach that relies more on carrots and Examples 2  
14 and 3 as approaches that rely more on sticks.

15           Second, the examples also differ on how much  
16 beneficiaries versus the government are responsible for  
17 paying for the regional variation in Medicare spending. In  
18 Example 1, there's a uniform base premium in every market,  
19 which means that the federal contribution is responsible  
20 for picking up any additional costs due to regional  
21 variation across markets. In Examples 2 and 3, the base  
22 premium buys the lower of fee-for-service or the reference

1 MA plan in each area, with the beneficiaries who use a  
2 higher-cost delivery model paying the difference. As a  
3 result, the federal contribution would be more uniform  
4 across markets, and beneficiaries would bear more of the  
5 responsibility of paying for geographic variation.  
6 Finally, the use of locally set base premiums in Example 3  
7 would reduce premiums for many beneficiaries compared to  
8 Example 2.

9           On the next two slides, I'll show how Examples 1  
10 and 2 would work in the Portland, Columbus, and Miami  
11 markets. We're setting Example 3 aside to keep the  
12 presentation manageable and because its impact is broadly  
13 similar to Example 2. For illustration only, we used the  
14 MA plan with the median bid as the reference plan, but how  
15 you define the reference plan is a policy choice. For  
16 instance, it could be the lowest bid, the average bid, or  
17 something else. We also assumed that the base premium  
18 equals 13.5 percent of the Medicare Part A and Part B  
19 benefit cost. This percentage approximates the share of  
20 fee-for-service spending for Part A and Part B benefits  
21 that will be covered by the Part B premium in 2016.

22           Slide 8 has our first example. Each market has

1 two columns: one shows the cost of fee-for-service, and  
2 the other shows the cost of the median MA plan. In each  
3 column, the beneficiary premium is shown at the top in  
4 green, and the remainder, which is the federal  
5 contribution, is shown below that in gray.

6 In this first example, a nationally set base  
7 premium buys fee-for-service Medicare in every market. The  
8 base premium equals \$106, which is 13.5 percent of the  
9 national average fee-for-service spending of \$784. If  
10 beneficiaries enroll in an MA plan instead, their premium  
11 is increased or decreased by the difference between local  
12 average fee-for-service spending and the plan bid.

13 In Portland, which is shown on the left, the  
14 median MA plan costs \$60 more than fee-for-service (\$712  
15 versus \$652), and as a result, the premium for the MA plan  
16 will be \$60 higher than the base premium, for a total  
17 premium of \$166. By contrast, in both Columbus (which is  
18 shown in the middle) and Miami (which is shown on the  
19 right), the median MA plan is less expensive than fee-for-  
20 service, and premiums for the MA plan would be reduced  
21 accordingly. In Miami, the cost of the median MA plan is  
22 so much lower than fee-for-service (\$744 versus \$1,102)

1 that the difference would completely eliminate the  
2 beneficiary's premium and still leave another \$252. Here  
3 we show the beneficiary receiving the remainder as a cash  
4 rebate -- that's the gray segment with white lines -- but  
5 it could also take the form of extra benefits.

6 Note also that within each market the federal  
7 contribution is the same regardless of whether the  
8 beneficiary enrolls in fee-for-service or MA. However, the  
9 amount of the federal contribution would vary across  
10 markets, from a low of \$546 in Portland to a high of \$996  
11 in Miami. In Miami's case, the total federal contribution  
12 includes the cash rebate.

13 Slide 9 has our second example. There is still a  
14 nationally set base premium of \$106, but it now buys either  
15 fee-for-service or MA, depending on which costs less in a  
16 given market. In Portland, fee-for-service is less  
17 expensive, so the base premium of \$106 buys fee-for-  
18 service, just as it did in the first example. However, the  
19 situation is now different in Columbus and Miami. In those  
20 markets, the median MA bid is lower than local average fee-  
21 for-service spending, so the base premium of \$106 now buys  
22 MA instead of fee-for-service.

1           Beneficiaries who enroll in the more expensive  
2 option would pay a higher premium that reflects the full  
3 additional cost. For example, average fee-for-service  
4 spending in Columbus is \$40 higher than the bid for the  
5 median MA plan (\$744 versus \$704), so beneficiaries who  
6 enroll in fee-for-service instead of the MA plan pay a  
7 premium that is \$40 higher. The difference between the  
8 fee-for-service and MA premiums is particularly stark in  
9 Miami, where the cost of fee-for-service is more than \$350  
10 higher than the median MA plan.

11           As in the first example, the government  
12 contribution is the same for beneficiaries in a given  
13 market area, regardless of whether they enroll in fee-for-  
14 service or MA. However, since the base premium would now  
15 buy the lower-cost option in each area, the government  
16 contribution in many areas, such as Columbus and Miami,  
17 would be lower than in the first example.

18           Moving now to Slide 10, the illustrative examples  
19 that I have just discussed would give beneficiaries an  
20 incentive to enroll in the lower-cost delivery model. That  
21 incentive would be provided through beneficiary premiums  
22 that vary based on the relative costs of fee-for-service

1 and MA in each market. As a result, the extent to which  
2 those two benchmarks differ is a key factor in determining  
3 how much premiums might increase or decrease.

4           This slide shows the distribution of the  
5 difference between fee-for-service spending and the median  
6 MA bid for 2016. The values on the horizontal axis show  
7 local average fee-for-service spending minus the median MA  
8 bid in each market. As you can see, there are areas where  
9 MA is more expensive and areas where fee-for-service is  
10 more expensive.

11           The two biggest columns in the slide indicate  
12 that about 45 percent of beneficiaries live in areas where  
13 local average fee-for-service spending and the median MA  
14 plan bid are within \$50 of each other. Under our  
15 illustrative examples, the change in beneficiary premiums  
16 for these areas would be relatively small.

17           On the other hand, about a third of beneficiaries  
18 live in areas where local average fee-for-service spending  
19 and the median MA plan bid differ by \$100 or more. Most of  
20 these beneficiaries live in areas where fee-for-service is  
21 much more expensive than MA -- that's the right-hand tail  
22 of the distribution -- but there are also some

1 beneficiaries who live in areas where MA is much more  
2 expensive than fee-for-service -- that's the left-hand tail  
3 of the distribution. Tables 6 and 7 in the paper list the  
4 biggest markets where MA and fee-for-service premiums would  
5 see significant increases, using our third illustrative  
6 example.

7           When we presented on this topic last spring, many  
8 of you expressed concern over the magnitude of the  
9 potential increases in premiums that could result in  
10 certain parts of the country and asked us to examine ways  
11 of mitigating the potential impact on beneficiaries. We'll  
12 turn to that now.

13           On Slide 11, there are many ways that  
14 policymakers could mitigate the impact of higher premiums  
15 on beneficiaries, and this slide just sketches out some  
16 broad options. As we go through these, keep in mind that  
17 the examples we've discussed are meant to give  
18 beneficiaries a financial incentive to use a more efficient  
19 delivery model for their Medicare benefits, and that  
20 mitigating the impact of higher premiums reduces the  
21 effectiveness of that incentive.

22           First, the higher premiums under the new system

1 could be phased in over time, which would give  
2 beneficiaries and plans time to adjust. During the  
3 transition period, premiums could be a weighted average of  
4 the amount calculated under the old system and the amount  
5 calculated under the new system, with the weight for the  
6 new system rising over time. Second, policymakers could  
7 limit how much premiums increase from year to year, using  
8 either a dollar or percentage limit. Under this approach,  
9 the transition to the new system would take longer in areas  
10 where the difference between fee-for-service and the median  
11 MA bid is larger.

12           Policymakers could also tie efforts to mitigate  
13 premium increases to other program goals. For example,  
14 prior Commission analyses have found that supplemental  
15 coverage such as employer-sponsored or Medigap plans  
16 increase Medicare program spending. Policymakers could  
17 discourage the use of supplemental coverage by providing  
18 more protection from premium increases to beneficiaries  
19 without supplemental coverage.

20           Finally, policymakers will also need to consider  
21 the potential impact of higher premiums on state Medicaid  
22 programs and low-income Medicare beneficiaries. Medicaid

1 currently pays the Part B premium for about 15 percent of  
2 all Medicare beneficiaries through the Medicare Savings  
3 Programs. Under our illustrative examples, higher premiums  
4 could lead to a significant increase in Medicaid spending  
5 in some states. Policymakers could mitigate this impact by  
6 exempting Medicaid from paying the higher premiums or by  
7 limiting the amount of assistance that Medicaid is required  
8 to provide. On the other hand, policymakers could also  
9 expand the eligibility rules for the Medicare Savings  
10 Programs if they believe that beneficiaries who currently  
11 do not qualify would need assistance with the higher  
12 premiums.

13           This next slide demonstrates how different  
14 approaches could be used to mitigate premium increases.  
15 The figures here are based on the second example that we  
16 discussed earlier in the presentation, where a nationally  
17 set base premium pays for either fee-for-service or the  
18 median MA plan, whichever costs less. This time we use  
19 Chicago as an example because it is one of the largest  
20 markets where the cost of fee-for-service exceeds the  
21 median MA plan by \$100 or more. Here we roughly project  
22 premiums for 2016 through 2021, using growth rates from the

1 latest Medicare trustees report, and assume that the  
2 transition to the new system starts in 2017.

3           The green line at the bottom of the graph, marked  
4 D, shows fee-for-service premiums under current law. The  
5 yellow line at the top, marked A, shows how premiums would  
6 increase if Medicare switched immediately in 2017 to the  
7 new system for calculating premiums. The two lines in  
8 between, marked B and C, illustrate two options for  
9 mitigating the increase in premiums. Under Option B, the  
10 higher premiums are phased in over a five-year period and  
11 take full effect in 2021. Under Option C, fee-for-service  
12 premiums could not increase by more than \$20 annually  
13 during the transition to the new system. Given the size of  
14 the difference between local average fee-for-service  
15 spending and the median MA bid, the transition to the new  
16 system would still be under way in 2021 and would likely  
17 take more than a decade to fully implement.

18           Again, these options are for illustration only,  
19 but they demonstrate how policymakers could substantially  
20 mitigate the impact of higher premiums under a premium  
21 support-type model.

22           Moving to Slide 13, we've now reached the end of

1 the first part of this presentation, and it's worth noting  
2 some caveats to keep in mind about our analysis.

3 First, we have assumed here that quality does not  
4 vary across the beneficiaries' choices, which is  
5 unrealistic.

6 Second, for simplicity, we only compared fee-for-  
7 service and the MA plan with the median bid in each market.  
8 But as we noted in the paper, there are numerous other MA  
9 plans available in many market areas, and the premiums for  
10 those plans could be higher or lower than what we've shown  
11 here for the median plan.

12 Third, our analysis is static; we haven't tried  
13 to model how beneficiaries and plans might change their  
14 behavior if the rules for calculating beneficiary premiums  
15 change. Our analysis used plan bids from the current MA  
16 program, which is different from the three examples that we  
17 looked at today. Under different rules, MA plans are  
18 likely to bid differently and make different decisions  
19 about whether to enter or exit a particular market. One  
20 potential consequence is that some markets where fee-for-  
21 service is more efficient might no longer have MA plans.  
22 We also haven't tried to quantify how beneficiaries would

1 respond to changes in their premiums. Our examples show  
2 that changes in the method for calculating premiums can  
3 have a major effect on their finances, but we didn't  
4 address how individual beneficiaries would weigh premiums  
5 against other factors such as provider access and their  
6 perception of quality in deciding which delivery model to  
7 use. In markets where MA is more efficient, one potential  
8 consequence of the examples we've presented is that the  
9 share of beneficiaries enrolled in fee-for-service could be  
10 quite small.

11 Finally, we'd like to reiterate that our examples  
12 are for illustration and don't represent a definitive or  
13 comprehensive set of design choices. There are many other  
14 ways to calculate beneficiary premiums.

15 That concludes the first part of our  
16 presentation. I will now be happy to take any clarifying  
17 questions.

18 DR. CHRISTIANSON: Okay. Who wants to start with  
19 a clarifying question? Jack.

20 DR. HOADLEY: So thank you for all the new  
21 analysis. It's really very helpful, and I think that  
22 overall, the presentation of this, which is obviously very

1 complicated, you've done a good job of making it clear.

2 I asked in advance some version of this, but I  
3 wanted to get some of this on the record, which is how  
4 you're treating the extra benefits that most, if not all,  
5 MA plans today would have and include in what beneficiaries  
6 purchase. So can you talk about how that plays out in  
7 these models and how you've done it so far?

8 MR. ROLLINS: Sure. So, as you know, right now  
9 the provision of extra benefits is common under the MA  
10 program, and under the approaches we've outlined here, that  
11 would really no longer be the case. MA plans on the one  
12 hand and fee-for-service on the other are primarily going  
13 to be competing based on the overall price of providing  
14 benefits, which would be reflected in the premiums, and so  
15 that would be the main way that the two systems would  
16 interact.

17 DR. HOADLEY: So would you anticipate that extra  
18 benefits, the kinds of things that are offered today,  
19 whether it be some of the more marginal benefits, like  
20 hearing or vision coverage or things like providing the  
21 maximum out-of-pocket, cap on out-of-pocket expenses, would  
22 those come as an additional premium?

1           Again, on the Part D side, those are unsubsidized  
2 by federal dollars. I mean, obviously, we could look at  
3 any of those as policy choices, I assume, but have you  
4 thought at all about sort of how to build that in?

5           MR. ROLLINS: I think I would agree with you that  
6 its' very much a policy choice. It's not part of the  
7 examples we presented here, but it's certainly something  
8 that you could add. And it will be an element of something  
9 that Carlos and Scott are going to talk about in their half  
10 of the presentation.

11          DR. HOADLEY: And I would just add that one of  
12 the extra benefits in effect that many MA plans are doing  
13 in their bid is assigning some of their rebate dollars over  
14 to subsidize the Part D premium. So I would presume in a  
15 simple version of this, sort of following along the lines  
16 you do, the Part D premiums for the MA plans, instead of  
17 being subsidized and in some cases down to a zero premium,  
18 would revert back to having the sort of normal, full Part D  
19 premium.

20          MR. ROLLINS: Under the examples we've outlined  
21 here, yes.

22          DR. HOADLEY: Okay, thank you.

1 DR. MILLER: In a sense, it's sort of when you  
2 think about going to models like this, you are sort of  
3 shifting off of -- I think this is the case. You're kind  
4 of shifting off the current circumstance where plans bid  
5 based on extra benefits -- or compete -- I'm sorry -- on  
6 extra benefits to one that's more clearly a premium signal,  
7 and then he said, "Could you build that in?" And I was  
8 surprised by nobody breaking a sweat out there.

9 It would be, at least in a behavioral way, hard  
10 to do that. All we could do is sort of take a block and  
11 say I'm going to assume, you know, 5 percent of extra  
12 benefits or something like that. Is that what we're  
13 thinking here? Because I couldn't immediately envision how  
14 we would at least behaviorally -- because he was saying  
15 certain benefits go away, some benefits stay, that type of  
16 thing.

17 MR. ROLLINS: I guess my thought was that to the  
18 extent that there are elements that MA plans now offer that  
19 fee-for-service does not, that you would want to include,  
20 such as the cap on out-of-pocket spending, you could think  
21 more broadly about is that something you would want to have  
22 in both fee-for-service and MA as sort of the standard

1 benefit package.

2 DR. HOADLEY: I mean, I'll come back to some of  
3 this on the other round, but I think part of it is just  
4 thinking about when we're thinking about the changes in  
5 out-of-pocket cost that beneficiaries face, I just want to  
6 make sure we don't forget that that's already built in what  
7 people -- people don't think about the fact that they're  
8 getting extra benefits in the sort of standard MA kind of  
9 thing. And I just think we need to make sure we're  
10 thinking that through.

11 DR. CHRISTIANSON: I've got Bill, Craig, and  
12 Scott. Bill?

13 MR. GRADISON: Thank you. I think this is a  
14 related question. Looking nationally at these numbers, do  
15 you have any rough estimate of the difference -- do you  
16 have any rough estimates of how price versus volume varies  
17 within fee-for-service; that is to say, if we look at the  
18 high and the low fee-for-service geographic areas, how much  
19 of that could be explained by either price versus volume?

20 And the second question, somewhat closer, I  
21 guess, to what Jack was asking about, is whether, again, on  
22 a national basis, you can give us a rough idea of how much

1 on average these extra benefits in dollars and cents are  
2 worth for the average MA plan as against the standard fee-  
3 for-service Part A plus Part B.

4 MR. ROLLINS: I'll answer the questions in  
5 reverse, and Scott and Carlos should correct me. My  
6 impression is that right now under the MA program, the  
7 extra benefits or the rebates that the plans receive are  
8 between \$60 and \$70 per month, per beneficiary.

9 In terms of your first question, how much of the  
10 regional variation that we see in Medicare spending is due  
11 to price versus utilization, I don't have a good number off  
12 the top of my head.

13 DR. MILLER: We did do that a couple years back.  
14 I don't remember the numbers off the top of my head. Do  
15 you, actually, Dan?

16 Why don't you come up here.

17 DR. ZABINSKI: Oh, thank you. How about if I --  
18 Kate. Thanks, Herb.

19 DR. MILLER: Sorry, Kate. You lost your seat.

20 [Laughter.]

21 DR. ZABINSKI: My recollection -- and this is --  
22 I mean, I always caveat things. If I did it more than two

1 weeks ago, you know, take it with a grain of salt.

2 DR. MILLER: We know that.

3 [Laughter.]

4 DR. ZABINSKI: Yeah, yeah. Okay.

5 But my recollection is if you take out price and  
6 health status, you get like 45 percent of the variation  
7 reduced.

8 DR. MILLER: And I can't remember how much health  
9 -- we can get this.

10 DR. ZABINSKI: Health did a little more than  
11 price is my recollection. Yeah. Right?

12 Thanks, Herb.

13 MR. KUHN: You bet.

14 DR. MILLER: And, Bill, we can get you the actual  
15 number.

16 MR. GRADISON: Well, I'll wait until the next  
17 round. I have a follow-up related to that.

18 DR. CHRISTIANSON: Craig.

19 DR. SAMITT: So I'm trying to understand the key  
20 drivers between the various alternatives, the examples, and  
21 I just wanted to clarify. So it seems in Examples 1, 2,  
22 and 3, the relative value to beneficiaries between fee-for-

1 service and MA in each market is the same. So the driver  
2 to select one over the other should remain the same because  
3 at least the relative value is equal.

4 And let me finish my thought. But the remaining  
5 difference between 1, 2, and 3 would either be the  
6 difference in federal contribution versus beneficiary  
7 contribution or the difference between beneficiary and  
8 beneficiary from various geographic markets.

9  
10 So I just wanted to make sure that those were the  
11 distinctions between the various examples.

12 MR. ROLLINS: For the three examples we discuss  
13 in the paper and the two I sort of outlined here, yes. We  
14 were comparing the average cost of fee-for-service on the  
15 one hand and the bid for the median MA plan on the other.  
16 So, in dollar terms, the differential between the two is  
17 the same in all the examples.

18 Where you see the premiums differ is because sort  
19 of what that reference plan is buying and what it's tied  
20 to, whether it's fee-for-service or whether it's the lower  
21 cost option in each market.

22 DR. SAMITT: So that the incentive should still

1 exist in every example for the beneficiary to choose the  
2 lower cost option.

3 MR. ROLLINS: Yes.

4 DR. BAICKER: Just there's one other difference  
5 that you didn't mention that seems important is there's a  
6 difference across them in how much you're flattening across  
7 areas versus not. I think your point about the delta  
8 always being there is important, but depending on how you  
9 do the benchmark, there can be more or less flattening of  
10 the difference in contribution between the high-cost areas  
11 and the low-cost areas.

12 DR. SAMITT: Yeah. I referenced it as geographic  
13 difference.

14 DR. BAICKER: Yeah.

15 DR. SAMITT: But, yeah, thank you.

16 MR. ARMSTRONG: So this is an amazingly  
17 complicated topic, and I have to just say the slides you  
18 just walked through, I think I get it better than ever, and  
19 so congratulations on that. But now my questions may  
20 convince you I was wrong.

21 [Laughter.]

22 MR. ARMSTRONG: Is it true -- first of all, when

1 we started this, part of what we were trying to do is  
2 reconcile and create a comparative choice per the goals  
3 that we laid out between -- within markets between MA and  
4 fee-for-service options, and so we're clearly doing that.  
5 But I read this -- and correct me if I'm wrong, but it  
6 looks like potentially some of the biggest implications are  
7 actually reconciling the variation in fee-for-service cost  
8 from region to region. Is that a fair statement?

9 MR. ROLLINS: That would certainly be a major  
10 element of moving to this type of model, as we noted in the  
11 presentation, who is paying the cost or who bears the  
12 responsibility for the variation that you do see in  
13 spending across markets.

14 MR. ARMSTRONG: It actually seems that you're  
15 accomplishing different policy goals if you pick Example 1  
16 versus Example 2, shifting between a reconciliation between  
17 the different types of plans within a market versus  
18 accomplishing that and trying to reconcile the regional  
19 variation that you see across the country. So, anyway, I  
20 think that's brilliant. So you affirmed I am kind of  
21 getting that.

22 Second, you made the point that even in the

1 examples -- particularly, I am thinking about Example 2 --  
2 you are using a median MA plan, but there's huge variation  
3 in some of those markets. So the real impact could be  
4 quite different when you drill into the actual experience.  
5 I got that, correct?

6 MR. ROLLINS: That's right.

7 MR. ARMSTRONG: And then, finally, building on  
8 Bill's questions, particularly if this has as much to do  
9 with how you reconcile variation region to region, the  
10 question I think becomes quite relevant: Well, why is  
11 there so much variation? And is it possible that  
12 implementing some of this will really change practice  
13 patterns in Miami, as an example, and change what the  
14 impact for beneficiaries will actually be in terms of the  
15 choices they face once you start putting this into place?

16 MR. ROLLINS: In terms of the actual effect,  
17 obviously that would be something that --

18 MR. ARMSTRONG: You don't want to predict?

19 MR. ROLLINS: No. I predict that I would be  
20 wrong.

21 [Laughter.]

22 MR. ROLLINS: But, you know, the broader goal

1 here is to give beneficiaries an incentive to use a more  
2 efficient delivery system, and so exactly how that would  
3 play out in a specific market, it's difficult to know in  
4 advance.

5 MR. ARMSTRONG: Okay.

6 DR. MILLER: I want you guys to hold that  
7 question in your mind because the last time I went through  
8 this, Kate also went after this point, which is when you  
9 make these decisions, how much are you asking the  
10 beneficiary to bear the geographic variation in the market  
11 versus the program? And that is decidedly one -- as you've  
12 picked up on, one of the things that's going on here, and  
13 she was on that point last time, and now you're on it. And  
14 so, when we get back to discussion, you guys should express  
15 opinions on that.

16 MR. ARMSTRONG: She's always been ahead of me.

17 DR. MILLER: She's been a head of me too, so --

18 [Laughter.]

19 DR. CROSSON: I have Warner, and then I have Jon,  
20 Kathy, and Rita.

21 MR. THOMAS: So one question I had is the MA  
22 premiums continue to be normalized to fee-for-service

1 rates. Is that in your model and in your projections here  
2 going forward, kind of the continued reductions and in MA  
3 premiums?

4 MR. ROLLINS: I'm not sure I understand exactly  
5 what you mean by --

6 MR. THOMAS: So, as part of the setting of MA  
7 premiums going forward, there is a continued modification  
8 to get them closer to fee-for-service rates.

9 MR. ROLLINS: For paying for benchmarks?

10 DR. MILLER: Well, I would answer that  
11 differently. I would have said now you're not modulating.  
12 You're letting whatever the competitive price between fee-  
13 for-service or MA set the benchmark in a market. So,  
14 whereas now it's sort of the benchmark in MA -- and I may  
15 be misunderstanding the question too. But right now, the  
16 benchmark is what's -- in the county or whatever we're  
17 talking about, what's fee-for-service in the MA benchmark,  
18 is either 95 or all the way up to 115 percent of that. Now  
19 the benchmark would be which is the lower bid. So, in a  
20 sense, some markets, fee-for-service will drive that, like  
21 we said Portland. Other markets, MA will drive that, if I  
22 understand your question.

1           MR. THOMAS: So I guess the question I would have  
2 is, have we looked at a comparison of what the difference  
3 would be with this new model here versus what the existing  
4 MA model would be going forward? Is there a comparator  
5 there? Once again, maybe I'm kind of going down where  
6 Scott was a couple years ago and just trying to understand  
7 this. I'm not sure I necessarily understand it.

8           So, basically, you're saying that the MA premium  
9 would be pegged off of the fee-for-service or the median MA  
10 bid that comes through that year.

11          DR. MILLER: Yeah. There's a couple of different  
12 -- I should probably let this go back over to Eric.

13          I mean, what I was trying to say is right now you  
14 have an administrative benchmark, and it is fee-for-  
15 service. That's expressed in law, and the plan's bid is  
16 judged relative to that.

17          In this circumstance -- and it varies a bit by  
18 example, but in the lower -- the two lower-of examples, the  
19 benchmark would be set by whichever of those two is lower,  
20 MA or fee-for-service. So it's no longer, in a sense, tied  
21 to fee-for-service, but I want to be clear. In some  
22 markets, fee-for-service could be the price-setting option.

1 MR. THOMAS: Okay, yeah.

2 DR. MILLER: And then to your other question,  
3 what we've done here, Eric, is we've said out in this  
4 hypothetical examples, the beneficiary's premium would  
5 compare across fee-for-service. What we haven't done is  
6 necessarily said in any given market, how much it's  
7 different from the average current MA premium. Is that  
8 right?

9 MR. ROLLINS: Correct. We just looked at the  
10 median plan. We didn't get into sort of -- as Scott noted,  
11 there's a range of MA plan costs. We haven't sort of  
12 probed into that in terms of how much the variation -- how  
13 much variation you'd see in premiums within just the MA  
14 sector.

15 DR. MILLER: And I would just align myself with  
16 Eric's earlier comment. The other thing beyond your point  
17 of, like, look at there's a lot of variation in here,  
18 that's still even saying static, looking at current bids.  
19 You put this in place, the whole dynamic would change. We  
20 could look at some stuff, but it would be -- so it would be  
21 very heavily caveated because once you put something like  
22 this in play, as you're intending, it changes the dynamics

1 significantly if someone were to do this.

2 DR. SAMITT: So now I am like Scott. I am more  
3 confused --

4 DR. MILLER: I'm sorry about that.

5 DR. SAMITT: -- because I presumed there are two  
6 things going on here. One is what is the benchmark and  
7 then bid process, and then what is the premium-setting  
8 methodology? And so I presumed in these models that the  
9 benchmark would still be set comparable to average fee-for-  
10 service, and then the bids would follow. But that would  
11 presumptively stay the same as it is historically. But, in  
12 terms of how to determine the premium that would be  
13 charged, it would be done differently than it is  
14 historically in these models.

15 So I presumed the benchmarking and bidding  
16 process, short of the second part of the presentation  
17 today, would be somewhat comparable.

18 MR. ROLLINS: I think somewhat comparable. I  
19 mean, I think for this process, if you went down this road,  
20 when the MA plans submit their bids, they would know what  
21 the estimate for fee-for-service spending is going to be  
22 for their area, and so the various plans would each submit

1 their bids. There would then have to be sort of a  
2 reckoning, once you had all the fee-for-service information  
3 on the one hand and all the MA plan bid on the information  
4 to figure out what is the -- you know, which is cheaper, MA  
5 or fee-for-service, which plan, if it's MA, is cheaper as  
6 sort of your benchmark. And then and only then would you  
7 be able to say here are what the premiums are going to be  
8 for the coming year for fee-for-service on the one hand and  
9 all the various MA plan options that are available on the  
10 other.

11 DR. CHRISTIANSON: [Speaking off microphone.]

12 DR. CROSSON: On this point, Jack?

13 DR. HOADLEY: Yeah. I mean, one of the ways I  
14 think helps me think about it is MA would work a lot more  
15 like Part D. So, when Part D plans are bidding, they don't  
16 know what the benchmark is going to be because it's a  
17 product of the collective of their bid. So the best  
18 example of that is like the LIS benchmark, whether you're  
19 going to be a zero-premium plan. You know if you bid low,  
20 you've got a better chance of any up there, but you don't  
21 know how your competitors are going to bid. So you don't  
22 really know where you're going to end up, and MA would

1 become like that with this extra variable of fee-for-  
2 service, which is like one piece of advance knowledge. But  
3 you don't know in advance whether the average or the median  
4 or whatever we pick as the benchmark ends up below fee-for-  
5 service or above fee-for-service until the bids come in.

6 DR. SAMITT: So what you're saying, that we would  
7 uncouple the MA bidding process from average fee-for-  
8 service as it's done today?

9 DR. HOADLEY: But not completely uncouple it.

10 DR. SAMITT: Well, you would have the  
11 information, but average fee-for-service wouldn't peg to a  
12 benchmark. You would have the knowledge of average fee-  
13 for-service, but the bidding process would be uncoupled  
14 from --

15 DR. HOADLEY: But, if it turns out that fee-for-  
16 service average is the lowest, then that becomes the  
17 benchmark. So it's like they're like one of the bidders,  
18 except their bid is known in advance.

19 MR. ROLLINS: I would agree with that.

20 DR. CROSSON: I'm sorry. Warner, you were not  
21 done.

22 MR. THOMAS: Right. Sorry to cause all that

1 confusion.

2 [Laughter.]

3 MR. THOMAS: Now I'll go back to my original  
4 question. No, I'm just kidding.

5 So, on the MA bidding -- so right now, for MA  
6 plans that have additional benefits because they feel like  
7 there's room in the premium to add additional benefits, in  
8 this new model, essentially does that go away because you  
9 are essentially bidding on just what the traditional fee-  
10 for-service benefit structure is?

11 MR. ROLLINS: In the examples I have outlined  
12 here, yes. There are obviously other scenarios you could  
13 consider. But for what's outlined here, yes. It's just  
14 the standard A/B benefit package, and they're competing  
15 essentially on the price of providing that coverage.

16 MR. THOMAS: And they could add other benefits if  
17 they felt they could fit it into the model, or they would  
18 just bid just solely on what those A/B benefits are?

19 MR. ROLLINS: Well, again, as we saw in one of  
20 the examples with Miami where there's a big spread between  
21 fee-for-service in Miami, you could see a scenario where  
22 some MA plans are so much cheaper than the benchmark that

1 they do have -- in the case I showed, it was a negative  
2 premium, a cash rebate. But as I said, you could have a  
3 scenario where that is provided as extra benefits instead.

4 But unlike the current MA system where the  
5 benchmark is known in advance and so the plans, when they  
6 submit their bid, know sort of what they're going to have  
7 to work with in terms of rebate dollars and what kind of  
8 extra benefits they can provide, under this system plans  
9 wouldn't know until later in the process sort of whether or  
10 not they were going to have that -- be in that position.

11 MR. ZARABOZO: Of course, to the extent that the  
12 difference is cash, you as a beneficiary, if you get a cash  
13 rebate, can use that cash to purchase the extra benefits  
14 that you otherwise would have gotten through the plan.

15 MR. THOMAS: Sure.

16 MR. ZARABOZO: And as we move into the next  
17 section, the various designs that we're going to talk about  
18 include extra benefits, to get to Jack's question. So the  
19 Bipartisan Policy Center, they have a standardized benefit  
20 package that is the Medicare benefit package plus a set of  
21 extra benefits defined as reduced cost sharing and out-of-  
22 pocket cap. But it's standardized across the plans, and

1 then in the President's budget proposal, there are extra  
2 benefits valued at 5 percent, as we'll talk about, 5  
3 percent of the average bid in a given area. So there would  
4 be extra benefits. And in the case of the Bipartisan  
5 Policy Center, they also say, in addition, plans can offer  
6 as optional supplemental packages, other extra benefits  
7 that beneficiaries would pay for. And, of course, they  
8 would have the cash to pay the premium related to the extra  
9 benefits.

10 DR. MILLER: And on that point, Warner, there are  
11 markets around the U.S. where there's such a strong culture  
12 of managed care and a perception on the part of the  
13 beneficiary that they're getting a better benefit that  
14 right now there are supplemental premiums in some markets  
15 where beneficiaries as a regular matter of course pay them.

16 MR. THOMAS: Two quick questions, the first being  
17 on the fee-for-service cost structure that's mapped out  
18 here. Does that include the administrative costs of the  
19 program in the kind of per member per year cost structure?

20 MR. ROLLINS: Yes.

21 MR. THOMAS: Okay. And then my last question is:  
22 As we look at differentials across geographic areas, do we

1 look at the percentage of Medicare eligibles that are duals  
2 versus traditional Medicare recipients? Do we look at any  
3 sort of breakdown of the population? Or do we just kind of  
4 look at a Medicare recipient as just being the same across  
5 the country?

6 MR. ROLLINS: For these purposes, we're sort of  
7 just looking at Medicare beneficiaries in aggregate.  
8 Again, these are all figures sort of adjusted for health  
9 status for a beneficiary of sort of average health.

10 MR. THOMAS: Great. Thank you.

11 DR. CROSSON: Jack, you were not--

12 DR. HOADLEY: No, thanks.

13 DR. CHRISTIANSON: I guess what I want to say is  
14 partly something that Mark just brought up, which is on  
15 your Slide 13, the second bullet point where you talk about  
16 this being a static analysis, I think is really, really  
17 important to underscore because this whole story about how  
18 you set prices using this methodology really depends a lot  
19 on dynamics and responses and so forth. So some of this  
20 stuff we're seeing is quite limited, and I thought if you  
21 go back to Slide 12, maybe you could help highlight that  
22 point for us, because that looks like it's dynamic because

1 it's over time. But I think it would be helpful if you  
2 could be very clear about the static assumptions that  
3 underlie that graph, because I think the graph is -- could  
4 be misleading to people if they don't understand what those  
5 assumptions are.

6 MR. ROLLINS: Certainly. It's static in the  
7 sense of it's a projection of sort of what the premiums  
8 would be for each sector, fee-for-service versus MA. I  
9 think the dynamic part is what would beneficiaries choose  
10 to enroll in in response to these.

11 DR. CHRISTIANSON: You are essentially assuming  
12 the premiums stay the same as that first year, right, as  
13 you project -- as you roll that projection out?

14 MR. ROLLINS: You mean under Line A? That's the  
15 one for the premium under the new system.

16 DR. CHRISTIANSON: Yeah, as you do these  
17 comparisons, are you looking -- you're looking at how to  
18 mitigate that difference that you saw in the first year and  
19 what that would look like over time? Or am I not getting  
20 that right?

21 MR. ROLLINS: No; that's correct. The extent to  
22 which it differs is going to potentially vary from year to

1 year, obviously, and the plan bids vary from year to year.

2 DR. CHRISTIANSON: Yeah, because each plan, there  
3 will be new bids every years.

4 MR. ROLLINS: Yes, that's right.

5 DR. CHRISTIANSON: Yeah, so the static part of it  
6 is kind of an assumption that there aren't new bids every  
7 year and that you're playing with the initial set of  
8 differences, right?

9 MR. ROLLINS: In that sense, yes.

10 DR. CHRISTIANSON: Yeah. So it looks dynamic.  
11 It's not dynamic. It's really -- we know that the bids  
12 will change year to year, and that graph is just  
13 representing a very extreme set of assumptions about  
14 bidding behavior.

15 MR. ROLLINS: Yes.

16 DR. CHRISTIANSON: Okay.

17 MS. BUTO: I hope I'm not throwing us back to,  
18 you know, do we really understand this, but I want to -- I  
19 know we haven't talked about Example 3, but I just want to  
20 go back to it for a second to figure out whether Example 3  
21 is an example where it actually doesn't address or wouldn't  
22 have a noticeable or a major impact on regional variation.

1 In other words, because it's a locally based premium  
2 situation, it would tend to be less disruptive to the local  
3 area but would leave in place or might actually, you know,  
4 never address the issue of regional variation in spending.  
5 So I just want -- that's Question 1.

6 And then Question 2 is: Do we think that Example  
7 2 will generate the most program savings over time? Or  
8 don't we have a sense of that?

9 MR. ROLLINS: In terms of the first part of your  
10 question, which is sort of how does Example 3 versus  
11 Example 2 compare in terms of dealing with regional  
12 variation, the effect of them would be fairly similar at a  
13 high level because in both cases the base premium is going  
14 to be paid to the lower of fee-for-service or MA in a given  
15 market. And so relative to Example 1, where there's sort  
16 of a uniform premium that everyone pays in every market, in  
17 this case you're only going to link it to the less  
18 expensive option in each area. And so in the two slides  
19 that I showed here where between Example 1 and Example 2  
20 you had a reduction in the federal contribution in Portland  
21 and Miami, and you saw that the government contribution was  
22 much more uniform in Example 2, the scenario in Example 3

1 would look fairly similar to what you saw in Example 2.

2 MS. BUTO: I was assuming that having a  
3 nationally based premium would actually drive more change  
4 from region to region, but you're saying you don't think  
5 that's going to happen.

6 MR. ROLLINS: I think the incentives would be  
7 strong under both Examples 2 and 3 because they're being  
8 tied to the lower-cost option in each area.

9 MS. BUTO: Okay.

10 MR. ROLLINS: And then the second part of your  
11 question was, as I recall, which option essentially saves  
12 more for the government. In that sense, comparing just  
13 Example 2 versus Example 3, Example 2 would save a little  
14 bit more for the government than under Example 3. You'll  
15 see -- and this is in the examples in the paper. Under  
16 Example 3, in a lot of cases the base premium would be a  
17 little bit lower than that sort of \$106 that I was talking  
18 about, because in a lot of markets you've either got fee-  
19 for-service is cheaper than national average or there's an  
20 MA plan in the area which is cheaper than the national  
21 average, and that would sort of determine the base premium.  
22 And since in a lot of markets the base premium would be a

1 little bit lower than what we have now, you know, by  
2 corollary the federal contribution would be a little bit  
3 higher.

4 MS. BUTO: And 2 versus 1 in terms of which would  
5 save more money for --

6 MR. ROLLINS: Example 2 would save much more.

7 MS. BUTO: Okay.

8 DR. CROSSON: Jack, back on this?

9 DR. HOADLEY: Yeah. Would I be right in saying,  
10 when we look at Slide 5, the median or average MA bid is  
11 fairly constant -- you made this point -- across these  
12 otherwise disparate markets in terms of fee-for-service  
13 spending. And it seems to me that's why Examples 2 and 3  
14 kind of end up with relatively the same effects. If it was  
15 -- if the universe were such that Portland MA bids were  
16 significantly lower or Miami MA bids were significantly  
17 higher, then Examples 2 versus 3 could have rather  
18 different effects. Is that right?

19 MR. ROLLINS: I think that's right, yes.

20 DR. MILLER: And to the extent it is, it also  
21 means that where you peg the MA bid may matter. You know,  
22 if the average is very different than the median, if you go

1 to the 75th percentile or you go to the 35th percentile,  
2 depending what those distributions look like in a market,  
3 your comment would extrapolate even further.

4 DR. HOADLEY: As well as Jon's comment about sort  
5 of the dynamic effects. If this bidding pattern is in some  
6 way a result of the current rules and new rules might lead  
7 to much different bidding patterns, then it would matter a  
8 lot more as well.

9 DR. MILLER: And on that point, Carlos and Scott,  
10 based on some work you guys -- and I think Jeff was  
11 involved in this as well, just to make sure that all of the  
12 suspects are rounded up on this. You were making the  
13 argument in that work that the benchmark was a high  
14 determinant of the bid.

15 MR. ZARABOZO: That's right.

16 DR. MILLER: Yes, so I think you can say that the  
17 current bids are a product of the current rules pretty  
18 strongly, and that's why, you know, Jon's point -- and  
19 we've tried to point these caveats of what you're seeing  
20 here in a static market you shouldn't attach yourselves to.  
21 These are illustrative examples based on what we know. If  
22 you change, I mean, you're changing the dynamics

1 considerably.

2 DR. REDBERG: I just want to be sure I  
3 understand. With regard to the premiums, and you were  
4 talking about mitigating the effect of higher premium, but  
5 wouldn't another way -- the beneficiary could just choose  
6 the lower-price option, right?

7 MR. ROLLINS: That's right.

8 DR. REDBERG: So we wouldn't --

9 MR. ROLLINS: In some ways you could argue --

10 DR. REDBERG: I mean, it does seem to then get  
11 away from the whole point of this, is to try to make it  
12 more efficient if we offer these other choices.

13 MR. ROLLINS: Yes.

14 DR. REDBERG: The differences are striking in  
15 some of the areas. I mean, certainly it would be nice to  
16 have more data on quality, but my strong suspicion is we're  
17 looking at increased volume of questionable quality.  
18 That's all.

19 DR. CROSSON: Okay. Seeing no more clarifying  
20 questions on the first part of the presentation, let's move  
21 on to Carlos and Scott. I believe we're on Slide 15.

22 MR. ZARABOZO: The illustrative examples of

1 competitive bidding that Eric has presented show the  
2 financial obligation of a Medicare beneficiary choosing  
3 among MA plans and traditional fee-for-service as an  
4 option. The Medicare program achieves savings by limiting  
5 what the government pays on behalf of each beneficiary.  
6 There are also clear incentives and price signals to show  
7 the options that are least costly to the beneficiary.

8 Another possible means of reducing program costs  
9 is to use competitive bidding in the Medicare Advantage  
10 sector only. A proposal of this nature was put forth by  
11 the Bipartisan Policy Center and is also an element of the  
12 President's recent budget proposal; and a number of years  
13 ago Medicare designed demonstration projects of health plan  
14 competitive pricing that had similar design features.

15 The current Medicare Advantage program is  
16 referred to as a competitive bidding program. What would  
17 be different in the MA-only competitive bidding proposal is  
18 that there would not be a predetermined, administratively  
19 set benchmark for plan bidding. Instead, the benchmark  
20 would be determined based on plan bids. For example, it  
21 could be set at the weighted average of the bids. In  
22 addition, in each of the proposals or examples of this

1 approach that I mentioned, plans would not be basing their  
2 bids on the current standard Medicare Part A and Part B  
3 package. Instead they would bid on a standardized enhanced  
4 package, or a package with a fixed value of additional  
5 benefits for all plans, that includes extra benefits beyond  
6 what Medicare covers. Having an enhanced package  
7 recognizes that MA plans are currently providing extra  
8 benefits, and those extra benefits are what makes MA  
9 attractive to beneficiaries. The President's proposal, for  
10 example, specifies that the benefit package for bidding  
11 purposes will have a value that is 5 percent greater than  
12 the average bid for the standard Part A and Part B benefit  
13 package in the area.

14           Regarding the potential for program savings, both  
15 of the recent proposals of this nature include mechanisms  
16 whereby this alternative approach to MA bidding would apply  
17 only in areas in which there would be program savings when  
18 compared to current law Medicare Advantage expenditures.

19           Now I will discuss what would happen in an MA-  
20 only competitive bidding scenario. When plan bids  
21 determine the benchmark -- for example, by using a weighted  
22 average premium -- some plans will be above the benchmark

1 and other plans will be below the benchmark. This  
2 contrasts with the current situation, where the norm is to  
3 bid below the administratively set benchmark. What will  
4 happen under the options where benchmarks are determined  
5 based on bids is that beneficiaries will receive a cash  
6 rebate, or premium refund as we are calling it here, when  
7 they choose a plan with a bid below the benchmark. Bids at  
8 the benchmark will have no added premium; and to enroll in  
9 a plan with a bid above the benchmark, a beneficiary would  
10 have to pay an additional premium (as is true today).

11           However, as I mentioned, in the various designs  
12 that have been proposed, all plans will include extra  
13 benefits beyond the basic Medicare Part A and Part B  
14 benefit package. In the bid-based system, when  
15 beneficiaries are choosing among plans and between a plan  
16 and fee-for-service, beneficiaries will take into account  
17 the value they place on the extra benefits that all MA  
18 plans will offer and the associated premium cost or premium  
19 refund available through each plan. The differences will  
20 vary from market to market and from plan to plan.

21           From the beneficiary point of view, here is how  
22 an MA-only bidding approach differs from the current

1 system. One difference is in the premium structure. Most  
2 beneficiaries are now in plans that charge no premium for  
3 the Medicare Part A and B benefit package, and a small  
4 share of beneficiaries are in plans that reduce or  
5 eliminate the Part B premium that beneficiaries would  
6 otherwise have to pay. So, currently, as shown on the left  
7 portion of this slide, the primary basis of competition  
8 among MA plans is through the offering of extra benefits,  
9 but what those benefits are and what their value might be  
10 vary from one plan to another in a given market. Because  
11 of this variation in benefits, it can be difficult to  
12 compare one MA plan to another in a given market under the  
13 current system. However, when compared to fee-for-service,  
14 MA plans are offering extra benefits beyond the Medicare  
15 benefit.

16           The bid-based benchmarking option is different,  
17 as shown on the right-hand side. The primary basis of  
18 competition in MA would be based on the premiums that plans  
19 charged or their level of cash rebates. In a given market,  
20 some plans will have cash rebates, and some will require  
21 the beneficiary to pay a premium to enroll. With regard to  
22 benefits, in the bid-based benchmarking, all MA plans in a

1 given market are essentially equivalent to each other in  
2 that every plan would be offering the same level of extra  
3 benefits -- either a specified package of benefits, such as  
4 coverage of cost sharing, or a benefit package with a fixed  
5 actuarial value, such as 5 percent above the value of the  
6 standard Medicare package. This benefit standardization  
7 simplifies a beneficiary's ability to compare one MA plan  
8 to another because the main distinction among MA plans will  
9 be the premium differences from one plan to another. So  
10 beneficiaries can easily compare one plan to another just  
11 based on dollar differences in cash rebates or premiums.

12           As for the comparison with fee-for-service, in  
13 the bid-based benchmarking, there are two factors: the  
14 extra benefits and any associated cost. The system is  
15 designed to have all plans offering the same level of extra  
16 benefits. In plans that are at or below the benchmark,  
17 beneficiaries receive those extra benefits without paying  
18 an additional premium, so the benefit package is clearly  
19 more generous than fee-for-service Medicare. If there is a  
20 plan premium, to compare such a plan with fee-for-service,  
21 the beneficiary would have to weigh the premium cost of MA  
22 enrollment against the value of the extra benefits not

1 available in fee-for-service Medicare.

2 Scott will now walk you through an illustrative  
3 example of how the bid-based benchmark system would work.

4 DR. HARRISON: Thank you.

5 Carlos mentioned that the bid-based benchmarks  
6 would be used only in markets where the new system would  
7 lower Medicare spending compared with current law. On this  
8 slide, we revisit our three markets. The first two lines  
9 show the market averages for the current MA benchmarks and  
10 bids. The third line shows the current MA payments that  
11 result, excluding adjustments for quality ratings that  
12 would be dealt with separately under the bid-based  
13 benchmarks.

14 For illustration purposes, we are assuming that  
15 the bid-based benchmarks and, thus, payments would be set  
16 at the weighted average bid for a benefit package valued at  
17 5 percent above the value of Medicare fee-for-service Part  
18 A and Part B benefits. In other words, the payment under  
19 bid-based benchmarks will be the average of the current  
20 bids plus 5 percent.

21 So we can compare the two rows highlighted in  
22 yellow to determine whether these markets would use bid-

1 based benchmarks. You can see that the plans in Portland  
2 are currently paid an average of \$736 per member per month  
3 and would be paid \$759 under the bid-based benchmarks. So  
4 moving to the new benchmarks would actually cost Medicare  
5 an additional 3 percent in Portland. Medicare would pay  
6 plans an additional 2 percent in Columbus, but would pay 13  
7 percent less in Miami.

8           Thus, we assume that for now the bid-based  
9 benchmarks would not be used in Portland and Columbus, and  
10 the rest of the analysis slides do not show them.

11           Bid-based benchmarks would be used in Miami under  
12 our assumptions, so we illustrate what we might expect in  
13 that market through the bids of three hypothetical plans.  
14 Recall from the previous slide that the average bid in  
15 Miami was \$743 per member per month for the Medicare  
16 benefit. For the bid-based benchmarks plans submit for a  
17 package equal to 105 percent of the Medicare benefit, 105  
18 percent of \$743 is \$780, so here we assume that the  
19 weighted average bid for the bid-based benchmark package is  
20 \$780 per month.

21           The top row shows the bids of three hypothetical  
22 plans, and for symmetry, Plan B is bidding the average, the

1 \$780 I just mentioned. Plan A bids five percent below the  
2 average, and Plan C bids five percent above the average.  
3 Under the bid-based benchmark system, Medicare pays all  
4 plans the weighted average bid, shown by all the \$780s in  
5 the second row. For that bid, plans provide Medicare fee-  
6 for-service benefits plus the extra benefits valued at five  
7 percent, or in this case that would be \$39 per month.

8 Under the bid-based benchmarks, the reward for a  
9 plan to bid low is the ability to charge the enrollees  
10 lower premiums or simply to give cash back to the  
11 enrollees. Plan A would refund about \$39 per month to  
12 beneficiaries who enrolled in the plan. Plan B would have  
13 no premium, as its bid is equivalent to the weighted  
14 average bid that determines benchmark. And Plan C would  
15 have to charge a premium of \$39 per month.

16 On the bottom line, we have added the two sources  
17 of extra value that beneficiaries might consider when  
18 deciding whether to choose fee-for-service or Medicare  
19 Advantage. Plan A could be seen as providing \$78 of value  
20 in addition to the value of the fee-for-service benefit.  
21 That takes the form of \$39 in extra benefits funded by the  
22 five percent rebate and \$39 in cash for a beneficiary that

1 would receive -- that the beneficiary would receive for  
2 enrolling in a plan that bid \$39 below the benchmark. For  
3 Plan C, the \$39 in additional premiums offsets the \$39 in  
4 extra benefits, so the value of that plan looks like the  
5 value of the fee-for-service package.

6 Now, let's compare the bid-based benchmark system  
7 in current law through the eyes of the beneficiary. The  
8 first three lines here are the same as the last three on  
9 the previous slide, and they show the extra value these  
10 plans would provide under bid-based benchmarks. The last  
11 row shows the current law rebates that these plans would  
12 have received in Medicare payments to provide extra  
13 benefits.

14 Focusing on the last two lines, we see that under  
15 current law, beneficiaries who enroll in these three plans  
16 in Miami would get extra benefits with a much higher  
17 actuarial value under current law than under bid-based  
18 benchmarks. We do see that under bid-based benchmarks,  
19 beneficiaries would have clearer incentives to enroll in  
20 lower-bidding plans, as the differences between the plan  
21 benefits is in easy to see premium differences, although  
22 perceived differences in networks and quality could still

1 play an important role in plan choice.

2           However, there could be a concern, because the  
3 plans do not look as attractive relative to fee-for-service  
4 as they do under current law. For example, Plan C members  
5 pay no additional premium under current law and receive  
6 extra benefits funded by \$133 in rebates. Under bid-based  
7 benchmarks, however, Plan C enrollees would pay an  
8 additional premium of \$39 and receive extra benefits valued  
9 at \$39. So, there is some risk that while beneficiaries  
10 have stronger incentives to join lower bidding plans, they  
11 may have weaker incentives to join any MA plan rather than  
12 staying in fee-for-service Medicare.

13           This slide shifts the focus to Medicare program  
14 savings. If we compare the Medicare payments to the three  
15 plans, we see that the uniform payments of \$780 per member  
16 per month under bid-based benchmarks are well below the  
17 payments under the current MA system, which range from \$876  
18 to \$914 for these illustrative plans. While Medicare saves  
19 \$96 to \$134 for each member that remains in these plans,  
20 remember that each member that feels that the new plan  
21 benefits may not be so great a value and so returns to fee-  
22 for-service, those numbers would cost Medicare \$1,100 per

1 member per month in Miami. That \$1,100 cost is about \$200  
2 more than these members are costing Medicare under current  
3 law. So, any budget savings from moving to bid-based  
4 benchmarks in Miami is dependent on beneficiary perceptions  
5 of plan value and their subsequent movement between fee-  
6 for-service and MA.

7           Let me highlight some broad conclusions from our  
8 session. Currently, competition, both among MA plans and  
9 between MA plans and fee-for-service, focused less on price  
10 and more on benefits, which may be more difficult for  
11 beneficiaries to evaluate. Because of the nature of the  
12 competition and the lack of financial neutrality in many  
13 markets, the beneficiary does not always have an incentive  
14 to choose the most efficient option. Thus, the current  
15 system is not truly competitive. Competitive pricing  
16 systems, like those we have discussed today, have such  
17 incentives, though they may not always be well targeted.

18           Given the magnitude of the possible increases in  
19 premiums if fee-for-service is part of the competitive  
20 pricing system, policy makers may want to consider options  
21 for mitigating the impact on some beneficiaries, both in MA  
22 and in fee-for-service. The potential impacts on low-

1 income beneficiaries and state Medicaid programs would also  
2 be important considerations.

3           And, now we look forward to all of your questions  
4 and comments. Please let us know if you have requests for  
5 additional information to be included in the chapter for  
6 this June's report or any additional research you would  
7 like us to do for the next report cycle.

8           DR. CROSSON: Thank you, Scott and Carlos.

9           We are open for clarifying questions on the  
10 second half of the presentation. I have Rita, Kate, Jack,  
11 and Bill -- I'm sorry, and Jon. Rita.

12           DR. REDBERG: I'm just wondering if we have any  
13 idea how beneficiaries find out about what MA plan benefits  
14 and costs are. It doesn't seem that easy to get that  
15 information out.

16           DR. HARRISON: Now?

17           DR. REDBERG: Yes.

18           DR. HARRISON: They get lots of mailing, plans.  
19 There's a Medicare Plan Finder, which some people find  
20 useful and others may find more confusing. That's  
21 currently what goes on.

22           DR. REDBERG: And --

1 DR. HARRISON: Now, there are also state CHIPs,  
2 which can help out beneficiaries searching for plans.

3 DR. CHRISTIANSON: And senior centers and  
4 advisors in senior centers are an important source of  
5 information for beneficiaries.

6 DR. REDBERG: To use Cori's example, I'm pretty  
7 sure my mother has no clue on any of what her Medicare  
8 Advantage options are, and I was just thinking, is that  
9 unusual.

10 My other quick question, do you think  
11 beneficiaries in high-cost fee-for-service areas are aware  
12 that they're in high-cost fee-for-service areas? I mean,  
13 it seemed to me like one advantage, or sort of, would be to  
14 increase awareness of the cost, but I'm not sure they're  
15 aware currently that they're in a high-cost fee-for-service  
16 area.

17 DR. HARRISON: I don't know that they are aware,  
18 but they certainly know that the benefits -- people in  
19 Miami know the benefits in MA are much better than the  
20 benefits in fee-for-service because of that difference.

21 MR. ZARABOZO: And they may also know the cost of  
22 a Medigap plan, which varies from area to area, very high

1 in the Miami area. So, it's an indicator of --

2 DR. REDBERG: Interesting.

3 DR. CROSSON: Kate.

4 DR. BAICKER: So, I thought it was really helpful  
5 to frame the competition as being on a standardized set of  
6 benefits to understand how that would play out. The  
7 advantage of that is that beneficiaries can figure out  
8 what's going on. The disadvantage is you maybe lose some  
9 of the heterogeneity and innovation in benefit packages.  
10 So, my question is whether you have any data or information  
11 on how much variation there is now, and I don't even know  
12 what units you would describe that in, in what MA plans  
13 currently offer. What's the spread on the actuarial value  
14 of those extra benefits, or how variable are they? How  
15 much potential customization would we be losing?

16 DR. HARRISON: Well, certainly, just the size of  
17 the rebates in a market varies terrifically, so the benefit  
18 packages should vary a good bit. I mean, there are -- you  
19 know, the plans maybe tend to pay down the Part D premium  
20 first. They tend to lower cost sharing, but not  
21 necessarily in the same way. But, it can -- the benefits  
22 can vary quite a bit and the beneficiaries may not always

1 be able to appreciate that.

2 DR. CROSSON: Jack.

3 DR. HOADLEY: Yeah. I would reinforce Kate's  
4 question. I mean, I think you asked about additional  
5 information. I think -- I know it's not easy information  
6 to put together, and some years ago, I tried to look at  
7 sort of benefit variations and offerings, and we used to --  
8 you know, years ago, we used to just count up how many had  
9 vision benefits, hearing, and that never seemed to really  
10 capture it, and the cost sharing differentials are so  
11 varied in the way they're structured, they're very hard to  
12 quantify. You know, the rebate dollar is one thing, but  
13 I'm not sure that really captures what beneficiaries see.  
14 So, I think to any extent we can get information on that  
15 would be really helpful.

16 My specific question was on Slide 21, and when  
17 you talked about the Medicare savings, I think what you  
18 were doing is comparing the cost of the average  
19 beneficiary, the average fee-for-service is your metric to  
20 sort of talk about the savings. The reality is that the  
21 actual switchers could be other than sort of average cost  
22 beneficiaries. Am I reading the way you calculated it

1 right, and how much difference -- I mean, we know over the  
2 years sort of the risk selection and so forth into the  
3 different sides of programs.

4 DR. HARRISON: Yeah. This is just the average,  
5 average beneficiary.

6 DR. HOADLEY: So, it might be interesting to sort  
7 of think about, at least conceptually if not necessarily  
8 quantitatively, sort of how that estimate of savings might  
9 vary if we know at least, say, the risk difference today  
10 between the average MA enrollee and the average fee-for-  
11 service enrollee and could play with that a little bit.

12 DR. CROSSON: Bill Hall, David and Bill and  
13 Scott.

14 DR. HALL: At sort of the front line of this  
15 whole thing, in many American communities, I don't think I  
16 agree that consumers will always go -- I think we're  
17 talking about -- for the low-price option when they start  
18 comparing systems. I have a community that has relatively  
19 low Medicare expenses nationally, probably in the lower  
20 quartile for sure, and maybe even lower. We have high  
21 penetrants of MA, largely two competing systems. And  
22 during the week or the period that -- where people are

1 allowed to enroll or change plans, the airwaves are full of  
2 options and presentations by the MA plans.

3 I think the average 90-year-old consumer doesn't  
4 read those things, doesn't hear them, and doesn't want to  
5 even know about that, and their decisions are made usually  
6 by their caregivers, their children, usually.

7 But, the emerging population, my sense is, of  
8 Medicare, present new Medicare recipients and future, is  
9 that they are incredibly knowledgeable and don't always  
10 compete on price. The old adages, do you want your brain  
11 tumor removed by the lowest bidder, that kind of thing, or  
12 something like that, something very -- well, I'll stop.

13 So, the conclusion slide is -- and here is my  
14 question. What if we assumed that people do not just  
15 compete on price, but they do compete on benefits and that  
16 probably MA is going to win that argument in the vast  
17 majority of cases. Does this change any of these dynamics  
18 at all in terms of what we're doing with this analysis?  
19 And how do we actually put the potential value of benefits  
20 into the equation? That's where I am on that.

21 DR. HARRISON: So, this analysis actually assumes  
22 that people don't move. The bids are the same and the

1 enrollment is the same. This is what happens if people  
2 don't move. If people moved, I think you would see some  
3 movement toward lower-priced plans. And then the other  
4 issue is, then, what happens if you were looking for a  
5 dynamic system, what happens in year two --

6 DR. HALL: Right.

7 DR. HARRISON: -- plans that bid high may not  
8 come back, that kind of thing. So, it could be a lot more  
9 complicated than this. This was trying to take the easiest  
10 example.

11 DR. MILLER: I also would say, and again, in  
12 terms of your clarifying question, you know, there's  
13 somewhat different answers for the two different ideas that  
14 we put in front of you today, which I realize is very  
15 complicated, but, you know, in the first example, one of  
16 the things that came out of the comments over here is the  
17 system definitely has a propensity to move towards more of  
18 a premium-driven decision set as opposed to an extra  
19 benefit-driven set, and then you've got questions like,  
20 well, how do you value that? What if you wanted to inject  
21 that back in? There's a certain complexity to that.

22 Here, then the second example, which takes fee-

1 for-service out of the equation, which is the big shift,  
2 but then says, I'm going to quantify and define that extra  
3 benefit package and builds it in and asks the plan to bid  
4 on that, and at least conceptually to your question is  
5 that's kind of what you could think about, is whether you  
6 compete on pure premium, and you take the Carlos point that  
7 the extra cash allows the beneficiary to purchase extra  
8 benefits if they want to do that, or you somehow try and  
9 build it into the package and ask the plan to bid on that.  
10 That creates certain complexity in comparisons, but it's  
11 conceptually the direction you could go in.

12 DR. CROSSON: Jon.

13 DR. CHRISTIANSON: On the conclusion slide, the  
14 last bullet point where you talk about policy makers may  
15 wish to mitigate the effects, could you talk a little bit  
16 more -- I mean, there's a connection, I think, between  
17 mitigating the effects and also how aggressively the plans  
18 might bid in terms of submitting low bid prices, at least  
19 in my mind. Most of the things I can think about in terms  
20 of mitigating effects actually result in sort of less  
21 immediate revenue for plans that bid low, or am I getting  
22 that wrong?

1           MR. ROLLINS: I think, broadly speaking, I think  
2 that's a fair characterization, that to the extent you're  
3 blunting this sort of incentive, this price signal you're  
4 sending, you know, the plans -- there's less reward.

5           DR. CHRISTIANSON: So, the more that we're  
6 concerned about protecting the beneficiaries from the  
7 financial consequences of the system are softening it over  
8 time, the less the potential savings might be for the  
9 Medicare program?

10           MR. ROLLINS: To the extent that there are  
11 positive consequences of moving to a system like this, it  
12 would take longer to realize them.

13           DR. CROSSON: David.

14           DR. NERENZ: I may ask this to Bill as well as to  
15 you guys. In a low-cost fee-for-service area, like  
16 Rochester and Portland, are the plans offering supplemental  
17 benefits, because you don't have a rebate full of dollars  
18 to fund that. Just as a yes/no, are there extra benefits?

19           DR. HARRISON: There are some plans with extra  
20 benefits in Portland. They would be generally lower level  
21 of extra benefits than offered in other markets, but there  
22 often are. And then people with Portland are okay with

1 paying premiums, and so they may also get some premium-  
2 funded extra benefits.

3 MR. ZARABOZO: And, of course, these areas are  
4 currently 115 percent of fee-for-service areas plus bonus  
5 payments of five or ten percent in these areas, so --

6 DR. NERENZ: I'm just trying to understand --

7 MR. ZARABOZO: In other words, the plans can  
8 afford currently to offer extra benefits in those areas.

9 DR. NERENZ: Okay, good. That was what I was  
10 looking for. Thank you.

11 DR. MILLER: [Off microphone.] But that's  
12 because the system that they're currently operating under  
13 don't look like this. Their benchmark is set above fee-  
14 for-service.

15 DR. NERENZ: Right, and that's exactly what I  
16 wanted to clarify. I know this has been in front of us,  
17 but as we get into the next round, I'm more interested in  
18 what's happening to the dynamics in that end of the  
19 distribution. I just wanted to clarify this point. Okay.

20 DR. CROSSON: Bill Gradison.

21 MR. GRADISON: In general, I like the idea of  
22 standardizing the benefit package, or at least having a

1 package with an ascertainable cost, five percent  
2 additional, whatever it is. The idea of having just one  
3 standardized package bothers me. Maybe I'm too wedded to  
4 the concepts that we wrote into laws years ago to try to  
5 standardize the Medigap market, which have different  
6 prices, but they're originally the A through J, and with  
7 some modifications since that time.

8           And, I just wondered whether you've taken a look  
9 or could maybe take a look at what would happen if there  
10 were additional -- yes, standardized, but several  
11 standardized packages and the common denominator would be,  
12 let's say, that they're five percent cost actuarially  
13 equivalent and spell it out, because there might be in some  
14 markets beneficiaries who would prefer one standardized  
15 package versus another standardized package.

16           DR. HARRISON: So, I think that the system thinks  
17 about one standardized bid for the basic package, or in  
18 this other system of the one higher level. But, we would  
19 expect that plans would then be able to offer extra  
20 benefits for cash. So, if you wanted to standardize what  
21 those other offerings could be, that seems like a  
22 possibility, also.

1 DR. CROSSON: Scott.

2 MR. ARMSTRONG: So, I just -- I'm thinking about  
3 the two parts to this presentation and how they relate to  
4 each other, and I assume, and I'm trying to figure out, can  
5 you do the first part and do the second part or not? I'm  
6 thinking you can't. But, you could do this sort of  
7 standardization and new bidding process for the MA plans  
8 without having done the first part of this presentation.  
9 Did I get that right? I'm trying to just understand how  
10 these two pieces work together or don't.

11 DR. MILLER: What I would say is yeah. I think  
12 he's got it right that we -- and maybe there is some  
13 imagination that I am lacking, but I think we put these in  
14 front of you to say, typically, when people talk about  
15 premium support, it's mostly the first half of the  
16 presentation, and fee-for-service in the mix. You have to  
17 think about the distributional impacts and all that.

18 Then the second half of the presentation is  
19 there's this new animal that kind of showed up on the scene  
20 if, well, what if you did it? And like a lot of these  
21 things, these ideas have history, and so new-ish animal on  
22 the --

1 [Laughter.]

2 DR. MILLER: Yeah. Sorry, Jack. We've seen this  
3 before.

4 On the scene. But it has gotten some attention  
5 more recently in two, couple of places, and you would be  
6 saying, "No, the competition applies to MA only," and very  
7 much the standardization of the benefit in order to "Why  
8 would a person pick MA if MA didn't offer them something  
9 extra?" comes into play. And since you've held fee-for-  
10 service neutral, it's like, okay, you could do competition  
11 here, but you need to add something for the beneficiary to  
12 say, "Oh, I want that," in addition to whatever price  
13 signal you drive out of the competition.

14 So that's the long way of saying I think you have  
15 this organized in your head right.

16 MR. ARMSTRONG: Yeah. No, actually, that was  
17 helpful to me, and I think I got that.

18 We've talked a lot about we're building this  
19 modeling to sort of distinguish between the impact of price  
20 on choices versus the impact of extra benefits on choices,  
21 and I just think it's worth saying. I'm not sure we've  
22 been explicit about it, but there are a lot of other

1 variables, too, that influence these choices, and so we  
2 just need to attend to that. I mean, your provider is a  
3 really good example of that and the different networks  
4 people have. I don't know where or how that comes into  
5 play, and I'm fine with this approach, but it is -- there  
6 are other variables there.

7           And then the final thought -- and I haven't  
8 really given this very much thought, but particularly in  
9 this section, it sounds -- this sounds familiar to me, the  
10 way we're building this, given the work we've just been  
11 doing in the last few years to build individual and family  
12 state exchanges and the standardization of the benefits and  
13 creating a competition. And I just wonder if we thought at  
14 all about -- so what worked and what didn't work in that,  
15 and is that in any way relevant to what we're trying to do  
16 here with the kind of MA bidding structure, standard  
17 benefits and so forth that you guys are talking about?

18           DR. CROSSON: Scott, thank you. Okay. So  
19 Warner, Jon, and then Kathy.

20           MR. THOMAS: I guess one of the things I wonder  
21 as I look at this is if we're making this more complicated  
22 than it needs to be, and it seems to me that we have

1 markets where MA is significantly cheaper than fee-for-  
2 service, and why wouldn't we start with those markets and  
3 try to get more people in the MA plans, just with the way  
4 MA works today? I mean, it might be part of the benefic  
5 structures, why they are either more cost effective or why  
6 people are choosing them, and if you go to just a standard  
7 benefit package, even with the dollars, I mean, maybe we  
8 don't know if that would change why people move or not  
9 move. I mean, we just don't know.

10           It just seems like instead of retooling the whole  
11 MA program, are there ways that we could start in areas  
12 that we know are challenges, very high-cost areas, and get  
13 more folks to move into a more cost-effective model with  
14 some type of either financial incentive or how we want to  
15 structure it?

16           And then in areas that -- I don't know. It just  
17 seems to me like we're really making this very complicated.  
18 We could do that, and then that would drive those costs and  
19 those areas, hopefully, lower to what are more of the  
20 national benchmarks, and then we could continue to evolve  
21 from there. But it just seems like the proposals that are  
22 on the table are going to take so much time to implement,

1 that by the time we get there, you know, who knows kind of  
2 where the overall cost structure would be in general? So I  
3 would just put that out as one thing to consider and think  
4 about.

5 DR. CROSSON: Jon.

6 DR. CHRISTIANSON: So, on your Slide 15, you kind  
7 of drop in there that there's some experience that CMS has  
8 had with an earlier demonstration program, and not  
9 everybody may be conversant with that. Maybe you could  
10 talk about that very briefly and what lessons do you think  
11 -- what insights from that, Kathy's -- what insights could  
12 be drawn from that, that have informed your thinking about  
13 what you're doing now?

14 MR. ZARABOZO: Yes. In 1996, Kathy --

15 [Laughter.]

16 MR. ZARABOZO: -- the then-HCFA designed a  
17 demonstration project which was going to start in Baltimore  
18 where there would be plan bidding. They would be bidding  
19 on a package above the Medicare benefit package, but the  
20 bids, it would be a similar thing, that you would have a  
21 bid. You would have the weighted average bid or a median  
22 bid would determinate what plans would charge, and the

1 program would not state in advance what the benchmark would  
2 be.

3           So the Baltimore concept ran into political  
4 opposition, and it didn't happen there because the plan  
5 said, "Well, we'd like to know the benchmark in advance.  
6 We'd like to be able to offer extra benefits," and then  
7 that didn't go forward.

8           Then they moved to Denver, and in Denver, they  
9 also tried a similar thing. The requirement for  
10 demonstration was they had to be budget-neutral, but the  
11 plans already, the cost -- the fee-for-service costs were  
12 very high, and it was expected plans would come in below  
13 that and still be able to offer extra benefits. So there  
14 was a standard extra benefit package.

15           In Denver, they went as far as getting the bids  
16 from the plans until there was a temporary restraining  
17 order which ended -- essentially ended the demonstration.

18           The bids were revealed in an article in Health  
19 Affairs, and they were shown to be well below the Medicare  
20 fee-for-service levels, including the extra benefits. And  
21 then the Barbara came a long and required that there be a  
22 demonstration of this concept, and it also said there would

1 be a national -- there will be a standard benefit package,  
2 but in each area, there will be a committee that will  
3 determine what kind of benefits are we talking about in  
4 this area. And that was going to be in Kansas City and  
5 Phoenix, and those didn't happen either.

6 So, yes, there was an experience with this, but  
7 it did not come to full fruition where we could judge what  
8 might really have happened.

9 DR. CHRISTIANSON: And I think one of the  
10 conclusions was that the plans did not see this particular  
11 pricing approach as advantageous to them.

12 MR. ZARABOZO: Yes, yes. And so, when they moved  
13 to Denver, the, again, issue was "We want to know the  
14 benchmark in advance, and we want fee-for-service to be  
15 included now." That was not raised in Baltimore.

16 DR. CROSSON: I just --

17 DR. HOADLEY: Wasn't there also an ACA provision  
18 for a demonstration as well?

19 MR. ZARABOZO: Yes. There was going to be a  
20 demonstration through various -- in various parts of the  
21 country, and what happened there was that different --  
22 different bills were introduced that said this is not going

1 to happen in my area, this is not going to happen in my  
2 area. So, if you look at this list of this is not going to  
3 happen, it pretty much covered the country, and that was  
4 repealed recently, that particular provision. Yeah.

5 DR. CHRISTIANSON: So, back to my question, was  
6 there anything that you learned from this that could inform  
7 your design of such a program going forward in terms of  
8 just -- you know, not the politics of it, but just the way  
9 this should be designed?

10 MR. ZARABOZO: Well, the bids coming in, very  
11 much lower in Denver, is indicative of -- because they're  
12 not bidding against a known benchmark. They are bidding  
13 against each other, essentially, so --

14 DR. CROSSON: I just want to add a point here,  
15 sort of a cautionary note, because we had a little bit of a  
16 similar discussion yesterday as we were talking about maybe  
17 reinvigorating the CAP program. I mean, I think there's a  
18 tendency -- I share it sometimes as well -- to look at  
19 something that's happened in the past and that's either had  
20 an execution failure or a political failure or both and  
21 say, well, let's not do that again. And I think we have to  
22 recognize, particularly in this case, that this is 20 years

1 later.

2           Now, a lot of the forces that you've described  
3 are probably still in place, but on the other hand, we're  
4 20 years further along in terms of the cost of the Medicare  
5 program, on the Treasury, and on beneficiaries, and so I  
6 think, going along with what Jon said, I would look at  
7 these things that have failed in the past as most  
8 entrepreneurial businesses do, not as an indication to not  
9 proceed, but as a learning opportunity in order to improve  
10 ideas.

11           MS. BUTO: I was just going to add, first of all,  
12 when we did get bids in from Kansas City, but we were not  
13 allowed to open them, I think the real lesson we took at  
14 the time was that the plans initially opposed any  
15 demonstration. Then they agreed to work with Congress on  
16 language to enable a demonstration that would have public  
17 input and so on and so forth. In the end, the lesson I  
18 took away from the two, Phoenix and Kansas City, being  
19 stopped was that the argument they kept coming back to was  
20 including fee-for-service.

21           I think that's still a relevant lesson because  
22 the areas that were chosen were areas with high fee-for-

1 service spending, where there was likelihood of program  
2 savings, but they made the case I think pretty strongly  
3 that those savings should be gotten from fee-for-service as  
4 well, not just -- what did we call it back then? --  
5 Medicare plus Choice.

6 DR. CROSSON: Maybe at the time, you might have  
7 employed Johnny Carson as Carnac because I think I remember  
8 he was able to read the information without opening the  
9 envelope.

10 MS. BUTO: The answer, yeah, before he had the  
11 question.

12 DR. CROSSON: On that note --

13 [Laughter.]

14 DR. CROSSON: Wow! This is a complicated issue.  
15 I am going to call on you in a second, Craig. Do you  
16 remember you volunteers?

17 DR. SAMITT: I did.

18 DR. CROSSON: Okay.

19 MS. BUTO: I have one more question.

20 DR. CROSSON: Kathy, I thought we got you. Go  
21 ahead.

22 MS. BUTO: I just wanted to go back to something

1 that -- I want to make sure I got this. I thought that --  
2 and it's sort of related to the last comment -- that in  
3 discussing the MA-only approach, what I was hearing is we  
4 would go to areas where there was high per-beneficiary  
5 spending, high fee-for-service spending. Not necessarily?  
6 Okay.

7 DR. HARRISON: You'd end up going to places where  
8 the bids were well below the benchmark.

9 MS. BUTO: Oh, where the bids are well --

10 DR. HARRISON: Current bids are well below the  
11 benchmark.

12 DR. MILLER: But, Scott --

13 DR. HARRISON: That would then give you room to  
14 have an extra benefit.

15 DR. MILLER: But wouldn't that tend to be the  
16 areas with high fee-for-service?

17 DR. HARRISON: Miami, yes.

18 MS. BUTO: I thought that was --

19 DR. HARRISON: But, like, Albuquerque would be  
20 another areas which is a low-spending area. Yeah, it just  
21 depends.

22 DR. MILLER: I take it back.

1 MS. BUTO: Okay. Because what I was -- one of  
2 the lessons I thought I took away from the discussion was  
3 that there is a hazard when fee-for-service is not included  
4 that the benefits are not going to be -- especially in a  
5 competitive environment like that, the extra benefits with  
6 the lower premiums are just not going to be attractive  
7 enough at 5 percent to stop people from kind of escaping  
8 back into fee-for-service. So that that to me is a  
9 cautionary note about going down that route, even though it  
10 sounds appealing.

11 And then my question to you was whether the 5  
12 percent -- I thought I heard you say to Bill Gradison that  
13 it would have to be a standard 5 percent extra benefit  
14 package, or could it be an actuarially, you know, variable,  
15 if you will, extra benefit package?

16 DR. HARRISON: There are different opinions on  
17 that, and we've tried to stay neutral on that.

18 MS. BUTO: Okay. No, I was just thinking back to  
19 Kate's point that this issue of having some ability to vary  
20 the benefit, the extra benefits might have some value, even  
21 though it undermines the simplicity part of it.

22 DR. HARRISON: Right. We think even if it was a

1 standard actuarial value and you let there be some  
2 variation, at least the beneficiaries would sort of see --  
3 they'd be more likely to see the plans as more equal in  
4 benefits.

5 DR. CROSSON: Okay. I am going to call on Craig  
6 in a second to start us off, but I am struck not just from  
7 the reading, but from the discussion in the presentations  
8 that we've got, as a number of people have said -- we've  
9 got a lot of moving parts here, not just within what's been  
10 presented in the two presentations or even within the  
11 presentations, but also, as Jon and others have pointed  
12 out, the fact that we're looking at a static set. We're  
13 looking at a set of static models, when in fact we would --  
14 in order to make the right judgments here, we have to at  
15 least take into consideration the dynamic impact of  
16 whichever set of choices we choose.

17 So I want to -- I'm don't want to steal Craig's  
18 thunder because I know he's got important points to make,  
19 but I wanted to suggest that in our discussion, in order to  
20 help the staff, we talk about -- or those who wish to talk  
21 about the relative -- our perspective of the relative  
22 importance of a set of values that have been expressed here

1 and in these models. And I may not have them exactly  
2 right, so feel free to correct me.

3 But one of those -- and these are not discrete.  
4 They interact, unfortunately, but one of them is to  
5 increase program savings. That's one goal I've heard in  
6 the presentations and in the discussion.

7 Another one -- and, of course, it's related -- is  
8 to create incentives for beneficiaries to choose more  
9 efficient care. So those are related, but they're somewhat  
10 discrete in terms of what models we might choose.

11 A third one, which we've talked about in the  
12 past, is sort of along the lines of our general site-  
13 neutral policy, would be equalize the cost to the Medicare  
14 program across the various offerings within a market, so  
15 that Medicare is essentially held harmless, depending upon  
16 the beneficiary's choice.

17 Another one that has come up as well is a goal to  
18 try to equalize costs, both to beneficiaries and to the  
19 program, across geographic areas.

20 And the last one -- and, again, I'm sorry these  
21 are not discrete -- is to change the competition for  
22 beneficiaries from benefits to price.

1           Now, I may not have captured everything, but I  
2 think it might be helpful -- and, Mark, jump in if you  
3 want, but I think it might be helpful to guide the next  
4 phase of this work for the staff to hear from people in  
5 terms of which one of these values or potential  
6 achievements you would see as the most important because  
7 that then helps drive to the right model or set of models  
8 or approach.

9           So, with that, having hopefully not stolen any of  
10 Craig's thunder, take it --

11           DR. SAMITT: Thanks, Jay. I think it was helpful  
12 for you to frame the principles, and I just want to thank  
13 the team for making what is very complex pretty  
14 understandable in this session. I think I do get it better  
15 than I have before.

16           So there are -- my feelings are somewhat mixed,  
17 even about the principles that you've described. What I  
18 like about all that I've heard today, both Part 1 and Part  
19 2, is it does hit on several of these key principles, an  
20 incentive and encouragement for beneficiaries to select  
21 higher value alternatives -- and I'll come back to that --  
22 as well as a savings to the program. And so I do think

1 that it hits on several principles.

2           But something that you said pushed my button, and  
3 it actually is in Slide 22 as well. Should our principle  
4 be that the beneficiaries incented to choose the most  
5 efficient option, or is it that the beneficiary should  
6 choose the highest-value option? Because there's very  
7 little that I've heard -- and it even says in the paper --  
8 that quality is assumed as equal. And I don't think we  
9 should presume that quality is assumed as equal, and so I'd  
10 strike the most efficient option language and describe it  
11 as the most high-value option because I assume what we want  
12 is beneficiaries to choose alternatives that have better  
13 access, better quality, better service at a lower cost.  
14 And I'm afraid that all that we've been talking about  
15 simply boils it down to price alone.

16           And I could envision alternatives through this  
17 model, especially in markets that may have a higher MA cost  
18 than a fee-for-service cost, that beneficiaries will pick  
19 lower quality alternatives because all we're doing is  
20 really offering a comparative price. And so we need to  
21 find a way to integrate the other key variables, and I  
22 think Scott alluded to this as well. There are other

1 variables than price. It's pure transparency about network  
2 -- is your doctor in the network? -- about access  
3 standards, about quality and service.

4           So I like the idea. We're moving in the right  
5 direction. I just think we have to factor in several other  
6 things than what we're describing here, which seems to be  
7 boiling down to cost alone.

8           DR. CROSSON: Okay. Comments? Let's go to Jon,  
9 Alice. We're going to move down this way and then come  
10 back this way.

11           DR. CHRISTIANSON: Okay. Just a quick comment  
12 here. I think several people have noted how complex this  
13 is, so I'm going to make it more complex now. I think  
14 actually Scott and Carlos and Eric have done a good job of  
15 simplifying it.

16           Some of the things they haven't talked about  
17 which are big design issues in Medicaid bidding programs  
18 are eliminating plans that are high bidders. We haven't  
19 talked about that at all. But that, the data shows us,  
20 tends to drive bids down. If you know, the consequence of  
21 not submitting a low bid is you don't get to enroll  
22 anybody. That's a bigger incentive. So that's one issue

1 that you haven't talked about that I think you might want  
2 to at least raise. When you talk about your design, you  
3 have to explicitly say we haven't built this into the  
4 design.

5           The reason I think it's important to do that,  
6 again, is because several Medicaid programs have done that,  
7 so it's not like it's out there and can't be done. It has  
8 been done politically. Of course, you have a real budget  
9 constraint at the state level, so they're really willing to  
10 push on this.

11           Length of contract, you know, we're assuming  
12 bidding every year. Bidding doesn't have to occur every  
13 year. It doesn't occur in the private sector every year.  
14 It doesn't occur in some Medicaid programs every year. So  
15 that kind of goes together with not letting everybody be a  
16 winner because if you have a program in which you are going  
17 to say some plans are not going to have access to Medicare  
18 beneficiaries and they won't have access for three years,  
19 that's another package of incentives that's pretty strong.

20           Now, the negative of that, we all know, is that  
21 if you have that kind of a program, it's going to  
22 disadvantage smaller regional plans or plans that just

1 really concentrate on Medicare beneficiaries because they  
2 may not be around to bid again after the three-year  
3 contract. And we've seen that in some Medicaid programs.  
4 So it will be advantageous to large national plans that are  
5 bidding in different service areas all across the country.  
6 They win some, they lose some, but they're going to be  
7 there the next time.

8           So there are these different kinds of  
9 consequences to research design choices that you have  
10 implicitly made in terms of modeling, but the Medicaid  
11 programs are made differently. So I think one of the  
12 things I would encourage you to do is look at some of those  
13 Medicaid program bidding systems that are out there now and  
14 say, okay, here's some examples of things that have been  
15 tried in the real world, and they are feasible. They may  
16 not be what we want to do, but I think they at least should  
17 be out there.

18           DR. COOMBS: Thank you very much. I've learned a  
19 lot this morning. And, Jay, thanks for those guidelines.

20           One of the things I thought about in reading the  
21 paper is: What do we do for this large group that we don't  
22 have a good idea about the dual eligibles and the LIS? And

1 the graph that you have on page 10, Slide 10, which is also  
2 in the reading material, one of the questions I wanted -- I  
3 looked at the graph and I thought about it, and I said,  
4 What would be the distribution of dual eligibles in the  
5 side to the right? And does that impact some of what we  
6 see here? And is the population equally represented on  
7 both sides of the graph for both LIS and the dual  
8 eligibles?

9 I know this is a hard thing to get our arms  
10 around, but the question would be: Would any of the models  
11 disproportionately affect one group versus another?

12 DR. CROSSON: Who wants to take that on? Who  
13 wants to run for the hills?

14 MR. ROLLINS: We could look to see sort of the  
15 distribution of the dual eligibles specifically, how that  
16 compares to sort of this slide that you're referring to,  
17 which is sort of the overall Medicare population, to give  
18 you a sense of sort of whether it looks about the same or  
19 to the extent that it differs.

20 DR. COOMBS: Thank you. And then the other  
21 question is benefits versus rebates with surplus. One of  
22 the things that I thought about was how often does the

1 surplus extrapolate into outcome, and that's the whole  
2 notion of what is a quality benchmark that can be assessed  
3 based on surplus. In other words, underbidding is  
4 associated with equal quality, so the question would be,  
5 you know, we're making an assumption when an MA plan does  
6 very well that the surplus trickles down to an outcome  
7 event. And so that I don't think is necessarily a valid  
8 assumption always. It's the same assumption as saying when  
9 corporations do well, they affect the unemployment rate.  
10 And that isn't always true.

11           So, you know, as I thought about the whole notion  
12 of, well, should there be a defined benefit package, that  
13 would be one avenue. But how well does that defined  
14 benefit package actually result in -- I mean, a lot of  
15 plans might have smoking cessation, weight reduction, gym  
16 memberships. You know, I have a health plan that has a gym  
17 membership. I have it taken out of my deduction, but I  
18 imagine that some people are the same way.

19           So how much does that actually extrapolate into  
20 outcome? And I know that some plans might have innovative  
21 things where they do, especially with the smoking cessation  
22 and things like that, weight management, where they can say

1 these are the kind of data we have.

2           Now, that's not something that you can do on a  
3 large scale, but certainly some of the places that you have  
4 in the graphs, like Chicago, I think Hawaii, you pointed  
5 out some areas that are the highest bidders in one area,  
6 and I don't know if that's something that you could look  
7 at, but to see if there's any kind of outcome-driven  
8 programs that correlate with the surpluses in terms of what  
9 they do in terms of monitoring those folks, those benefits  
10 that seem to be -- beneficiary benefits that should result  
11 in some changed behaviors as well.

12           DR. CROSSON: Thank you.

13           DR. HOADLEY: So, again, as I said before, I  
14 think you guys have done a great job of expanding what  
15 you've had out on the table before and sort of helping to  
16 clarify, and I agree with several people that the material  
17 even in this presentation has helped to clarify things in  
18 significant ways beyond what was written. It's hard for  
19 us.

20           I guess some of what I'm trying to think about --  
21 and you've heard some of my earlier questions on sort of  
22 how extra benefits play into this; I think it goes, Jay, to

1 one of your questions about changing the competition from  
2 benefits to price -- is just really trying to think through  
3 what we're doing here. And I guess I'm struck, for  
4 example, by the second, the MA-only thing, and using this  
5 105 percent benchmark. If you sort of took that back into  
6 the first illustration, on the one hand, that feels like it  
7 reflects more like what MA plans do today, because most MA  
8 plans are probably doing something -- I don't know. Again,  
9 we don't necessarily have the quantitative measure, but  
10 something like a 5 percent enhancement with the maximum  
11 out-of-pocket cost limit and some of the cost-sharing  
12 changes, and maybe you go well beyond that certainly in  
13 many markets.

14           But, on the other hand, I don't know that we'd  
15 want to see a competition with traditional Medicare where  
16 we built in a benefit advantage. So we're saying this is  
17 price competition, except that the MA plans get to play  
18 with a bigger benefit package, and you're sort of saying a  
19 traditional Medicare, you can't have a level playing field  
20 when you're bidding.

21           So, you know, should we be pairing this if we're  
22 doing something more dramatic like the first set of

1 examples with an enhanced traditional Medicare benefit  
2 package, so really change the A/B to include that maximum  
3 out-of-pocket limit, maybe clean up some of the cost  
4 sharing. Obviously, we've talked about those benefit  
5 design changes in other cycles. But maybe if we really  
6 want to move this to a competition on price, we should make  
7 a better benefit package and let both players compete over  
8 that. So that's one point to throw out there.

9 DR. MILLER: Can I say one thing before you move  
10 to another one [off microphone]? Because I was trying to  
11 think about this, and some of that was driven by Scott's  
12 comment and maybe some comments down there that I can't  
13 pinpoint.

14 I almost wondered whether, if you tried to drive  
15 it back -- you know, the 5 percent concept back into the  
16 true premium support concept, whether you ask for two bids  
17 from a plan, because my mind immediately went less to build  
18 up fee-for-service and more to you give me two bids, one  
19 for fee-for-service and one for 5 percent, but then my  
20 thinking kind of ran off the end of the pier. It's like  
21 now I have two bids, what do I do?

22 DR. HOADLEY: Well, you can go into the Part D

1 kind of model where, you know, again, I don't know how much  
2 of it you'd replicate, but in Part D you say to every plan  
3 you have to offer a basic plan, so on the P2P side.

4 DR. MILLER: Right [off microphone] enhanced one.

5 DR. HOADLEY: And then you can offer an enhanced  
6 one if you want, and, you know, in the marketplace, we said  
7 yes, and your enhanced plans have to be at certain levels.  
8 So we have the gold, platinum, and silver, and all that.  
9 So we've helped a little bit with the standardization. So,  
10 again, maybe there are concepts, and I don't know the right  
11 mix or even whether I like all the outcomes. But I think,  
12 as we want to work it through, I think we could look at the  
13 Part D, sort of basic enhance, think about whether  
14 traditional Medicare ought to have a chance to have an  
15 enhanced -- that might get at some of the Medigap -- now  
16 I'm making this three times more big and complicated in  
17 doing this -- or whether drawing from the marketplace sort  
18 of several levels but not sort of infinite variations, and  
19 maybe it's at levels of actuarial value, not necessarily  
20 levels of absolutely standardization to address some of  
21 what other people said, although complexity from a  
22 beneficiary choice point of view, you know, there are pros

1 and cons from all that.

2 DR. MILLER: Sorry I interrupted [off  
3 microphone].

4 DR. HOADLEY: So the other kind of thought I have  
5 is trying to think about the core focus on what we're doing  
6 under -- again, now I'm talking about the broader, the  
7 first part of the presentation, and with Examples 2 and 3.  
8 And it was sort of a revelation to me in thinking about the  
9 fact that the difference between -- because up until now, I  
10 keep thinking, well, 2 and 3 are really kind of the same,  
11 but that is a product of sort of current bidding patterns  
12 that have MA being pretty flat across the country. So I  
13 don't want to try to get into that complexity.

14 But with those two examples, the question is:  
15 Are we essentially asking the majority of beneficiaries to  
16 pay for the health system's either inability or  
17 unwillingness to figure out why we have geographic  
18 variation and fix it? And is that -- I mean, this was one  
19 of the questions that we started to highlight in earlier in  
20 the day. And why should we be asking beneficiaries to pay  
21 for this or beneficiaries being on the hook somehow to  
22 behave in a way that will cause that behavior to change?

1           And the simple result, without a lot of  
2 complicated dynamic changes that we might, in fact,  
3 anticipate, in a market like a Miami or a Dallas or a  
4 Houston or some of those high-cost markets, you could  
5 easily imagine a scenario where almost everybody slides  
6 into MA because the cost of staying in fee-for-service is  
7 so great.

8           Now, people's stickiness and other kinds of  
9 things will keep that from happening. Our mitigation  
10 strategies would slow down that process, but if we just  
11 sort of, you know, jump to the conclusion. Well, now we've  
12 had other conversations about the impact, say, on hospital  
13 prices of having traditional Medicare in the market, and as  
14 traditional Medicare has -- its pricing of hospital  
15 services, for example, helped to set the basis for lower  
16 savings, and without that factor in those markets, do we  
17 lose that?

18           So I think trying to think through do we really  
19 want to be in a situation where we essentially move the  
20 entire market to Medicare Advantage -- and I worry about  
21 that for a number of reasons. One is that sort of, you  
22 know, absence of the public sector price impact that we've

1 talked about. The other is whether, you know, again going  
2 back to sort of the quality of the MA plans, in some  
3 markets we have really good, robust integrated systems. In  
4 other markets we have what seem to be pretty much just  
5 plans that organize or reduce network but don't do a whole  
6 lot more in managed care.

7           Now, again, what's the dynamic effect of all that  
8 in a bidding process? I think that gets really complicated  
9 and more than my little brain can try to figure out today.  
10 But I think that's the concern I have of sort of thinking  
11 about putting all the burden on the beneficiary to sort of  
12 pay the price of what we've otherwise been unable to do in  
13 terms of trying to address costs in high-cost areas and  
14 would it actually not help things if everybody just said,  
15 okay, fine, we'll shift to MA, and now we've lost one of  
16 the levers that may have helped to damp down costs.

17           DR. MILLER: You know, to a point that Kathy made  
18 that some of the plans when those demonstrations were going  
19 on, you know, it's not fair if fee-for-service isn't in it,  
20 which is an equity issue and probably an argument. The  
21 other argument we've made in previous iterations of this  
22 conversation is you keep fee-for-service in there as part

1 of the bidding process precisely to keep some of that  
2 anchor.

3 Now, if a market completely evaporated, you know,  
4 maybe there's issues there. But the whole idea of keeping  
5 fee-for-service in the bidding process is to provide an  
6 anchor to -- you know, we don't immediately absorb the  
7 private sector prices, which are much higher than Medicare.

8 The other thing to keep in mind -- and I'm about  
9 to say something that I'm not 100 percent sure of, so I  
10 need some -- I mean, the way we've structured these models  
11 in terms of between 2 and 3 and the geographic variation,  
12 the beneficiary carries some of greater of the geographic  
13 variation between the two. But there are other ways to  
14 actually make that occur even much more heavily -- right? -  
15 - if you keep the federal contribution constant. And so  
16 there's even a design choice underneath it where you'd be  
17 really saying to the beneficiary you're carrying the weight  
18 of the geographic variation. Between 2 and 3, you carry  
19 some of it. But the heavy lift on it is still, I think --  
20 unless I'm missing something -- carried by the federal  
21 government. Is that right? Or did I totally --

22 MR. ROLLINS: I think for 2 and 3 you've shifted

1 a lot of the responsibility to the beneficiary.

2 DR. HOADLEY: Especially 2, right [off  
3 microphone].

4 MR. ROLLINS: Arguably, for both of them.

5 DR. HOADLEY: If plans bid -- I mean, if the  
6 variations we see in -- I mean, the problem is we don't  
7 really understand the variations in fee-for-service very  
8 well, and why is it that we're seeing this large gradient  
9 in fee-for-service and much closer to flat on MA. Is it  
10 some combination of selection? Is it because there's a lot  
11 of fraud in Miami? You know, is it something that, again,  
12 all beneficiaries are part of? Or is it really just  
13 because, you know, there's -- is it rates of providers?  
14 You know, we don't understand that very well. But if there  
15 was much more of a tilt, then it seems like Model 3 was  
16 designed to shield the beneficiary from more of that. We  
17 just don't get to see it very well given the way the  
18 numbers play out. I think.

19 DR. HARRISON: 3 would basically charge the  
20 beneficiary 13.5 percent of the variation between areas.  
21 There is no variation in 2. They're all going to pay the  
22 same base premium.

1 DR. HOADLEY: Right [off microphone].

2 DR. MILLER: So in 3 you are building into [off  
3 microphone] the beneficiary's premium, 13 percent of it,  
4 that geographic variation. And so you are asking them to  
5 carry it, but --

6 DR. HOADLEY: I said it backwards [off  
7 microphone].

8 DR. MILLER: Exactly. Yeah, right, you could  
9 actually -- we didn't discuss this here and didn't  
10 construct it here. You could design models where they even  
11 carry a heavier portion of that.

12 DR. HOADLEY: Do we have any markets that are  
13 more extreme variations in their average bid than the three  
14 examples that we've mostly been working with?

15 MR. ROLLINS: Variation between the --

16 DR. HOADLEY: Where the median MA bid is more  
17 deviant from national fee-for-service.

18 MR. ROLLINS: Miami would be high on the list --

19 DR. HOADLEY: But it's not very different in  
20 terms of on that chart.

21 MR. ROLLINS: I mean, there are a lot of -- you  
22 see a similar differential, if you look at Table 7, for a

1 lot of other major areas, like Los Angeles.

2 DR. HOADLEY: But the -- right. I mean, I'm  
3 talking about the fact that the median MA bid on Slide 5 is  
4 almost constant between Portland, Columbus, and Miami.  
5 It's \$712 to -- \$704 to \$744. And I'm thinking that maybe  
6 it's in some of the examples in the longer paper. But  
7 where the MA is more off the line and sort of how things  
8 play out there, is what I'm trying to think about. This is  
9 more detailed than we probably have time for right now.

10 DR. CROSSON: Kathy, do you have a point on  
11 Jack's point?

12 MS. BUTO: I do, actually. I wanted to go back  
13 to his point about enhancing fee-for-service. And I guess  
14 I want to go back to your list, Jay, and partly Craig's  
15 comment about value. One of the things that wasn't on your  
16 list was the issue of continuing to have incentives for  
17 beneficiaries to move into more managed environments, more  
18 managed scenarios, whether it's ACOs or MA plans. So  
19 that's not in there.

20 If we then go to -- one of the proposals or  
21 suggestions Jack was putting out there is enhancing fee-  
22 for-service seems to me -- although it would make the

1 bidding process more of a level playing field, I don't know  
2 why we'd want to enhance fee-for-service. I'm just trying  
3 to understand that in light of our other principle, which  
4 we haven't put out here, that we'd really like to encourage  
5 people to move into high-value managed care settings.

6 So I just want to ask that question as we think  
7 about this in some of these permutations that we not forget  
8 that we don't necessarily want to make fee-for-service more  
9 attractive.

10 DR. NERENZ: So, Kathy, could you just qualify  
11 what you mean by "enhance" in this question?

12 MS. BUTO: Enhancing fee-for-service?

13 DR. NERENZ: What does "enhance" [off  
14 microphone]?

15 MS. BUTO: I don't know. I was picking up on a  
16 point Jack was making about if we're going to have the  
17 added benefits in MA --

18 DR. HOADLEY: What I meant was things like the  
19 maximum out-of-pocket limit that doesn't exist or some of  
20 the kind of wacky cost sharings for longer hospital stays  
21 and some of those -- the things that Medigap deals with.

22 DR. CROSSON: Yeah. And just to be clear in

1 terms of a list that I gave you, I was using the language  
2 that we were using here today at the Commission, move  
3 towards more efficient care. I don't know that, in my own  
4 mind, at least, that's terribly different from what you're  
5 saying.

6           And to Craig's point, I certainly would not argue  
7 with the fact that underlying that -- and the word  
8 "efficiency" doesn't carry it, I understand that -- but the  
9 notion of at least equal quality, if not a preference  
10 towards higher quality, would also be there.

11           Kate.

12           DR. BAICKER: So, I, too, wanted to echo Craig's  
13 point that, clearly, quality matters and we need to think  
14 about how you layer on improvements in quality and rewards  
15 for improving quality onto all of this. I'm going to  
16 abstract from it and I'll just call everything value, but  
17 to focus on some of the premium points we're trying to put  
18 a finer point on, but we have to keep Craig's point in mind  
19 about how then the quality metrics layer on top of that.

20           To boil it -- I've tried to just boil it down in  
21 my thinking to a couple of the key questions because there  
22 are so many practicalities in variance, and the point that

1 seems most important to me is that beneficiaries face the  
2 full import of how much higher or lower value the plans  
3 they're choosing are and that they reap the benefits if  
4 they're enrolled in a much more efficient high-value plan.  
5 And, so, again, back to Craig's initial point that the  
6 delta between what they pay if they're in fee-for-service  
7 versus what they pay if they're in an MA plan, each of the  
8 three options in the first part maintains that incentive  
9 for enrollees to choose the lower cost, higher value plan,  
10 and I think that that's a great move in the right  
11 direction.

12           And then we're left with the question of should  
13 fee-for-service be in that mix, as in the first set of  
14 options, or should it just be among MA plans, as in the  
15 second set. And Jack's point about, well, fee-for-service  
16 would be competing on an unlevel playing field if there was  
17 a five percent, highlights the point that there is no fee-  
18 for-service plan. There's nobody bidding. It's this  
19 collection of individual people that has no collective bid.

20           So, then, the question is what is the beneficiary  
21 entitled to under the Medicare benefit? Is every  
22 beneficiary entitled to the lowest cost provider of care

1 that we deem of sufficient quality and providing at least  
2 this much, this generous a benefit, regardless of how  
3 that's provided, or is every beneficiary entitled at the  
4 existing premium structure to fee-for-service?

5           If you say, every beneficiary is entitled to fee-  
6 for-service, then you go with the -- at this price -- then  
7 you go to the second option and you let the plans compete  
8 amongst themselves with the beneficiary really getting the  
9 full advantage of choosing a lower value -- a lower cost,  
10 higher value plan.

11           Or, you say, you know what? Beneficiaries are  
12 entitled to this package of care delivered at this quality,  
13 and if MA is doing that more efficiently than fee-for-  
14 service, then that's the Medicare contribution, and if the  
15 beneficiary wants to stay in fee-for-service, the  
16 beneficiary has to pay that delta, even if it's going to be  
17 huge in someplace like Miami.

18           In choosing that, you're thinking, who's bearing  
19 the cost of the system delivering really high cost care?  
20 Do we want to say that beneficiaries in a high cost place  
21 are just not able to get the fee-for-service benefit at the  
22 same price as their fellow citizens in an area where the

1 system is working better, but it's through no fault of  
2 their own that they're living in the high cost area? And  
3 that goes back to Scott's question about who bears the cost  
4 of the geographic variation.

5           If I thought we would be in a world where  
6 immediately everybody would move over into MA and fee-for-  
7 service would just disappear, that would present a lot of  
8 logistical problems. So many of our other programs are  
9 built on the fee-for-service chassis. We rely on fee-for-  
10 service prices to mitigate private prices. If the world  
11 transformed that way instantaneously, there would be some  
12 problems, although we spend a lot of time thinking about  
13 how we could drive people into better managed plans. So,  
14 we can't do too much hand wringing if it were to happen  
15 overnight.

16           But, I don't think that that's a real  
17 possibility. I don't think that our risk is people  
18 switching over just too fast. And, so, I'm willing to live  
19 with that risk while moving towards a really equal footing  
20 kind of competition as laid out in the first set of  
21 options.

22           One of the problems with the first set of

1 options, you note that beneficiaries have a pretty hard  
2 time knowing, and you picked up on this, as well, what the  
3 benefits really are, and it's apples to oranges, and one of  
4 the advantages of the second set was that it would  
5 standardize that a little bit. But, I suspect, although I  
6 don't have any data, that part of the reason we're in that  
7 world is that beneficiaries are not able to reap the full  
8 benefit of the lower cost plan.

9           So, in today's world, plans add in benefits to  
10 get up to that level per force. If we were in a world  
11 where, rather than throwing on some benefits that the  
12 beneficiary was not even able to perceive, the plans just  
13 gave them cash, I suspect that they would spend less of  
14 their resources on plans that had benefits that the  
15 beneficiaries didn't perceive. So, maybe you solve that  
16 problem a little bit or mitigate it by being in a world  
17 where the full pass-through of the savings goes to the  
18 beneficiary.

19           So, I think that that leaves me favoring the  
20 first set of options over the second with a moderated glide  
21 path. You don't want to have beneficiaries suddenly face  
22 the full costs of living in a high cost area and have to

1 switch plans. So, you want to transition that in a  
2 rational, reasonable, smooth way. Have fee-for-service in  
3 the mix in the competition and then let plans offer  
4 flexible benefits that beneficiaries actually value, and it  
5 would be the plans' problem to make sure that they  
6 presented that in a way that beneficiaries could perceive  
7 well.

8 So, that's where I am.

9 DR. MILLER: [Off microphone.] Can I get you to  
10 say one more sentence? If I followed your cascade --

11 DR. BAICKER: My rant?

12 [Laughter.]

13 DR. MILLER: No, no, no. No. I thought you were  
14 really clear, and I think you're being fairly precise about  
15 looking at all this and saying, if it were me, this is  
16 where I'd go, and I think this is helpful.

17 I also -- do I infer correctly that if you're on  
18 the first option side of things and you're concerned about  
19 the beneficiaries carrying the weight, you'd gravitate more  
20 to -- and I'm sure I'm going to get it backwards -- but, I  
21 think, two over three, where the bene carries more of the  
22 geographic variation in three, if I have that right.

1 DR. BAICKER: I -- yeah --

2 DR. MILLER: Because you did express a concern of  
3 how much the bene has to carry --

4 DR. BAICKER: So, I think in the long run, you  
5 probably do want to be a force towards flattening. So, in  
6 the long run, there should be some more national -- I don't  
7 want to use the word benchmark, because -- contribution  
8 definition. But, I would get there gradually.

9 DR. MILLER: Yeah.

10 DR. BAICKER: It's not the individual  
11 beneficiary's fault for living in a high cost area, but the  
12 way we're paying is making it a high cost area. And, so,  
13 you have to balance those two things by saying, in the long  
14 run, we shouldn't be enabling this excess cost. In the  
15 short run, we can't put the whole burden on the  
16 beneficiary. So, that's what I would be trying to weigh.

17 DR. MILLER: Mostly, you'd go after that through  
18 a transition and some mitigation of how --

19 DR. BAICKER: And then there's always going to be  
20 -- you do always want to build in -- some places just are  
21 more expensive overall. Rents are higher in New York than  
22 they are in rural areas. So, I don't think that it would

1 be literally equal, but I think that you would squeeze out  
2 the excess that's not attributable to broad cost-of-living  
3 and cost of doing business differences.

4 DR. MILLER: And unless I'm really missing  
5 something, I mean, we're talking about bidding that adjusts  
6 for health status and prices and that we're really down to  
7 talking to why are there ten MRIs here and only one here,  
8 right?

9 DR. CROSSON: Thank you, Kate.

10 So, we're moving down this way. Cori, you look  
11 pained --

12 MS. UCCELLO: I feel like I just should say  
13 something, but I don't --

14 [Laughter.]

15 MS. UCCELLO: I'm going to sign on with Kate's  
16 comments.

17 I think -- you know, we talk about, or I've  
18 talked about in my day job how important it is when people  
19 are choosing plans not to focus solely on the premium.  
20 And, so, we're, in a sense -- when we're moving in these  
21 directions, which I am supportive of broadly, we're  
22 focusing more on the premiums. And, so, just within these

1 kinds of structures, we just have to make sure that benes  
2 signing up understand that premiums aren't the only cost  
3 that they're going to be incurring, and in standardizing  
4 plans versus allowing variations in plans by the actuarial  
5 value, you know, at the end of the day, those still aren't  
6 going to tell any individual person what their spending is  
7 going to be. So, they're useful just in terms of general  
8 generosity to an average set of people, but for one  
9 particular person, two plans that have the exact same AV  
10 can impose severely different out-of-pocket costs to them.

11           So, I don't know where that fits into this, but  
12 just kind of something to keep in mind as we're thinking  
13 about these standardizations or not kinds of issues.

14           DR. MILLER: I'm sorry to keep interjecting, but  
15 what I was thinking about, because this started with Craig,  
16 and as we're going around the table in a couple of these  
17 comments, it's almost like -- just for the moment, let's  
18 say that five stars is the correct measurement system, just  
19 to use that as someplace to draw a bead, where you'd almost  
20 say -- and I'm sure I'm going to get this wrong -- you say  
21 to the beneficiary, you know, if you move to MA, there is a  
22 premium impact. But to Jon's point about plan

1 participation, you could say no plan can participate unless  
2 they have at least some minimal quality standard, so you're  
3 sort of trying to drive the decision in that sense, and  
4 that connects something to what Jon said.

5           But, also you could say, and your premium impact  
6 -- and this connects to something that Eric was laying out  
7 -- if you could tie the premium impact to other policy  
8 goals -- he mentioned Medigap, but perhaps it's quality in  
9 the sense you say -- here's your full premium impact if you  
10 go to a three-star plan. Here's your premium impact if you  
11 go to, you know, a five-star plan. And you try and signal  
12 to the beneficiary, you get a premium reduction -- or, I  
13 mean, you have to pay -- you get more -- I did it  
14 backwards. I knew I would.

15           You get a greater reduction in your premium if  
16 you go to a five-star plan than if you go to a three-star  
17 plan, so try and send some signal that way and have some  
18 mitigation on a quality benchmark. That assumes you have a  
19 measure, and I've left out networks and all the other  
20 things and --

21           DR. SAMITT: But, the problem is you'd also need  
22 to harmonize the comparison between fee-for-service, so --

1 DR. MILLER: [Off microphone.] And, I've got to  
2 tell you, and we've said that many times in this room and  
3 we're not there.

4 MS. UCCELLO: And I think the network issue is  
5 not just some throw-away. Oh, yeah, and the networks are  
6 different. That's a big deal --

7 DR. MILLER: [Off microphone.] Yeah. I agree.

8 MS. UCCELLO: And, so, it's just hard.

9 One short comment that I was going to make, but I  
10 think has been corrected, but I'm going to make it anyway.  
11 The second -- the MA only stuff. As we're going through  
12 this, I'm thinking, why don't we just lower the benchmarks  
13 in these high-cost areas? Aren't we going to get to the  
14 same result without all this other stuff going on? But I  
15 think I heard the answer is, this is not just the high-cost  
16 areas where you would have savings under this MA only  
17 bidding system. Is that right?

18 DR. HARRISON: That's true.

19 DR. CHRISTIANSON: Warner, you're next.

20 MR. THOMAS: So, just a couple of comments. I  
21 guess the first, I agree with Craig's comment that I think  
22 we need to look at the highest value, not necessarily just

1 the lowest cost, and I think Cori brings up a great point,  
2 that we cannot -- we really can't evaluate that across the  
3 different models because we just don't have consistent  
4 quality measures. So, I think whatever we do, that needs  
5 to be kind of paramount, as well.

6           The other comment I would make is I think it's  
7 important for us to understand, especially in the high-cost  
8 areas, why do people choose traditional Medicare versus MA,  
9 I mean, because in many cases, they're turning away -- it's  
10 a better financial incentive to actually be in MA versus  
11 traditional Medicare because they don't have the out-of-  
12 pocket costs. They more than likely have more benefits.  
13 So, there's something here.

14           I think what our experience has been is that  
15 people continue to go into traditional Medicare, one,  
16 because they're not price sensitive, and two, because they  
17 travel or want to be, you know, want to make sure they kind  
18 of have a broader area that they feel like they can use the  
19 services in a much broader area. Now, with a national,  
20 that would be a lot easier to do than with some of the  
21 regional MA plans.

22           So, I just -- I come back to, I'm not sure just a

1 financial incentive will do this, or maybe there is some  
2 tipping point on a financial incentive there. But, I think  
3 it's -- I think there's something more significant than  
4 just the financial piece that's driving the decision making  
5 in these other markets. So, I just lay that out as just  
6 another piece for consideration.

7 DR. CHRISTIANSON: Rita, do you want to speak on  
8 this topic?

9 DR. REDBERG: My only comment, and it really is  
10 just on Warner's, is I thought we had seen data previously  
11 that a lot of fee-for-service beneficiaries kind of default  
12 into the fee-for-service as opposed to actually actively  
13 choose it because they've looked at -- they made those  
14 decisions that they wanted to travel. And, that's why I  
15 think, particularly with the Secretary and the move to get  
16 away from fee-for-service for Medicare in the next few  
17 years, I think focusing on value could improve the program  
18 as well as make it more efficient, because, I mean,  
19 clearly, we can see from the different fee-for-service  
20 costs around the country, there's a lot of inefficiencies  
21 going on and I suspect very low-value care. So, I think  
22 moves that would at the same time increase efficiency and

1 increase value and eliminate sort of the waste in the  
2 program, which I'm hoping that these alternatives would do,  
3 would be great.

4 DR. SAMITT: Can I weigh in on that, as well,  
5 which is one of the things you haven't talked about in the  
6 report, and I would imagine it would be a subsequent step,  
7 is this notion of defaulting to fee-for-service. And, so,  
8 how does that factor into this? If we believe that, by  
9 market, there are higher value alternatives, should the  
10 auto assignment or the default methodology change so that  
11 if not actively selected, that a beneficiary would actually  
12 be assigned to the highest value alternative as opposed to  
13 fee-for-service?

14 DR. CHRISTIANSON: Warner, did you want to weigh  
15 in on something Rita said?

16 MR. THOMAS: Yeah. I think this concept of -- I  
17 mean, we all know when it's reenrollment period time that  
18 the MA plans are very aggressive from a marketing  
19 perspective, so I think they're trying to get the message  
20 across.

21 You know, perhaps, once again, going back to what  
22 Craig is saying, maybe the default should be different in

1 these markets. I mean, maybe the default should be MA  
2 versus traditional Medicare.

3 DR. CROSSON: Bill.

4 DR. HALL: This has been very informative. I  
5 hadn't expected these two hours to be as informative as  
6 they've turned out to be.

7 [Laughter.]

8 DR. HALL: I just want to say a word about I  
9 think the common theme around the table is that we're very  
10 much concerned about paying for quality. If you just take  
11 the people sitting at this table, we know that there are  
12 differences in quality that are not only regional, but are  
13 within -- largely within large regions, but are there in  
14 every single American community. Doctors pick their own  
15 doctors knowing with a great deal of insider knowledge.  
16 Hospital administrators have that same kind of knowledge.

17 But, I think one of our goals on this committee  
18 is to deal with the vast majority of Medicare recipients  
19 who are disadvantaged. In other words, we're saying to  
20 them, in some senses, you're entitled to pick poor care if  
21 you want to. That's your God given right. I don't think  
22 any of us would agree with that, but it kind of comes out

1 that way.

2           So, I think as we go into these discussions, of  
3 course, we have to be price sensitive, but I think we need  
4 to speak much more about pushing people into systems of  
5 care that are probably going to give them a higher quality.  
6 The quality measures are getting better. They're not  
7 perfect, of course.

8           So, any time we get into these discussions, yes,  
9 price is important, but I think we also have to remember  
10 that quality is even more important in the final analysis,  
11 and if it's good enough for us in making decisions, it  
12 should be for us to help individuals to pick according to  
13 quality.

14           So, I get a little nervous when we say we're  
15 going to see which is the cheapest system. I don't think  
16 we have to do that any more. I think things are moving  
17 very rapidly in the quality spectrum.

18           DR. CROSSON: David.

19           DR. NERENZ: Most general comment, I think this  
20 is moving in the right general direction, and I think we're  
21 on the right track in looking at these various options  
22 about pegging payment at a certain level and then letting

1 beneficiaries be more responsible for choices around that.

2           Kate expressed eloquently much of what I was  
3 thinking. I can't improve on that, so I'll just say I  
4 second that. Nicely done.

5           Just a couple of fine points. Many of the things  
6 we're talking about strike me as sort of most easily and  
7 most naturally right in places like Miami where it's very  
8 high fee-for-service cost, and we're talking about options  
9 that would encourage people either to move to something  
10 else that has distinctively lower cost -- and I'm going to  
11 get to value in just a second -- and then if you want to  
12 stay fee-for-service, you pay the difference. And, as Kate  
13 pointed out, you can calibrate that. You can weigh it.  
14 Okay. Then that part, on that side, it seems pretty good.

15           I think there's a little, slightly different  
16 issues on the other side -- the Rochester, Portland, that  
17 side. As a first thing, I like the policy symmetry, and  
18 I'm actually comfortable with the idea that it just flips  
19 the other way, that basically what Medicare would pay for  
20 in some of these models would be now a fee-for-service  
21 choice, and you would pay more if you want to be an MA.

22           But where I think that hits just a little bit of

1 policy wall is that what could happen, then, is that MA  
2 plans in those areas could go away. I mean, if people  
3 don't find extra value and choose them, they could go. So  
4 now we're left with a situation where in perhaps many of  
5 the low-cost fee-for-service areas, there just are not MA  
6 plans. Now, that's the quandary.

7           Personally, I'm okay with that, but I know  
8 there's another policy direction that says, well, there  
9 should be MA everywhere. You see this pop up in the annual  
10 update renewal time for MA, and I just think there may be  
11 two conflicting policy goals in that particular area. And  
12 you just have to wrestle with this question: Do we accept  
13 as a simple policy goal that there should be MA everywhere?  
14 And I don't see it myself.

15           Then, to Craig's point -- I guess Cori as well --  
16 on the issue of value, I accept the idea. The concept is  
17 fine. The question I think, then, that we'd have to pursue  
18 is where, at what level of analysis and what level of  
19 beneficiary choice, are there meaningful differences in  
20 quality from which you could determine value. Are there  
21 meaningful differences at the product level, fee-for-  
22 service versus MA? Maybe. I don't know that I see it

1 clearly.

2           Are there meaningful differences at the plan  
3 level within MA? Maybe. We got star ratings, but, again,  
4 are those meaningful? Are those important? And then you  
5 just keep doing down. How about hospital? How about  
6 doctor?

7           I don't know the exact answer, but I think part  
8 of our discussion of this and to incorporate value into the  
9 discussion is going to have to be informed by at least  
10 whatever we can know on that point. And if we think there  
11 are truly meaningful quality differences all the way up to  
12 this big product level, then I think that has to be  
13 factored into how we talk about this.

14           If the meaningful differences are way down  
15 deeper, more fine grain, then I think we worry less about  
16 policy incentives that push people either into MA or fee-  
17 for-service because the important quality and value  
18 decisions are yet to come. They're within those.

19           MR. GRADISON: I think I'm picking up from Dave's  
20 point, which in part relates to the degree of national  
21 uniformity versus local variation.

22           When Medicare and Medicaid were created, one of

1 those grand compromises was struck where basically the idea  
2 was Medicaid would have great variation across the country,  
3 state by state, and Medicare was going to be a uniform.

4           But I've been struck over the years how much  
5 pulling and hauling there has been on that. I would  
6 suggest in Medicaid, there is somewhat of a drift towards  
7 national standards in certain respects, and in Medicare,  
8 I'd say the drift is actually in the other direction. And  
9 we've talked about a lot of those variations today. For  
10 example, some of these variations around the country in  
11 Medicare are tangible and somewhat immeasurable; for  
12 example, traditional fee-for-service versus MA plans, MA  
13 plans versus other MA plans. Networks obviously vary. The  
14 price varies. The benefits vary, which is not, in a sense,  
15 strictly exactly what people might have been thinking about  
16 in 1965.

17           Quality is the wildcard here, and we know it  
18 varies, but how to measure it on an ongoing basis is one of  
19 the great challenges of our time. Now, that may sound  
20 pretty abstract in terms of what we're talking about, and  
21 I'll try to be more specific as quickly as I can.

22           After listening to this discussion and the

1 previous discussions on the same subject, I can understand  
2 better than ever why new beneficiaries -- we've talked  
3 about this -- tend not to decide to go into MA right away.  
4 There's more of a movement, I believe, in year two than in  
5 year one, and there is a message there. This thing is hard  
6 to size up, and so as we consider choices, additional  
7 choices, in a sense, I think that it's just worth  
8 reflecting upon, not that they shouldn't happen, but what  
9 this all looks like from a beneficiary's point of view.

10 I'm tempted to make a point. I probably ought to  
11 because I've only got one more year here. I may go down,  
12 at least so far, on record as having been on Medicare more  
13 years than anyone who has served here before, a record  
14 which may go unchallenged for perfectly good reasons.

15 [Laughter.]

16 MR. GRADISON: But with regard to new  
17 beneficiaries, there is one element that we haven't  
18 discussed here, and frankly, I don't remember discussing it  
19 in any other context, so I'd just like to throw it into the  
20 mix for the future. And that is trying to, maybe more  
21 pointedly, think about the transition. There are lots of  
22 different ways people have health insurance before they

1 ever reach Medicare eligibility. Medicare is different for  
2 most of them. Does it have to be? Let me be more  
3 specific. The ACA sets up bronze through platinum plans.  
4 Is there some way in which there can be some kind of  
5 interrelationship between those plans and the Medicare  
6 benefit package for those who might say, "I kind of like  
7 what I'm under. I like my bronze, or I like my platinum,"  
8 recognizing there are price differentials? Interestingly,  
9 people seem to be accepting the fact -- those who passed  
10 the law certainly did, and a lot of beneficiaries seem to  
11 be accepting the fact that there's significant price  
12 differentials, and you get more choice if you pay more and  
13 so forth and so forth.

14           So I would like a little bit more focus on that  
15 aspect, with particularly asking the question how does this  
16 issue, very important issue we're talking about, relate to  
17 choices that might be made by people who will be getting  
18 their benefits under the ACA.

19           DR. CROSSON: Okay.

20           MS. THOMPSON: No one has been more educated  
21 today than me, so I want to say thank you to all of you.

22           And from a state with very, very low MA

1 penetration, this is a fascinating discussion to listen to  
2 because we will have many, many Medicare beneficiaries, and  
3 this is complex stuff.

4           But I just want to restate a point that was made  
5 earlier. My 83-year-old mother, who pays more than I would  
6 care to even admit for her supplemental insurance through a  
7 very dominant commercial company in the State of Iowa,  
8 being very hesitant about moving to an MA plan, as these  
9 plans start to become available, but the one criteria she  
10 looks at is will she be able to go to her physician. And  
11 she'll pay what it takes to be able to see her provider.  
12 So I can't emphasize that patient-physician relationship  
13 enough.

14           DR. CROSSON: Scott.

15           MR. ARMSTRONG: So I just wanted to weigh in and  
16 acknowledge. I think this topic is profoundly important  
17 for MedPAC. I'm glad we spent a couple of hours on it, and  
18 I think it deserves many, many more hours going forward.  
19 In fact, I think this debate will be one of the key policy  
20 debates for the Medicare program in the next couple of  
21 years. Well, of course, I encourage future generations of  
22 MedPAC commissioners to take it on, and hopefully,

1 actually, you'll solve it before I'm a beneficiary.

2           Example No. 2, I think describes a future that we  
3 should find a way to make implementable. I won't repeat  
4 Kate's points, but I really agree with her comments, and  
5 there are issues in this, of course. And I think the  
6 balance between the beneficiary's responsibility to deal  
7 with high costs in certain markets versus the program has  
8 to be one of those issues that we reconcile, but we've  
9 solved those kinds of issues in a variety of other ways,  
10 and at the very least, managing the transition process is a  
11 key part of that.

12           Also, just to these points about value and  
13 quality, the spectacularly high costs in Miami, to me,  
14 alone are an indication of poor quality, and so I think  
15 it's an issue we have to take on. And I have never seen a  
16 better path described for how MedPAC through payment policy  
17 could begin to address some of the issues around that  
18 spectacular regional variation.

19           The last point I would make -- and this is in  
20 part because of the people I hang out with. When we talk,  
21 what Jack was mentioning, we are looking for a more pure  
22 way of price or value basis to -- I don't think that was me

1 -- on a price or value basis to offer comparisons to our  
2 beneficiaries, not only is it difficult for beneficiaries  
3 to really judge -- and that's complicated, but there are a  
4 lot of variables that you have to consider. It is a  
5 complicated comparison, and one point that hasn't been made  
6 but just needs to be put on the table is that comparing  
7 fee-for-service to the MA plans, we haven't acknowledged  
8 that we require MA plans' compliance with very complicated  
9 and very expensive regulatory requirements and quality  
10 reporting and a lot of other things that also at some point  
11 has to be folded into. If we are really trying to compare  
12 apples to apples, somewhere that has to be acknowledged.

13 DR. CROSSON: Kathy, on this?

14 MS. BUTO: Yeah. I just wanted to associate  
15 myself with Example 2. I think I would also like to see  
16 that fleshed out, including how to account for or take into  
17 account value and so on.

18 I am increasingly -- I am having trouble with the  
19 second bucket of MA-only options and whether -- to me, the  
20 downsides are it doesn't include fee-for-service. It could  
21 actually drive people back to fee-for-service, and it might  
22 reduce the helpful variation of extra benefits. So I'm

1 just trying to figure out -- I know there might be the  
2 benefits are a simplicity for the beneficiary and  
3 potentially savings, but it seems to me, the more savings  
4 you are able to actually get from that option, the more  
5 likely it is people will go back to fee-for-service. So  
6 I'm just not sure that's a good tradeoff.

7           So, again, for that whole bucket of things, I'm  
8 wondering if we want to put a huge amount of more time into  
9 it.

10           DR. CROSSON: Jon.

11           DR. CHRISTIANSON: I'm probably just extending or  
12 piling on maybe on Scott's comments too. But I'm glad from  
13 the recent comments here that we don't seem discouraged by  
14 the complexity here. I think that's one possible outcome  
15 we could come away from this and say, well, we just -- you  
16 know, it's just all too complex.

17           I think we've made a lot of progress in terms of  
18 setting prices for MA plans over the last decade or so. I  
19 think it's a lot better now than it was, and I think one of  
20 the advantages of keeping on in this track is that we want  
21 a system by which the MA plans eventually reveal through  
22 their bids, the cost of providing services plus a

1 reasonable profit. And that has enormous value to us and  
2 to the Medicare program to know for a given level of  
3 quality, what it actually costs to provide that care. And  
4 the closer we can get to that, I think -- I mean, we really  
5 accomplish something. So even moving marginally in that  
6 direction is an important thing for us to do.

7           So I guess my general point is I really think we  
8 need to keep working on this, and yes, it's complex, and  
9 it's probably going to get more complex, the more we get  
10 into it, but if we can make even marginal changes that move  
11 us to this world where the bids reveal to Medicare what the  
12 costs are of providing high-quality care to the Medicare  
13 population, which we don't know based on the fee-for-  
14 service system, I think that's a real value.

15           DR. CROSSON: Thank you. I had Rita next and  
16 Jack.

17           DR. REDBERG: I just wanted to sort of follow on  
18 the point of quality because, when we talk about quality,  
19 as Scott said, when you look at the high cost, you think it  
20 can't be good care. But I think a better way to measure  
21 that perhaps is -- right now, none of the quality measures  
22 that we use look at overuse. As we know, fee-for-service

1 is a system that encourages high-volume care and high-  
2 volume care of questionable quality because you get paid  
3 the same for an inappropriate procedure or operation as you  
4 do for one that was needed to life saving. And so I think  
5 we need to have measures that penalize overuse or that rate  
6 overuse so that overuse gets into quality because otherwise  
7 we never get at that in a fee-for-service system, and we  
8 know that a lot of the variation we see in the high costs  
9 are due to inappropriate and wasteful procedures that are  
10 harmful for our beneficiaries. No one is benefitting from  
11 something that they didn't need. If they're going to get  
12 no benefit, they only have downside to it. But right now,  
13 as I said, none of the quality measures reflect that. So,  
14 when we look at quality, we really have to have overuse  
15 measures and measures that you're not doing inappropriate  
16 procedures as well as the ones where we're trying to  
17 encourage things that are beneficial for our patients.

18 DR. MILLER: Just for a commercial, Jim, I think  
19 for April, we have another low -- or I mean --

20 DR. MATHEWS: Yes, that's correct.

21 DR. MILLER: Yeah. So I think, Rita, you're  
22 going to get another shot at that in the April meeting.

1 DR. CROSSON: Jack.

2 DR. HOADLEY: So I continue, I think, to have  
3 more qualms about some of these directions than many of the  
4 folks around the table. But I think I just wanted to  
5 reemphasize a couple of points about, so if we go in this  
6 kind of direction -- I think Craig at the very beginning  
7 highlighted things like network transparency, and it goes  
8 to Sue's comment about so many of the beneficiaries. The  
9 first thing they care about is maintaining their  
10 physicians. If we are moving into something that is more  
11 aggressively going to encourage enrollment into Medicare  
12 Advantage, we've got to make sure -- something that is very  
13 hard to do now is where are my doctors, what plans cover,  
14 including my doctors, under what conditions. We get into  
15 tiered networks and all kinds of things, where is it going  
16 to be, extra high copays and all those kinds of things, and  
17 sort of revisiting issues about what is the definition of  
18 "network adequacy." And I know that's challenging because  
19 an integrated system like Scott's looks at a network in a  
20 very different way than a traditional commercial plan that  
21 is trying to offer sort of a network. And we've seen so  
22 much of a trend towards narrow networks, which, again, an

1 integrated system, it's the core of how it works, but in a  
2 non-integrated system can mean much more constricted choice  
3 to beneficiary, so that's one thing.

4           Thinking a lot more on -- and, Scott, you alluded  
5 to this -- sort of beneficiary support mechanisms, if  
6 people are going to have a lot more consequences to their  
7 choices, we will probably need to do things like beef up  
8 resources for things like the SHIPs that can help people,  
9 one on one, figure out how to do it, so they're not just  
10 trying to look at all those letters they get in the mail  
11 and the advertisements on TV to pick a plan, but somebody  
12 who can actually help them find a plan that meets their  
13 needs. And a lot of that, it feels like from the research  
14 needs to be one-on-one sort of counseling kind of  
15 resources, and we don't provide a lot of help in that  
16 dimension, plus building up some of the tools. So the plan  
17 finder right now cannot help you match your providers. So,  
18 again, that goes to sort of that point.

19           Three, if we get into some of the questions of  
20 what's the default choice for a beneficiary when they first  
21 turn 65, how do you make that interact with the network  
22 issues? We're going to assign you to a plan that has none

1 of your doctors, and then you'll only figure that out when  
2 you show up to try to get your appointment. We've seen a  
3 lot of those issues in Medicaid, where they do have that  
4 kind of default enrollment.

5           And what about sort of the quality dimension? We  
6 may evolve to a system where there are low-bid plans who  
7 could then become a default choice, which are really low  
8 bid because they're low quality, and this sort of goes back  
9 to one of Jon's earlier points. Should we be thinking  
10 about a system that rejects some plans? In some cases, it  
11 might be on high cost. In some cases, it might be on low  
12 quality. Now it takes -- you've got to get really bad  
13 before you get kicked out of the program. We do suspend  
14 plans, and we've had some fairly large plans suspended from  
15 being able to enroll new members because they've had  
16 significant quality issues or noncompliance issues. But I  
17 think thinking about the intersection between are we  
18 starting to do some kind of default choice into Medicare  
19 Advantage and then what should be the criteria for that,  
20 but that also brings in this question of what are the  
21 minimum standards to be in the program. I think Jon's idea  
22 had some appeal that maybe we should be thinking about a

1 system where some plans just don't make it into the  
2 program.

3           So that's a set of things that I think are really  
4 very important to think about. Again, I still have some  
5 fundamental issues about sort of the fairness to the  
6 beneficiary of some of these directions we're talking  
7 about, but if we do go there, we need to make sure the  
8 mitigation factors we obviously did talk about in terms of  
9 just stalling the process or making the process on a more  
10 gradual glide path and that's all appropriate, but a bunch  
11 of these other things, I think need to be thought about  
12 very clearly to make sure either during that transition or  
13 as well as once that transition is over that the  
14 beneficiary is fully empowered to not end up in a bad spot.

15           DR. CROSSON: Okay. This has been a good  
16 discussion, great work in terms of setting it up for us  
17 with the models. At the risk of my own neck, I'm going to  
18 try to summarize what I think was the main points that I  
19 heard here, which would help create direction.

20           Number one -- and I think we heard this starting  
21 with Craig and from multiple people -- please don't make  
22 these considerations here, the choices, purely based on

1 price or premium levels or the amount of savings for the  
2 Medicare program or even for the beneficiaries on a  
3 financial basis, but make sure that the considerations  
4 include quality or value or issues with respect to access,  
5 for example.

6 I thought I also heard something a little bit  
7 similar perhaps, and that is that there should be a bias  
8 towards promoting care coordination or care management. I  
9 heard that a number of times. I'm not sure that that's  
10 synonymous with Medicare Advantage. I think it may be  
11 synonymous with certain types of Medicare Advantage  
12 programs, and so I think, you know, one consideration here  
13 that might be derivative from that is, as we apply this,  
14 think about, whether it's through quality measurement and  
15 management and rewards to quality or some other mechanisms,  
16 modeling payment mechanisms that may, in fact, do just  
17 that, which is to promote the development of the movement  
18 of patients towards organizations which do manage and  
19 coordinate care.

20 I think there was not a unanimous but a majority  
21 perspective that favored the first part of the  
22 presentation, that is, moving towards a model which

1 incorporates fee-for-service as opposed to the second set  
2 of ideas that were brought forward.

3 I think that within the examples provided in the  
4 first set of presentations, the most commonly referred to  
5 model I heard during the discussion was Example 2. I think  
6 I also heard Kate mention that as well as the question of,  
7 as I started out earlier, what do we want to do about  
8 flattening the regional differentiation, not a lot of  
9 support for moving to Model 3, but a general sense that  
10 perhaps in some way over time, perhaps over an extended  
11 period of time, we grapple with that issue, but that to do  
12 it in a relatively short period of time would be quite  
13 disruptive and potentially penalize individuals just based  
14 on where they happen to live -- although in the long run, I  
15 mean, I think from the perspective of equity for the  
16 Medicare program itself, this has to be dealt with.  
17 Whether it's dealt with through pressure on the  
18 beneficiaries or dealt with through other mechanisms, I  
19 think we can perhaps spend some more time on.

20 I think also the point -- Jack raised this, but  
21 others did as well -- that the direction we go in needs to  
22 include beneficiary protections, not just financial

1 protections but protections in other areas, which may be  
2 made more acute by the change in the financial models that  
3 we end up with. And I agree with that.

4           And, finally, I think Bill Gradison's point that,  
5 you know, we are in a different world today after the  
6 Affordable Care Act, and that there may be a place for  
7 giving some consideration -- I'm not sure exactly how that  
8 would work, but some consideration to the fact that at  
9 least a large number of our citizens are going to be  
10 receiving their care through the exchanges, through the  
11 Affordable Care Act, will get used to a certain type of  
12 benefit design, and that potentially there may be some  
13 considerations there that we need to give to how we move  
14 forward with these models.

15           So that's about as focused and comprehensive at  
16 the same time as I can get. What have I left out?

17           [No response.]

18           DR. CROSSON: Okay. Thank you. Wonderful  
19 discussion.

20           Now it's time to move to the public comment  
21 session. I would ask any individuals of our audience who  
22 would like to make comments to come to the microphone so we

1 can see who you are and how many we have.

2 [No response.]

3 DR. CROSSON: Seeing none, we are adjourned until  
4 April. Thank you so much.

5 [Whereupon, at 11:18 a.m., the meeting was  
6 adjourned.]

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