MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
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International Trade Center
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9:44 a.m.

COMMISSIONERS PRESENT:
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KATHERINE BAICKER, PhD
KATHY BUTO, MPA
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AGENDA PAGE

P R O C E E D I N G S [9:44 a.m.]

MR. HACKBARTH: Okay. Good morning. Welcome to our guests in the audience. We have two sessions this morning, the first on international comparison of rates paid to hospitals, followed by a session on sharing risk in Part D. Jeff?

DR. STENSLAND: All right. Good morning. Before we start, I want to thank Anna Harty for her work on this project. The topic is an international comparison of rates paid to hospitals. The literature has long shown that United States hospital pay rates and have costs that are higher than other countries. I'll try to explain the factors that go into the higher cost structure in the United States and discuss why it is challenging to bring costs down using the tools that Medicare has.

First, let's briefly touch on the literature that I'm sure most of you are quite familiar with. The common headline is that the U.S. spends over 17 percent of GDP on health care, which is 50 percent higher than the next highest comparable country. The OECD has also shown that the U.S. consistently spends more on hospital care than other countries, despite the fact that the U.S. has fewer

discharges per capita and shorter lengths of stay. So other countries are providing more services. Therefore, the higher costs in the U.S. must be due to higher rates paid to hospitals. This is the basic story in the OECD data and past studies by the Commonwealth Fund and several academics.

We present some new information today that, I think, at least I have not seen in the literature. First, we'll compare the payment rates for services in high-income countries to Medicare payment rates. Most of the literature compares international rates to U.S. private insurer rates. Second, we will investigate why rates paid to hospitals are higher in the U.S. Is it the price of inputs such as labor, drugs, and devices? Or do our hospitals use more labor per unit of output? We'll show that it's mostly prices, but there also appear to be some extra administrative costs in U.S. hospitals.

Our analysis of data from the OECD and CMS indicate that Medicare pays hospitals and physicians roughly 50 percent more than providers in comparable countries. Our analysis and research by others suggest that costs are also roughly 50 percent higher in the United States. As the third bullet states, I will also present research by others

that indicates private rates are often over 100 percent higher than international rates. And as a word of caution, when I say 50 percent higher or 100 percent higher, I mean these to be rough estimates. For example, if one study shows rates are 45 percent higher and a second shows they are 55 percent higher, I will simply state the analyses together suggest that rates are roughly 50 percent higher. While the numbers are not precise, they are clear enough to tell us the cost differences are large.

Now we focus on why Medicare rates and U.S. hospital costs are roughly 50 percent higher than in other countries. The general story is that the inputs hospitals buy are often 50 percent more costly in the United States. OECD data coupled with work done for us by the Urban Institute suggests that Medicare pays physicians roughly 50 percent more than the average cost of physician labor in other high-income countries. The OECD also reports that nurses make about 50 percent more in the United States. In addition, McKinsey and other sources report that drugs cost roughly 50 percent more in the United States, and the literature suggests that at least some devices also cost roughly 50 percent more in the United States. So most

inputs used in a hospital stay are therefore about 50 percent more expensive in our country.

Now, there are some categories of inputs that are not more expensive. For example, utilities cost less in the United States. It also appears that the clerks that work in U.S. hospitals are not paid more than in other countries from the limited data we have. But these inputs are a fairly small share of total costs. The majority of the categories of inputs have close to a 50 percent price differential.

What we show here is an international comparison of hip replacement surgery across different countries.

Let's start with the first row. This shows that a hip replacement in comparable countries often costs in the range of $9,000 to $12,000. Medicare pays about 50 percent more, at $17,000, and commercial insurers pay far higher rates.

In the second row we show rates as a share of the average person's income. In the comparison countries, workers pay 20 to 26 percent of their annual wage for a hip replacement. In the U.S. workers pay more. For Medicare the rate is 31 percent of the average person's wage, and

it's significantly higher and varies widely for commercial payers. What this tells us is that higher rates in the U.S. are not simply due to incomes being higher in the U.S.

The third row adjusts for the cost of input prices using RN wages as a proxy. The rate for hip replacement in Europe is about 20 to 26 percent of an RN wage. The rate in the U.S. is 24 percent of an RN wage. What this tells us is that the difference in international rates and the Medicare rates can largely be explained by input prices.

The last column shows commercial rates. These are too high and vary far too widely from hospital to hospital to be explained purely by input prices. It may reflect the high level and wide variance in hospitals' market power relative to the insurer in their market.

So now we've shown that input prices are higher, but the question is why.

One factor that partially explains higher wages for physicians and nurses in the United States is that highly educated individuals in general tend to earn a bigger wage premium in the U.S. than in other countries. However, the wage premium for health care workers in the U.S. is higher than for other highly educated workers. So there is

something other than just the structure of the U.S. labor market going on.

A second possible reason is that hospitals are under more pressure to constrain input costs in other countries, and we find some support for this in the data. When we look at hospitals and compare hospitals within individual counties in the U.S., the hospitals in U.S. counties that are more profitable than their neighboring hospital tend to pay their nurses slightly more. Therefore, the high rates received by hospitals from private insurers could place hospitals in a position to pay nurses wages well above international rates. There's lower financial pressure in the United States, and that could result in higher wages.

Finally, drug and device prices are higher in the U.S. This could reflect the fact that sellers of drugs and devices have relatively more power in the U.S. In Europe, governments can influence the price of drugs and devices and often use reference pricing, as Nancy talked about last month and you all discussed. Because sellers of drugs and devices have relatively more pricing power in this country, they tend to receive higher prices.

The next issue involves what could be done to

restrain input prices. If the Medicare program -- and that's if the Medicare program -- wanted to reduce input prices, it still has limited tools to do that.

Medicare can restrain updates in the near term. A reduction in Medicare updates may slow the growth of private rates and may in turn reduce input prices a bit in the short run. But over the long run, having private payer rates continue to grow faster than Medicare is problematic. Hospital and physician revenues would depend more and more on the payer mix and less and less on the quality of care or the access to care provided to the broader community.

With respect to drugs and devices, the Medicare program has historically let the market forces determine drug or device prices, and this has generally led to higher prices than in other countries.

We have talked about how input prices are related to hospital costs. Another factor is whether there are some added costs in the U.S. system. The literature consistently points out that administrative costs are higher in the United States. We find that administrative and billing labor take roughly twice the share of hospital costs in the United States as in German or France. This could explain

between 5 and 10 percentage points of the roughly 50 percentage point difference in the costs across countries.

One factor that is behind the administrative differences in prices that has received some attention in the press, including a recent JAMA article, is the issue of high CEO salaries in the United States. CEOs have a relative mean total compensation of roughly $700,000 at nonprofit hospitals, with a median of roughly $500,000. From the limited data we have from Canada and the U.K., this appears to be at least double the salary in some other countries. While the salaries for those individuals are high, the number of executives at each hospital is small. And because the number of executives is small, this is not the primary factor behind higher administrative costs.

The key driver behind higher administrative costs is the administrative complexity of the system, and this results in a large number of administrative support workers. There are over 700,000 administrative support personnel in U.S. hospitals. So while the clinical costs may be high due to the price paid per hour of labor, the administrative costs are more likely to be high due to the number of hours of labor required to deal with our complex system of coding,

billing, and collecting payments for the care.

Now, here we have some examples of how the Medicare program could move toward trying to reduce administrative complexity.

First, to simplify billing, there could be a greater alignment of how the government and private payers bill for services. Even greater alignment between different private insurers could help streamline the administrative process.

Second, the program could move toward fewer quality measures, as we've talked about in the past, and they could be driven more by outcomes.

A third possibility is site-neutral payments, which removes the incentive to move low-priced services from physician offices to hospitals where overhead is higher.

Last month we also discussed concerns with respect to the Recovery Audit Contractor process which is now too administratively burdensome for hospitals and for CMS.

Now I will try to summarize what was in your mailing materials and the presentation.

First, we showed that Medicare rates and costs are roughly 50 percent higher than rates in comparable high-

income countries. That difference can largely, though not completely, be explained by higher input prices with higher administrative costs also playing a role.

We also showed you data from the International Federation of Health Plans that indicates that commercial rates are often 100 percent higher than rates in other countries. The level of these rates and the wide variation across different insurer/hospital pairs cannot be explained by input costs.

While the input costs are higher, the Medicare program has limited tools to lower input prices. Updates could be constrained in the short term, but in the long term the divergence between Medicare and private rates could be problematic. The evidence we see is that rates private insurers pay hospitals continue to increase faster than general inflation. As long as this continues, it will be difficult for the Medicare program to constrain input prices and rates paid to hospitals.

A less controversial way to reduce costs would be to reduce administrative complexity at the hospitals. Administrative costs could be reduced through lots of little changes, as we discussed in the last slide, and each would

help a little. But in the end, we would not expect this to move more than 5 or 10 percentage points of the 50 percentage point difference in costs between the different countries.

So that is the data, and it has raised several issues that could be discussed. Among them are:

First, what can the Medicare program do to reduce hospitals' administrative costs?

And, second, how should Medicare set rates in an environment where private payer rates are often high and those rates can influence hospitals' input costs?

That's it.

MR. HACKBARTH: Okay. Thank you, Jeff.

So we'll have a round of clarifying questions, narrowly defined, and then we'll go to a round where we have more open discussion where somebody will lead off and see if people want to pursue that thread, and if not, we'll open a new thread. That's the approach we'll use.

Let me ask a clarifying question, Jeff, on Slide 6, the table. This isn't a major point, but it just caught my eye. I'm looking at the last two rows. It looks to me from the international range column that -- I'm inferring

that a nurse must be about the average person's wage since those are the same. But then you get to the Medicare average, and the numbers are different. And I don't see why the numbers in the Medicare column should be different if the nurse's wage is about the average wage.

DR. STENSLAND: And that's because in the international countries we looked, at comparison countries we looked at, a nurse makes basically the same as the average person. But in the United States, a nurse makes a fair amount more than the average person.

MR. HACKBARTH: Oh, okay.

DR. STENSLAND: And that's why that middle column referring to the United States is --

MR. HACKBARTH: I've got it. Thank you.

Other clarifying questions? We'll just come down the row here starting with Bill.

DR. HALL: Thank you, Jeff. Again, this is information that's not readily available.

In all these international comparisons, one of the things that I've noted is that a lot depends on the metric and the ability of the metric you use for comparisons. So is there much literature on the use of average nurse salary

as the important metric to compare us with other countries?

DR. STENSLAND: I don't think anybody has done that before this study.

DR. HALL: Okay.

DR. STENSLAND: And the idea was to come up with something that is a proxy for input prices and to say what would happen if we control for input prices, and so we're using nurse as that proxy. And I'm not aware of any other studies that have tried to use a proxy for input prices and come up with price differentials adjusted for that.

DR. HALL: It's just that the role of nursing is probably arguably very different than it is in European countries, a much wider range of responsibilities, and others might have some comments on that.

DR. COOMBS: One of the things that's in the back of my mind kind of relates to the other components of cost drivers in the international spectrum. So if you took things like technology -- and drugs are probably disproportionately higher. But what are the other cost drivers in the international market that's separate from the United States, that's different from the United States? Are there other cost drivers? Is it proportional, is there an

equal proportions if you do a pie chart for international hospitals versus United -- is there some different pie out of the circle that looks very different in international hospitals?

DR. STENSLAND: Well, there is that section in the mailing materials that wasn't in the slide show that looks at the relative cost shares of different things in different countries. And the cost shares generally looked fairly similar except for the administrative costs. The cost shares were almost exactly the same for drugs, which would imply if input prices in general are 50 percent more, then we're using a similar amount of drugs in the U.S. hospitals and these comparison country hospitals. Maybe we're using a little bit more on the device side on average than they are, but it's not something I can clarify precisely from the data.

MR. ARMSTRONG: So I'm not sure exactly how to ask this question, but there is a point of view, a theory that would suggest that, given admissions and length of stay in the U.S. are so much lower than the comparator countries, that we're taking out all the really inexpensive days, and only those left in hospitals are highly acute and costly.

Is there a way to know or did we look at whether that was influencing the cost per unit of service?

DR. STENSLAND: I'll have to think about that and get back to you. I think the other stuff is so strong and so clear in terms of the input prices that if that is there, there must be some other offsetting effect.

MR. HACKBARTH: So continuing clarifying questions.

MS. BUTO: So I have two. One is if you -- you know, I looked at the basket of countries, and three of them -- Switzerland, Australia, and New Zealand -- are relatively small countries. Not in the comparison are Japan and Germany and Italy, all of which are larger than any of those -- and I think Germany may be the highest, the largest of the OECD countries.

If you throw those in, does that change any of these differences? Or was it just too difficult to deal with the data? So that's Question 1.

Question 2 was whether in the nurse pay comparison, are we talking apples and apples? Like in this country, does nurse pay reflect the fact that nurses may have to buy their own insurance and, you know, other issues

like malpractice? I don't know if that's a big issue for nurses. But I guess I'm wondering what's in that comparison between nurse pay in the OECD countries and in this country, and whether we're really comparing two things that are really the same?

DR. STENSLAND: The nurses are the wages between the two places, so this doesn't include your benefits. So if, indeed, the benefit structure is higher over there than it is over here, that would be different.

But, of course, the key thing is that table where we compare the nurse wage in Europe, the RN wage, to everybody else's average wage. So the only problem wouldn't be if we're different from there. It's just that the RNs in Europe are different from everyone else in Europe by somehow getting a lower benefit structure than everybody else.

In terms of the countries, I picked all the countries that had high incomes, that had all the data there. So, if Germany would have had all the income, had all the different data components available, I would have used it, but it wasn't there.

MS. BUTO: I don't know if it's possible. I know you used Germany in part of the paper to do some

comparisons, and Germany is such a big part of the OECD, and so is Japan. Although in Japan, they use hospitals for long-term care, so it's very difficult to tease out.

But just still, like losing those two countries are such a huge part of the experience of upper income countries, that if there was some way to at least look at some of their data, even if you can't average it in, it would be helpful.

DR. BAICKER: Also, to clarify factual questions, one is that you mentioned on the slides and then in a little more detail in the chapter, the potential returns to education, of highly educated populations, and you said that the differential for physicians was more than for other highly educated people. Do you have any little facts about lawyers or other people to show us OECD versus U.S.? Is this specifically about medical professionals, or how big is the difference between that factual picture versus other highly educated people?

Answer that one first.

DR. STENSLAND: We have a little bit of data in there one people with, at most, a high school education or above, and so that difference exists, but the difference is

bigger for health care workers. We can add lawyers as a separate data point.

DR. BAICKER: Somebody with an advanced degree, not Ph.D.'s that lowers your income, but somebody else.

[Laughter.]

MS. BUTO: Pharmacists.

DR. BAICKER: And then a second question, all of this is about per unit of output, and the chapter mentioned something like hip replacements or C-sections or something like that as a unit of output. What data is there on the apples-to-apples nature of that unit of output? When you get a hip replacement here, does it mean the same thing as getting a hip replacement somewhere else, or are we bundling in other goods in there, such that it's just a different thing that's being produced with these higher-priced inputs?

DR. STENSLAND: Everything I can see from at least what I read was it's similar for the vast majority of them.

Hip replacements, if anything, we might be getting less in this country than they're getting at the hospitals in the other countries, and that the hospitals do more of the post-recuperative care there, and maybe we go off to an IRF or a SNF, and then there's a second round of payment.

But that would just exacerbate the difference.

MR. HACKBARTH: So clarifying questions? Mary.

DR. NAYLOR: Thanks, Jeff, for this great report.

On Table 1 in the report, it talks about, just so I am clear, RN wages, and are these average RN wages in hospitals?

DR. STENSLAND: Yes, hospitals.

DR. NAYLOR: Okay. So we know that there is a difference, and that will be important.

The second is, in the RN wage calculation, I am assuming it is hospital employees, and that would include all levels of RNs, including with doctorates and masters and bachelors. Is that right? Did you limit it to just those? I don't know how you would, but have an RN right out of school, without advanced degrees?

DR. STENSLAND: There would be the whole spectrum of everybody that is an RN.

I don't know if the OECD took out RN Ph.D.'s, but I am guessing on a weighted basis, that is not a huge share.

DR. NAYLOR: Thank you.

MR. HACKBARTH: Other clarifying questions? Cori and t hen Warner.

MS. UCCELLO: Can you just remind me if the commercial insurer rates include MA, or are they just pre-65? What are those representing?

DR. STENSLAND: Yes. The commercial insurer rates for this task should be under 65, the employer rate.

MR. THOMAS: Hi. Just a couple of questions. First of all, you made the comparison of salaries for physicians and nurses being 70 and 54 percent higher. Did you look at the comparison of other items, other inputs, such as drugs or devices? How much differential is there in other countries versus the U.S.?

DR. STENSLAND: I didn't look at that directly. What we did is just look at the literature, and there is some literature that looks at the prices of hips and knees, and it looks from that stuff that it's about 50 percent more, at least here, at a minimum, but with a huge amount of variation, depending on what device you are getting, which hospital is doing the buying.

The drugs, the data we cite in the paper was the McKinsey estimate that they are 50 percent higher. The McKinsey data is very similar to a couple of other studies, one by some people at the London School of Economics and

another one by the Commerce Department, using different years, but they all go back to this IMS as their data source, and that also shows roughly 50 percent higher cost of drugs in this country per unit.

MR. THOMAS: Per unit.

The next question I have is around -- and it may actually kind of dovetail into Scott's question, to some extent. It is really around utilization rates. Is there any data that is out there around the utilization rates kind of globally, kind of per thousand people covered in international areas versus the United States?

DR. STENSLAND: Yes. I didn't put that in the paper, but they do have that rate, number of discharges per capita, length of stay per capita. There are some other things, like the number of stents per capita that some people do, but we don't have it for all the different DRGs.

MR. THOMAS: Okay. Then as far as the type of care, is there any data or was there any investigation into the type of care? We are talking about specifically hospital care, but was there any end-of-life care or things like that to see if there's material differences in specific areas or specialties or whatnot?

DR. STENSLAND: No. I was pretty much limited to the types of services, that there was data published by the others.

MR. THOMAS: All right. Thank you.

MR. HACKBARTH: So, Jeff, I think we have seen in Medicare and different provider sectors a pattern where not-for-profit organizations respond to higher prices differently than for-profits. For example, in a hospital, I think our analysis of a high pressure, low pressure, financial pressure, institution studies show that, that where a not-for-profit hospital is under low financial pressure because it is getting generous payments from private payers, that its costs go up correspondingly, which actually seem sort of logical. A not-for-profit institution exists to spend money on health care, and so they are going to spend it if they have more resources available. Whereas, my recollection is that the for-profits are more likely to keep the costs lower and converted into profit that then is passed, presumably, on to shareholders, to some degree. Am I accurately characterizing?

DR. STENSLAND: Yes.

MR. HACKBARTH: In the hospital sector, which is

the focus of this work, the hospital sector is predominantly not-for-profit, and so this dynamic of high private payments is converting into high costs.

What would happen if we just looked at the for-profit hospital sector and compared their cost to Europe? I don't know how hospitals are organized in Europe. Are they also predominantly not-for-profit? But if you don't have the resources, because it is constrained due to rate setting or negotiation, some other mechanism, then you don't have the opportunity to spend the money on higher costs.

I will stop there and let you react.

DR. STENSLAND: I think the for-profits are going to have a little bit lower cost structure in the United States, maybe 3 percentage points, so maybe 3 out of the 50 percentage points would be reduced if you're a for-profit hospital, presumably because you are using fewer inputs to produce your output due to some -- for good or bad, whatever it is, you are using less inputs.

MR. HACKBARTH: So the 3 percent is what we see in the hospital sector in our Medicare data, that the cost of 3 percent, on average, lower?

DR. STENSLAND: I don't think it is exactly 3

percent, but it's around that range, yes.

MR. HACKBARTH: Okay. Let's open up Round 2.

DR. REDBERG: I was just going to comment on the numbers, just because I happen to have a slide for a talk I am giving, which I actually took from Liz Rosenthal's "Paying Till It Hurts," but the prices she gave are even way more. The difference between a hip replacement in the U.S., she has $40,000, and Spain is $7,000; Lipitor, $124, New Zealand, $6; angiogram, $914 in the U.S., Canada, 35, so 50 percent perhaps. I don't know. It seems, if anything, under at least if you look at these.

DR. STENSLAND: Yes. There's some of those things where if I would have put in all the OECD countries, it would have looked more extreme, but I only limited us to the really high-income ones. So I didn't include places like Spain and Portugal, which are done to be lower costs.

That $40,000, what was for the hip, I think you said, that's probably the commercial insurer rate, which would fit into that big --

DR. REDBERG: Right.

MR. HACKBARTH: Okay. Round 2. We will have Herb kick off, and then we will see where we go from there. We

have got Jay and Craig's hand.

MR. KUHN: So, Jeff, thanks. This is a really interesting conversation.

What I am interested in a little bit is maybe some of the things that I've read in the past and went back when I read this paper and looked at it a little bit more is the concept or the idea, it might not be how much we are spending more on health care, but how we allocate the things that we spend.

For example, in some European countries, they spend a lot more on social services than we do, whether it's rent subsidies, family support, things like that. So when you look at health care and the allocation between health care and social services and you add those up, the United States is much further behind than a lot of those countries that are out there. In a way, it might be an allocation.

I know we talked about input prices, but I am curious of exploring the notion, or is there more information we could look at or to look at the social service spending? Because we tend to -- whether by default or by design, we are putting a lot of those social services on the backs of health care providers and in hospitals,

whether it is the readmission policies, different things that are out there right now.

And if we looked at it more totally, at health and social services combined, would we have a bit of a different picture here as we looked at this kind of spending? Obviously, we've got the input prices issues out there, but there is so much more going on in the health care sector than just the delivery of health care. We are asking a lot of these providers to do much more than that in the social service side.

Just a recent article in the last week in the New York Times about an ACO and their work with a homeless person and how much effort they went to try to find them housing as part of the effort, that is a large expense to the health care system, not a social service cost that's out there, so I'm just curious about that part of this dynamic as we look at this information.

MR. HACKBARTH: Jeff, do you want to respond to that at all?

DR. STENSLAND: We could look at it. It sounds like a gigantic task, though, to try to understand the social service structure of all these countries, and it

seems that the effect of those different social service structures would vary a lot, depending on what the service is.

I can maybe see the social service structure as somebody who has a hip replacement. Maybe you are helping them through the process or something, but the social service structures with regard to an MRI seems less important in a very different kind of a thing. We could consider looking at it, but it sounds like a really big project to me.

MR. KUHN: Yes, I think it is. I think there's some work that -- I went back and looked at some stuff by Elizabeth Bradley and Lauren Taylor that did some work a few years ago in this area that I would be happy to pass along to you, as well, but I think there might be some advance work out there that we could help tap into here.

MR. HACKBARTH: Okay. Anybody want to build on Herb's question? I have Dave and Mary.

DR. NERENZ: I am just curious. As a bite-size approach to this or a manageable approach, it might be just simply within the hospitals in some of these comparable countries, how many social workers are there? How many

discharge planning nurses are there? How many people are there who are paid by the hospital to do things that in other countries might be handled in the social service system? Rather than studying the whole social service system itself, stay focused on the hospital.

There is a little bit of a conflict here between that line of thinking, what Scott said about how we have the tight and the intense and the not-long length of stay, but that just creates the more mystery. What exactly are we doing from admission to discharge, and how comparable is it? That might be one way to at least get into this a little bit.

MR. HACKBARTH: Mary and then Rita.

DR. NAYLOR: I don't know if this takes bite size, and I think that is an extraordinarily important -- just the whole organization of health care and social care in these countries is vastly different than it is in the U.S.

But what this paper I think is helping to point to is the kind of investment we make in the U.S. in acute care, relative to what other countries are doing in primary care. And I think framing this in the beginning, with reminding us all about how we rank in health outcomes -- Commonwealth and

others have done this -- and whether or not there is an opportunity here to have this paper cast a light on investments and relative return investments on health outcomes. So I think the primary acute in addition to the social and where investments are made in community.

I think there are tremendous limitations in this apples-to-apples for those reasons, which are so fundamental, so about where people place -- societies place values. Even thinking about the nurse in those countries and the nurse in the U.S., they're vastly different. I mean vastly different in terms of numbers of college educated, how many are advanced practice nurses, but despite those limitations, using it as a proxy, I think is really going to help us draw.

But I will want to call your attention to the fact that the average salary of nurses in hospitals is quote high relative to what it is in communities in the U.S., and so as we are pointing out the opportunities here to say maybe different kinds of investments could yield better health outcomes overall, we might want to just draw attention to that, as well.

MR. HACKBARTH: Okay. So we are building on

Herb's comments about relationship between acute care and social services. Is there where you want to go?

UNIDENTIFIED: No.

MR. HACKBARTH: No. Okay. Then we will come back to you in a minute.

Anybody else want to build on Herb's point?

[No response.]

MR. HACKBARTH: Okay. We will open up a new line. I have Jay, Craig, and Rita and Bill and Warner and so on.

DR. CROSSON: I have two points, and I am not sure whether the right term here is "input costs" or "input prices." We seem to be using the two terms somewhat interchangeably. Thinking about this issue, this paper, which was really interesting, from the perspective of where it might take us in terms of policy, like later considerations, I have got two thoughts.

One is, first of all, thinking about input costs, it occurs to me that it is kind of like the Russian nested dolls. Everybody got that? I mean, if you look at the hospitals have high costs, one of the input costs into that is the wages that are paid to physicians and nurses, but physicians and nurses themselves have input costs. And I

think I heard Kathy getting to that a little bit and Mary getting to that.

So we could take the issue of the hospital cost as an issue we want to look at, we could take the issue of how much nurses and doctors make as an issue, or we could say, "Well, what are some of the elements contributing?" Mary said what about nurses bearing excessive malpractice costs compared to Europe.

I think in the paper, it talks a little bit about the fact that medical education costs more in the United States than it does in Europe. In many places in Europe, it's free. There is also the length of medical education and residency training in the United States and the opportunity costs foregone that one could think of as debt, which is an input cost, as well. So I am not saying that we need to do any of those, but I think in terms of thinking about where we want to attack the problem, it is useful to think about at least some of that nesting down to a certain level.

The second point is the suggestions we have here in the last slide or the one before that, I guess, in terms of how to attack the problem seem small compared with the

amount of money that we are talking about, and I just make this point which is a long-term actionable point. But I think my experience and Scott's and some others in the United States has been that when the payment system to the hospitals evolves away from the current payment system that we have now and we end up thinking about hospital cost as a cost, not a revenue, a cost center, not a revenue-generating center, then I think the financial dynamics that seem so problematical begin to be resolved in a very different way.

I think long term, it's one of the most important issues that we need to take on. I think we need to begin picking at it over time. We have already during the time I was on before and now, but ultimately, it is a long-term process, and it's one in which we have to think down the line about how we help -- and I am talking about the Medicare program here and MedPAC -- how we help American hospitals make that transition and not end up in the process destroying the very effective and efficient hospitals that we want to preserve.

MR. HACKBARTH: So who wants to build directly on something that Jay has said? Craig's a little wishy-washy. Alice seems more convinced, and Warner. So we'll do them

first.

DR. COOMBS: So I wanted to speak specifically about the wage and the input to the wage as truly an important piece of it, but I'd like to tie that to something else in terms of hospital management in that some of the regulatory and capacity issues within a hospital forces -- in terms of the total number of FTEs working within the framework of the hospital, to have an FTE that works a full-time shift, but there's a lot of overtime built into the RN salary. And so as a result of that, there may be 20 to 25 percent extra additional wage result from the overtime. I think that that piece of it cannot -- probably is going to be very difficult to tease out.

I know that -- I interface with a number of physicians internationally, and their work week is very different than my work week. I'm part-time. And so that I would be qualified as a full-time employee there. So you're looking at, you know, an average work week for most physicians in this country between 55, 65 hours a week for a full-time position. And primary care, hospital-based physicians -- hospital-based physicians tend to have a lower hourly requirement, but that hourly wage is such an

important piece of the wage differential between the United States and other countries.

And as far as the cost of what the wage maker -- I mean, you know, whether it's a nurse or a physician or a physician assistant, the cost of that education that goes into is just -- you can't compare it to one of the OECD nations. And I think that piece of it is such an important part of what happens to this generation. I don't think a CEO or human resources thinks at the end of the day, well, we made a lot of money last year, let's just pour it into the workforce. I don't think that's the way the generation happens. It may be that the hospital's occupancy rate goes does, and they say we have this part-time pool of employees that we call in when we have the time or we really need them, and we pay them double time.

So you might have one FTE nurse -- and I have very many colleagues that are nurses who work in the critical care alongside of me. Some of them actually make more than primary care doctors, okay? And it has to do with the fact that they're coming in on a night differential, which you get a differential and you get extra time and a half. So that piece of it in the United States, we work a lot harder

on an hourly wage so that it generates a different type of wage at the end of the year. So I think that's an important piece of how we go forward.

MR. THOMAS: Just building on Jay's comment, I do think it would be important to look at a comparison of the payment mechanism in the countries that are compared to the United States to see, you know, what type of payment mechanism they operate under versus, you know, what's happening in our country. I would agree, I mean, I think we're seeing -- as we move to more global types of payments, that we're seeing a flattening of cost, and certainly hospital cost is a piece of that as well. So it would be interesting to look at that comparison to see if there's -- how much, if any, differential is there and has there been any differential over time, you know, for those countries, you know, from a global payment perspective versus fee-for-service.

MR. HACKBARTH: Okay. Anybody else want to build directly on Jay's comment?

MS. BUTO: I'll build on Warner's comment [off microphone].

MR. HACKBARTH: Okay.

MS. BUTO: I wanted to just agree with Warner that I think, you know, to the extent we are going to rely heavily on these comparisons to make a point, I think it is very important to try to be as apples-to-apples as we can be, although I don't think it's really entirely possible. And knowing which of these countries are under -- put their hospitals in a global budget environment where they have a fixed budget or something very rigid like that is quite important. So an appendix to or an add-on to the paper that would explain these differences would, I think, shed some light on the underlying causes.

But having said that, I think we all would agree that the U.S. has the highest costs, probably, I'm sure, in the world in this area. So maybe the fundamentals are really -- this is suggestive or strongly suggestive, but maybe we don't want to tinker with it so much that we try to get really precise about the comparisons but, rather, go to the issue of how does the current cost structure for hospitals, how could that be strengthened or improved by changes in payment policy in Medicare in a way that doesn't destabilize the commercial environment. Because I think what you're saying in the paper is the commercial

environment's already probably at some risk of picking up the slack. If they're paying higher rates, there may be some cost shifting that's already heavily going on. I don't know. But that would certainly suggest that. So anything that Medicare does may exacerbate that, make it worse, not improve the commercial side.

MR. HACKBARTH: I have Mark who wants to jump in here for a second, and then we're going to open up a new line, and Craig will be next.

DR. MILLER: Okay. So I want to pick up on the first half of Kathy's comments, and I think, you know, this is your guys' call, but you could look at this paper and say we could spend a lot more time kind of getting down the widgets and making the comparisons.

Now, I certainly think there's a ton of caveats that should be built into the paper based on the comments here. You know, nurse wages and hospitals are higher; social costs are handled differently inside a hospital, that type of thing. That could be one route, but I almost would look at this paper as more suggestive and, you know, clean it up, caveat it, as opposed to chase down, you know, remeasuring and getting all the units right.

For me, what I think -- and you were saying some of this in the early part of your comment. Should we be focusing on what is driving the input costs in the hospital sector? So we had some conversations last time about drugs and devices, for example, and, you know, I hear complaints frequently from the hospital sector of like, you know, I can't do much about this. So I think there's that.

I think Jeff has put on the table what about administrative costs, and at least two things that the Commission has been on about is: Is there a way to streamline the quality reporting requirements? And, two we've recently raised the RAC stuff, which would be places for you guys to focus. And then also the site-neutral, and then eventually we're going to have to get to the update.

And I think for those of you particularly if you're close to the hospital sector, some insight into what could, beyond the administrative stuff on the input side, be a place for us to pay attention to for policy purposes might be of some comments that I would like to get.

Now, if you really do want to clean up the paper and spend a lot of time, Jeff has nights and weekends, and I'll make him do it, be clear about this. But I think that

we could spend a lot of time churning through this, and I think Jeff's intent was this is more illustrative to kind of provoke some thinking along those lines. And I feel like some of that was in your comment, and I wanted to tease it out.

The very last thing I want to say is I don't think the paper is -- and this is with all respect -- making the cost-shifting argument. It's making the opposite argument. It's saying that the prices are being driven up on the private side because of consolidation rather than the notion that the private side is picking up Medicare's slack. And we can have that deeper conversation on that offline on why we think that's the case, but I wouldn't have reached that conclusion.

MR. HACKBARTH: And we will come back to that, no doubt, in December when we talk about the hospital update. But, you know, we've seen evidence over the years that, in fact, the cost shift is the reverse, that it's the institutions that have very generous levels of private payment, they use that to increase their costs, and then they say, oh, Medicare doesn't pay us enough money. Whereas we see institutions that are under financial pressure across

the board have lower costs and equivalent quality. So I think the evidence we see is that the cost shift is sort of the reverse to the conventional wisdom.

MS. BUTO: [off microphone].

MR. HACKBARTH: Yeah. So Craig is next.

DR. SAMITT: Actually, I think I'm going to jump where Mark left off, because I'm not sure that a discussion about labor, in particular input prices, is really a fruitful direction here. And it stemmed from -- and let me see if I can follow my train of thought here as to why I think that's the case. It stems from this hypothesis that -- or I believe the paper implies that a harmonization of the commercial payment rates with Medicare rates would result in a reduction of labor or input costs. And I'm not so sure that is true, actually.

First, I would ask is there any evidence of that. In markets where there are more comparable rates between the commercial markets and Medicare, do we find that labor costs are different in those hospitals? I would wager to say that we may not see that.

The second thing that I would say is there may already be some pressure to harmonize the rates between the

commercial and the Medicare side. You know, the hospital leaders can comment on this more, but I think there's a prevailing sentiment in the hospital market that hospitals may very well need to manage at Medicare rates for all of their line of business. So I think that there is a feeling, despite consolidation, that there's going to be downward pressure on reimbursement, even on the commercial side. And I think there will be things that exacerbate that, whether it's exchanges or reference prices, that will continue to create suppression there.

But the point is that if hospitals face downward revenue pressure both from Medicare and commercial, where will they find their savings, I would wage it's not going to be in labor costs. I would imagine that hospitals will, A, seek alternative payment models so that it's not just fee-for-service reimbursement. They'll more aggressively pursue ACO or Medicare Advantage. Or they'll look at utilization under that framework as another way, a more effective way probably, of reducing costs. Or they'll look at other efficiencies other than labor. And, again, the hospital leaders can comment. But I think whether it's administrative complexity or I would imagine information

technology costs are also a significant burden on hospitals, or even holding costs associated with capital investments for facilities. I know they're a smaller percentage in the paper, but my guess is that if hospitals were truly put under pressure, they would not reduce salaries for nurses, that they would find a way to manage through other means.

MR. HACKBARTH: Okay. Who wants to pick up on what Craig has said here? And, you know, I've got Rita and some other people on the list for other comments. God bless you if we get to your comments. So I have Kate and Jon and Scott and -- right. We'll stop there for right now.

DR. BAICKER: So this is a point that I was hoping to draw on initially, which is that I feel very nervous about thinking about policies to affect the wages paid to the people who are working in hospitals or other settings in the sense that I think that's the outcome of a complicated set of markets from hospitals negotiating with employees, insurers, be it Medicare, dictating prices or private insurers negotiating with hospitals. Those markets are not working well in many instances, so it's not to say that there isn't anything going wrong there, but trying to improve our payment policy by affecting those downstream

things that will then percolate up seems like exactly the same thing that makes me nervous about undue reliance on margins and costs as dictating what Medicare should be paying in the first place. If we can improve our payment policy, I think that that will then filter down and create pressure, and I don't know -- I'm sure you have more insight on the ground than I do -- whether that will result in different wage structures, different input structures, different capital investments. I don't know and I don't think that I can know. What I think is that if payment policies were aligned, those things would work better than they're working now, although other things on the consolidation side should surely also change as well.

So policies like reducing administrative burdens, harmonizing quality reporting that's both going to improve outcomes and reduce paperwork, thinking about other system-level things that are making life less efficient, those are all good because they're good in and of themselves, and if they have this consequence, that's great. And I would much rather take the approach of making our payments more sensible. I think when we pay too much for stuff, that filters through into lots of other people downstream getting

paid too much for stuff. And us fixing that and letting it then exert the downward pressure is much better than us saying, well, we're going to set this based on what's going on down here. I hope the transcriptionist is getting this.

[Laughter.]

DR. BAICKER: And then we're going to try to meddle with what's going on down here and hope that it filters back up to us and then filters back down.

DR. CHRISTIANSON: Pretty much the same point. Hospitals just can't go out and say, "I'm going to pay less to people." There are labor markets out there, the supply of labor that's determined by all sorts of different things, and the intersection of what hospitals want to pay and what labor is able to extract in the labor market determine how much the unit price of labor is. And I totally agree with everything you said, Craig, in terms of where -- and I think very reasonably, where hospitals will look first to try to drive down costs.

MR. ARMSTRONG: Yeah, I would acknowledge, after the last couple of comments, my question was raised. But just one more related point, and that would just be the logic of the analysis, and that is that overall we spend 17

percent of our gross domestic product on health care services, which is exorbitant relative to comparative countries. But I have to say I read this, and it seems to me a conclusion I might draw is that Medicare is actually doing pretty well, and that where we really have problems in the context of the overall health care system and its consumption of the GDP, it's really on the commercial side or it's outside of Medicare.

And so I know we've tried to affirm that Medicare itself pays 50 percent more than these other countries, but it just -- I don't know if it's possible, but it would be interesting to know how does Medicare perform relative to services provided to 65 and older people in these other comparative countries, because I'm uncomfortable -- and this is where Craig was going, too. The big issue to me here, beyond just core Medicare costs, is the dynamic between Medicare payment policy and commercial payment policy. And I just don't know how much we can -- how much responsibility we can take for really trying to drive some of those questions.

MR. HACKBARTH: We have about 15 minutes left, and I want to open up some new threads here. I have Rita and

Bill Gradison, Warner and Jack, and my guess is that's going to take us to the end.

DR. REDBERG: Now that I have waited, I have more points, but I will try to be very brief.

My first point, I thought you did an excellent chapter, and I think I agree with someone. It wouldn't be worth spending your nights and weekends, although I know you are keen to do that, on manipulating the social work, because I think it is not going to change the overall conclusion that we pay a lot more for health care in this country. And I like the way you kind of compared it in terms of average salaries. I think that helped put it in perspective.

Like anything, overall what we spend is not just a consequence of price, but it is a consequence of volume, and we have to remember that we also do a lot more. We are spending 17 percent in GDP because we are paying more for everything, and we are doing tons more of it, and a lot of that is capital equipment-heavy. So once you, for example, built your proton beam center, you probably are going to use your proton beam center, and we have more proton beam in the U.S. more than anywhere else, more CT, more MRI, and that

medicine is also one of those funny things where supply can drive demand. We are one of the only two countries in the world that allows direct-to-consumer advertising, and in every city you go in, you see hospitals advertising, you see drug companies advertising, you see device companies advertising. And all of this is intended to drive demand.

As I think Kathy said, we don't have a central control. We don't have a set budget for health care, for Medicare or commercial insurance, and so we kind of have this continuous expansion, and we have continued to increase spending way more than the consumer price index for the last 20, 30 years. That is where we have gotten, but there are a lot of parts that go into it, and you did highlight the administrative complexity is not so much salary, but we just have so many more personnel because we have this incredibly complex health care system. And I think Medicare is doing well, because we have kind of a single payer and a lot less paperwork, but on the commercial private side, there are lots of different exchanges. And so practices have lots of people that have to deal with lots of different insurance companies, lots of different forums. None of that is found in -- though they are not high paid, but there is just so

many of them, and I don't think that's a great -- where spending a great value in terms of how patients are doing.

Quite honestly, I have very good private insurance. I still have to spend a lot of time with forms that I really resent, having to pay so much on premiums and then having to spend a lot of my time filling out silly forms, and if my daughter, heaven forbid, gets sick when she's not in California, then I have to fill out more forms explaining why she had -- anyway, so I think we have a very complex system.

In terms of the market, also, I think we have a -- we don't have a really operative market in a lot of parts of health care. There is not competition. Like you talk with drug prices -- and Solvadi has gotten a lot of attention and deservedly so, because it is incredibly expensive and the market is potentially huge. That was approved on an accelerated review process, and so they got to market quickly and are now, it seems to me, priced much higher in the U.S. than anywhere else in the world. There is nothing to prevent the drug company from pricing as high. They have no competition right now, because it's the only drug of that type on the market, because of partly the accelerated view

and the lack of other.

And so we have a situation where -- and then we have a third-party insurance system, and so a recent article I read where the executive from one of the pharmaceutical companies was defending the high drug pricing, he was blaming the insurance companies and said it's because they are higher copays. So it wasn't -- and that's the whole point, because patients are not really feeling the high prices, because we have this very funny third-party system, where you pay a set amount and then the insurance company pays the rest. And so the consequence is insurance premiums go up very rapidly because expenses keep growing and growing.

And now because of the newer plans with higher copayments or percentage of copayments, people are starting to realize that we have an incredibly expensive health care system. Again, I think Medicare is doing better than the commercial plans, but when you start looking at it, I think there are a lot of things that we need to address overall, and some of them, we can address in Medicare, and some are outside. But all of the inputs to the system and then the whole kind of valuation of what are we paying for, is that

really what we want?

And the last thing I'll just say is for everything we are spending on health care and all of these inputs, I don't think we are doing as well as some of European countries in terms of things that patients really would want, like more home care, more social services, more home visits. I think all of those are much -- covered better in other countries than we are doing currently.

MR. GRADISON: This is a minor point, but I want to share it with you. It has to do with, perhaps, a positive aspect of these significant differences, and the pay for nurses is an example. The U.S. is kind of the go-to place for some very capable people from around the world who come over here and practice medicine and do other parts of health care. I am not suggesting it is all the higher wages. I know better, but it's a factor, on doubt.

I have seen at least two examples, and I am not the expert on this that some of my hospital colleagues are, so I will just tell you what they are that may be relevant. I was doing some work for the Government of Puerto Rico a few years ago, and I was really struck by the challenges their hospitals face. They are American citizens, and

therefore, there is no immigration issue involved if they want to change jobs.

At one point, I put together a file folder with ads that happened to come from hospitals in Louisiana that were seeking to recruit nurses from Puerto Rico, and that is within. Then it sets the context of the United States.

And the other point -- and here, this is purely anecdotal, and I may be wrong about the facts, but my sense is that we have been doing a lot of hospital recruitment of nurses from the Philippines, as well. In a way, that's a good thing because there are times where there are shortages of nurses, and there are times that we have sort of a cycle going on there, and it does provide a safety valve for the benefit of patients and presumably improving quality.

So I just want to find one little nugget in the sense of a positive comment as related to these significant differences in real costs.

MR. THOMAS: Just a couple of comments, really actually responding to Mark's comments about suggestions going forward.

I think on the administrative expense area, I think certainly -- I know in our organization, we track more

than 200 different quality metrics across our organization for Medicare and commercial insurers, and it is virtually impossible to keep up with it. It takes a tremendous amount of time and resource to do that.

I think if there can be recommendations around having directionally kind of consistent metrics and also making the same recommendation that the commercial insurers follow that, I think that can be helpful for the system overall.

The other two pieces -- and they are issues, I know have been dealt with -- is the additional administrative expense around the RAC auditors and the additional administrative expense around regulations or rulings such as the one-day stays have added significant expense from an administrative perspective in the hospitals.

Frankly, I don't think hospitals generate profits in the side I am going to reinvest and just hire more people. I think part of this comes to making sure you can be adhering to the certain regulations that are there.

So I think there are specific recommendations that could come from this Commission to Congress around administrative changes that could generate savings in the

system.

The second piece would be around drugs and devices. It is interesting that we really have fixed payments around certain procedures, really across all hospitals in the country, but yet the pricing that those hospitals pay for implants or drugs are very different. I am sure if you really did a study -- I haven't, but we have looked at hospitals that have joined us and whatnot, very different pricing on drugs or devices across very similar hospitals, because it is based upon the market of what can be negotiated or paid.

I think there could be reference pricing there that would create and set a baseline. Once again, it would create savings, I believe, in the Medicare program, but it would also set a baseline for how commercial insurers may look at how they price some of those drugs and devices.

The third and probably, I believe, the most important, going back to Jay's comment, is around changing the payment model. If we really want to see innovation and we want to see reductions in costs and utilization, we have to change the payment model because it creates, frankly, the incentive and the pressure on the system to be innovative

and to look at safe and high-quality ways to reduce utilization and take waste out of the system.

I am sure you could look at many of the ACOs, and you will see lots and lots of examples of great innovative projects that have been done to reduce utilization, and I do think changing that payment model will drive more innovation in the delivery system, not just in hospitals. It will have an impact on hospital cost, but it will have an impact on the total cost of the system.

So just responding to Mark's comment, those are some specifics that I think could be looked at and investigated by the Commission.

DR. HALL: Just two comments, one on this administrative cost issue. Because we are sort of framing this from the international comparison side, it made me think about whether some of the issues that you put on the slide about the potential ways to reduce administrative cost, have international comparison points that would be of interest.

Something like the RAC is probably pretty unique to the way we do things, but site-neutral or quality reporting, I wonder if there is anything to be learned from

what other countries are doing in terms of approaches to quality reporting or, for example, whether they have some of those same issues of hospital ownership of physician practices and if indeed that bleeds into the same kind of site-neutral differences. So maybe there is nothing there, but it just seemed like something that seemed like a natural outgrowth of what we are looking at here.

The other point -- we have looked a little bit through this at the data from the commercial side. It made me think about the rate-setting states in the U.S., and you may have looked at this at some point in the past. We only have a couple of them left at this point, but whether in a rate-setting environment, how much that differential shifts and whether there's any lessons to be taken from that.

MR. HACKBARTH: Rita?

DR. REDBERG: I'll be quick. Thanks.

Just Warner's comment reminded me that the other absence of a market that we have in the U.S. is the lack of price transparency. We don't know what drugs and devices cost. You can't even call different hospitals and find out what a common procedure would cost.

There is some move, I think, now in California,

also in Massachusetts, for price transparency just starting, but that would be an important -- and Medicare, again, I think does better than the commercial plans on price transparency. But to have a real market, you have to know what prices are and be able to negotiate.

MR. HACKBARTH: Like Rita, I don't look at this as a place where we ought to spend a lot of time trying to refine our comparisons. I don't think that's where the bang is.

The thing that struck me or that I focus on here is the high prices paid by private payers. You don't need the international comparisons on that. There is ample documentation of that.

In addition to the high average level, there is enormous variability across markets and within markets, as well, and I think that's been pretty well documented by a number of people.

I connect that set of facts to some policy discussions, including the recent discussions about the networks of private plans. It has been, as you know, a hot topic in the Affordable Care Act where a lot of the plans have offered limited networks. Predictably, that has

resulted in some pushback and some people saying, well, the networks are somehow too narrow, and they need to be expanded to include essential providers. All sorts of different language is used.

And then within Medicare, there's also been some debate about network adequacy and how much you have to include. If we think our private prices are too high and too variable and we want to hamstring the ability of private plans to limit their networks, those two don't go together to me. If there is to be any hope of rationalizing payment on the private side, private plans need to have the flexibility to move their business away from providers that they think about too costly, and so sometimes we are at war with ourselves and our policies.

I want to be clear that I think issues about changing networks after the enrollment period, sort of the bait-and-switch concern that people enroll thinking the network is one thing and then it becomes dramatically different after they have enrolled, and they can't change for a year, I think that is a different issue in that they are sometimes glommed together, so that's my speech on the network issue.

Thank you, Jeff. Appreciate your work on this.

I will now move on to sharing risk in Medicare Part D.

[Pause.]

DR. SCHMIDT: This morning I will introduce the topic of how Medicare shares risk with private plans in Part D. Shinobu Suzuki contributed to this work as well, and she's here to answer your really tough questions.

You may recall that when Part D was first being set up, there was concern that no private entities would want to offer stand-alone drug plans. The designers of Part D included provisions for Medicare to share risk with private plans in order to help create a market for stand-alone drug plans. Today the main question for discussion is whether Part D's original structure for sharing risk is still set up in a way that addresses current goals for the program.

In this session, I'll review Part D's approach to providing an outpatient drug benefit, how Medicare shares risk with the private plans that deliver Part D benefits, and experience so far under those risk-sharing arrangements. I will also discuss issues related to Part D's low-income

subsidy as they relate to risk sharing. I'll end by describing some potential approaches for change, and then I'll open it up for discussion.

In Part D, Medicare pays private plans to deliver outpatient prescription drug benefits. Those plans compete for enrollees mostly on the basis of their premiums, but also on other features such as the plans' formularies (that is, the list of drugs the plan covers), their cost-sharing amounts, their networks of pharmacies, and quality of services. There are two types of Part D plans: drug-only plans that beneficiaries in fee-for-service Medicare can join, and Medicare Advantage plans that combine drug and medical benefits.

Medicare pays for about 75 percent of covered basic Part D benefits through different types of subsidies, and the enrollee pays about 25 percent through premiums. One piece of Medicare's subsidy is a capitated, fixed-dollar amount that it pays to plan sponsors each month based on the national average of the bids that sponsors submit to CMS. Part D premiums vary from one plan to another. Each plan's premium depends on whether the plan sponsor bid higher or

lower than the national average bid. Medicare also has other pieces of its subsidy that offset some of the insurance risk that plans face.

Part D was set up this way so that sponsors would have incentives to strike a balance with drug benefits. Sponsors need to offer an attractive benefit package, but they also have to manage their enrollees' benefit spending in order to keep their premiums competitive.

For beneficiaries with incomes below 150 percent of poverty, Part D also provides extra help with premiums and cost sharing. This is called the low-income subsidy.

The largest amount that Medicare will pay for a plan premium is set by averaging the premiums for basic benefits in each region of the country. Medicare will not pay more than that regional threshold for the premium of a beneficiary with the low-income subsidy. LIS enrollees can choose their own plans, but if they do not, CMS assigns those beneficiaries randomly among the plans that have premiums at or below the regional threshold.

Medicare also provides extra help with cost-sharing amounts for low-income subsidy enrollees. For enrollees who do not get this extra help, plan sponsors get

to set the cost-sharing amounts, and sponsors do this in a way to encourage enrollees to use generic medicines and preferred brand-name drugs on which the sponsor has negotiated rebates with drug manufacturers. The situation is different for low-income subsidy enrollees because plans cannot set cost sharing. LIS co-pays are set in law. For example, in 2015, LIS enrollees will pay $2.65 for generics and preferred multisource drugs and $6.60 for other brand-name drugs. And LIS enrollees also have no coverage gap.

Just to remind you, in 2012 the Commission recommended that the Congress give the Secretary authority to modify the LIS co-payment structure to encourage greater use of lower-cost generic drugs when they're available.

This slide lists the ways in which Medicare shares risk with private plans. First, Medicare pays a fixed-dollar amount to plans each month, and the plan sponsor is on the hook to pay for all the covered prescriptions that their enrollees fill. Second, Medicare risk-adjusts those capitated payments by factors that take enrollees' health and expected spending into account. Now, you're already familiar with these first two concepts because they're used in payment systems for the Medicare Advantage program and in

prospective payments to hospitals, so for the rest of the presentation I'll focus on the second two -- individual reinsurance and risk corridors.

As Part D starts into its 10th benefit year, the objectives for sharing risk may have changed. Today there is less concern about forming a market for stand-alone drug plans and rivalry around plan sponsors. There may more concern about how to better manage prescription benefits for enrollees who have high drug spending. So it may be time to consider whether these mechanisms are still structured in a way that makes sense for today's priorities.

Let's look first in more detail at individual reinsurance.

This slide shows the structure of Part D's standard benefit. Working from the bottom up, you can see there is a deductible, an initial coverage limit, partial coverage in what has been called the coverage gap, and an out-of-pocket threshold. Notice at the top of the slide in white that Medicare pays 80 percent of benefit spending above the out-of-pocket threshold, while the plan pays 15 percent and the enrollee pays 5 percent. That cap is currently at about $7,000 in total covered drug spending.

So Medicare pays 80 percent of covered benefits above that amount. It's taking a lot of the risk for the highest spending enrollees.

In 2012, about 2 million Part D enrollees had spending high enough to reach the point where Medicare pays for individual reinsurance. More than 70 percent of those two million individuals receive Part D's low-income subsidy, and that's disproportionately high: only about a third of Part D's enrollees overall receive the low-income subsidy.

So you can probably guess which piece of Part D's payments has grown the fastest. The red section of this chart shows Medicare program spending on individual reinsurance. It has grown from $8 billion in 2007 (or about 19 percent of program spending) to nearly $20 billion in 2013 (or 31 percent of program spending). That's cumulative growth of 143 percent.

This will come up again at the end of the presentation, but one potential way of changing Part D's risk structure would be to change how individual reinsurance works. For example, Medicare might pay for less than 80 percent of benefits above the out-of-pocket threshold and plan sponsors might pay for more than 15 percent. The goal

of that would be to give plan sponsors greater incentive to manage benefits for high spending enrollees.

Before I leave this slide, let me also bring your attention to the yellow section of the chart, spending on the low-income subsidy, and this is just to point out that it's the single largest component of Part D program spending.

Part D also uses symmetric risk corridors that were designed to share losses and gains that are larger than expected. This slide shows the current structure of the corridors. Several months after a benefit year is over, CMS reconciles its prospective payments to plans with what actually happened -- final enrollment numbers, risk scores, reinsurance payments, and so on. At the end of that process, CMS compares the plan's average cost for actual benefits paid with what the sponsor bid. The sponsor has to pay for all benefit spending that is up to 5 percent higher than what they bid. They also get to keep any profits that are up to 5 percent lower than their bid. If the plan paid out even more in claims, Medicare shares those losses or gains with the plan sponsor. If it's even more than -- between 5 percent and 10 percent more or less than the bid,

they split things 50/50. And if costs are even more than 10 percent different from bids on the upside or the downside, then Medicare pays for 80 percent for larger losses or gets 80 percent of the gains.

So another avenue for potentially changing Part D's risk sharing is to adjust the structure of these corridors. For example, the risk corridors could be wider -- plans could bear more risk than they do now -- or you could ask whether the corridors are even necessary at all today.

Why do we have risk corridors? The initial objective was to encourage private entities to create a market that didn't exist before 2006 for stand-alone drug plans. Beneficiaries can often predict the drugs that they'll need to use, and at first plan sponsors were afraid they would attract too many high-spending enrollees and not enough healthier ones. There also wasn't very good information on which plan sponsors could base their bids. Today there's broad choice among plans. There's on the order of 30 stand-alone drug plans available in every Part D region, and in addition, there are often 15 to 30 Medicare Advantage plans with drug coverage available depending on

the part of the country.

So what has been the experience with risk corridors? Generally, plan sponsors have bid too high compared to their actual benefit spending. In every year since Part D began, plan sponsors have, in the aggregate, paid back money to Medicare -- meaning their average spending was lower than what they bid. In each year, about three-quarters of sponsors had to make risk corridor payments to Medicare. The aggregate amount they paid has been on the order of $900 million to $1 billion each year for benefit years 2010 through 2012. So if the corridors were eliminated and plan sponsors continued to bid too high, they would keep those payments instead of giving them back to Medicare. The flip side is that if you had tighter corridors, Medicare could take back more of the unanticipated profits. If you did that, though, plan sponsors would face less insurance risk.

If sponsors have bid too high, that also means that enrollee premiums were too high as well. However, enrollees haven't gotten a portion of their premiums back.

I need to tell you a few things about the low-income subsidy population because this has implications for

any changes to Part D's risk sharing. The most important point to note is that LIS enrollees are not distributed evenly across Part D plans. Among all Part D enrollees, about one-third get the low-income subsidy. But most of those individuals are in stand-alone drug plans: 75 percent are in PDPs and 25 percent in Medicare Advantage drug plans.

Even just among PDPs, LIS enrollees are not distributed evenly. If you look at the 20 stand-alone drug plans that had the most enrollment in 2012, eight of those only had 25 percent or fewer of their enrollees with the low-income subsidy and nine plans had 75 percent or more with the low-income subsidy. So they tend either have a small share or a large share of LIS enrollees. Few plans are in the middle.

This situation comes from a combination of factors. I told you earlier how CMS assigns LIS enrollees to low-premium plans with basic benefits. So that assignment process is one of the reasons for the distribution. Another factor may involve strategies of plan sponsors. Remember that low-income subsidy enrollees tend to have higher drug spending, and plan sponsors cannot use differential co-payments to encourage those beneficiaries to

use lower-cost drugs to the same extent as others. Some plan sponsors may decide that even with risk sharing, it's less desirable to enroll beneficiaries with the low-income subsidy.

This point about an uneven distribution is important because if risk-sharing arrangements change -- for example, if Medicare started paying less than 80 percent in individual reinsurance -- it could disproportionately affect plans that have high shares of their enrollees with the low-income subsidy.

Here's some information that shows the challenge that plans face in managing Part D benefits for LIS enrollees. First, on average they have higher disease burden, which you can see from the big difference in the average risk scores on this slide. Relatedly, they tend to use more prescriptions drugs: 5.2 prescriptions per month compared to 3.8 for non-LIS enrollees. We need to be concerned about safety because the more medicines a beneficiary takes, the greater the risk of drug-drug interactions and other risks associated with polypharmacy.

LIS enrollees tend to use fewer generics. Of course, generic substitution isn't always clinically

appropriate. Some of the difference you see here in generic dispensing rates reflects their poorer average health status. Still, a 5 percentage point difference in GDRs can have large financial implications, especially when you consider that that's an average across all the therapeutic classes of drugs.

You can see that low-income subsidy enrollees are much more likely to reach Part D's out-of-pocket threshold, the point at which Medicare starts paying for individual reinsurance.

When you add up the pieces of Part D spending for LIS enrollees -- he individual reinsurance paid on their behalf, extra help with premiums and cost sharing, and their share of Medicare's capitated payments -- it comes to about two-thirds of all program spending for private plans. So for all of these reasons, managing benefits for the low-income subsidy enrollees is a challenge and a concern.

Let me mention one way that some plan sponsors have been trying to manage their risk -- essentially by segmenting the market. Remember that CMS only assigns LIS enrollees into low-premium plans that have basic benefits. In addition to basic benefits, sponsors can also offer plans

with enhanced benefits -- that is, an average benefit value that is higher in an actuarial sense than the basic plan. But Medicare doesn't pay more for beneficiaries that pick enhanced plans. The enrollees in those plans have to pay all the difference for the extra coverage.

Some plan sponsors have been offering minimally enhanced plans -- enhanced plans that have an average benefit value just a bit higher than basic benefits. For example, the only difference might be that those plans have no deductible or they include more generous coverage of drugs on their formularies. Plan sponsors can offer minimally enhanced plans at very low premiums, and some have been available for premiums even lower than the basic plans offered by the same sponsor in the same part of the country.

Since beneficiaries with the low-income subsidy cannot be assigned to enhanced plans, only basic plans, they don't tend to be enrolled in these plans. Plan sponsors have figured out a way to offer a no-frills benefit at very low premiums and not have to take many enrollees with the low-income subsidy.

To wrap up, this slide provides a starting point for discussion about possible ways to change risk sharing in

Part D. One category of policy approaches centers around the risk-sharing mechanisms themselves. It's important because bearing risk is what provides strong incentives to try to manage spending. Keep in mind that you might not want to make changes to just this category without also making changes in the second category at the same time. One approach might be to widen or even remove the risk corridors, but remember that plan sponsors have been paying money back to Medicare every year. Another approach is to make changes to individual reinsurance -- for example, asking sponsors to pay more than 15 percent for benefits above the out-of-pocket threshold. But it's important to also consider how that would affect plans with large shares of LIS enrollees.

The second category of potential changes reflects the goal that low-income enrollees need good access to appropriate medications, but in a way that is financially sustainable. Consistent with that goal might be to give plan sponsors greater tools to manage LIS benefits. For example, the Commission's 2012 recommendation was for the Congress to give the Secretary authority to make certain changes to LIS cost sharing. Medicare could also consider

different ways of assigning LIS enrollees to plans. Perhaps regional thresholds could be set by looking at the combination of plan premiums and average low-income subsidy cost sharing. Or Medicare could perhaps assign LIS enrollees to any plan -- basic or enhanced -- with a premium below the regional threshold.

Finally, I want to emphasize that Medicare will probably need to combine policy approaches to balance their policy goals. If plans bear more insurance risk, keep in mind that relatively few plans have high concentrations of LIS enrollees, and that could worsen incentives to enroll those individuals.

And now let's take your questions.

MR. HACKBARTH: Okay. Thank you, Rachel and Shinobu.

So remind me -- I know I should know this, but remind me why the decision was made to do both the individual reinsurance and the risk corridor. The risk corridor provides the aggregate protection, and, you know, I might say that if they have aggregate protection, that ought to be sufficient to get them into the market. The individual level protection seems potentially duplicative.

I'm sure there was a reason for that -- in fact, I think, Scott, if you buy reinsurance, there's also individual and aggregate level. I just can't remember what the rationale is for that.

DR. SCHMIDT: I think, again, it just boils down to needing training wheels until there was a market established for this kind of product that hadn't existed before. Remember there were lines along the lines of, "Why do you need insurance for hair cuts?" Prescription drug spending is so predictable. The individual reinsurance is at the individual level. It's kind of something in addition to risk adjustment. And then it was just an added layer of protection.

MR. HACKBARTH: If you just have one individual case qualifying for the individual reinsurance, it's trivial in terms of its impact on getting plans into the market. I think they're worried more about the aggregate experience.

DR. BAICKER: So just a thought on that and then a related clarifying question. I agree that this -- you know, in Round 2 we can talk about how this is maybe not so needed, but I think there's an added component to the individual side of cream skimming if you think that you

haven't got the risk adjustment right. So the aggregate one protects you from, whoa, crazy new market, and the individual level undermines any remaining need to not enroll high-cost people with the risk adjustment. So maybe they serve slightly different purposes, although a whole separate thing.

But a clarifying question following up on that is: My understanding is that with the rebates in the donut hole, it has this potentially underappreciated consequence that that actually still counts towards out-of-pocket costs and pushes people into that over the cap more quickly than if you looked at their actual out-of-pocket costs. But I'm not clear on how that provision plays out in the aggregate risk corridor component. So how does all of that -- how do those all interact?

DR. SCHMIDT: Well, I will take your last part first, and then Shinobu can comment on the other part.

I think in calculating the aggregate risk corridor part, they are supposed to take out the rebates in that process.

Now, I think they do probably get to keep the rebates for what is happening in the donut hole, as well,

but those portions are coming out as a kind of remuneration that is taken out when they calculate the final profitability or loses in the plan.

MS. SUZUKI: And I think on the effect in discounts on the number of people reaching the catastrophic phase of the benefit, I think we have done some analysis in the past that shows that it did seem like there was a jump in the number of people who reached the catastrophic phase.

It was not clear whether that was due to more people using brand-name drugs. We did not see a change, dramatic change in generic use rate for those people, but maybe more people just using drugs.

MR. HACKBARTH: Okay. Let me see hands on clarifying round on questions. I have Jack and Bill. We will go down this row. Jack.

DR. HALL: On the last slide, on the option for considering premiums and average low-income cost sharing when setting thresholds, can you just say a little more about how you envision that working?

DR. SCHMIDT: Well, now in the process of submitting bids each year, plan sponsors are submitting assumptions about how many of their enrollees will receive

the low-income subsidy. And they have historical data on what the cost-sharing payments for at least past enrollees have been.

So, as part of the bid process, it might involve looking at those averages, a weighted average by region or something along those lines, along with the average premium for basic benefits, to take both pieces into consideration, so that there is greater incentive to worry about the overall management of that portion of the benefit, as well.

MR. GRADISON: What proportion of LIS eligibles are randomly reassigned, roughly? I mean, I am just trying to get a sense whether that is a big problem or not a big problem. The higher the percentage, the bigger the problem, I gather.

MS. SUZUKI: So there are about 10 million, a little over 10 million LIS enrollees. Not all of them are eligible for assignment, because you have to be a full dual.

We have seen reassignments ranging from a couple hundred thousand to a little over a million in any given year, but once a beneficiary chooses a plan on his or her own, that person is considered not eligible for reassignment, even if the plan premium is above regional

benchmark.

DR. SCHMIDT: So, in other words, those individuals that are called "choosers," they have selected a plan. Some of them are paying a premium, even though they are low income, but CMS doesn't touch them anymore.

MS. UCCELLO: I think you said that about in any given year, about three-quarters of plans are paying risk corridor payments in. So I guess the answer to this question will be yes. So there is a lot of persistence in plans over time. Is this one-quarter that's not paying in, are they consistently not paying in, or is there movement between them?

DR. SCHMIDT: I think that is something that we will have to go back and get a better answers. We have looked into it year to year, but we haven't tracked the same specific plans over time. But we could do that.

DR. NERENZ: Slide 11, please.

On the generic dispensing rate, you are drawing our attention to the difference between 78 and 83, and then in the materials, you have more figures for different years. It struck me that both of these are high relative to other comparators. How should we interpret that? I don't know

that off the top of my head. I just came across something where somebody was claiming record-high achievement for generic dispensing at 70 percent out in the commercial arena. I don't know those numbers like back of my hand.

But the one point here is that one is lower than the other, but then is it also true that they are both relatively high, or are they not high?

DR. SCHMIDT: I have also seen some data that suggest that these are a bit higher than what some commercial PBMs have achieved, yes. But I don't think that argues that we're necessarily efficient in all aspects of Part D delivery. I still think that this is suggestive that there might be room for greater efficiencies or greater use of generics, but that is for you to consider.

MS. SUZUKI: And the one thing I will add is these comparisons don't necessarily control for the mix of drugs, and one thing that would be interesting to see is for the same class of drugs, is Medicare doing better or worse than commercial.

DR. NERENZ: And that was it. I understand the difference here between the two groups of enrollees. I was just trying to -- the next layer of interpretation, how do

we think about it? Thank you.

MR. HACKBARTH: Round 1. Clarifying questions? Rita?

DR. REDBERG: We can stay on slide 11.

This was a really informative chapter. Thank you.

My question is if you could tell us what are the kinds of prescriptions that were the 5.2. What are the major drug classes that we're seeing in LIS?

MS. SUZUKI: A couple of classes that I mentioned in the mailing materials, like antihyperlipidemic and mixed diabetic therapy, antihypertensive drugs. Those are usually one of the high-spending classes taken by both, actually LIS and non-LIS, and we saw bigger differences in the 5 percentage points seen here for some of those classes.

DR. REDBERG: And that kind of relates to my next clarifying question, because you do have those. In Table 5, it was antihyperlipidemic, peptic ulcer therapy, and diabetic therapy, where you showed the bigger differences in genetic dispensing rates. Were those the major drug classes that accounted for the non-generic use?

MS. SUZUKI: So we have only looked at the top 5, top 15 classes, but these were one of the higher spending

classes. There were others. Some classes are a little bit difficult to compare apples to apples.

For example, antivirals, it just may be it's a broad class. It may include different kinds of drugs within them that's used by LIS versus non-LIS. So I would say these are sort of representative of the higher differences that's seen.

DR. REDBERG: I just was interested, because those are classes that I would expect generics are available as well as non-generics. Obviously, for some drugs, there are no generics available.

Thank you.

DR. MILLER: If I could just say something here, given both of those sets of questions.

When Shinobu went through this work before -- and I can't remember -- a year or two years ago, what I think was striking about the LIS population, I think someone like myself went in thinking, "Oh, it's really a different mix of drugs, and they are taking drugs where there is less likely to be generic substitutes," and what she found is a lot of that profile is very similar. They are just taking name-brand versions of those drugs, which is why we emphasize

that difference, and I understood your question was different. But that kind of came up a couple years ago.

DR. REDBERG: It is clear that there's potential here to have more generic dispensing.

MR. HACKBARTH: Okay. Clarifying questions? Craig and then Kathy.

DR. SAMITT: So in the mailing materials, it talks about the fact that since 2012, the Secretary of HHS has the authority to change the structure of Part D's risk corridors, as long as they keep at least the same amount of plan risk as 2011. Can you clarify what that means? What flexibility does the Secretary have?

DR. SCHMIDT: Essentially, this is the current structure of the corridors on this slide, and that is what has been in place since 2008, I guess it is. There has been no change to this, but there could be.

It could, for example, look at a wider range, starting at plus or minus 10 percent of 100 percent of the bid. So we are looking at the ratio of actual cost to relative bids when you are considering this risk corridor.

If they started risk-sharing arrangements with that wider distribution, then you have the plans bearing

more risk, for example.

MS. BUTO: Slide 6, please.

I should know this, but I could not remember whether generics during the coverage gap have to provide a discount.

DR. SCHMIDT: No. the discount is only on brand-name drugs, but there is more generous -- let's see. The coverage, I think in the mailing materials, there is a discussion of how much the plan is to be covering now during the coverage gap, so the plan is paying for 35 percent on generics.

MS. BUTO: Right. Right, okay. So even at that, the generic might still be cheaper for the LIS beneficiary, but it could be that without a further discount -- I guess I am just pointing to a question I have about some area that we might consider looking at for the future.

The other question I had was about the comment around unanticipated profits related to the risk corridors and the fact that the premiums are set fairly high. I guess there is a risk premium there or something that plans are putting in place. Has that been something that has been sustained over time? In other words, from the very

beginning, have there been unanticipated profits? You may have had a table on that, but --

DR. SCHMIDT: Yeah, I think there is a table in the mailing material about aggregate payments back and forth.

But in the very first year, all of the sponsors bid way too high, and that reflects the lack of good data for putting together a bid that you could feel confident about. So in the first year in particular, there are large payments back to Medicare, so yeah, it's been consistent.

MS. BUTO: So, Rachel, if you were to eliminate the risk corridors, then all of that sort of unanticipated profit would go to the plan?

DR. SCHMIDT: That's right.

MS. BUTO: So we would hope some of the benefit would flow to the beneficiary, but actually, the way the program is structured, it would all go to the Part D plan.

DR. SCHMIDT: Yes, that's right.

There are some folks we have spoken with who say maybe you just tightened the risk corridors, so that Medicare can recoup more of those profits. The downside of that is there is less incentive to manage the overall

spending.

MR. HACKBARTH: Bill Hall?

DR. HALL: I will wait until next round.

MR. HACKBARTH: Okay. So we may have started on Round 2. We started on this side last time. Let me look over here this time for lead-off on Round 2. Jack, do you want to do that?

DR. HOADLEY: Sure.

This was a great setup on a very complicated issue that obviously takes a lot of thinking.

I have been thinking for a long time that there needs to be some changes to either the risk corridor or the reinsurance, and this discussion and the chapter is kind of making me think a little differently about sort of how to think about the relative importance of those two.

But I guess what helps me think about it is to think about a drug like Sovaldi, and I did a little mini analysis this summer to sort of say what is the expected impact of an expensive drug like Sovaldi on Medicare. You can do numbers and suggest that there could be 3 to 7 percent higher overall cost, and that could lead to higher premiums. So people have asked, if that was the case, why

don't we see any increase overall in premiums this year, and one answer is, well, maybe the premiums would have actually gone down, otherwise, and this is just coming up. That is obviously one possibility.

But another possibility is really what this chapter is about, which is there's so much of that cost of a drug like Sovaldi, which is immediately going to put somebody up in that catastrophic phase. Eighty percent of that is paid by the government. So maybe there is not a lot of reason for plan to increase their bid for what they have to pay, because 15 percent, that's not trivial, but it is not nearly as much. And so the cost of a drug like that may be mostly borne by the Federal Government.

It also can make an argument why the risk corridor makes some sense if a drug like that comes up sort of quickly and unexpectedly and gets approved by the FDA, kind of when nobody is looking for it to happen, and that could be a good argument for maintaining that kind of risk corridor approach that says, "Oh. Well, it turns out this year, the costs overall were skewed higher than we expected, and that's something where" -- I mean, that was really kind of the concept of the risk corridor is to help with that

unexpected kind of thing.

To me, it kind of makes the case that the reinsurance share might want to go down and the higher share be borne by the plan, so that there is a greater incentive to manage and to think about how -- whether it's managing the cost of the drug, more negotiation over price, or managing use, which is, obviously, those are the levers that plans can work with. But the Federal Government has no levers in this situation and is just going to pick up the cost tab.

The other comment I wanted to make was on the LIS side, and this whole phenomenon that you raised about the so-called "low-value enhanced plans" and the way that interacts with the LIS -- and I have said for a while, even before the market sort of evolves, so many of these particular kinds of low-value enhanced plans. And really, these are the kinds of plans that show up as just as cheap premium-wise as the so-called "basic plans." It is actually very hard to figure out what is the enhancement or value in these plans when we sort of look at the benefit.

And I do think that the suggestion that you have in the list here that says if CMS can assign and allow LIS

beneficiaries to roll in some of these enhanced plans, when they are equally below the benchmark as a basic plan, including picking up the enhanced value of that plan, especially when we don't think there's much -- and there are other ways you could tinker with the details of that -- that that could be a way to both increase the number of possibilities for low-income beneficiaries to go in, but also maybe, as you put it, address some of the tradeoffs between these two overall issues, so that's an option that is pretty appealing to me.

So I will stop at that point.

MR. HACKBARTH: So, Jack, on your first point, did I understand you correctly to say that you are sort of interested in making the individual reinsurance less generous while keeping the risk corridors where they are?

DR. HOADLEY: Yes on the first, and I don't have a number in mind, but I think somewhere less than the 80, putting the plan exposure higher than that 15. There's even issues about whether we should, for thinking about these things, think about whether 5 percent is excessive for the beneficiary. That's not sort of on the table right at the moment, but that is where, if we're starting to tinker with

these numbers, it's -- people sometimes talk about Part D as if it has an out-of-pocket cap, but with 5 percent, the beneficiary's share can go up pretty quickly when you start talking about these expensive drugs.

But, yeah, I would take the 80 percent down somewhere, take the 15 percent up somewhere, don't have a number in my head. I would probably be tempted to make the risk corridors wider or less protective, but I'm less sure about that than I was earlier, because these kinds of drugs do illustrate the potential to have shock. I mean, even something like Ebola, if we suddenly had a lot of Ebola cases in this country or pick whatever would happen, just a bad flu year, there could be higher-than-expected costs, and that is the kind of thing were some kind of protection does kind of make sense.

I probably still would end up thinking it is more generous than it needs to be in the government, even though -- I think the other point that came up in this earlier dialogue -- we say if we widen those corridors, it all goes into plan profit -- you also have to ask does it change bidding behavior. If plans know they are less protected, do they bid differently? I think that is why that is a hard

one to think through, and maybe some of the economists who think more about bidding behavior could help us think about if there is less protection out there at this point, how much of an impact might that have on bidding behavior and therefore not necessarily show up on the profit side.

MR. HACKBARTH: So let me invite people to pick up on Jack's comment, maybe toughening up the individual reinsurance or the relationship between the individual reinsurance and the risk corridors. Anybody want to go with that?

I say Jay, Kate, Craig.

DR. CROSSON: So I do want to pick up on Jack's first comment, because I thought I was hearing something similar to a point that I wanted to make, and it has to do with what to do with the reinsurance corridor.

One would be to broaden it or increase the risk or the gain, but I thought in what you were saying, I was hearing something, a little addition to that, and that would be to think about the nature of the kind of risk that was being insured for.

I had a little different categorization than you had in the paper, but it seems to me -- and perhaps this is

over-simplistic -- that there is utilization risk, the number of prescriptions per beneficiary, for example.

Then as you pointed out with Sovaldi, there is price-mix risk, particularly short-term price-mix risk, where something comes on, and it's not necessarily a massive increase in utilization, but a significant increase in the average cost. Then there is selection risk, as you had in the paper, which you may want to keep reinsurance for. And then there's the regulatory risk.

But would it be possible, either with or without changing the structure of the corridor, to also think about changing the nature of the risks that were being reinsured for? So perhaps you might want to broaden the corridor for everything except price-mix risk, within the category of a year or two years or something like that. Just a thought.

DR. BAICKER: I share the view that I don't really understand why there needs to be so much government-provided reinsurance for what fundamentally seems like an insurable risk or a privately reinsurable risk. You know, the government needs to step in when there a big missing markets, when it's a systemic risk that is not offloadable onto anybody else. But these are individual things where

there may be a lot of variability, but it doesn't seem like there is a reason there should be a missing market for the reinsurance, and I'd love to hear if I'm just missing something on that.

On the individual side, we worry about incentives for selection. My impression is that the risk adjusters are pretty good and that there isn't a lot of residual incentive to try to avoid whole classes of patients. If there were evidence of that, then I would think there would be a greater need for individual-level offloading of some of that cost. But I haven't seen that evidence, and I'd love to know if there is that evidence.

On the risk corridor side, I don't see a reason why it couldn't be wider, the exposure of the Part D providers. Again, you know, the risk of a really expensive drug coming along, you could privately reinsure that. If for some reason you couldn't, I would think it would have to be a bigger share of total expenditures than the current corridor for it to be a really threatening problem that couldn't get built into the pricing with whatever risk they want to offload in private markets being offloaded. A really huge risk, suddenly, you know, there's a system-level

drug that everyone needs and maybe that's hard to reinsure, that would blow you way past those corridors.

So I'm having trouble understanding why we need so much of both of these things together.

MR. HACKBARTH: It almost sounded like you're saying I'm not sure we need either one of them, that there could be privately purchased reinsurance on both types of risk.

DR. BAICKER: Certainly for some of the range in the corridor now. Somebody could make a case that there are extreme values that are not so easily reinsurable. Somebody could make the case that the risk adjusters are imperfect enough that there needs -- but I need some evidence to show that we have to step in with public dollars to do that.

MR. HACKBARTH: Okay.

DR. SAMITT: So one observation and one recommendation. Similar to Kate and others, it seems like this belt-and-suspenders approach to reinsurance is really unnecessary and excessive, and I'd leave it to the experts on how to do it. It certainly seems like first and foremost reducing the reinsurance would be the top priority, but I think also taking a look at the corridors makes sense.

My recommendation is, is there any forum of sort of maturity in thinking in reinsurance elsewhere in the Medicare program that could serve as an example here? And what I'm specifically thinking of is the way that CMS has thought about reinsurance for either the two-sided risk ACO or the Pioneer. So how is reinsurance addressed there? It seems like it's not nearly as excessive in Part D. And can that potentially serve as a model for some modifications here as well?

MR. HACKBARTH: All of you are on the same general topic here, everybody with their hand up? I have Bill and Kathy and Cori as well.

MR. THOMAS: One of the questions I have was just it seems as though the reinsurance has just continued to be, you know, a challenge. Do we have any idea what the original thinking was on how large that would be and how much funding would be in the reinsurance versus kind of where it is today? Any high-level thinking?

DR. SCHMIDT: He's laughing because several of us were at the Congressional Budget Office at the time trying to estimate the cost.

[Laughter.]

DR. SCHMIDT: Boy, that was so long ago, I'm having trouble recalling, actually.

DR. MILLER: I'm very interested in how you handle this question.

[Laughter.]

DR. SCHMIDT: Thanks a lot, Mark.

I don't think that we envisioned it would be nearly the magnitude it is today. That's probably the best answer that I can give at this point in time. But --

MR. THOMAS: [off microphone.]

DR. SCHMIDT: Well, probably the early years of the program where you can see on the slide it was, you know, on the order of 19 percent. That's probably the magnitude, not far off from the magnitude we were expecting. But it's gotten to be not quite double that but close.

DR. MILLER: I agree. And the other thing I would say -- and there are different ways you can think about how story developed. Another way you can think about the belt and suspenders and the words that you're using over here is that you wanted to have a catastrophic cap, however configured, as a part of the benefit, but that the corridors might fall away over time as people got experience. And

that was one story that was talked about at the time. But I agree with you; I don't think we expected it to -- the reinsurance piece to get to this point.

DR. HALL: So every time we talk about LIS, this business of the prescription benefit, generic versus trade name comes up, where almost 100 percent of the drug prescriptions are brand name and not generic. And that isn't really -- it's kind of counterintuitive if you think about what we know about pharmaceutical prescribing. So I thought that the reason for that was that there was something selective about this population, but -- and that -- but I think from what you're saying is there a potential gain for some providers to encourage the use of trade-name drugs rather than prescription in terms of their corridors? Is there some nefarious -- I shouldn't say that word. Is there some profit angle here that we haven't looked at?

MS. SUZUKI: Are you talking about plan sponsors?

DR. HALL: Yeah.

MS. SUZUKI: So I don't know that we know for sure, but there are rebates associated with brand-name drugs.

DR. HALL: Right.

MS. SUZUKI: At the same time, using brand-name drugs does increase their program spending. So I'm not sure that we have an answer to whether or not -- what is driving this. Part of it might just be that the usual tools aren't available to the sponsors; they're not able to use the cost-sharing differential, like for the other beneficiaries.

DR. HALL: Right.

MS. SUZUKI: And that may be driving some of the differences. Some of the difference, like Rachel said, may be the health status differences. And what we've heard in focus groups is that a lot of times non-LIS enrollees will see the cost differentials between some brand medications even, the preferred ones are cheaper, and certainly with generics, and will ask for a change in their prescription; whereas, LIS enrollees may not ask for a change in their prescriptions.

DR. HALL: Thank you.

MS. BUTO: I just wanted to follow up on a point somebody was making back when -- I think it was Craig -- about dropping reinsurance altogether, maybe, as a possibility. And I think if we were to go down that road of recommending dropping reinsurance, I think we'd have to look

at the basic structure of the benefit, because I think reinsurance was partly put in there because of the coverage gap and beneficiaries having to bear 50 percent of the cost. And that has gone down with the latest round of changes, but still it leaves them out there with a large part of the cost share. The question would be if you're going to do away with any kind of catastrophic cap, which is what the reinsurance is in essence.

DR. BAICKER: But there's a difference about who bears that. You can still have a beneficiary cap --

MS. BUTO: Oh, yeah.

DR. BAICKER: -- and have the plan bear it, so I think this debate is whether it's the plan or the Medicare program, not exposing the beneficiary to the cost.

MS. BUTO: Okay. I thought Craig was suggesting we drop it altogether. That was my only point.

And then the last thing I just mentioned is that's why the reinsurance was put in in the first place, because we had this weird thing of running out of money to provide a full benefit, and they decided to invest it in a catastrophic cap rather than in extending the benefit a little longer.

MS. UCCELLO: And, again, going back to your question, I think the reinsurance was not in there because of this catastrophic coverage per se. That was going to be there. It's how that's funded. And of concern was that the risk adjusters may not be enough to fully capture the differences between enrollees putting plans at risk for very high cost enrollees and leading to incentives to perhaps avoid them.

So I agree with a lot of what has been said so far and what Kate was saying about the reinsurance and the risk adjusters being good. I would want to know -- I agree with having the plans bear more of that risk that's currently being reinsured by the government. But I would want to know more about -- so, yes, the risk adjusters are good, but it's easier to have a good risk adjuster if you're capping the spending. And so if you kind of uncap that, how good does that get? I mean, reinsurance is used to kind of in a sense turbo the risk adjustment. So I would just want to be more comfortable about that.

In terms of the risk corridor, I had been thinking, too, what Jack was saying about the Sovaldi kind of cases, those kinds of unexpected spikes, suggesting it

makes sense to retain some kind of perhaps wider risk corridor. Obviously the issue at hand is, well, these plans are paying money, and so we don't necessarily want to just be giving that all away back to them. And I'm still kind of interested in how there could be an interaction with this with an MLR requirement, which would then instead of paying the government if plan costs were lower than what were priced for, the consumers, the beneficiaries, would actually be getting some of that premium refunded. And is that a way to guard against over -- setting the premiums too high?

Just one more thing that I'll add. I did reach out to an actuary working for a plan on the risk adjusters for the LIS folks. Reading this, I was just a little concerned that, you know, is one reason for this bimodal distribution of LIS enrollment, do plans think that the risk adjusters aren't adequate enough to reimburse plans for those LIS folks. And the reaction I got, this is a sample size of one, but that it was that those risk adjusters are, in fact, pretty good, so they didn't see a problem with this.

It may be that plans that had previously seen problems with the risk adjuster, because the risk adjuster

has in the past few years been improved, maybe prior to that improvement plans maybe were looking more to avoid some of these folks. But maybe that's not necessarily the case anymore. But these plans may not know that that risk adjuster is a lot better now, and maybe it's okay to see these folks.

And I also agree with the idea of allowing LIS folks to be assigned to any plan, enhanced plan or not, that has the premium below the threshold.

MR. HACKBARTH: So I want to pick up on a couple distinct threads in what Cori said. There's the Sovaldi risk that Jack first mentioned. Is that risk in Part D any different from comparable risk in Medicare Advantage? Why are we focused on, oh, we've got to provide extra protection in Part D but not Medicare Advantage? Is there any rationale?

DR. MILLER: I mean, and if anything, I think the sense is that this is more predictable. We always have to use that hair cut analogy. I'm not sure why that's the case. But there is a sense that it's a much more --

[Comment off microphone/laughter.]

DR. MILLER: A little bit, yeah. I thought we had

agreed not to use that, Rachel.

MR. HACKBARTH: Jack, on that --

DR. HOADLEY: On that point, I mean, I think the -- I was really raising the Sovaldi not as much, although we got into that, not as much on the risk corridor side as on the just more general question of reinsurance of the government is going to pay 80 percent overall of the cost of Sovaldi and that reduces the incentives to manage.

I think to your particular point, in Medicare Advantage as a whole, if you have rising costs say in the drug sector, you might have falling costs on something else, there's just more pieces going on. So, you know, drug is one product, and so if you've got something going on in that, you may have more of a one-at-a-time thing going on. But I think the general point you're making is still right. I think, you know, there's not a huge amount of need to go all that far in protecting.

MS. UCCELLO: And I think that you're going to have a risk premium as part of the premium that, yeah, should be able to account for a lot of this. So, yeah, I'm not wedded to retaining these, but that could be a reason to -- I mean, just to think through of whether that's...

DR. CROSSON: This is something that could be looked at. I just have the sense that in the drug arena, at least in recent years, there's been a lot of volatility, more volatility than you might see in acute care delivery. I mean, Sovaldi is an example. The ramping up of the cost of vaccines, in the paper we had some comments about the ramping up by an order of some magnitude in the cost of some generics. I don't think necessarily you see that much volatility in the routine delivery of health care services, but that's something that could be looked at.

MR. HACKBARTH: And then the second thing I wanted to pick up on is, you know, I've heard -- and I think you've said this to me, Mark -- that one of the concerns about changing the risk corridors is it has been producing money for the federal government in the current design. And if we do away, what happens?

I think Kathy first mentioned that, you know, it's a dynamic marketplace, and there would be corresponding changes elsewhere. Presumably premiums would fall. And I wonder about, you know, what the distributive implications of that right now. We're charging relatively high premiums. The beneficiary is paying a percentage of that. Then the

federal government is getting this nice check at the end of the year. The beneficiary doesn't get any part of that. Whereas in a system that resulted in the premiums falling would actually help the beneficiaries. Have I got that right?

DR. MILLER: Yeah, but can I ask a question here? If there was time, I was going to get back to this, to Cori and Kate, to think about. In the absence of anything else, if you remove the corridors, don't the premiums go up?

MS. UCCELLO: The premiums are supposed to be reflecting what they think the costs are going to be. So they're over --

DR. MILLER: [off microphone].

MS. UCCELLO: Yes, so I'm talking about in theory, which is not reality. So you could see -- the same discussions are going on in other areas.

DR. HOADLEY: But you would think that if the premiums go up -- if they've been paying back every single year now for nine years, that should have had its own effect.

MR. HACKBARTH: You would think.

MS. UCCELLO: But you also see CMS overstating

what they think the drug costs are going to be in -- based on the information that they're coming from. So there's kind of overstatements coming on from multiple places.

MR. HACKBARTH: Mark, maybe I'm confused and I'm sort of twisted here. But if, in fact, the premiums are here and then at the end of the year the plans are writing a check to the federal government for a big sum of money, if you do away with the risk corridors, that means at the end of the day their net revenue is less than they would get from the premiums. And if the market competition is such that they can live on less net revenue, the premiums would fall. You do away with the risk corridors. In this situation where every year, year after year, they're writing a check to the federal government at the end.

MS. UCCELLO: But why aren't you doing that now?

MR. HACKBARTH: Well, that's a good question that I've asked, and Rachel and Shinobu were going to talk to plans yesterday afternoon and give me the answer to that, why this persists. But...

DR. SCHMIDT: I don't think that we have a good answer for you yet, but we'll continue to talk to plans and try to...

DR. BAICKER: So if I'm understanding it all -- and it seems very complicated to me -- there are two separate components. Suppose there were unbiased risk, symmetric, that weren't systematically paying in versus not, and the government takes some of that risk, basically providing reinsurance without charging a premium, that should lower premiums overall. It's a different way of subsidizing plans in the aggregate. And if you said, you know, we're not providing that risk protection, go buy it on the private market, they would offload that risk and the premiums would go up a bit.

So if that were the only thing going on, then I think taking away risk protection would, all else equal, raise premiums, because the program is in essence subsidizing the premiums by taking that risk itself without charging a reinsurance premium. But --

MR. HACKBARTH: Now, that sounds to me like an apt description of the individual reinsurance.

DR. MILLER: I'm thinking very much about the corridors --

MR. HACKBARTH: But the corridors all --

DR. BAICKER: But then going -- so that would be -

- if it was all symmetric and there weren't some systematic something going on. But what we've learned from this very helpful spread of information is they're systematically giving back money, which is not about risk. If year in, year out, you're bidding too high and you're giving back money, something else is going on in the incentives for the bid. That's not just about risk protection, because if it was just about uncertainty, it wouldn't be systematically wrong.

MR. HACKBARTH: Now we --

[Laughter.]

DR. MILLER: Can I just say one other thing? And this is not for any more time --

MR. HACKBARTH: That was pretty helpful.

DR. MILLER: It was really helpful, and I want Kate and anyone else who wants to get into that world to think about this, because I think we're nervous that you pull something off and we've got the behavioral response wrong. So we need to be thinking about that. And anything you could bring to the table or anybody else who feels like they can play in that game. And then I'm going -- I'm getting there. I'll just do it in, you know, order here,

alpha order.

And then, Cori, same drill for you, and also if you have actuary friends and you can ask why have you consistently -- that would be helpful to us, too. We're going to be doing it ourselves, but if you, you know, at cocktail parties -- I know you're out there.

MS. UCCELLO: You know, the other --

[Laughter.]

MS. UCCELLO: You know, we actuaries like to party. Did you get that?

[Laughter.]

MS. UCCELLO: What was I going to say? Oh. So the other part of this, which has not been said, but these rates are also getting approved.

DR. MILLER: That's a very good point [off microphone].

MR. HACKBARTH: Anybody else who wants to get tangled in this? Dave.

DR. NERENZ: Hopefully not tangled, but just maybe on that last point, we would kind of whispering clarification over here.

We're just curious how much movements at the top

of the chart, like in the risk corridor, would translate into premium reduction at the bottom, and the speculation would be that sort of the significant movement in the big dollar amount might not move the premium enough to make it worth the beneficiary's time to choose a different plan or therefore worth the plan's time to go ahead and do all that stuff. It might be simpler for them or just as good a business decision to write that check as opposed to bid lower if we're talking about a trivial amount, but there being an arithmetic function here that we can't do on the top of our heads.

MR. HACKBARTH: On this point or anybody read to go in an entirely new direction?

MS. SUZUKI: Can I just --

MS. BUTO: One point, I just wanted to pick up on Cori's just to say I don't see why CMS couldn't take the history into account in reviewing the rates, premiums from year to year, and then make their own adjustment, if they've got the authority to do that.

MS. SUZUKI: I just wanted to clarify that reinsurance does go into the premium that beneficiaries pay.

MR. HACKBARTH: Okay. We are ready to go in a new

direction. Craig?

DR. SAMITT: So what I wanted to talk about was, even if you could enhance the risk with the plan sponsors, I am concerned about whether we have aligned incentives appropriately at the provider level.

I am interested in sort of the ACO movement, and David may way to weigh in on this more than anything else. But to what degree have we aligned incentives with ACOs to manage prescribing behavior? Do Part D costs attribute to, in some way, the gain-sharing or risk-sharing element of the ACO world, and should they be?

So would that add yet another influence to reduce Part D costs if we considered some policy recommendations to include that in the ACO incentive model?

MR. HACKBARTH: My recollection -- and somebody leap in and tell me I'm wrong -- is that Part D does not factor into the ACO at all, and conceptually, I agree to you that this is an important element of cost and proper management of care, even more importantly, and so, logically, it makes sense to include it.

The fact that it's run by Part D plans, not by Medicare, may raise some -- create some hurdles as to how

you would actually integrate Part D with an ACO model that's based on a traditional Medicare fee-for-service chassis. I have not thought that through, but I suspect there's some logistical issues about how you would pull that off. But, conceptually, it makes a world of sense to me.

Anybody want to pick up on that?

DR. CROSSON: Is there anything to be learned from looking at MA-PD plans on that note?

MR. HACKBARTH: The thing about MA-PD that I like is that it's one organization that assumes joint clinical and financial responsibility for A, B, and D services. It is all one pot. The challenge on ACO is that you have got traditional Medicare as the A/B insurer, and then another company on the Part D side. So, potentially, there are data issues, barriers there, in terms of real-time integration of the information.

DR. SAMITT: And I would imagine you would see differences in terms of utilization patterns between the MA-PD groups and PDP and traditional Medicare.

The other example would be systems that take capitated commercial risk already bear a significant amount of the drug costs and the risk for drug costs, that you

could also do comparisons there. So that is why I am encouraging us to think about including Part D cost in the ACO model.

DR. CROSSON: Yeah. I was a little telegraphic in what I said. I completely agree with Craig.

The question is, if we were to look at, on a comparison basis, the performance of MA-PD plans, particularly those who have a close integration with the delivery system, that should -- I mean, if what you are saying makes sense -- and I believe it, as well -- there should be some differential improvement in performance that we could look at, and if there isn't, then the question is why not.

MR. HACKBARTH: Improvement relative to --

DR. CROSSON: Pharmaceutical cost.

MR. HACKBARTH: Where is isn't integrated with the particular --

DR. CROSSON: Yeah, yeah. Right.

Now, it gets complicated because you have to play off the usage of pharmaceuticals versus savings on the hospital side and the like, but if it really does make sense -- and I believe it does -- and particularly, you selected

for those organizations that are both integrated delivery systems and carrying Part D risk -- one would imagine you would see a better performance.

MR. HACKBARTH: Yeah.

Well, set aside ACOs for a second. It has always seemed to me to be a conceptual problem to have two separate insurance pools for A and B services and drugs, because often there is a substitute effect. You want people sometimes to take expensive drugs. Sovaldi may be an example of this. Take an expensive drug, and it is going to reduce expenditures on A and B services. If you have two separate insurance pools, the incentives aren't really lined up right. The drug insurer wants to limit the use of the really expensive drug, because it bears all of those costs, when in an MA plan, it may be, "Oh, we really want them to use even this expensive drug," because it is more than offset on the A/B side. So I think, independent of the logistics of trying to merge these for ACOs, I think the separate pool, insurance pool problem, is potentially a big one.

Now, having said that, didn't we try to look at that at one point and see if there was a big difference in

behavior, total cost? I just have a really vague recollection here that in fact my --

DR. SCHMIDT: Between MA-PDs and PDPs?

MR. HACKBARTH: Yeah.

DR. SCHMIDT: Well, I mean, Shinobu has run lots and lots of claims data and consistently seen things like higher generic dispensing rates, lower spending per person. It is hard to fully control for the differences in the population because so much of the low-income subsidy people are in PDPs, but it does seem that they are delivering things more efficiently. We'd have to kind of do a careful analysis.

MR. HACKBARTH: So is there any way to look at really expensive drugs that are likely to have an offset on the A/B side and see if there is a difference in what the MA-PDs do versus the freestanding plans, really a targeted look at those areas where you think the incentives might be wrong?

DR. SCHMIDT: And, Glenn, don't forget that Part B drugs are managed by the ACO, but Part D are not. So that is another kind of cost versus whatever, total cost.

MR. HACKBARTH: I am all in favor of looking at

it. I think your conceptual point, Craig, is right on. I just don't know what the challenges might be logistically to achieving that integration.

Dave and then Rita.

DR. NERENZ: Just a friendly amendment to that suggestion. We could probably identify some examples where actually the two costs tend to run up or down together. So, in some cases, you would prescribe an expensive drug. Then you have to see the patient, do monitoring. Anticoagulants might be an example of that, but then you can see other examples where it might be a substitution. So now they move in different directions; antidepressants, for example, if you are trading that off of psychotherapy, if you manage things that way.

So if we could identify ones in which we think they either run up and down together and then do they behave differently and do those things behave differently in these different environments or the other examples where they move up/down, there might be some interesting areas when you look at how different structured organizations work in those two domains.

MR. HACKBARTH: I have Rita and Jack, and then I

think we will be just about on time.

DR. REDBERG: Okay. So just on a related point about generic dispensing rates, I just wanted to share, because I am on a UCSF Quality and Value Committee, and I didn't realize we were looking at our generic dispensing rates. And we use EPIC, as a lot of centers do, and it turns out, for example, for beta blockers, if I start typing in the name of a beta blocker like metoprolol that is available in brand name and generic, evidently EPIC for some of those -- and I think that was one of them -- was defaulting to the brand name, and then the prescription was going in as brand name, even though I thought I was writing a generic prescription. I imagine if that's happening with us, it's happening in a lot of places.

None of us knew it in the division, and now we're going to work with EPIC and try to change it, which doesn't happen overnight. But I imagine that that kind of thing would be an easy fix, because I thought I was writing generics.

DR. HOADLEY: On the ACO point, I seem to remember that there was at least an ACO that had proposed to incorporate drugs -- I don't know what's the status of that

or whether that had happened -- and/or I seem to remember there was a CMS request for information to think about how to do it.

MR. HACKBARTH: I think I do remember that.

MR. GLASS: There was a CMS request.

DR. HOADLEY: Yeah.

I think one of the challenges on that is you can think about how in the ACO model, the person is getting their care, their primary care from a doctor that's in the ACO sort of by definition and then potentially should be getting their specialty. But if they are enrolled, they could be enrolled in any of the 30 PDPs that are in the area, so to really get to thinking about that in a creative way, you have to start thinking about encouraging people to maybe enroll in one particular PDP that was willing to work with them on that.

The other issue I just wanted to mention when we were thinking about all of these risk issues, I think one of the things that hasn't really hit us yet is how are biosimilars or biogenerics, whatever term you want to use, going to play into this, and when those eventually get approved by the FDA and depending on whether they have

interchangeability and all those other kinds of complicated issues, how are Part D plans and then how do we think about sort of under these different risk structures, the degree to which they are encouraged to get people to use those, because it won't be as automatic as it is with generics today, or it won't necessarily be as automatic as generics are today. And so making sure that when that time comes that the plans will help to encourage that use, which will bring everybody's cost down, I think is just another way, another angle to think of that issue with.

MR. HACKBARTH: We are down to our last two minutes, so we can squeeze Alice and Scott in if they are economical.

DR. COOMBS: Thank you very much. This has been a really good discussion on risk.

One of the questions I had was specifically about the LIS, and Jack, I had the privilege of looking at some of the studies that Jack has done. If we direct the Secretary to have greater flexibility with the copayments for the LIS, one of the things that I have learned from one of his recent papers was that the $20 cutoff for copays seemed to be a benchmark for where there were decisions to leave a plan or

switch, and I was wondering if that kind of information is available for LIS, because I would think that that might impact drug adherence and compliance and could ultimately result in poor quality of care if we were to have that kind of impact by increasing the copayments.

DR. SCHMIDT: Yeah. I think there is certainly some literature, including Jack's, looking at how different levels of copay might affect adherence, and we can certainly bring that to you for a discussion.

In the discussion about the 2012 recommendation, I think there was maybe some conversation on even having lower cost sharing than what's in the law potentially for generics, so bear that in mind, as well.

MR. ARMSTRONG: I think, just very briefly, actually building on a point Alice just made, much of our conversation was about risk corridors and missed stop losses on individuals and so forth. I think it's useful. Let's not forget, though, that I think where the real opportunity to impact cost for this part of the Medicare program is really dealing with LIS population. I know that's implied in our work, and we have done work on that.

Just one point to add, a small fact to acknowledge

there is a real interaction between these. It is that in my organization, LIS represents about 10 percent of our total enrollment, but that same population is more than 50 percent of the patients who surpassed the out-of-pocket thresholds. So managing LIS and this generic ratio and some of the other issues with that population in and of itself could have an impact on how many patients we actually see hitting some of those high-cost thresholds.

MR. HACKBARTH: Okay. Good work, Rachel and Shinobu. Thank you very much, and obviously, we will hear more about this subject in meetings to come.

We will now have our public comment period before lunch.

[No response.]

MR. HACKBARTH: Seeing nobody moving to the microphone, we will adjourn for lunch until 1:30 p.m.

[Whereupon, at 12:16 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:29 p.m.]

MR. HACKBARTH: It is 1:29. That's good enough, isn't it? Okay. Never let it be said that we are not efficient.

Okay, Shinobu. The ball is yours. We are talking about opioid use, right?

MS. SUZUKI: Yep. So, in this session, we will discuss opioid use by Medicare beneficiaries enrolled in Part D. why we should be concerned, and the various measures in place or under way at CMS to prevent inappropriate use of opioids.

First, here is a quick background on opioids. Opioids are a class of narcotic analgesics that are used to manage and relieve pain in patients experiencing moderate to severe pain that is not well controlled by other non-narcotic pain medications, such as ibuprofen.

Drugs in this class are all derivatives of opium and can be naturally occurring like the opium and morphine or semi-synthetic agents such as hydrocodone or oxycodone.

Most opioids are classified as Schedule II drugs under the DEA classification for controlled substances, which are the most restrictive of the medically legitimate

drugs.

Because of their addictive properties, overuse and abuse of opioids has become a significant concern in the U.S. Most opioid analgesics do not have a clearly defined maximum dose in the FDA-approved labeling, which can make it a challenge to determine when a quantity exceeds the amount that is medically appropriate.

There are several reasons that we should be concerned about the opioid use in Part D. The use of opioids is widespread among Part D enrollees, with over one-third using opioid in any given year. Opioid accounts for about 5 percent of prescriptions and spending for drugs covered under Part D, making it one of the most commonly used class of drugs in Part D.

Recent reports by GAO and OIG have found potentially inappropriate use of opioids by beneficiaries, as well as questionable prescribing by physicians and potentially fraudulent billing by pharmacies for opioid prescriptions.

As we will discuss shortly, our examination of the Part D data also raises concerns about inappropriate uses by some beneficiaries. Inappropriate use of opioid is a

concern because it can harm the beneficiaries. Even appropriate uses may result in adverse health outcomes, such as drug-drug interactions, because many Medicare beneficiaries suffer from multiple chronic conditions which are often treated by multiple drug regimens.

In addition to the potential harm to the beneficiaries, inappropriate uses of opioids also increase Part D's program costs without providing health benefits.

To understand the patterns of opioid use and characteristics of beneficiaries who use opioids, we took a closer look at Part D data for 2011. In 2011, 11.5 million beneficiaries filled at least one prescription for an opioid. Of those, about 400,000 had used hospice during the year, and another 1.1 million with no hospice use had a cancer diagnosis. Opioid use for pain associated with cancer and at the end of life is well established in medical literature.

While other uses can also be medically appropriate, the treatment guidelines are not well established. The findings we report in the next few slides are for the 10 million Part D enrollees who used opioids in 2011, who did not have hospice stays or cancer diagnosis

during the year.

Here is a map showing the prevalence of opioid use by Medicare beneficiaries enrolled in Part D. Nationally, 32 percent of Part D enrollees filled at least one prescription for opioid in 2011, but it varies widely across states, ranging from 20 percent in Hawaii to slightly over 44 percent in Alabama. The darker blue indicates a higher proportion of Part D enrollees using opioids. As you can see, many southern states had the highest shares of enrollees using opioids.

This table shows opioid spending and use by Part D enrollees. The first column is for the 10 million Part D enrollees who did not have a hospice stay or cancer diagnosis in 2011. Gross spending totaled $2.7 billion for about 63 million prescriptions.

On average, beneficiaries filled about six prescriptions at about $270. As you can see at the bottom, over 90 percent of the prescriptions were for generics.

Annual spending on opioid varied widely, ranging from about $4 for at beneficiary at the 10th percentile to over $400 at the 90th percentile. The highest-spending beneficiaries had well over $1 million in spending for

opioids.

The second column shows the spending and use for beneficiaries with the highest spending for opioids. Those with spending in the top 5 percent accounted for $1.9 billion, or nearly 70 percent of the total spent on opioids. The share of prescriptions accounted for by those with highest spending was 18 percent.

Beneficiaries in the top 5 percent filled, on average, 23 prescriptions at a cost of over $3,700, more than 10 times the average for all opioid users. Finally, those in the top 5 percent were more likely to use brand versions compared to the other users.

The top portion of this table showed selected demographic characteristics comparing opioid users to overall Part D enrollees. Focusing on the first and the third columns, you can see that demographic characteristics of those in the top 5 percent differ from the overall Part D population. They were more likely to be white and be disabled, under the age 65. About two-thirds received a low-income subsidy, which is a much higher share compared with the overall Part D share of 37 percent. About three-quarters were in PDPs, compared with 64 percent for all Part

D.

A few rows at the bottom shows the share of beneficiaries who may have engaged in doctor shopping or pharmacy shopping. There is no agreed-upon standard for identifying possible doctor or pharmacy shopping, but three or four prescribers or pharmacies is typically used as one of the criteria in identifying doctor or pharmacy shopping.

You can see from the table that 9 percent of all opioid users obtained opioids from four or more prescribers. That figure was 29 percent among those in the top 5 percent.

While only 7 percent of opioid users filled their opioid prescriptions at three or more pharmacies, that figure was 31 percent for those in the top 5 percent.

Finally, states that tended to have beneficiaries with very high opioid use were not necessarily the states with widespread use of opioids; for example, we found somewhat higher shares of Part D enrollees in the top 5 percent, by spending, in states such as Delaware, Alaska, New Hampshire, Vermont, and Wisconsin.

In response to the widespread use of opioids among Part D enrollees, CMS has implemented two changes in 2013. The first is a requirement for plan sponsors to conduct drug

utilization reviews, which include edits at the point of service, such as denying a prescription that is refilled too soon, imposing quantity limits, and conducting retrospective reviews to identify beneficiaries who may be at risk of an overuse. The expectation is that once beneficiaries are identified, plans will work with their prescribers and, in some cases, with the beneficiaries to ensure appropriate level of opioid use.

Another new development is CMS's implementation of a centralized data system to track potential opioid overuse cases. This is called the Overutilization Monitoring System. The OMS produces contract-level reports on potential opioid overuse cases and requires plans to provide status updates within 30 days.

This centralized system can also be used to track opioid overuse risk across plans, even when a beneficiary changes plans.

Other changes that are taking place in 2015 or later focus on prescribers and pharmacies that may be enabling abusive or fraudulent behaviors, or are part of abusive or fraudulent schemes themselves.

Beginning in June of next year, all prescribers

must be enrolled with Medicare or have a valid opt-out statement in order to have a prescribing privilege under the Part D program. Plan sponsors must deny claims with invalid prescriber IDs or claims ordered by unauthorized individuals. In addition, a recent final rule provides CMS with the authority to revoke a prescriber's Medicare enrollment if CMS determines that he or she has an improper pattern of prescribing.

CMS is also developing a tool called Predictive Learning Analytics Tracking Outcomes, or PLATO, to assess fraud and abuse risks of prescribers and pharmacies based on an analysis of Part D data. Once PLATO is operational, it would allow plan sponsors, CMS's program integrity division, and law enforcement agencies to identify potentially fraudulent or abusive actors. CMS plans to expand this tool for use beyond cases related to opioids, such as making predictions about the future to prevent adverse outcomes associated abusive prescribing and dispensing of other medications.

Concerns about inappropriate use of opioids are not specific to the Medicare population. All states, with the exception of Missouri, operate or are in the process of

implementing a Prescription Drug Monitoring Programs, or PDMPs, which is an electronic database that tracks dispensed prescriptions for controlled substances. There are wide variation in the scope and effectiveness of PDMPs across states; for example, each state determines which controlled substances are covered and who is required or authorized to access the PDMP data.

There are efforts in place to allow sharing of information across a group of states, which would aid in tracking overuse and misuse of controlled substances, particularly in counties that border other states.

Although pharmacists can play a key role in preventing misuse or abuse of controlled substances, in reality there is limitation on what they can do, given the laws governing their conduct, complex nature of dealing with suspected drug abuse cases, and other concerns, such as personal safety. Some pharmacies have instituted a checklist or standard protocol that helps pharmacists in identifying and dealing with potentially illegitimate prescriptions for controlled substances.

Commercial insurance and some state Medicaid programs use prescriber and/or pharmacy lock-ins for

individuals identified as being at risk of abusing controlled substances.

So here are a couple of questions that Commissioners may want to comment on. You may recall from the data presented in the mailing material that beneficiaries with high opioid use were more likely to be in a long-term care setting. Given other concerns about medication used in those long-term care facilities, such as use of antipsychotic medications, we may want to understand prescribing patterns in those facilities and the effects on beneficiaries residing in those facilities.

Understanding the effectiveness of the utilization review requirements and the OMS in preventing inappropriate opioid use could have broader implications for measuring and improving quality of services provided under the Part D program; for example, by applying the framework to identify and prevent other potentially inappropriate medication use, such as contraindicated drug combinations and polypharmacy, which we will be discussing in the spring.

Although early data from CMS suggests that the new policies may have had some effect on reducing potential overuse and abuse, it is too early to know the full extent

of the effectiveness, how they are affecting beneficiaries, plan sponsors, and other actors such as pharmacies and prescribers. The additional changes taking place in 2015 that focus on provider behavior may further reduce the incidences of opioid overuse and abuse.

You may also want to comment on whether we should go further and consider other policy options to prevent overuse of opioids, such as lock-ins, or other policies that we have not discussed.

That concludes my presentation.

MR. HACKBARTH: Okay. Thank you, Shinobu.

Round 1 clarifying questions. I have Herb and then Rita.

MR. KUHN: So thanks for that information.

On Slides 8 and 9, you enumerated a number of initiatives that CMS has in place, but as I look at those and if I remember from the reading, most of them look like they are after drugs have been prescribed or have been dispensed. How many of the things that they have in the queue now are going to be preventive to try to -- I guess when you think about payments, the whole issue of pay and chase, that kind of scenario, what is going to prevent some

of this from going on at the very beginning versus going after folks after they have done the prescription and filled the prescription?

MS. SUZUKI: I think there is a mixture. So point-of-service edits and quantity limits can be used sort of before the payment occurs, but identifying those cases that are subject to point-of-service edits or quantity limits may have the element of pay and chase, initially.

MR. KUHN: So it sounds like most everything they have is kind of after the fact, and then they might go back and revoke a license or do some other things after that, but not too many proposals right now in terms of program integrity in this area in terms of prevention up front, some but not as much right now.

DR. REDBERG: I guess it follows onto Herb's question.

But it seems like denied prescriptions on Slide 9 ordered by unauthorized individuals, e.g., with suspended DEA, would be preventive. So that is proposed, but currently, we fill prescriptions, narcotic prescriptions, even if you have a suspended DEA certificate? I just find that surprising.

MS. SUZUKI: And there may be some differences across state licensing requirements, and plans may do things differently where they are actually checking the database to make sure that the prescriber is authorized.

But I think going forward, with the requirement that all prescribers have in NPI and is enrolled with Medicare, it would be easier for them to deny claims. I think CMS has used the ACA authority to exclude providers from the Medicare program if their prescribing patterns are abusive.

DR. REDBERG: They have currently used it?

MS. SUZUKI: They will be using going forward. This will be June 2015.

DR. MILLER: Bear in mind this hasn't happened yet.

MS. SUZUKI: Right.

DR. MILLER: They have talked about this is the direction they are going.

DR. REDBERG: Right.

DR. MILLER: And to answer your question, yes, it is possible for someone to be prescribing without a DEA certificate.

DR. REDBERG: That just doesn't make a lot of sense to me, and I would have thought you had to be enrolled with Medicare to be a prescriber. So I was surprised to see that's a coming change. I'm glad, but I just assumed you already had it.

MS. SUZUKI: So part of this is, on the claims, the IDs reported by prescribers were not always consistently NPI. It could have been DEA ID or other IDs, and I think it was difficult to determine whether the IDs were appropriate prescribers or not.

DR. HOADLEY: Two questions around the data on Slide 6. One, I was wondering if you have looked at all at whether there is any difference in the drug mix for the top 5 percent users versus all users, and if so, does that tell us anything?

MS. SUZUKI: So not in detail, but we did find that there were more brand-name drugs.

DR. HOADLEY: I saw that.

MS. SUZUKI: And on average, I think the brand-name drugs were very expensive brand-name drugs.

DR. HOADLEY: And do those tend to be brand-name drugs that are somehow special purpose, different drugs, as

opposed to just brand versions of existing -- where there's also generics?

MS. SUZUKI: So I can't speak to that, but I have seen a couple claims where it is long-acting.

DR. HOADLEY: Okay. Formulations and things.

MS. SUZUKI: Mm-hmm.

DR. HOADLEY: And my other question is, Did you think about sort of eliminating people who have maybe just one prescription during the year on the notion that their -- or two, so whatever the threshold, the kind of people who might be getting a pain relief immediately post-surgery or something like that and whether that would yield any differences?

MS. SUZUKI: So it definitely would change our averages and the number of people who are using opioid for longer than just one-time use. There are lots of people who had maybe just one prescription for opioid.

MS. BUTO: So, Shinobu, I was wondering, also on Slide 6, where the top 5 percent have an average use or average prescription number of 23, aren't there generally like 30-day scripts? Are these duplicates we are talking about here? Could you speak to that?

Then, secondly, do we have any idea of what the categories of pain management are? Like are they for back pain or arthritis? Are there any general therapeutic issues that are involved with long-term use of opioids, I wondered?

MS. SUZUKI: So the 23 prescription is standardized prescription, although the standardization means that it's either counted as one prescription if it's 30 days or less, and many prescriptions will be for less than 30 days. But for a 90-day supply, we consider that as a three-prescription equivalent.

MS. BUTO: Therapeutic categories are the clinical conditions to which -- do we have any grouping of those? Does there seem to be a group of patients or type of patients that gets opioids more than others?

MS. SUZUKI: So we didn't directly address that question, but we did look at what are the prevalent conditions among those in the top 5 percent compared with the overall Part D population, and there are certain categories like depression or dementia that seem to have higher prevalence among those in the top 5 percent compared to others. And we can look into this in more detail.

MR. HACKBARTH: Any other Round 1 clarifying

questions? Seeing none --

DR. MILLER: Yeah, Glenn asked me to say something perhaps for the audience about why this relatively narrow topic might be of interest to us.

First of all, there has been a lot of activity and discussion around it, and we've gotten inquiries both from the Hill and I think from some of you. But I think the other thing we're trying to get -- you know, to ask ourselves as staff and the Commissioners is whether there's anything in the surveillance, in the monitoring, and particularly in some of the ideas that are being brought forward that might more generally be applicable. So the PLATO system, does that create any opportunities for other patterns, drug-drug interaction, that type of thing? At a staff level, we're asking ourselves those questions, one of the reasons we were interested.

And then more from a policy perspective, for example, Shinobu put up there do we want to think about lock-in, those types of things, and some of you have closer experience than us on that, and so we were curious to see what your guys' view was on that. So even though it's about opioids, which it is, there's also a couple of other angles

that we're looking for here.

MR. HACKBARTH: Okay. So let's open up Round 2. Who has a comment? Bill, why don't you lead off? And then Mary.

DR. HALL: Apropos to a number of the questions that came up in Round 1, there are just a couple of points I'd like to make. Opioid use and control is very much a state's phenomenon. It varies tremendously by state, as your diagram here showed, by a factor of 100 percent or more. That's a moving target because more states are now getting involved in their own regulatory mechanism. So if you've seen one state, you've seen one state, not all.

The other thing is that CMS has been pushing the so-called meaningful use so that there's a big push that all prescriptions should be e-prescriptions. That makes it a lot easier to track things going on, and so these are things that are in the pipeline over the course of the year that will make a difference.

And then there's another thing that often isn't talked about in these statistics, and that is that, in general, in Medicare-eligible patients or what I call geriatric patients, there's a big push to use narcotics as

the drug of -- opioids as the drugs of choice in most pain situations. The reason is that the alternatives for those, such as nonsteroidals or analgesics or a number of other medications -- Tylenol -- they have pretty bad side effects in older people: a lot of renal failure, a lot of gastrointestinal problems. So that a number of the large organizations have said that opioid use is preferred to what we now talk about as these less toxic drugs. And that's also a moving target that's going around. So somehow all of this has to be incorporated into this.

So I think anytime we talk about opioids or narcotics in general, everybody has such strong personal feelings about their use. It's never entirely a rational medical decision. Some people think that everybody who uses opioids are drug-seeking.

And I should have added that, at least in New York, where we are very carefully regulated, I still occasionally will get a report from the state agency that says that I've been overprescribing narcotics, and clearly somebody at some point in time must have been stolen prescription pads, when we still used prescription pads, and some pharmacies will accept that. So I've had to defend

myself, just to put all my cards on the table -- and I'm not defensive about this.

[Laughter.]

DR. HALL: But, anyway, there's a lot here. It's not quite as straightforward as it seems.

MR. HACKBARTH: Does anybody want to pick up directly on that? Mary, is your comment related to --

DR. NAYLOR: I absolutely agree that this is, first of all, an extraordinarily important issue and very complex for the reasons -- I would recommend reinforcing Jack's comment about trying to disentangle users one time or two times for surgical reasons. And I was actually following Mark's comment on why MedPAC would take this on. And I think how is it that we can use payment as an incentive to develop and foster the use of these systems, which I think are extraordinarily important -- not that they're simple to interpret the findings. And in your report, you also commented on how providers can use them and how there is pretty substantial variation in states with very little use or somewhat good use and how important current data is and making it simple enough for clinicians to be able to access the information and use it, and then

for us to be thinking about measuring this as part of our efforts to look at the quality of care.

So I think there are reasons in addition to it being a framework for multiple medications, but I think it's really important for us to be able to promote the development, use, and measurement of these systems.

MR. HACKBARTH: So who would like to build on either Bill or Mary?

MR. KUHN: Yeah, to follow up on Bill's comments, the thing that I was thinking about here, particularly in light of the next steps that are put up here as well, is, you know, is there a way to look at this, I think as Mary said, in the quality space and a way to think about this a little bit differently in terms of symptom management that CMS could look at here. So could CMS create, maybe through CMMI or somewhere else, a set of NOC codes or J-codes, the Not Otherwise Classified codes, where you could begin to look at some of the protocols from some of the medical societies in terms of proper prescription or activities here and begin to look at this more as a quality initiative, so that ultimately that comes into play in terms of payment bonuses or whatever that cohort and some of the quality

incentive payments that are out there, because, you know, you can do all this other stuff, all this surveillance, you know, take people's licenses away or whatever the case may be. But if it's kind of more embedded in terms of we know there are a set of guidelines, we need to adhere in this area, here are some codes that we have to put in place to let them know how we're managing the symptoms of certain patients out there -- you talked about the top 5 percent, some cancers in there and some of the others -- it might be another way to look at this as a more -- more proactive, up front, and as well as aligns it with some of the other things that we're trying to achieve here in some other areas. So just a thought in terms of what you were building on there.

DR. CROSSON: Just picking up on Mary's picking up on Mark, so the question I think that Mark brought up or the possibility is that this issue or the development of this database, PLATO, could provide broader utility for us on other issues. But I don't know from the chapter what's actually going on. What is the PLATO database? What is it being built on? Does it have information from Part A and Part B? Is it only Part D or what?

MS. SUZUKI: So PLATO is a database with Part D claims aggregated at the pharmacy or prescriber level to identify some behavior that may look unusual. So they try to target the outliers. It's a little bit different from the OMS, Overutilization Monitoring System, in that in the OMS they're looking at beneficiary-level data to see whether there's an overuse occurring.

DR. CROSSON: Maybe I'm not thinking properly, but -- so in PLATO it's not beneficiary level, it's overall. But part of the utility, it would seem to me, if there was a broader utility, would be to have that correlated with other Medicare data which was beneficiary specific, right?

MS. SUZUKI: And I believe they do have the capability to link the prescriber- or pharmacy-level data with CMS' data for beneficiary-level utilization to identify whether there's a pattern that they need to investigate.

DR. CROSSON: All right. And then that pattern could, for example, be diagnosis specific or could be related to other utilization patterns within Medicare proper, or not.

MS. SUZUKI: My understanding is that they're both based on Part D data, not linked to A, B, or diagnostic

information on medical claims.

DR. MILLER: And I think the reason that I raised it is -- and you know how these things go. We kind of bring what we have to the meeting, sort things out with you, and then decide how much further to go. I think the question among -- for myself, and maybe only for myself, but among myself and the other staff is: Is something being developed here that could be put to broader use? And if so, maybe that's what we would want to comment on and build on. I think at this point what this actually is and how it will work is still a little bit falling together, and so answering your question is, A, somewhat difficult; and then, B, what would we want it to do if we thought it was a worthwhile platform to even investigate? That's kind of where we are in the process.

I guess the other thing is, you know, in any of your experiences, if you've been with plans or, you know, insurers or whatever the case, if there's a related experience that we ought to go and investigate, that kind of thing -- and maybe I'm getting a nod out of Scott. Maybe.

MR. ARMSTRONG: Yeah, just a point I would make to the degree it's helpful. It's not an area I know a lot

about. To me this is much more a quality of care issue than it's really a management of costs. I know this -- what's so difficult here is that all of our interventions are retrospective. And in my organization, when this became an issue, the first thing we did was we identified every patient that had an opioid prescribed, and we began to monitor what percentage of those patients have a proactive care management plan. Because every patient's needs are going to be different, but it was really about are we paying attention to the evidence and the kind of use of opioids that should be appropriate given every individual patient.

So that's hard to do in fee-for-service, but it just strikes me that maybe in our special needs plans or maybe in some other parts of the Medicare program there are strategies we've used to be more proactive about engaging particular populations of patients in initiatives that, you know, proactively help to achieve quality outcomes.

DR. REDBERG: Thanks, Shinobu. This was a really great chapter, and I think a really important topic, and I want to agree with and build on what Scott just said, because I think it's not a cost issue. This is really an issue about quality of life and also, I mean, there are a

lot of people dying -- more people dying now of prescription drug overdose than of street drug overdose. It's a big problem in the Medicare population and non-Medicare population.

You know, when I look at your Slide 4, when I did my training 30 years ago, we basically used opioids for short-term post-op use and then cancer diagnoses or end of life. And the problem is that they're now being used for a lot of other non-specific pain. Back pain is probably part of it, Kathy, but a lot of it is really the pain of life, you know, kind of there's just pain. And there's absolutely no data of effectiveness. There's data showing the pain doesn't get better, and, of course, from the ever increasing, escalating doses of opioids, it's clear that the pain's not getting better, but the need for opioids is getting better. And in some ways it reminds me of Adelaide's lament: The medicine doesn't get anywhere near where the trouble is.

So the idea of having, maybe as Scott just said, sort of a management program for people with pain that does not include opioids but includes kind of addressing the other issues, that would be a much more constructive and

positive way, because the problem is with the opioids you kind of lose your quality of life because life then becomes about finding your next opioid prescription refill and getting more opioids and not having sort of the enjoyable, productive parts of life.

And so I think it would be a really positive thing to work with, you know, patients, but there are often a lot of non-medical issues. I mean, life is really tough, and unfortunately now the guidelines, I think with good intentions, we were told 10 or 15 years ago, I think JCAHO added a measure, Does your patient have pain? And now everyone started giving narcotics. Unfortunately, it wasn't taking away the pain, but, you know, it was -- it has led to a big problem.

I guess the other thing that kind of opened my eyes was probably ten years ago I read Barry Meier's book on OxyContin and the marketing of OxyContin painkiller, and I noticed -- I mean, there was a lot of marketing now to primary care physicians and anybody could give opioids. I think there has been a lot of reasons for why it has become such a huge problem.

And the last thing I was going to say is it does

seem we could also limit Plan D prescribing to one pharmacy. I mean, why do beneficiaries have to use multiple pharmacies? Because then you always know for all medications when they're being filled and how often.

MR. HACKBARTH: So, Shinobu, would you put up your last slide that had your policy questions?

So in that last bullet on policy options, I think the first bullet there, Should we go further and consider other policy options such as lock-ins? That's a reference to pharmacy lock-in specifically for opioid users. And what I heard you saying was even broader than that, for all drugs. Did I hear you correctly, Rita?

DR. REDBERG: Yeah. I mean, that's what we identified -- on our electronic health record, we have a pharmacy for every patient so that when I do e-prescribe, it goes to their pharmacy.

MR. HACKBARTH: Now, in both Scott's and Rita's comments, I also heard, well, maybe not a pharmacy lock-in. Let's just focus on opioid users for a second, but a clinical lock-in. If you're going to be certainly on longer-term use of these drugs, there ought to be a clinician responsible for the ongoing care an pain

management, whatever else is involved. So it could look at the lock-in both on the pharmacy and the clinical side, just as an option. I'm not endorsing that, but look at it on both dimensions.

Let's see. I have Bill next.

MR. GRADISON: I guess this is Part 1, Part 2. First of all, I'm really glad we have this report. I think it's a terribly serious problem, a very difficult one to figure out what to do about.

When do you think we might get some sense as to the impact of these new rules that are going into effect? That's my first issue, first question. More or less when? Months or years?

MS. SUZUKI: CMS has been reporting on their progress every fall, and they just recently had a webinar covering this particular issue. I expect them to again maybe report with additional data next fall, so maybe in a year we'll have some information about how this is working.

MR. GRADISON: The second thing, I'm interested to get some sense of the proportion of Part D, let's say Medicare beneficiaries in general who are involved in this overuse or more specifically are dying because of it, as

against the total in the entire population; that is to say, this is a serious problem within the population that we focus on. That's reason enough. But is this a major part of it, or is this a minor part of the national problem of overuse of opioids?

MS. SUZUKI: The question is whether Medicare is a big part of the national --

MR. GRADISON: Yeah, I mean, really what I'm wondering is -- I guess I could say it more specifically. Do you have any what proportion of those whose cause of death is overuse of opioids are Medicare age?

MS. SUZUKI: So I could definitely get you additional information, but a recent study, I believe by AHRQ, showed that the growth in inpatient admissions due to opioid overuse grew most rapidly for the Medicare population compared to others.

MR. GRADISON: That's very helpful to know. I think what I'd be particularly wondering is how this works when it doesn't apply to the total population, but specifically the extent to which those who might have difficulty continuing to get it from their regular source, they'll just buy it on the street or through other people.

I don't want to draw an exact parallel to cigarettes because you don't need a prescription to get cigarettes, but minors do seem to find a way to get them through people who aren't minors, and maybe Medicare beneficiaries, especially if it's a serious addiction problem, may not make -- try to find ways, especially what strikes me is so much of this is these really expensive actual prescriptions, so somehow or other these folks are coming up with a lot of money. Maybe it's Medicare's money, maybe it's their own, but in order to maintain this unfortunate habit.

Thank you.

DR. SAMITT: So I have two comments.

One is on the policy front. You know, one of the things I'm wondering if we should look at -- and there may not be any substance here -- is where the new prescribers are coming from.

I'm interested in, you know, yes, we've got a problem today, but if we're accelerating new opioid prescriptions then it's going to continue to be a problem in the future.

And the reason I ask is I was historically part of a system that did a study that showed that the greatest

correlation with satisfaction with a hospital stay was happiness with pain control. So you could argue that that could result in a process in the hospital setting that you're a bit more liberal in pain control, and then that starts a new problem.

So that would be one question on the policy front.

And then the other thing I want to talk about is the applicability of these strategies to other things, like polypharmacy. I'm a bit -- at first, I was optimistic about it, and now I'm concerned.

I looked at something like PLATO. In an organization that already has accountability, an MA plan or a commercial plan, something like that would be useful because these groups are accountable and they're looking for data strategies to identify examples of opportunities to manage polypharmacy or a drug-drug interaction. So, when the accountability exists, one wants a system like that.

My question is in the environment where accountability doesn't exist because at the present time there are not a lot of provider incentives to minimize polypharmacy or other pharmaceutical misuse.

So even if we were to apply PLATO to other

settings, what is the leverage that we would have to address the problem?

Would we disenroll providers from Medicare? Sure, you could do that. I could see that's applicable with the fraud and abuse that comes with opioids.

But I have a hard time, in the absence of greater incentive leverage, understanding how we would use something like this in other settings unless we're just going to continue to use a stick because I'm not sure what we would use as a carrot.

DR. BAICKER: I think I would benefit from understanding a little bit; what about this set of problems is specific to opioid use and what is a more general set of problems?

And there's the -- that we could then think about solutions that would have broader benefits.

And there's the provider side of things where providers may be prescribing things that they shouldn't either because they're not coordinating care or they're not paying attention to care management of which pain management is just one flavor. And there's one set of tools then that could help line that up in terms of real-time monitoring at

the provider side.

Then, on the patient side, there are patients who are actively circumventing providers because they have a problem with opioids and they're shopping around to different providers and different pharmacies, which maybe the policy levers there don't line up as neatly on any one provider.

Is it because some of them are addicted to these medications?

There's probably much higher resale value for these than lots of other classes of drugs. So there's a whole different set of problems there.

So, in some sense, I think the policy levers on the provider side that aim for better coordination, better monitoring, more thoughtful prescribing seem somewhat more generalizable.

I don't picture patients as much venue-shopping for statin prescriptions or other kinds of prescriptions. So the policy levers on the patient side, if I'm understanding the source of the problem on the patient side, seem a little more opioid-specific.

Again, I'm not sure how much of this is resale and

how much of this is just overuse for shorter periods.

MR. HACKBARTH: I have Alice and Jack and then Kathy.

DR. COOMBS: Thanks.

So I'm one who actually gives more narcotics than most people think about.

As an anesthesiologist, one of the things that I think of when we talk about opioid use is many elderly patients will undergo procedures and will start with perioperative pain control and, for a myriad of reasons, will stay on narcotics for an extended period of time.

I'm not sure what the process is in terms of how soon they come off narcotics, but it's clear that some narcotic introduction after an operative procedure is really an important transition for an elderly who hadn't been formerly been on narcotics to now be on narcotics.

So that would be one piece that I would want to tease out for non-cancer pain.

And there's a number of reasons they may come in -- for abdominal adhesions or hernias, you know, any small procedures, and wind up with narcotics.

A piece about the regulatory aspect, I think the

NPI, the utilization review, those are all very, very good things.

And I think some providers, even within the context of my colleagues, sometimes will have an escalation -- and it will be a gradual escalation -- of opioid dosages and someone will happen to kind of check and say, well, you know, this person is actually taking this much Vicodin; did you realize that?

And I think part of that process is the continuity of care and the communication that occurs.

It's much better when you have an EMR that has an alert and some intelligence. You know, some of the EMR systems will actually warn you that this person has been on this narcotic for this long and this much, and also, the drug-drug interaction. So I think that's really important.

In terms of whether or not this is a quality or cost issue, I think it's both.

There are several communities across states now that say, yes, you must have Narcan in your patrol cars now. The reason they have Narcan in the patrol cars is because opioid is king. There are more opioid overdoses than heroin and cocaine.

And, in the intensive care unit, we see people who come in for whatever reason, and maybe they've had a drug-drug interaction where the potency of the opioid becomes a little greater because of a myriad of reasons. But they will wind up actually on a respirator, and we'll wind up actually treating them aggressively for several days because of an opioid issue.

So I think it's both quality and it's both cost.

The other piece that I think what utilization review would help with is the piece of treating pain with non-narcotic drugs, such as Neurontin. There are diabetics who have diabetic pain, foot pain and various pains for various reasons, that would benefit -- with neuropathic pain -- from other non-opioid interventions.

So I think utilization review would also be able to develop algorithms for when we're not to use opioids and when to avoid.

The DRG diagnosis would probably be helpful for hospitalizations that are opioid-related in terms of the toxic effects of why someone winds up in the hospital.

And then, lastly, there's a number of case reports where people have NPI and one provider may have more than

one NPI number for whatever reason. I know it was hard to believe that you could actually prescribe narcotics without a DEA. Imagine one provider having more than one NPI.

So I think you might think that having an NPI number and being able to track individuals in terms of their prescription behavior might be -- but I think if you had a lens that transected at different levels it would make a difference.

And then the Federation of State Medical Boards has done a very good job of looking at disciplinary actions within states on narcotics and patterns. So I think that that might be another source of information going forward.

DR. HOADLEY: So, in thinking about this issue of the policy options, it takes me back to one of the points we made this morning, which is the limitations of the standalone drug plans, the PDPs, in dealing with an issue like this.

So a PDP can do some of the things Scott talked about, about counting the number of uses, the number of prescriptions you've had -- you know, all that kind of tracking. They can certainly apply some of the basic prior authorization quantity limit kinds of checks and edits to

see what's going on.

What they lack is much of a relationship to the physician. So they certainly can't go that step of worrying about a care management plan, at least not readily.

And I really think we need to think hard about, as long as we're in the system with standalone drug plans, what's the right thing to do?

Do we want to develop some kind of performance measures around this issue so that we encourage PDPs to think about ways to forge relationships with some of their providers or other ways to do these kinds of things?

Or, more generally, what are the right tools?

I mean, there are certainly tools, and a lot of them are around those edits. So a lot of the things of requesting information about what's the pattern of use, what's the diagnosis that was associated, how many times -- so the kinds of things that Alice was talking about -- the PDP, at least under a prior authorization, can get into.

We, of course, have to worry about all the issues that we've talked about at other meetings about using those utilization management tools in a way that doesn't become too burdensome.

Here's the kind of case where we can all agree that they are good edits to have, and we don't mind some burden if we're going to prevent abuse, but again, it could get us caught into that balancing thing.

And it occurs to me that when you think about how to apply this to something like polypharmacy a lot of those same issues are going to apply, but some of the details are clearly going to play out differently.

But, again, the PDP can monitor the existence of somebody who has 12 different drugs that overlap in sort of inappropriate ways, and we could do performance measures.

But they're not in a very good position other than through the medical therapy management programs, which we've talked about before and aren't necessarily being run very well. Or, we don't really know how well they're being run maybe is a better way to say that.

But I think those are things we need to get into and think about how some of this applies in that PDP world.

The only other comment I would make, totally unrelated to that, is on this question of the lock-in. And it's just making sure that if we think about pharmacy lock-in policies that we get the right amount of flexibility in

them.

So there is certainly encouragement a lot of times for beneficiaries to price-shop among pharmacies, and we hear beneficiaries who say, hey, I go to this pharmacy to get this drug because it's cheaper than here. And even when they're -- you know, if they've got co-insurance or they're paying under the deductible, that matters to them.

So we just want to make sure that whatever policies we do either are specific to the opioid prescriptions or have enough flexibility. I mean, nobody wants to go to four or five pharmacies probably.

But we just need to make sure those kind of policies are done and sort of get the right balance of flexibility for the beneficiaries, not trying to abuse anything other than the price-shopper and the ones that we're aiming.

MS. BUTO: So I think I want to make a pretty -- just an observation, and that is that this area of pain management, this paper, it seems to me, sort of splits into the area of abuse and what to do about that.

There's also a big question, and an unanswered question, about how to -- how Medicare can better manage

pain management, if you will, or how Medicare can incent better pain management.

In other words, we can go at it with sort of the hitting the providers and trying to prosecute, and so on and so forth, and that should be done. But meanwhile, it seems to me this is a growing part of Medicare, and it's difficult to attend to these issues that cut across providers even though this is Part D.

And the same issue, I think, will come up when we talk about the under-65 disabled and issues around mental health services. Mental health is such a fragmented thing in Medicare, with all different settings and so on, and we tend to look at the individual payment streams and try to figure out how to optimize those. Meanwhile, plan of care is kind of missing in that equation.

So I think, as we think about these things, it's not a bad idea to have sort of a parking lot of these cross-cutting issues like pain management, that we know is going to be an issue with us forever, maybe growing, that we maybe ought to take a more comprehensive look at kind of both sides of the equation, both the penalty side and the better management side.

MR. HACKBARTH: Other comments, questions?

[No response.]

MR. HACKBARTH: Just to pick up on your comment, Kathy, which I agree with, isn't part of the challenge on the traditional Medicare side that you're operating in the context of free choice of provider for the beneficiary?

Now the beneficiary may have made a good choice or a poor choice in opting for a managed care, using the generic sense, but that is the choice they made.

And to the extent that you try -- traditional Medicare tries to impose some management on that, it starts to bump up against that freedom, potentially.

And then I think you're going to need a powerful rationale for saying, well, we're going to intrude on that freedom that the beneficiary selected.

And you can imagine that in a case where there's a significant problem of abuse and risk to the beneficiary that is a rationale, potentially, for saying, we're going to intervene.

Overall pain management or care management, however good I think it may be, if the beneficiary has chosen free choice, then maybe I don't know if you have the

sound rationale that you need to override that.

MS. BUTO: No, I agree with you on that.

It's a long conversation, but I think beneficiaries -- if they perceive that there's an added benefit to that management, not a penalty or undue restrictions, but actually they get something for it -- I think would be much more amenable to it.

And beneficiaries, in the course of my experience at CMS, would actually come and say, I'd be willing to -- in an assessment of my health care, the annual assessment, if somebody would help me navigate some of the physicians that I choose to choose and help me with this and that and help me understand what I'm doing, I would love to have that experience as a fee-for-service patient. I don't feel comfortable going into managed care.

I'm not saying there's an easy answer. And it may vary from pain management to, say, mental health to other things, but it seems to me the real crux of getting at the underlying cost trends in Medicare is really getting at those issues of what's driving the patients to lose their electricity.

[Pause.]

MS. BUTO: Anyway, enough said.

DR. SAMITT: To tag onto this and also to a comment that Jack made -- and it goes back to sort of the recommendation in the prior session of considering whether ACOs should be accountable for the cost of Part D. You could say the same would be true here if we believe that this is a quality issue.

And the last thing I want to do is add another quality metric to ACOs, but you could think that efficient opioid prescribing or even a methodology to assess polypharmacy would be a good measure of quality for ACOs.

And so is that another potential policy recommendation, perhaps to replace other quality measures if they're redundant?

But this would be another way of encouraging accountability without being punitive at the beneficiary level. It still preserves freedom of choice, but now it asks the providers to at least be attentive to the issue where they may be inattentive to it right now.

DR. NAYLOR: Briefly, I just want to reinforce the point that we need to separate pain management from abuse.

And Craig's comment about the patients feeling

that they've had a very positive experience with care in the hospital if their pain has been managed can be interpreted in two ways. It could be maybe more use of drugs, but it could be that something that really fundamentally needs to be enhanced in our country -- that their pain, in fact, was managed and with all of the kinds of tools that we have available.

So I think distinguishing in the work in the Commission on palliative care and symptom management, pain management. I think that needs to be -- we need to constantly keep a frame of reference that separates these two, which is, one is looking at abuse of medications and medications that might threaten the life and well-being of people versus how it is that we can use all the tools to really get to better pain management.

DR. HOADLEY: Just very quickly to your point, Glenn, that what do you do in this sort of fee-for-service world where people have made their choices, well, again, the medication therapy management concept in Part D is a program that says, okay, once we've screened some people they can still opt out, but we're supposed to be offering this to them as a management service that they can use as they want.

I mean it's sort of Kathy's point as well, I think.

That is a model. Again, whether it's worked well, we can talk about, but-

MR. HACKBARTH: And, of course, exactly how well has it worked?

DR. HOADLEY: It's a concept. Maybe going back, we'll probably review those kinds of programs at some point again. It's been in the chapter most years.

But do we have any better evidence of success, and do we have any better ideas about how to make them work better?

MR. HACKBARTH: Yes. Any -- Dave?

DR. NERENZ: I think you did a number of reasonable things in the analysis, particularly taking out cancer and hospice and then looking at the others.

But with that in mind, on slide 6, I think it's striking, the average number of prescriptions we're talking about here -- that for all the people who get opioids, since these are 30-day supplies, the average is 6, which means the average person is on it with 1 live prescription for half a year or else double prescription, shorter time.

And then on the high end we've got people who seem to have two live prescriptions through the entire year.

It makes me want to go back and think, well, what are the underlying diagnoses here? What are the problems?

We're not talking about people who are in a hospital and have a quick surgical procedure and then they carry an opioid out for a week or two after that.

I mean, these are running long, apparently long, periods of time.

In the chapter on page 9, there didn't seem to be diagnoses that you flagged as being uniquely associated with this except depression.

So, to the extent that your resources allow it, I think it would be interesting to explore in a little more detail. What are these being prescribed for?

We just seem to have a lot of people on these drugs for a long time as opposed to an acute injury event where it's a little more understandable why these are done.

MR. HACKBARTH: Bill, last word.

DR. HALL: I think this is a very worthwhile topic just because of the public interest in it if nothing else, but again, it's more a question of management than catching

all the abusers.

Would there be any value in looking at the reasons why use varies so much in the Medicare population by state -- I mean, there's really no rational reason for that -- and whether some of it's due to very effective programs of regulation that we might learn from?

MR. HACKBARTH: Okay. Thank you, Shinobu.

DR. REDBERG: Quickly, I was struck that the states that had the highest opioid use also were the states that have the high rates of obesity and physical activity, and I wonder if depression is part of it.

MR. HACKBARTH: Yeah.

DR. REDBERG: And I would just say my informal survey of patients when they're on Oxycontin, and I ask what it's for.

And they say, pain.

And I say, well, where is the pain?

And they just say, all over.

I think it's a very nonspecific life hurts.

MR. HACKBARTH: Thank you, Shinobu.

Okay. Next up is a look at the next generation of Medicare beneficiaries.

[Pause.]

MR. HACKBARTH: Whenever you are ready, Julie.

DR. SOMERS: Good afternoon. This session is one of several sessions in this cycle focused on Medicare beneficiaries in response to questions that Commissioners have raised at previous meetings, but before we begin, Kate and I would like to thank Anna Harty for her work on this project.

The baby-boom generation began aging into Medicare in 2011 at a rate of about 10,000 people per day and will continue at that pace through 2029.

In today's presentation, we will examine some of the changes that this large cohort will bring to the Medicare population, including the baby boomers' effect on Medicare's age distribution and racial and ethnic profile, the life expectancy and health of future beneficiaries, projected enrollment in private plans, the experience of future beneficiaries with insurance coverage during their working years, and finally, Kate will provide information on income, assets, and wealth of future beneficiaries in the wake of the Great Recession and slow economic recovery.

While there are no policy recommendations to

consider today, we think these topics have implications for all the decisions the Commission makes, and so we are interested in hearing your views, insights, and suggestions for additional research or analyses in this area.

These graphs illustrate the aging of the U.S. population that is currently underway. The graph on the left shows the distribution of the population by age and gender in 2010. I would like to draw your attention to the red bars. They represent the baby-boom population who, in 2010, were aged 46 to 64. So, in 2010, the oldest baby boomers were a year away from Medicare eligibility.

Now turning to the graph on the right, the red bars represent the baby-boom population in 2030. By 2030, the baby boomers will be 66 to 84 years old, so they will have all aged into Medicare and will continue to contribute to rapid population aging.

And here in the graph on the left, we see that as the baby-boom generation ages, enrollment in the Medicare program is projected to surge from about 50 million beneficiaries today to over 80 million beneficiaries in about 15 years. And as the right-hand graph shows, as Medicare enrollment rises, the number of workers per

beneficiary declines.

Workers pay taxes to fund the Medicare program; however, the number of workers per Medicare beneficiary declined from 4.5 at the program's inception to 3.2 today, and by 2030, the Trustees project there will be 2.3 workers for every beneficiary.

The Medicare population over the next 15 years will be relatively younger as members of the baby-boom generation join its ranks and swell the younger segments, as shown by the pink line in the graph depicting the share of the Medicare population aged 65 to 74 years.

The share of the Medicare population aged 85 years or more is projected to decline slightly through 2025 and then grow as baby boomers continue to age, as shown by the green line.

Per-beneficiary spending for those aged 85 years or more is about twice that of those aged 65 to 74. So the changing age structure of the Medicare population will have somewhat less pressure on spending in the very near term, at least on a per capita basis, and then pressure will reaccelerate over the longer term.

The older population is, and will be for some

time, less diverse racially and ethnically than the total population. The graph on the left shows the distribution of the older population in 2012 and projected for future years. As indicated by the pink bars, whites will remain a majority among the older population through 2060.

In contrast, as indicated by the graph on the right, among the total population, whites will no longer be a majority by 2043.

There are two main reasons why the racial and ethnic diversity of the older population lags behind the total population. First, when baby boomers were born, almost 90 percent of the total U.S. population was white. Second, since then, the nation's population has become increasingly diverse through increases in immigration and minority births. However, recent immigration does not have much of an effect on the age structure of the older population because most immigrants are under the age of 40 when they arrive in the U.S.

Next, we examine how the health of the Medicare population will change over the next couple of decades as the baby-boom generation ages into the program. There is a lot of uncertainty surrounding that issue, and research has

been mixed. However, there are a few trends upon which researchers generally agree. First, the baby-boom generation enjoys a higher life expectancy than earlier generations. Between 1900 and 1960, life expectancy at birth improved by more than 20 years, from 47 years to 70 years. Second, baby boomers smoke at a lower rate than previous generations.

Third, and on the negative side of the ledger, the baby-boom generation has a higher rate of obesity. In the 1970s, about 15 percent of the adult population was obese. By 2010, that percentage more than doubled, reaching 36 percent, and the rate of obesity among adults who are baby boomers is even higher at about 40 percent. Finally, related to the higher rate of obesity, baby boomers have a higher rate of diabetes than previous generations.

Research is considerably more mixed on trends for other diseases and chronic conditions. Some research indicates that rates may have increased for cancer, hypertension, and high cholesterol, while rates may have remained stable for heart disease and stroke. However, many researchers dispute those results and maintain that the higher rates of disease and chronic conditions are the

result of increased diagnostic testing and more aggressive and expansive treatment practices. For example, an extremely slow-growing cancer may now be detectable in a person with no symptoms, but it would never progress to make the person sick.

As well, in terms of Medicare spending, some diseases and chronic conditions lead to higher spending and others do not. Fr example, while high blood pressure and high cholesterol are two of the most prevalent chronic conditions among Medicare beneficiaries, they are not the most costly.

Now let's turn to the issue of health plan choice among future beneficiaries.

Kathy, you asked at last month's meeting about the CBO's and the Trustees' projections for the share of Medicare beneficiaries enrolled in private health plans. This slide will hopefully address your question.

As shown by the green line, the MA enrollment share increased rapidly from 14 percent in 2005 to 28 percent in 2013, a growth rate of 10 percent per year, on average. That rapid growth was in large part due to per capita payment rates for MA plans that were higher than per

capita fee-for-service costs.

The yellow and pink lines depict the projections by CBO and the Trustees. Note the pronounced shift in the slope for the historical years versus the projected years. Both CBO and the Trustees project a marked slowdown from recent history, slowing from a growth rate of about 10 percent a year over the last decade, down to about 1 percent a year for the next decade. At that rate, the MA enrollment share would be between 30 and 35 percent in 2025.

Future enrollment in private health plans may also depend on beneficiaries' experiences with private health insurance coverage throughout their working lives. During the working lives of baby boomers, conventional plans all but disappeared. As shown by the yellow line on this graph, the market share of conventional plans fell from over 70 percent in 1988 to less than 1 percent by 2013.

Many baby boomers also experienced the rise and fall of managed care in the 1990s, as shown by the blue line representing the market share of HMOs.

Throughout that time, the market share of PPO plans grew steadily, rising from 11 percent in 1998 to 60 percent in 2006 and hovering a little over 60 percent since.

And for most of this time period, those PPO plans likely had broad provider networks.

It wasn't until about 2009, after the Great Recession and during the slow economic recovery, that employees and employers started to become willing to accept plans with narrower networks in return for lower premiums and cost sharing.

Finally, high-deductible plans appeared around 2006, obtaining a 20 percent market share by 2013.

So, summing up the baby boomers' experiences with private health insurance coverage, the oldest likely had broad network PPOs, while younger baby boomers and the generation that follows them may be gaining more experience in narrower network PPOs and high-deductible plans.

Looking to other evidence on health plan preferences of future beneficiaries, as Christine explained in September, we learned from MedPAC's focus groups that beneficiaries and near-beneficiaries listed out-of-pocket costs, access to current physicians, and adequacy of provider networks as main factors when choosing a health plan. Some near-beneficiaries said that, given the choice, they would not enroll in a plan with a narrow network, even

if the plan's out-of-pocket costs were lower.

MedPAC staff also interviewed insurance brokers and learned that while some beneficiaries are willing to trade off lower MA premiums for narrow provider networks, many still prefer Medigap in order to have unlimited provider choice.

And finally, for another perspective from MedCHAT, a computer-simulation tool used by the Center for Health Care Decisions to study the tradeoffs people are willing to make in Medicare, participants, which included current beneficiaries as well as younger adults, supported provider networks and limited coverage for low-value care in exchange for a better benefits package; for example, coverage for services not currently covered in Medicare, such as long-term care, transportation, dental, and vision.

Now moving on to briefly examine trends in employer retiree health coverage, the share of beneficiaries with employer retiree health coverage declined from 35 percent in 1996 to 26 percent in 2011. The share will likely continue to decline because, over the past decade, the share of employers offering retiree health coverage has declined, impacting future retirees, and while public-sector

employees are more likely to receive health benefits upon retirement than private-sector employees, the share of state and local governments offering retiree health coverage has also declined over the past decade.

And now I will turn it over to Kate to discuss income assets and wealth of future beneficiaries.

MS. BLONIARZ: So income growth for most age groups has been relatively modest over the past few decades, and in particular, over the past decade.

Real income for families headed by individuals aged 45 to 54 -- that is the top red line -- fell from 76,000 to 67,000 between 2003 to 2013. That is a decline of about 1 percent per year.

For those nearer to retirement, the next green line, the growth was generally flat, and they have a dip as a result of the most recent recession.

And then the third line, the families headed by individuals over age 65, which is the bottom yellow one, has also had relatively flat incomes but did not see a drop during the most recent recession, and this is because this group relies more heavily on Social Security and distribution from assets and less on wages.

Starting in late 2007, the economy went through the most significant contraction since the Great Depression, and unlike some other recent recessions, this one was characterized by effects in three areas: housing, financial assets and credit markets, as well as historically-high unemployment for some groups.

While GDP has recovered to its pre-recession level, this has not necessarily been reflected in household finances. Average household net worth is still about a third below its 2007 level.

A question relevant for our discussion today is whether the group of individuals nearest to retirement were disproportionately affected by the recession. On the one hand, this group on average has the highest asset values and less time to recover or adjust their behavior before retiring, and there was historically high unemployment among this group of workers. On the other hand, older workers were less likely than younger workers to experience multiple shocks, such as being underwater on their house, losing their job, or losing a significant amount of assets. And finally, while GDP has recovered to its pre-recession levels, consumer confidence has not recovered

commensurately.

Bill Gradison, you asked at last month's meeting how consumption patterns have changed over time. We looked at the past few years, with particular interest in the pre- and post-recession period, and that is this picture. And we looked at households, age 55 to 64. There are a few things to point out. First, total household consumption was lower in 2010 than in 2007, and it did rebound by 2013. Second is the trend in household spending on health care. The bottom bar in gray is health care spending, its premiums, cost sharing, and out-of-pocket. And this category, in both the absolute levels as well as the share of total spending, continued to increase between 2007 and 2013.

Households did reduce spending during the recession in other areas. The other category at the top, which includes things like recreation, entertainment, and clothing, did decrease, both as a share of total consumption and in dollar terms during the recession. So, over this time frame, where health care spending growth was at historic lows, households did spend more on health care, while reducing other spending.

To conclude, the near-term picture is dominated by

the rapid increase in the number of new entrants into Medicare, projected to grow from 45 million today to over 80 million beneficiaries in about 15 years. This group nearest to retirement will have, over their working lives, experienced a change from indemnity insurance products to PPOs with generally broad networks.

New beneficiaries are likely to have a greater lifespan than prior generations, but there is some question whether obesity and related diseases may impose a higher disease burden among this group. And the recent recession has worsened some near-retirees' financial situation.

In the longer term, there will be a significant rise in the share of Medicare beneficiaries in the oldest age categories. There will be increasing diversity among the Medicare population, but it will continue to lag behind the growing diversity in the population as a whole.

There will be a larger share of beneficiaries who may have had experience with narrower network PPO products and high-deductible plans, given the growth in these plans over the past decade. And if current trends continue, a smaller share of Medicare beneficiaries will have employer retiree coverage.

One way to place these findings in context is to think about the current tension in Medicare policy, the pressure to expand the program versus Medicare's financial outlook. These trends suggest that that tension is not going to go away and will become more acute in the future.

So we would be interested in your thoughts about that topic and look forward to your discussion.

MR. HACKBARTH: Okay. Thank you, Julie and Kate.

Clarifying questions? I have Bill and John and Craig and Alice.

MR. GRADISON: Quickly, thank you for the Table Number 15.

I don't want to ask for a lot of unnecessary work, but I think you see an even more dramatic change if you have a longer period of time. Let's say from when -- well, just arbitrarily, when health care was 8 percent to when it is 18 percent, because then you can see what is happening, and there's some pretty dramatic changes in other ways in which people spend money. As I recall it, food, household expenditures, and utilities. There were some categories that really dramatically dropped. Something had to give way.

The other thing, though -- this is very specific -- has to do with a role of exchanges. I appreciate that people going through exchanges then may end up in one of those other categories that you show, and that it is very early to make a judgment about what impact exchanges might have or even how many people will be covered.

Potentially, as at least the opportunity is there, not just for people who have individual policies, but for a lot of people involved in small business or, as we've seen recently, for part-time employees of large businesses to move into this category.

I have mentioned this before. I will never miss a chance to mention it again. I would, over time, like to see us really study whether giving an option -- not requirement, but an option to acquire insurance or retain insurance through exchanges out to be considered something for Medicare beneficiaries in addition to the choices they already have. So that may just suggest some maybe future thinking, and I will stop at that point.

Thank you.

DR. CHRISTIANSON: A quick question on Slide 9. I should know this, but I don't remember why the Trustees' and

CBO's projections flattened out.

DR. SOMERS: Well, the trustees just say that the quality bonus demonstration payment, as it disappears, and the gap between the MA payment rate and the fee-for-service payment rate narrows, then that growth in the share will taper off. I don't have information for CBO.

DR. CHRISTIANSON: So they're assuming nothing will ever take its place, I guess.

DR. SOMERS: Well, current -- you know, CBO -- it's current law, right.

DR. MILLER: We had this conversation internally, obviously, and I think there's a real focus on the letter of the law, and I think if you follow the law, the benchmarks begin to come down. And so all other things being equal, you would expect enrollment to slow down. But there's a lot of regulatory action that can offset those kinds of effects. There's a lot of market activity around these decisions that are broader than Medicare, and we kind of look at that trend, and we see it's pretty sharp, and then it flattens out, and we wonder ourselves exactly how to --

DR. CHRISTIANSON: It wasn't totally consistent with a lot of the other points you made in the presentation,

which might seem to suggest that it would continue to rise.

DR. SAMITT: My question is about the demographics of the aging population in light of the discussions we had earlier about certain higher costs and prevalence in the South. I'm wondering if we've looked at the baby-boomer spread geographically and whether that's equal, or whether we'll also see differentials in Asians by geography.

DR. SOMERS: I didn't focus on it in your materials. We could. There is a lot of information about the demographics vary a lot by geography and by race and by ethnic groups, and then disease burden also varies a lot by those groups.

DR. COOMBS: So Slide 4, you show the workers per Medicare beneficiary to drop off precipitously between 2010 and 2030, and then the average income to drop. Has there been any consideration of what the racial demographics do in terms of the average income being considerably less than the non-minority population and how that looks for this drop in terms of being able to actually -- if you were to consider that the average income projected will probably drop considerably more, or can you predict that? Is there any kind of trend that you can tell us about how that curve is

affected by -- you talked about unemployment in the chapter. But how does it -- and how is it influenced by the number of minorities who are now going to be supporting Medicare, and it's more of a minority population supporting more of the Medicare recipients going forward in the year 2030 and later.

So if you had a larger population base that has to support the taxes in terms of revenue generation and things of that nature, changing the base of the support, how does that curve -- does the curve change at all? Is that something we have any data about?

MR. HACKBARTH: Let me pick up on Alice's point, because it was sort of where I was going to go next. You know, I think it's very important to write about, think about the next generation of Medicare beneficiaries, but I think that needs to be done concurrently with looking at the people who are going to be supporting that next generation of beneficiaries.

DR. COOMBS: Right [off microphone].

MR. HACKBARTH: And as illustrated here, that support that's going to be expected from the working population, that burden is going to get increasingly heavy.

As Alice points out -- and I think it was in the chapter as well -- also the ethnic and racial composition of the working population is changing and it's moving away from Caucasian to more racially diverse. But even without that, if you just look at the economic aspect of it, I don't like to focus just on the near Medicare beneficiaries, but the young working families that are trying to figure out how to be able to send their kids to college and a lot of other things, and, you know, each working couple is going to be supporting a Medicare beneficiary. You know, those dynamics are really important.

So, you know, I'd like to see us talk about not just the next-generation Medicare beneficiaries, but also concurrently the people who are going to be supporting them.

DR. COOMBS: The reason I brought that --

MR. HACKBARTH: I think that's where you were headed.

DR. COOMBS: Yes. Joseph Stiglitz talks about the 1 percent of the population, you know, having the greatest amount of wealth and that kind of thing. And then you have this poor -- not poor but less than wealthy group supporting the older --

MR. HACKBARTH: Well, in fairness, you know, a lot of Medicare beneficiaries are not well off themselves, and I think we're all concerned about that. And much of the policy discussion about Medicare focuses on the fact that they need help. And we all agree with that.

But in this world, that help has to come from somebody, and the demographics of the situation means that there's going to be an increasingly heavy burden on that working population who isn't always well off itself. And therein is a lot of pressure.

Cori and I had a conversation about Gene Steuerle's calculation that the average couple retiring today and becoming eligible for Medicare will take out over three times from the program what they put into the program. Cori had some qualms about the exact calculation, but I think basically agreed with the direction of it.

That's a relationship, a transfer of income that can work with the old worker-to-beneficiary ratio but becomes increasingly problematic as it shifts. So we're going to have a lot of relatively low-income people providing, frankly, what is a welfare benefit to Medicare beneficiaries, some of whom are equally poor, but some of

whom are a lot better off. And so I just want to see, you know, both sides of that picture presented whenever we talk about the next generation of Medicare beneficiaries.

MS. BUTO: And just picking up on that point, Glenn, I think the other thing that's going on -- I think it's just beginning -- is with the income-related premium, people opting out of D, B, and Medicare becoming more of certainly a middle-income but more like a welfare program in the sense that it's more income tested or income related. And I think there are issues down the road of support, societal support for the social insurance program that Medicare is, the more you see that erosion.

And so I think as the pressure gets greater to potentially reduce the benefit or increase some of that cost sharing at the upper end, you might see even more of the welfare program sort of cast to Medicare.

MR. HACKBARTH: And there is reason -- I wonder what the effect on the politics of support for Medicare are if the ship goes that way.

MR. THOMAS: Just a clarifying question actually on this graph and whether there's been any additional work done. If you look at this, it obviously looks

unsustainable. And I guess the question is: Have we run any numbers with this escalating what the Medicare spend would be? And if you basically trend forward wages, what would actually be the payments that would have to come from the workers per Medicare beneficiary to really support the program and whether that's feasible? I mean, it's nice to put the graph up, it's interesting, but if you put some numbers with it and look at the economics, does it really tell a story that's totally not feasible?

MS. BLONIARZ: So one thing we could add is, you know, how much you -- the trustees do something where they say how much you would have to increase the payroll taxes to make Medicare Part A sustainable. And so that kind of gives a flavor of this is how much more would have to come from current workers. So we could put things like that in.

MR. THOMAS: And does that trend forward? Do they show that trending forward with this type of graph? And also take into consideration another topic we're looking at today, which is around disability and the escalation of disability. It would lead one to believe that, you know, perhaps the numbers of Medicare enrollment may be higher than this if the disability situation we're going to talk

about doesn't change as well. And I don't know if that has been factored into these numbers or not.

MS. BLONIARZ: We can add some context that will give you some of that.

DR. HOADLEY: Specifically to the point, Glenn, that you and Kathy were talking about, there is political science literature on the subject of universal entitlements that are more easy to support politically than entitlements that are more targeted to a particular population. So I'd just point all that out.

My clarifying question was on Slide 5, and the way you phrased this in the paper was that the changing age structure could have downward pressure on per beneficiary spending at first and then upward pressure, which is certainly true. But I wonder if you have a sense of the size of that impact. Just so often when we look at these sort of demographic trends, the spending implications are smaller than they sort of appear on the surface, and I wonder if you've tried to simulate that with current spending levels or anything to say, okay, but that's a percent or so or 5 percent or whatever.

DR. MILLER: Wouldn't some of that also be in the

same place that we would go to follow up on Warner's question when the trustees --

DR. HOADLEY: Maybe the trustees --

DR. SOMERS: Yes, well, and I think it would have the flavor of what we presented last month in the context chapter. I just don't quite remember what those growth rates were right now off the top of my head.

DR. HOADLEY: Yeah. I mean, the point, I think maybe it was one of the points you made in the context chapter, was that, you know, the impact of demographics is not the biggest driver and it's just sort of a sense of being able to quantify the -- I mean, it looks big on this picture. It's like a big dip in the age curve and a big rise in the other part of the age curve. But it may be a smaller deal when you look at it from a spending perspective -- or not.

MS. UCCELLO: I think there are two components to demographics. There's one that's the change in the age distribution, and there's the -- just enrollment, number of enrollees, and the number of enrollees I think is quite large. The demographics in terms of the age-gender distribution is not -- is more minor compared to that.

DR. HOADLEY: And I was thinking about the second of those, exactly.

MS. UCCELLO: I just looked this up. So in terms of the payroll tax increase that would be needed to bring the Part A into balance over the next 75 years is 30 percent, a 30 percent increase. Immediately. More if we delayed it.

MR. HACKBARTH: And the longer you wait, the bigger that number gets.

MR. ARMSTRONG: Just on that whole calculation, we're talking about two variables and a formula that has several variables. I mean, one is the number of people putting in and how much they're putting in, and the other is how many are spending money. But there's a third variable that I would be really interested in understanding better, and that is, assume those were fixed, what's the spend per beneficiary you need in future years for Medicare to make it work? Because then you start getting some targets. I mean, then you start asking yourself here, MedPAC, okay, well, what would it take for us to get an expense trend that's going to match? And, you know, to a certain degree you want to work with the variables. But, you know, to the degree

we're talking about these big macroeconomic kind of models, I'd really be interested in that number, too.

MS. UCCELLO: You would need an immediate 19 percent reduction in spending to --

MR. ARMSTRONG: [off microphone.]

DR. MILLER: This is the stuff that we have to go back to the trustees [off microphone] for Warner and Jack's out of the trustees. But I also think the stuff that you're going through there from the trustees report, that's the A Trust Fund, right?

MS. UCCELLO: So that's only A. That's not --

DR. MILLER: That's half the issue.

MS. UCCELLO: -- B because there's not the payroll tax for this.

DR. MILLER: Right. So we hear the nature of the question, how much more revenue, how much less spending, that type of thing. And while it's going to scare the hell out of two of them, we'll play around with this from secondary sources on our own to see if we can't come back on this.

DR. CHRISTIANSON: Yeah, to the extent that you're looking at the 70-year projections, I think we should be

highly skeptical. The trustees have expressed that opinion. In fact, they're required by law to do 70-year projections, and I don't know that we believe that's possible to do with any degree of certainty. So maybe the shorter projections we should focus on.

MR. HACKBARTH: We've sort of skipped, if you haven't noticed, from Round 1 to -- I don't know -- round whatever. Why don't we ask if there are any strictly clarifying questions?

[Laughter.]

MR. HACKBARTH: Before we go further into the weeds. Any clarifying questions? Okay.

DR. MILLER: This may be more of a question for Mark. I guess the -- and I'm just not sure if this is in the purview or how this would be done, but would it be prudent, as that analysis is being done, to look at different scenarios? I like Scott's idea to look at different expense targets, different other reconfigurations that -- because there are multiple, obviously, variables that play into the sustainability, and if we're going to look out over the next 20, 30, 40 years, what are the other things that could be considered as part of that?

Understanding that it probably would be difficult to drop expenses 20 percent starting next year. Are there other things that we should be considering that may be prudent changes that could start to be considered? Is that something that is in the purview or is it possible to be looked at?

MR. HACKBARTH: Part of the challenge here, of course -- and I'm not telling anybody anything they don't know already -- is that, you know, you can look at the expense trend, you can look at the revenues and say, well, we can't cut the expenses by 20 percent, but we can increase revenues. Or you can fund it through deficit spending and basically, you know, send it to a future generation. And therein is a huge political debate. What mix of those three things to do is, you know, what it's all about.

And, you know, what mix you choose has enormous intergenerational implications and, you know, implications across income levels, et cetera. But it's hard to say, well, you know, everything else is going to be fixed and, therefore, how much do we have to cut Medicare costs? Because there are a lot of people that just don't accept that as a given. They want to increase taxes, you know, on

the wealthy to fund it. Or some people -- you know, when we have gridlock, as we have recently, the default is just add it to the deficit and say somebody else will pay for it later on, which is a path that worries me.

So there's a certain artificiality in any exercise that tries to say here's how much we have to cut spending in order to make the numbers add up.

MR. THOMAS: Just a follow-on to that, I guess where I'm going with this is if we -- and, once again, we're non-political. We're just supposed to look at this as citizens. If there are other things we should be bringing into the discussion and understanding that maybe it's not just a medical expense trend and it's not just expenses, it's not just revenue, there's got to be other ways to maybe rebalance that graph of how many beneficiaries to how many workers are there, that may be something that should be another factor to be considered in the analysis.

MR. HACKBARTH: Like immigration policy, for example.

[Laughter.]

MR. THOMAS: Well, not necessarily that, but eligibility age. Eligibility age, should that be

considered? Because that would change the balance. I understand it's a very political issue, but it would change the balance of what that ratio looks like, which probably would be something that has to be addressed in order to for this to balance over time.

MR. HACKBARTH: Let's see. I have Cori next.

MS. UCCELLO: So I think this is a really useful chapter to help us think about the needs of the future Medicare population, and also, as Alice and Glenn have really highlighted, the resources of the pre-65 population that are going to be funding these, the beneficiaries, so in terms of the needs of the Medicare population thinking about the rising number of beneficiaries and the implications for provider supply and the mix of providers, in thinking about that, how the change in the composition of the beneficiaries affects that.

We know we focused here on the increase in the minority population. Will the trends that we see in terms of needs of a post-65 population -- will those kind of differences in needs continue in the future as the population becomes more diverse? And in the same sense, will for the pre-65 population, if we see differences in

income by race, as that population becomes more diverse, do we automatically think then those differences by income will continue, or will there be a convergence or more divergence? How are those with the interaction of those kinds of things?

And finally, I think it was helpful to think about the trends in chronic conditions and those kinds of things, but I am also interested in understanding disability, and I don't mean the disability enrollment, but frailty, ADLs of the oldest old population and what can we find out about those kinds of trends.

DR. SOMERS: So I did look at that a little bit. I thought the literature was more mixed and more confusing than the literature on health trends, but we can go back to that and give it another stab.

DR. MILLER: I would have said the same thing.

To the first half of your question --

MS. UCCELLO: [Off microphone.]

DR. MILLER: Well, I don't have to do any of this. They have to do it all. So, you know, in a way, who cares?

[Laughter.]

DR. MILLER: I truly couldn't follow, and I was a little worried.

MS. UCCELLO: So here is what I am saying. So if we see a difference in needs in current Medicare beneficiaries by race and now we are going to have even a more diverse post-65 population, are those differences in needs going to continue? Are they going to not?

DR. MILLER: And where I would leave this one is I now understand the question better. I think we will want -- there is a few things we are going to waddle on here, but that one for sure, it's our ability to respond to that.

DR. NERENZ: Okay, thanks.

I particularly was interested in the health section of this -- and three related questions. If you could put up Slide 8, I will start with that.

This is interesting, the first two sub-bullets, because the first two things are risk factors for the second two things, and if the risk factors are moving up, but the others are not, it suggests that control is a key factor. So the first question is what do we know about the extent to which these disease states are either controlled or uncontrolled in this population aging into Medicare, because I think it is going to matter a lot.

Then the second question is it's easier to be in

control if you are insured and you have a regular source of care. So although you told us a lot about the different types of insurance people have, I was curious in reading just what do we know about who is insured and not insured.

And then, finally, I am interested now, with the recent onset of the Affordable Care Act and presumably the coverage expansion that provides, what that means in these dynamics. So, for example, if you have been uninsured and you have accumulated 10, 15 years of uncontrolled hypertension, but now just as you age into Medicare, you've got 3, 4 years of coverage, does that coverage and presumably disease control eliminate the accumulated burden you build up before that, or do you carry that burden with you? Because now the damage that is going to become catastrophic when you are 70 is already in place.

I know some of this may not be known, but a lot of the big-picture part of this is what disease burden are we in this cohort carrying into Medicare, and I think we need to know something about the degree of control of these conditions to know what that burden is going to be.

DR. SOMERS: Yeah. I did look at those trends, and I think there's two things that address some of those

trends. One is the surveys will break it down into prevalence of, say, high cholesterol known by the person surveyed, but then also examine the person surveyed, and then say do they have high cholesterol and they didn't know it. So those rates of people surveyed not knowing they have high cholesterol have really gone down.

DR. NERENZ: Let me just sharpen the point a little bit. As I understand medical diagnosis and coding practices, which then feed ultimately these records, once you are diagnosed with hypertension, you carry that diagnosis, even if your blood pressure is controlled down to normal. That 401.9 just basically stays with you.

So, in the datasets we look at, we say, "Well, there is somebody with hypertension," but their actual measured blood pressure might be as normal as normal can be. I am interested in that phenomenon of control.

DR. SOMERS: Yeah. And that would be my second point. Some of them do break it down into who has high cholesterol, and then of those with high cholesterol, what is the prevalence of uncontrolled high cholesterol, and those have greatly diminished over time, as well. So we can add that to the materials.

In terms of -- I am not sure that we will have a breakdown. We will have to do a little digging on a breakdown of health indicators by insured status. I think there may be some health indicators maybe out there by insurance status.

DR. NERENZ: I think there are some studies. I can't name the authors, but they just talk about if you age into Medicare, having been uninsured, you cost X. If you age into Medicare, having been insured --

DR. BAICKER: The McWilliams study is looking at -- McWillians is using the national survey aging in from insured versus not insured into Medicare, age 65 regression discontinuity.

DR. REDBERG: Can I Just comment on that, Glenn?

Just to say what you already said in that slide -- and that is certainly one interpretation, David, but another, as Julie noted, it could be that we are just diagnosing these conditions more, because we know we are diagnosing these conditions more, and also, it is a moving target in that we keep changing the definition of hypertension and high cholesterol.

Also, I think particularly high cholesterol is a

very weak, if any, predicator of heart disease, and so you could have a lot of high cholesterol and still be reducing risk factors for heart disease, and so it's not clear what's going on there.

DR. NAYLOR: So just to continue, I guess, this line, on some of these, it's what burden people are bringing as they age in, but other issues are surfacing, so that a new diagnosis of cancer are expected to grow very rapidly in the over-65 population. So it is not just what they are bringing in but what will be accumulating.

I think this is a terrific chapter, and I just wondered whether or not, as we think about, except for the December and January meetings, whether or not in our framework for thinking about policies going forward, this shouldn't be beyond access and quality. Anticipating the future shouldn't be a key fundamental principle that we think about because it's -- and I know we can't predict seven years from now or whatever, but I think we have really good data that suggests we have got to be planning for a different future in a decade, 15 years from now, et cetera, so --

DR. CHRISTIANSON: Yeah, I would agree with that.

My comment is probably better made about 20 minutes ago.

These projections about whether we can afford Medicare in the future, we have been focusing on prices of health care utilization, changing demographics and stuff, but it also depends on what happens with the economy, and that determines how much money in part flows into Part A Trust Funds. It determines how much money flows into general revenue and so forth. So there's two parts of this projection, and I think it's appropriate for us to focus on what we are focusing on, but just reminding people that there is this whole other component in all of these projections.

And I won't go into any discourse on the reliability of macroeconomic modeling, but I'll just leave it at that.

DR. BAICKER: I am a micro economist, I just want to say.

[Laughter.]

DR. SAMITT: So, on Slide 9, this is probably the more concerning piece of news that was a surprise to me in the entire piece, and the reasons is, it was we collectively

believe in the power of accountable models and the potential innovation in quality improvement that comes with it. This would suggest that that sector isn't growing at least as rapidly as it has over the last decade. So the policy recommendation or the policy question for me is, How do we increase the enrollment and attractiveness of the accountable models without increasing the reimbursement levels?

I would love to have more conversations about that because I think that that would be a charge for us. I don't know if we can wait until 2025 to see an increase in accountable models more than we have in the last decade.

MR. HACKBARTH: So the actual rate of growth, we are still in this deep part of this, and they are projecting that is going to change.

Those same people predicted it was going to change right after the Affordable Care Act, and we wouldn't have had the growth that we have had the last several years.

Now, in fairness, what they say is, well, there was the quality demo that replaced a portion, a significant portion of the ACA cuts, and that is why our earlier projection that MA was going to fall off the table was

wrong. And now we are going to be right next time. Maybe they will be; maybe they won't be. Personally, I am not buying this.

DR. SAMITT: Well, it will be very telling to see what happens with MA enrollment --

MR. HACKBARTH: It will be.

DR. SAMITT: -- especially with the harmonization of reimbursement levels between fee-for-service and MA. If the suppression of reimbursement has not suppressed in any way, either the benefits or attractiveness of MA, that's a lesson learned as well for us.

MR. HACKBARTH: I think that it is a dynamic marketplace. I think MA plans, to the extent that payments to them are constrained, they will change. They will tighten networks. They will do various things to try to continue to offer an attractive option for Medicare beneficiaries.

These folks are all smarter than I am, but I do think that maybe they have sort of a static notion of the marketplace when they say, "Oh, it's all going to stop," for what it's worth.

Kate.

DR. BAICKER: I have a meta-point to make. I think the issues that are being raised are incredibly important for us to have in mind in thinking about policies, whether it's benefit design or how the financing would play out in the system. So I think it is really great to have this context.

I think I, for one, would vote for staying out of the business of trying to generate our own forecasts or calculations about how much payroll taxes would have to rise to fill the gap or what the effect of changing the retirement age would be or how different benefit designs would play out in different populations over a longer time horizon.

We already have trouble -- I do -- getting my brain around why the CBO projections look different from the Trustees' projections, and what is current law, and what is current policy, and which ones depend on which economic forecast.

So the contribution of this, I think, is in highlighting the commonalities of these outside projections, which really the big-picture demographics, nobody disputes, and focusing attention on that is a really important and

valuable thing, and let's try to do less hanging any new numbers on any of these things, rather than more, would be my vote.

DR. CROSSON: I found this very eye-opening.

When I was reappointed to MedPAC for this term, a number of people said to me, "Well, based on the CBO projections, it looks like you are going to have an easier time because things are really looking up," right? So if we go to Slide number 4 again, the frightening one, and just look at the current going-forward budget window of 10 years, if you kind of eyeball that on both of those curves, we are coming into the steep part of both of those curves, right?

So I just wonder whether or not we should all have these two charts tattooed onto our arms.

[Laughter.]

DR. CROSSON: So that as we look at some of these really difficult and complicated questions that we are going to have to look at over the year and beyond, we keep coming back to this.

I think about the -- that is probably not the right thing to talk about, but I think about the projection curve, or whatever you want to call it, that was set for --

that triggered IPAB. I don't think that took any of this into consideration.

Glenn, you were trying to get at it earlier. It is kind of like, well, one of the mindsets or the mission here has been to be concerned about federal Medicare expenditures, and we need to be. But even if the projections for federal Medicare expenditures look like they are coming under control, if we think about it in terms of -- I think John was getting at this to some degree -- the ability of the society to support this level of spending, age transfers, transfers between ethnic groups, any of the things, the implications that we have heard today, this is a much more acute crisis than I think maybe people realize.

MR. HACKBARTH: So even if beneficiary spending were to level off and we were to sustain recent low rates of growth, which I think is still very uncertain, but even if we were to do that, because of these demographic dynamics, there is still a significant pressure on the federal budget, significant intergenerational transfer issues, et cetera, even under the best scenario for beneficiary growth.

MR. ARMSTRONG: I don't want to belabor this too much, but really, Glenn, to your last point, the value to me

in this evaluation of how it all adds up over the future years is not to get it right necessarily, but it is to really challenge our thinking about our belief that we are successful when we hold cost trends flat. In fact, I think we could take 20 percent out. We do our best when we are looking for $350 billion worth of proposals, and that was easy.

[Laughter.]

MR. ARMSTRONG: Relatively.

But to have that kind of imperative with measurable objective framing our conversations, I think will help MedPAC get an edge and have an impact that I think eventually will be more beneficial to the program.

DR. CHRISTIANSON: Many of you may have seen this, but our recently former colleague, Mike Chernew, wrote a really nice Health Affairs blog about a month ago where he lays this stuff out in a way that you just can't avoid it, basically making the same points that you are doing here, so I recommend that to any of you who want to scare yourself.

DR. COOMBS: I just want to put a plug in for going forward, some kind of understanding of the relationship between access and workforce, disruptive

innovation, what is necessary to meet the needs of a growing Medicare population.

DR. HALL: My first question, are we on Round 1 still, or is this --

[Laughter.]

MR. HACKBARTH: Yes.

DR. HALL: All right. I can shoehorn my question into one. Let's stay right on this same one, and Jay just -- was that Jay or was it Scott who said this is a scary trend, particularly the yellow?

Some people might say this is a tremendous opportunity for us to weigh in on benefit design right now. So what would change things? And we will assume that the left side of that is correct; that is to say, that we are going to see a bulge for 10 or 15 years, and then there will be another bulge down the way when all the 85-year-olds -- but I will leave that to the younger people in the crowd here.

We already know that there are some preventive measures. Some are primary; some are secondary prevention. They are very much underutilized in the young Medicare population.

On the other hand, we have a baby-boomer population who is kind of used to these things. They know what a health club is. They have gone to discos. They know computer dating and all that sort of stuff.

[Laughter.]

DR. HALL: So what if we really started pushing existing benefit design and say we will -- I don't know what it will take -- we will give you a medal, or we will give you some sort of shared benefit. As we do, in conventional insurance for risk factors, to get yourself in, quote, shape -- and I would do this with a lot of evidence base that we can do this sort of thing. Welcome to Medicare, for example, very underutilized, and it's more just a way of getting an extra bill in rather than actually influencing patient care.

We had the other slides that showed that the good news is they don't smoke, but instead, they eat, right? And so there is a lot of obesity. These are all correctable things that, conventionally, we haven't thought of as being important to Medicare. I think that might be kind of an interesting attack on this to say that the scary thing is actually the opportunity until we get over this sort of

brink of crisis or past. I don't think we're quite there yet.

DR. REDBERG: I think you have set a new bar for Round 1 questions, working in computer dating and discos, and the clarifying questions.

DR. HALL: I'm projecting. I'm projecting.

MR. HACKBARTH: Another other round of clarifying questions? Jack.

DR. HOADLEY: I don't know what kind of question it is, but I have two quick comments. One is sort of at the global level and one is just a small comment.

As we talk about some of these big, big issues, it’s just important to remember that our jurisdiction or our way of sort of claiming our jurisdiction keeps out of some of the sides of this. And whether it’s -- I don’t know whether we consider age of eligibility part of what our mandate allows us, and certainly more likely not going to get into the revenue sides. But those are all part of what should probably be the broadest discussion of these kinds of issues.

The more narrow question is is there any evidence or is there any of the literature that says anything about

working patterns as people move to 65 and beyond? Differences in whether people are not necessarily keeping their career jobs but taking up work. We hear all of the anecdotes about that but I wonder if there's any knowledge on that?

MS. BLONIARZ: Yeah, last year we showed a graph, or two years ago, about the work patterns after 65. And they have been going up after time, both for men and women. What I want to look at is what happens since 2008, because that might have changed. But there has been increasing numbers of people working past 65 for decades.

DR. HOADLEY: And even thinking about how much of that is work with benefits, so that you get into secondary payer kinds of issues versus what I suspect is a lot more common, which is work without benefits where people are getting some additional income by taking on some work.

But I think it's just part of the picture that would be interesting to the extent that it's out there already.

MR. HACKBARTH: So, let me pick up on Jack's first point, before we conclude.

So, our mandate from the Congress, among other

things, says that we ought to look at broad development forces in the health care world beyond Medicare and periodically include that in our reports to Congress. So in that sense, we are not strictly confined to Medicare.

However, in terms of making recommendations, there I think we are confined to Medicare.

Now the age of eligibility issue which Warner raised, and Jack alluded to, is obviously a Medicare question. My feeling has been that it is a particular type of Medicare question, however, where we don't necessarily have expertise. It really doesn't have to do with how you pay for health care, organize health care. It really is a question about how society chooses to distribute its benefits and burdens. And that's a realm in which we have no particular expertise, and so I have always felt like going into the age of eligibility is not a place for MedPAC to go.

Now I have my own opinions about it, but I just don't think it's something that we should opine on because it doesn't play to our expertise.

So that's a specific response to Jack and Warner.

Just one other unrelated point before we conclude

this. As part of our mandate to look at the broader issues of health care, et cetera, without making necessarily recommendations, I do think that this intergenerational piece is an important thing for us to think about and try to package in a way that's useful to the Congress and others. We've talked about several aspects of that.

I just want to highlight one other. That is that I think it's true -- and there may be data that we can bring to bear on this -- that the younger population, which is going to be expected to support an ever growing number of Medicare beneficiaries, also their health care is changing. There is a growing prevalence of high deductible health plans. Workers who are lucky enough to have employer paid insurance, are being asked to pay, required to pay a higher percentage of the premium cost.

There's a growing prevalence of narrow network plans. Famously, those people who are getting coverage through the Affordable Care Act and the exchanges, many of them are experiencing narrow network plans as the ones that are affordable to them.

Meanwhile, traditional Medicare offers free choice of provider. And because of the way supplemental coverage

works, we're basically subsidizing first dollar supplemental coverage.

And so this transfer that's inherent in this graph is from young people who may not have a lot of money, who themselves are experiencing a very different kind of health care, to subsidize seniors who get free choice of provider first dollar coverage.

I don't think that -- for me, that doesn't work.

Herb?

MR. KUHN: I think that's a very good point. But at the same time, on an intergenerational transfer, if you look at PPACA and the reductions that were made in the Medicare program to help finance premium subsidies for individuals to go into the marketplace. So there has already been a bit of an intergenerational transfer from the Medicare Trust Fund into those folks to be able to get those high deductible health plans.

I mean, that's kind of going on right now.

MR. HACKBARTH: Very little of that, if any of it, came from Medicare beneficiaries. It came from you and it came from Scott and it came from the provider and health plan organizations.

MR. ARMSTRONG: Exactly.

DR. MILLER: Just two points.

I want to sum up a little bit so you know what's going to happen here, but also just go back for a moment to the managed care growth points that got raised over here. And particularly in light of the first dollar comment that was made.

The other thing to keep in mind about those kinds of projections is they assume the benchmarks go down. They assume that then the plan has -- the plans will do many things but one of the things it can do is it can ask the beneficiary to pay something. If that happens, then nobody will want it.

I think it's really important to keep in mind, there's a lot of managed care plans that actually have premiums and people want them because they feel like they are getting some benefit and something from that plan. And so just because that curve is bent and maybe somebody has to start to introduce a premium, there may still be a value to the beneficiary.

And in particular, if we go back to some of our recommendations on first dollar coverage and change the

proposition on the fee-for-service side, where that first dollar coverage is really subsidized, then that tradeoff becomes much more of a tradeoff than a beneficiary might be willing to make. I think that also plays into what will happen to that curve.

But really what I wanted to say is there were a bunch of ideas raised here: geography, intergenerational transfer, focusing on what are some of the estimates, secondary sources -- to Kate's point of how much taxes and spending would have to change.

We will huddle and go through how to respond to each of these. I don't know that there will be another set piece, given the rest of the agenda that we have to get through in this cycle, to sit down and talk about this. But we will make changes in the paper and then grind that back through you guys for you to review.

And I'll talk to Jim, and obviously Julie and Kate, as to whether there's another time we actually come back and think about this.

But what will happen is there will be adjustments to the paper for sure to track through these. And we will try to write something that we e-mail to you guys that says

"here's how we're going to deal with these" so that you have some follow up here if we don't have a public follow up.

DR. NAYLOR: I just wanted -- your comment about the intergenerational gap chasm that will happen as a result of slide 4 does raise questions about what investment we make in the next generation to help care for the Medicare population.

In the past, the Medicare program has largely been the interactions between providers and individual Medicare beneficiaries. But I think an opportunity here is to think about the family caregiving role of the next generation and the extent to which a program makes a deliberate investment in preparation for what is extraordinary burden that the family -- broadly defined -- takes on.

And so it's just a thought about how to help narrow some of these gaps.

MR. HACKBARTH: Okay, thank you Julie and Kate.

[Pause.]

MR. HACKBARTH: And finally for today, we turn to the entitlement based on disability in Medicare.

MS. BLONIARZ: So I want to make two quick points before we begin. First, this is part of our work on

understanding the beneficiary perspective and is one group of beneficiaries that is growing in size relative to the rest of the population, even with the trends that Julie and I just talked about.

And second, this is a new area of work for the Commission. We haven't focused specifically on this group of beneficiaries before.

So the background is that nearly 9 million people under the age of 65 are receiving Medicare because they are entitled to Social Security Disability Insurance, or SSDI.

After 24 months of receiving SSDI, people are automatically eligible for Medicare.

It is a growing share of the Medicare population. Disabled beneficiaries make up 17 percent of the population today, up from 10 percent, 30 years ago.

And demographically, they are also different from the average aged Medicare beneficiary. They are more likely to be non-white and male, and a little less than half of them are dually entitled to Medicaid.

So I will talk a little bit about the process of getting SSDI, since that process confers Medicare eligibility after 24 months.

The Social Security Administration oversees the SSDI program, and it is a benefit available to insured workers, people that have sufficient work in Social Security-covered employment, and they cannot currently be working when they apply.

The average SSDI benefit is just over $1,000 a month, or $12,000 a year. Once beneficiaries start receiving SSDI, they rarely leave the program because of medical recovery or returning to sustained work. It is less than 10 percent, and the remainder either convert to the retirement program or die.

The disability determination process for SSDI considers whether the applicant has a medical condition that is sufficiently disabling, such can they can no longer work, and so I will go through that in some more details.

So this graphic lays out the disability determination process, and starting from the bottom left corner. The applicant cannot be performing substantial work, and they must have worked enough in the past, so that they are insured.

The next stage is the assessment of whether the applicant's medical condition is severe. Then the

applicant's medical condition is compared to a listing of impairments. If the medical condition equals or exceeds in severity the medical listing, then the applicant is found to be disabled and entitled to SSDI.

If their medical condition does not meet or exceed the listing of impairments, then the next step is to review their medical condition in the context of their ability to work; specifically, can they do their current job or their old job or any other job. And if they are determined to be unable to work, then they are then entitled to SSDI.

I want to emphasize two things here. First, this is a complex and individualized assessment process, and that can result in variation and whether applicants are approved or not. I am going to come back to that point a little later. Second is the fact that the disability determination process explicitly considers whether applicants can do work, either their old job or another job in the national economy.

This graphic shows the range of conditions on which SSDI beneficiaries received benefits. For each of these categories, in SSA's listing of impairments, they will describe in detail the level to which each impairment has to affect the individual's daily function. So it is more than

just the diagnosis.

The largest single category are musculoskeletal system and connective tissue disorders. That is the top right slice in the pale green.

About a third of beneficiaries are entitled to SSDI on this basis, and this category include things like degenerative disc disease, spinal stenosis, and other conditions.

About another 30 percent are entitled based on mood disorders or other mental impairments, the two categories at the bottom of the pie. Mood disorders include conditions such as bipolar or depression, and the other mental disorders category includes conditions such as schizophrenia and anxiety disorders.

The share of applicants receiving SSDI on the basis of these categories, these three categories, musculoskeletal conditions, mood disorders, and other mental impairments, has significantly risen over time, doubling in the past 30 years.

There has also been a significant increase in the number of people receiving SSDI over time. Since the late '90s, the number of new entrants per year has nearly doubled

to just over 1 million. You can also see from this chart that there have been higher numbers of new SSDI beneficiaries since 2008, due in some part to the economic recession that began in late 2007.

I made the point earlier that once people start receiving SSDI, they rarely leave, because they return to work or medically recover. Of all the people leaving the SSDI roles in 2012, about 35 percent died, 55 percent switched to the retirement program, and less than 10 percent returned to work or medically recovered, such that they would no longer be considered disabled.

So when the numbers of new applicants and new beneficiaries rise as the result of economic factors, it does not fall similarly once the economy recovers.

So what are the factors that may be driving this this change in SSDI enrollment? First is demographics, and there's two factors going on. One is that women's work attachment has grown significantly over the past 30 years, and so they are more likely to be insured based on their own work history. The second is that disability rates for workers are highest for those over age 50. So, as the population ages, they become more likely to apply for SSDI.

The second factor is the labor market, including the recent recession. When rates of unemployment go up, individuals who may have worked but are no longer working may apply for SSDI.

Third are policy changes, particularly reforms in 1984 that liberalized the rules for applicants with multiple conditions and self-reported pain.

And fourth are underlying rates of work-limiting disability. But as I described in your briefing materials, this doesn't seem to be as big a factor as the other three.

A lot of federal organizations have raised policy issues about the SSDI program, and I have listed a few here.

First is the administrative complexity of the program. There are multiple stages to the application and appeals process, which I went through in more detail.

Second is the subjectivity of the disability determination process. There is some evidence that this leads to variable outcomes within and across the different stages of the process, as well as geographically and across different types of applicants.

Third are the incentives for applicants to permanently leave the labor force. Beneficiaries may lose

SSDI if they go back to work, and the application process can take a long time if people appeal, during which they are out of work the entire time.

And fourth is the financial outlook for the program. The DI trust fund is scheduled to run out of money in 2016.

Turning now to Medicare, disabled beneficiaries report higher rates of difficulty seeing physicians and other clinicians and are more likely to report that they delayed care due to cost than beneficiaries. This may be partially due to Medicaid coverage among disabled beneficiaries, but these findings persist across all types of supplemental coverage.

Among disabled beneficiaries overall, about 20 percent are enrolled in Medicare Advantage, and as Carlos told you last month, this is largely an effect of lower rates among dually eligible beneficiaries. Forty-three percent of the disabled population is also enrolled in Medicaid. However, even with these higher rates of Medicaid coverage, disabled beneficiaries are more likely to have Medicare only, Medicare fee-for-service only, than aged beneficiaries. Twenty-three percent of beneficiaries age 45

to 64 have Medicare fee-for-service only.

So with regards to spending, Medicare per-beneficiary spending is about comparable, but the service mix is different.

Disabled beneficiaries appear to use lower amounts of post-acute care and relatively higher amounts of inpatient care and outpatient care, and you can see this on the chart.

There are a few caveats to this figure, though, that I want to make. First, the disabled category includes beneficiaries with end-stage renal disease who also have SSDI, and per-beneficiary spending for beneficiaries with ESRD is very, very high.

And second, while total spending might be similar between the aged and disabled groups, it doesn't tell us about the variation in spending.

Disabled beneficiaries are quite heterogeneous in terms of their disabling condition, whether comorbid medical conditions are present, and their activity limitations. This variation results in very different spending patterns across types of beneficiaries in terms of total spending, types of services, whether other payers are involved, as

well as the likelihood that a beneficiary will incur very high costs.

There may be reason to pay particular attention to mental health services, given the qualifying diagnosis of many disabled beneficiaries.

There are higher rates of reported depression among disabled beneficiaries. In 2012, 28 percent of disabled beneficiaries had treated depression versus 13 percent for aged beneficiaries.

Access to psychiatric services has been highlighted as a particular challenge in the focus groups that we conduct.

Psychiatrists overall are less likely to accept insurance than other specialties, and this holds true for Medicare patients, as well.

Another feature of Medicare that may be a factor is the outpatient mental health limitation, but starting in 2014, the limitation went away, and the coinsurance for mental health is 20 percent, the same rate as other outpatient health care services.

So to sum up the presentation, we wanted to get your reactions and questions and, in particular, whether

there is other work you want us to do.

There are a few areas that could be of interest. First is further disaggregating service use and spending among this group of beneficiaries. Second is further understanding the role of medical and vocational factors in the disability determination process and what it means for new Medicare entrants. And third is to look at mental health needs and use of services among these beneficiaries.

And then in terms of Medicare policy, the changing characteristics of disabled beneficiaries can have implications for a number of policy areas. One in particular may be benefit redesign and the payment policies that flow from that.

So I am happy to take questions, and I look forward to the discussion.

MR. HACKBARTH: Thank you, Kate.

Could you put up the Slide 10, the two bar graphs -- or the bar graph?

So it is about the same, but you report that disabled beneficiaries are more likely to have fee-for-service, Medicare only, without any supplemental coverage.

MS. BLONIARZ: That's right.

MR. HACKBARTH: And we know from work that we did on benefit redesign that beneficiaries who don't have supplemental coverage use fewer services, all other things being constant. So, in that way, the equality of spending, it is sort of very different insurance arrangements here, and so that just might be worth highlighting.

MS. BLONIARZ: That's right.

And the other thing, if just under half of them are also entitled to Medicaid, then we don't have any of that on this.

MR. HACKBARTH: Yes. Right.

Okay. Bill has a Round 1 clarifying question, I think, right? No.

[Laughter.]

MR. HACKBARTH: I just want to make sure, Bill.

Clarifying questions? Kathy.

MS. BUTO: Yes. Kate, thanks for this very good paper, and I wondered -- we talked a little bit about this -- whether we have any sense of the growth of this category in particular over the next, say, 5 to 10 years, what the projections are for growth in this category. In particular, I am interested in the beneficiaries with disability based

on mental disease, which has already -- I have forgotten what the number is -- 30 percent or so of the total, if you add the two together.

And kind of a separate but related issue is the age of beneficiaries with Alzheimer's and dementia. So there is a large cohort if you actually add this group to the group of beneficiaries who are in need of mental health services who are aged, and I just wanted to get a sense of whether we know what the growth in that population is.

MS. BLONIARZ: So total growth overall for the disabled population is projected to kind of slow down relative to the trends recently, just because people are moving from the age of kind of peak, working-age disability into retirement, and so most people expect that that number will slow down.

In terms of the type of impairment, I am not sure I could say, but we could look at that.

MR. GRADISON: I would request that you take a look at any policy recommendations that may have been developed in recent years from outside of our organization. I haven't surveyed them. I got something the other day from some former colleagues that I think were working on some

kind of bipartisan proposal. The NASI has done very good work on issues having to do with a disability over the years. So I think their focus has been on private DI.

Also, I recall from my years with the Health Insurance Association that one of the types of insurance that we were trying to represent were DI, disability insurance, both group and individual, and they may have some policy recommendations. I am just suggesting that folks out there might have some ideas for us to consider.

Briefly, as an aside -- I will move on very specifically in just a moment -- back in the '90s when I was there, some of the insurers were having a difficult time related to managed care. What was happening was that the disability insurers used to sell a -- I don't even think they do this anymore, but anyway, they used to sell a kind of disability insurance, which was only for your own occupation. "Own occ," they used to call that. So we were running into situations that were reported to us at least of, say, neurosurgeons in a state like California which were going big into managed care, and they said, "I am so nervous with all this. I can't do that anymore." If they had an own-occ policy, you couldn't say, "Well, you could be a

general surgeon, can't you?" Well, no. The insurance only covered the specific specialty that they had, just an indirect observation.

I do have a specific request with related to my previous comment about exchanged. I would like you just to see if you could take a look at what would happen if on eligibility, prior to Medicare age, on eligibility, which today is for Medicare beneficiaries, they were instead given options through the exchanges. The income of this group is relatively low. The subsidies would probably be quite high, but I'd just like to see what that might mean and particularly in terms of how it would look from the point of view of the beneficiaries and also what savings it might provide to the Disability Insurance Trust Fund itself if they were included with others in the population who were being given the option of acquiring their insurance through the exchanges.

Thank you.

MR. HACKBARTH: Clarifying questions, anybody? Jack.

DR. HOADLEY: One question, I think I know the answer to, when you are looking here at this population, as

soon as somebody who becomes entitled on disability turns 65, they are no longer in the group that you are studying; is that right?

MS. BLONIARZ: That's right. I mean, this is just the under 65.

One thing we did do was look at people over 65, so with the current age of entitlement, but who were originally entitled based on disability, and spending for them is higher than a similar aged beneficiary.

DR. HOADLEY: I know sometimes when people talk about those issues, they sort of think of those as part of the disabled population, but I just wanted to make clear what we were doing.

The other one on Slide 10 sort of relates to Glenn's question, and he was focusing on supplemental insurance status, but it seems like there is also different diagnoses involved, and I wonder if you have thought about sort of looking at the spending differences, risk-adjusted, although, of course, the risk adjustors have disability in it, so maybe it is just the diagnosis part of risk adjustment to see if that explains away -- how much that explains away differences.

MS. BLONIARZ: So this was one of the questions that we wanted to get feedback on, is what kind of work we should do. In other work I have looked at, not that I have done myself, but there is vast differences in spending based on diagnosis, presence of comorbidities, ADL limitations, and the type of service people use, whether other payers are covering some of those services. It is quote variable. So if that is something of interest, we can do it.

DR. HOADLEY: It seems like that could potentially be helpful to understand how much the population is driven by what their health conditions are versus their status as being disabled under 65.

MR. HACKBARTH: Other clarifying questions?

DR. REDBERG: On Slide 8, just 2016 is coming soon.

MS. BLONIARZ: Yes.

DR. REDBERG: Is SSDI Trust Fund just the payroll tax?

MS. BLONIARZ: Yes. So I want to make one point on this. The DI Trust Fund has gotten close to exhaustion in the past, and Congress has just allocated the Trust Fund -- the payroll taxes between the retirement part of the

Trust Fund and the disability part of the Trust Fund. So that is how it has been handled in the paste, and I think some people expect that is what will happen this time.

DR. REDBERG: And then my other question is on Slide 9. Do you have any insight into why, even after you adjust for supplemental coverage, disabled beneficiaries have a higher rate of trouble accessing care?

MS. BLONIARZ: So there's some research that disabled people in all categories have worse health care experiences, more trouble getting services and report more problems.

In one study, they looked at currently employed with employer coverage, working-age people with disabilities, so no difference in employee status and insurance, and they reported higher rates of trouble getting care.

There's also been some studies that use kind of a secret shopper model, calling and saying, "I am taking a relative who is disabled and may have difficulty with stairs. Can you see them?" Even at that stage in the process, it seems like the medical system is not as accommodating.

DR. CROSSON: Thanks.

This is in the text. It is Figure 10. From that chart, it suggests that disabled beneficiaries have about 30 percent or so more hospital use in patient days than aged beneficiaries, but less than half of the use of skilled nursing facilities. Is this a function of the fact that there is a higher rate of diagnosis of depression or other mental disorders, or is there some other factor?

MS. BLONIARZ: I am not sure. I think this will -- I think we would just want to look at the distribution because, again, like I said to Jack, I think this varies so much by diagnosis and kind of what medical conditions people have.

I will put it off, and we will get you an answer once we think about it.

DR. COOMBS: Kate, that is a really good question.

I just wanted to let you know that the Committee on Health Council -- Health Policy Advisory Committee, has done some work in Massachusetts on the number of mental health beds, specifically designated for mental health, and it might be interesting to kind of look at that with what Jay just mentioned to see if that is something that would

change just the whole notion of what inpatient costs look like when you have mental health-designated beds.

MR. HACKBARTH: Other clarifying questions? Kathy.

MS. BUTO: Just two quick ones. Somewhere, you have the per capita spend for disabled beneficiaries. Was that on one of the tables versus the population as a whole, and was it a lot higher per capita spend? It is higher, but it doesn't look hugely higher because you are not counting Medicaid spending, right?

MS. BLONIARZ: Right. That's right. This is just --

MS. BUTO: So my other question was really whether we know if the dual eligible demonstrations, any of them, have a decent cohort or even target this population, the under-65 Medicare disabled.

MS. BLONIARZ: I believe that Massachusetts focuses on mental health, but Christine is --

MS. AGUIAR: Yes, that's right. The demonstration in Massachusetts exclusively enrolls the under-65 population, all of the under 65, not just mental health. And then the other demonstrations also will enroll both over

and under 65, and Massachusetts is the only one that focuses exclusively on that population.

MR. HACKBARTH: Other -- Cori?

MS. UCCELLO: I don't have a question, I just wanted to thank you for a clarification that you made in the document specifying and clarifying the pathways to eligibility for the ESRD versus the other disabled versus the ALS population. I really appreciated that.

MR. HACKBARTH: Well, a thank-you signifies the transition to Round 2, since there wasn't a clarifying questions.

DR. MILLER: Can we have a thank-you round?

[Laughter.]

MR. HACKBARTH: Kate.

DR. BAICKER: This is just a quick comment that I think it might be interesting to point to some of the literature on experiments freeing up -- I can't remember if it is specifically SIGNATURE or SSDI populations to work more and keep their benefits, and that that ends up being a big motivator to get people back into the workplace, because they are afraid of losing their benefits, and then once they do, if they end up getting work that has benefits, they can

transition to that. That seems like a potentially important contribution to what we are seeing out in the population.

MR. HACKBARTH: Other Round 2 -- Alice.

DR. COOMBS: One of the things -- first, you did a great job with this, and I actually will use this when I go back to Massachusetts. Thank you very much. Some of the data in it I think are very good.

For the mood disorders and the other part of the pie chart with the mental health, it would be interesting to look at the breakout for that, specifically because of the inpatient cost. And I know you might be able to do this, and that is to look at which one of those are more likely to result in inpatient and if it is related to either substance abuse or addiction, especially with the mood disorders.

MS. BUTO: I can't remember who, which Commissioner made the point last time -- David, it might have been you -- that we are seeing many more patients, Medicare patients, coming in with mental disease issues to the emergency room or showing up in the hospital or something like that, and I guess in the back of my mind, it would be really helpful, again, looking down the road to this issue of benefits that are available and are accessed

by beneficiaries across sites of care, where the program might take more responsibility for looking for ways to incent a plan of care or some better coordination in a population that generally uses fee-for-service. If we could figure out -- and, by the way, has two sources of insurance. If we could figure out ways that would make that more -- provide a better basis for that kind of coordination -- and I know people have thought about this, but mental health tends to be one of those issues that people just don't want to tackle. It's very tough. The benefit has been different from site of care to site of care, and then there was the outpatient mental health limit.

So it is just something that for the future, I feel like with Alzheimer's and dementia and this under-65 population with large amounts of depression and other conditions, something we ought to think about, whether it is more management kind of benefit aimed at mental health or something like it.

DR. NERENZ: Just to follow up on that -- and this may actually end up being a clarifying question. I didn't think of it until you mentioned it. For people whose disability is based on a mental health condition -- this to

insurance concept -- that they have Medicare coverage, but then also their state/Medicaid coverage for the severe and persistent -- so when we look at these numbers -- inpatient, outpatient -- that is the Medicare payment, but I presume it is not very much, if at all, for the mental health condition. Is that a fair presumption, because there is state coverage for that?

MS. BLONIARZ: I think this gets back again to condition-specific spending patterns.

What I have seen is that mental health -- it looks like beneficiaries with mental health conditions, Medicare and Medicaid are both involved in providing those services. When there is the beneficiaries with mental retardation, there is more likelihood that states would be involved, because they may be in state institutions, state hospitals. When beneficiaries have kind of another comorbid medical condition, then Medicare is much more of a payer. But it is really dependent on the type of condition and the type of services. Medicaid provides more kind of enabling and support services than does Medicare, which handles the acute care side. So there's just a lot of factors.

DR. NERENZ: So to clarify, just pulling off right

at the end of what you just said, that the care for a severe or persistent mental health condition would be paid for not by Medicare in these group of folks; is that correct?

MS. BUTO: No, that's not -- I don't think that is really correct. There is the inpatient site benefit. There is a partial hospitalization mental health benefit. There is outpatient psychiatric care.

DR. NERENZ: Some of my thinking here is just driven by the dual eligible categories from those demos and how we are pooling funding streams.

MS. BUTO: Medicare is sort of primary, though, in a lot of this.

DR. NERENZ: And it just seemed to me, loosely speaking, that in talking about pooling those funding streams, that a lot of what was coming in the mental health side was coming from the state -- or, say, from Medicaid. I guess I should be more precise, and it still seems a little confusing that in the whole range of mental health services, what is paid by Medicare, what is paid by Medicaid, and I am just trying to clarify in these charts what's what.

MS. BUTO: Yeah, I think that would be helpful.

DR. MILLER: I am not sure you guys are saying

things that are inconsistent.

I think, Kate, when you were talking about severely persistent, to the extent that they end up in institutions, those institutions will often -- and particularly have spent down, become poor, and all the rest of it, then a lot of that will be Medicaid.

But I think also Kathy is right to the extent that if we have an acute care experience, Medicare steps up to the plate.

And what I want to say is -- you can come to the mic, or you can use this one -- also, we have some datasets where we have combined Medicare and Medicaid data, and we may be able to bring that to this discussion and bring a little more richness to the picture.

MS. AGUIAR: Yeah. I would just add that these funding estimates that Kate is showing, those are Medicare fee-for-service, so that is Medicare-covered services.

And, yes, it's true. There are some wrap-around, more robust mental health services that dual eligibles will get through Medicaid that non-dual beneficiaries are not entitled to, so they don't receive.

And, yes, as Mark was saying, in our Duals data

book, which we published one last year in 2013 and we are working on an updated one now, we do have spending for Medicare and Medicaid that is broken out by subpopulation. We have one chapter where we do look specifically at Alzheimer's, dementia, and LTSS users.

We also have a chapter -- and this is, again, last year's 2013 publication, the characteristics of high users, high utilization, Medicare, Medicaid spenders. And in there, you sort of see -- you could see how some of the ones that are in the top 5 percent of spending also tend to have high -- be more of the SPMI population.

MR. ARMSTRONG: I want to ask a follow-up question. So do we know what percentage of dual eligibles actually fit the disability criteria? We know 43 percent of this population, disabled beneficiaries, are dually eligible, but does that represent a significant percentage of the dual eligible population?

MS. AGUIAR: Yes. The dual eligible -- and I don't have the numbers right in front of me. I believe the split is -- the majority are aged, but it is not an insignificant number that are under 65. We could get you that very quickly.

DR. NERENZ: Just for what it's worth, in Michigan, I think it's close to 50/50. I mean, in numbers that we have looked at in our planning, it is pretty close to 50/50, either aged or disabled.

MR. ARMSTRONG: Glenn, generally, I am not sure this is that helpful, but this is a great window into this population that I have not known very much about at all. I was stunned to learn it's 17 percent of our overall spend as a share of Medicare spend. It does feel to me a lot like the dual eligible population where we know its' big, we know it's complicated, it's unique, and we haven't really gotten a real good agenda around what we do with it. But it's only going to grow, and so I think it is worthwhile for us to build on this window into this population and begin to think about how do we lay that out relative to all the other work we do in fee-for-service and MA as a relative priority for our agenda going forward.

DR. NERENZ: It seems like it hasn't gotten the attention that we really need to be giving to it.

DR. HOADLEY: So I very much agree with what Scott just said. I am always struck when I am looking at a new article in a journal or reviewing an article for a journal

that says in one of those sort of throwaway sentences, "And we excluded all the disabled Medicare beneficiaries," as if it was a tiny little subset that kind of wasn't important. I realize for some analyses, that may be logical, but it is kind of symbolic to me of how they are not paid attention to, and I think it is really great that we are.

On this previous point, I think the way I like to think of on the Medicare/Medicaid is, I mean, Medicare is still the primary payer for a Medicare-covered service. So the ones that Medicaid pays a lot of are the ones that Medicare would not be paying for, and I think that was said, but I just wanted to reemphasize that.

The other policy issue that I know you had like a sentence in the background paper, but you talked here about the number of people without supplemental coverage, is to remind us that a lot of states do not have open enrollment for Medigap coverage -- and I think it is 22 states or something like that -- and then other states that don't have full access to all the different kinds of Medigap plans and so forth, whether that is an issue we might want to talk more about.

At one level at least, what would the number -- if

you just looked at the subset of states that don't have that open enrollment, how does that change that percentage that you showed? And we could sort of see just how much effect that has at least a global level. That would be simple, I think, but whether it is something we want to think about as a policy issue to at some point say something about is to have states provide that open access when people first become Medicare-eligible, so you don't have this sort of absence of access to that coverage. It has always been a strange kind of policy place that we're in for that reason.

MR. HACKBARTH: Other comments or questions?

[No response.]

MR. HACKBARTH: So let me go back to the point that Kathy has made now in both this session and the one on opioid use, that there are subsets of the Medicare population that are in traditional free-choice provider Medicare. They have made that choice. Yet the nature of their condition or conditions is such that they might especially benefit from some approach that results in better coordination, integration of their care.

It seems to me that this is sort of looking at things on a different vector than we usually looked at them

before, and I don't know what I think about it, but it seems to me that almost on its own merits, that is something worth thinking about.

On ESRD, which is sort of another population that has very significant, often multiple intersecting conditions, remind me where we are in the ESRD payment. There was some look at trying to provide more of an integrated -- there is a demo, I think, on an integrated ESRD program. Am I making that up? Are people nodding yes, I am making that up, or yes, that there is?

DR. MILLER: You are not making that up.

Did we lose Nancy somewhere along the way? Oh, we did.

MR. HACKBARTH: Yeah.

DR. MILLER: Okay. Actually, Nancy and I were just talking about this recently, and I can't quite dig it back up in my memory. Let me come back to you on it.

There is a demonstration out there where what they were trying to do was create an ACO model specifically for ESRD providers, and there was some --

Sorry?

MR. GLASS: [Off microphone.]

DR. MILLER: Right, but it is an ACO.

MR. GLASS: Right.

DR. MILLER: Right.

Okay. And my understanding is that there was some activity and then some pullback and reconfiguration of the parameters, and that is where I kind of lost track of it.

MS. BUTO: I may know just a slight bit more than you do about that. I think there was an issue when the demonstration was designed about which things were in and which things were out, and some politics got into it and so on.

But back when the demonstration was actually conceived, one of the striking things was that the ESRD population, unlike a lot of these populations, has very predictable costs. There is a much more stable cost. I think at the time I was involved, $25,000 per beneficiary. It is probably much higher now. You could more easily imagine capitating, providing capitation payments for that care, because there was a stream, et cetera, and that is what the demonstration is supposed to be doing. But I think there was an issue with what was in and what was out.

MR. HACKBARTH: Kathy, attaching the term "ACO" to

it means, in my brain, that the beneficiary doesn't enroll. They are assigned to a group of providers. Is that right? Is that how that should work?

MS. BUTO: When I looked at it, it was being designed as an enrollment model.

MR. HACKBARTH: Oh, okay.

MS. BUTO: But they may have moved away from that.

MR. GLASS: [Off microphone.]

DR. MILLER: Yeah. I think there actually is one that is not an enrollment model, and in some of the discussions with the industry, as you might imagine, the other reason -- and I think Kathy gets it. Some of the reasons this lends itself to this kind of model is you see that beneficiary frequently at the same location, and so there was some discussion for like we don't really need an enrollment model, because this person is basically presenting at your doorstep three times a week at the same facility.

And so if there was some talk about enrollment, I won't dispute that, but my more recent conversations have been ones that are not enrollment-based. But again, I can't dredge it all back up, either.

MR. HACKBARTH: So, at any rate, I will leave it there, but this may be an idea worth thinking some more about for patients, whether they are disabled patients or they have an issue with opioid use or something else, where there is more of a system.

Other comments, questions for Kate?

[No response.]

MR. HACKBARTH: I don't see any.

Anything you want to add here, Mark?

Okay. Thanks a lot, Kate. Good work.

We will now have our public comment period.

[No response.]

MR. HACKBARTH: Seeing none, we are adjourned until tomorrow morning at 8:30.

[Whereupon, at 4:30 p.m., the meeting was recessed, to reconvene at 8:30 a.m., Friday, October 10, 2014.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, October 10, 2014
9:34 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
KATHY BUTO, MPA
ALICE COOMBS, MD
FRANCIS “JAY” CROSSON, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
HERB B. KUHN
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
WARNER THOMAS, MBA
CORI UCCELLO, FSA, MAAA, MPP

AGENDA PAGE

P R O C E E D I N G S [9:34 a.m.]

MR. HACKBARTH: Okay. Good morning. We have two sessions this morning -- the first on post-acute care and then one on physician payment.

So, Evan, are you leading the way?

MR. CHRISTMAN: Good morning. For many years the Commission has been concerned about the way Medicare fee-for-service buys post-acute care. The PAC settings Medicare covers overlap in the services they offer and the patients they serve. Medicare operates four siloed payments systems that have different prices for the same patient. We also see broad variation in PAC service use across the country. As a whole, these facts raise concerns that Medicare fee-for-service does not provide incentives to ensure that beneficiaries are sent to the best PAC setting.

Private sector entities, particularly those that hold financial risk for quality and the efficiency of post-acute care, use many strategies that are not present in Medicare. A question for the Commission is whether some of these policies are ripe for consideration by Medicare fee-for-service.

As a reminder, the Commission has already made

several recommendations on PAC reform, some of which were included in the recent IMPACT Act that addressed many PAC reform issues.

The Commission recommended that Medicare establish a uniform patient assessment tool to allow Medicare to compare the quality and cost of PAC providers, and this data would also facilitate the development a unified PAC PPS.

We recommended hospitalization incentives for home health and skilled nursing financials. We also recommended that the skilled nursing facilities and home health payment systems be revised to rely solely on patient characteristics to set payment.

We examined the bundling of post-acute and acute care, and Medicare currently has a demonstration underway to test this concept. And the Commission just recommended changes to the LTCH and inpatient PPSs to improve payments for chronically critically ill patients.

We also have some projects underway. We are examining site-neutral payments for IRF and SNF providers. We have a project underway examining approaches to developing a unified PAC PPS. And we are also developing a cross-sector measure of readmissions for patients in IRFs,

SNFs, and home health.

These recommendations and analysis reflect our work to date, and we thought it might be useful to look at the experience of private sector entities that purchased PAC to see what other strategies were in use, and so we engaged a contractor to survey health care entities in the public and private sector.

The contractor and MedPAC staff reached out to PAC subject matter experts and identified 13 entities in three categories that had experience purchasing PAC. The range of entities interviewed included health plans, PAC benefit managers, and entities participating in the Medicare bundling demonstration. They included both for-profit and nonprofit entities and were from a number of different geographic markets, and they served the range of PAC patients found in Medicare. We conducted a one-hour phone interview with each entity.

Overall, the entities used a range of strategies. A key factor in the tools available to the entities was whether they were a Medicare Advantage plan or a fee-for-service entity. Medicare Advantage plans could exert a stronger influence on beneficiary decisionmaking because of

their ability to selectively contract with providers and review utilization. Fee-for-service entities did not have many of these tools, but still found ways to encourage better use of PAC.

All of the entities we spoke to had care coordination and readmission strategies in place for at least some share of their PAC population.

Entities generally were focusing on SNF care. Some were planning to look at home health next, though some believed that use of home health could increase if they were successful in driving down SNF expenditures. And some entities were testing financial incentives, but they were too early in the process to have results to share.

Starting with policies for selecting the site of care, one strategy involved educating stakeholders as a way to inform the decision on the PAC site selected For example, one entity provided comparative quality data like readmission rates on SNFs to doctors and beneficiaries. Another entity in the bundling demonstration provided stakeholders with data about the cost and quality provided by IRFs and SNFs. The impact of these techniques on utilization and quality is less clear, but entities did

believe that they were successful in influencing site-of-care decisions in many instances.

Entities also used strategies that established preferred network of PAC providers. MA plans could use exclusive contracting. Beneficiaries could face little or no cost sharing for using in-network providers and face significant cost sharing for out-of-network providers. And quality could also be--excuse me. Contracting could also be used as a quality strategy. One plan we spoke to narrowed its home health network by primarily contracting with providers that had better quality scores.

Fee-for-service entities were experimenting with establishing informal preferred provider networks; commonly these were ACOs or hospitals working with PAC providers that they usually send patients to. ACOs and hospitals would usually conduct some screening to identify the stronger providers and engage them in quality improvement activities. Beneficiaries would be encouraged to select these providers, but were not required to.

Some MA plans used prior authorization to determine the site of care and amount of services. They would use proprietary or commercial guidelines available

from vendors to determine the site of care and the number of days of SNF care or number of home health visits a beneficiary would receive. And beneficiaries could request more care through a reauthorization process.

Some entities are testing a carveout approach where a third-party vendor is assigned responsibility for managing the PAC benefit. The vendor determines the need for PAC, site of service, and amount of service. The vendor might be paid a fee, which could be based on past spending minus some minimum guaranteed savings.

Now we switch to looking at the strategies for managing care.

As we mentioned earlier, all entities had some form of care management in place. These programs took several forms, such as transitional staff that followed patients throughout their care, to adding on-site care at PAC sites to supervise care, and developing clinical protocols for high-risk patients.

Some ACOs and health systems were working with PAC providers to measure and develop quality improvement materials. Some developed provider quality scorecards for SNFs, allowing them to see how they compared to other

providers in the market. Other efforts including developing higher standards of care for SNFs based on best practices.

There were other strategies that the entities used that were focused on reducing hospitalization. One SNF went to around-the-clock nurse staffing to ensure after-hours coverage.

Some entities were monitoring patients after discharge through the use of telehealth, call centers, or in-person visits. One entity found the use of social support programs such as Meals on Wheels to be useful for supporting patients after discharge. And another entity was working with PAC providers to establish a shared electronic health record.

All of these approaches had impacts for the beneficiary, most with the goal of smoothing transitions of care and reducing unwanted readmissions.

Ideally, improved care can help reduce the stress and confusion beneficiaries experience after a hospital discharge when they are still adjusting from the health shock of an acute event.

Our respondents also found that patient education tools can help beneficiaries understand their options for

PAC and their forthcoming changes in care that may occur as they move along the PAC continuum.

The use of narrow or tiered provider networks can limit beneficiary choice. In some instances beneficiaries may not have access to desired providers, and beneficiary advocates might be concerned about access to care for sicker patients that require specialized services not available from every provider. However, focused networks can also help beneficiaries find higher quality providers. This approach is harder to implement in fee-for-service with its guaranteed choice of provider, but some fee-for-service entities have had success shifting beneficiaries to preferred providers that they have established collaborative relationships with.

In summary, private sector entities shared a number of strategies with us that fall into a few discrete categories.

They used strategies encouraging the use of high-quality providers.

Some entities educated patients and doctors about the quality advantages of select providers to influence the choice of PAC provider.

Some entities established preferred networks. For MA these took the form of closed networks. However, some ACOs and hospitals were able to establish preferred networks of PAC providers with the goal of influencing beneficiaries to select them.

Cost sharing was not always a preferred strategy, but health plans with tight networks encouraged beneficiaries to select in-network providers by not paying or paying significantly less of the costs for out-of-network providers.

Some programs used prior authorization to manage the site of service and the amount of service.

Medicare has limited experience with prior authorization. Currently a program is in place for DME in select areas that have aberrant patterns of utilization suggestive of fraud.

Establishing prior authorization for PAC would require significant effort. Medicare would have to determine the service to apply it to, develop more specific medical necessity guidance, and find funding for these reviews and any appeals.

Some entities were using a PAC benefit manager.

The entity assumed financial risk for PAC services for a plan and was responsible for utilization and quality outcomes. If Medicare wanted to pursue this approach, it would need to think about how to protect against stinting and ensure beneficiary choice was safeguarded under a vendor.

The entities had a number of approaches to post-discharge monitoring. These included operating call centers, additional staff, and telemonitoring of patients. And hospitals and ACOs also developed goals and interventions to help PAC providers improve their care. PAC providers would address quality issues identified by the ACO that help the ACO meet its quality and utilization goals.

The Commission may want to discuss whether any of these strategies should be considered by Medicare. If so, another question would be how to implement them. Two possible paths include modifying existing policies to permit their use in Medicare fee-for-service or permitting them as optional policies for entities willing to bear financial risk under models such as ACOs and bundling.

Beneficiaries will also have to consider the beneficiary role in new reforms and whether we should put

additional responsibility on the beneficiary to assure proper use of PAC resources.

This completes my presentation, and I look forward to your discussion.

MR. HACKBARTH: Okay. Thank you, Evan.

So let's follow the same format that we used yesterday, Round 1 clarifying questions, and then Round 2 we will try to build some threads of thought.

We might also aspire to a Round 3 and try to focus in on a few particular issues that come out of the Round 2 discussion. I thought we did pretty well yesterday in Round 1, being disciplined and limiting ourselves to clarifying questions, but I'm sure we can all do better, myself included. So I would appreciate it if people would really limit the Round 1 to strictly clarifying questions.

So I see several hands up already, and so we'll just go around this way.

DR. HALL: Thank you, Evan. In terms of the private vendors who provide the management services, the PAC services, do you have any inkling as to what cost that is? Does that add additional cost onto the system?

MR. CHRISTMAN: Well, I think the way they're

frequently doing it is they -- you know, in the case of an MA plan, they're do it pretty much as a carveout where they'll say, you know, the MA plan spent so much in the prior year, and the vendor will frequently come in and say, you know, we'll take that amount minus some guaranteed savings, you know, maybe 5 percent or what-not. And so, you know, in that sense it doesn't push any additional costs on the plan. It's sort of a question of how well the vendor does in managing the costs. They're taking some insurance risk there.

DR. HALL: Okay. Thank you.

MR. ARMSTRONG: Were you able to get any information about the impact on overall costs through these interventions?

MR. CHRISTMAN: I think that was hard to come by because a lot of these people were still kind of in progress. I think there were, you know, folks who felt that they were being successful in addressing readmissions, but nobody really had any hard results yet.

DR. CROSSON: Again, in terms of the choice of the private PAC benefit manager, the question is why. Why that outsourcing? Was it related to the nature of the health

system you're looking at? Is it, for example, nascent ACOs who don't have the capability to do that compared with more experienced robust systems? Or what was the basis for that business decision?

MR. CHRISTMAN: In our conversations it appeared that they were working with a lot of MA plans, and it appeared to be perhaps plans that had felt that this was an area that they had not completely addressed and were looking for -- and when they found a vendor willing to assume risk and implement a system, they brought them on.

MS. BUTO: Evan, I wondered if you have any information about the kind of geographic distribution of some of these other -- I know SNFs and home health agencies are kind of everywhere. But inpatient rehab facilities and long-term care hospitals, are those evenly distributed? In other words, as you look at managing post-acute care, is it an issue everywhere? Or is it really an issue just in certain parts of the country?

DR. CARTER: So I think it's an issue everywhere, but the issues might be different. So in terms of IRFs, those, you know, tend to be in populated markets, but not in all markets. I think something like three-quarters of

hospital service areas have an IRF, but a quarter don't. And LTCHs are not distributed throughout the country.

And so in terms of trying to realize PAC savings, in some markets you're trying to shift use out of IRFs and LTCHs where you can. But our sense from these interviews was there was a lot of SNF spending in terms of length of stay, and really managing to that benefit, even on the MA side, the providers were quite used to sort of the 20-day stay. And that spilled over into the MA practice of a facility.

And so our sense was that there were still post-acute savings and shifting things that didn't -- patients that didn't need to be in SNFs necessarily into home health.

So I would say across the markets there are opportunities, but the opportunities might be a little different.

DR. MILLER: The only other thing that I would add is that you do see geographic variation in the use of -- you know, beyond your question of IRF and LTCH, you see a lot of geographic variation in the use of post-acute care. The work that we've done over the last few years, the most variation in the program is in the post-acute care area.

And I'll also just reinforce I think the benefit managers are, at this point at least, very focused on SNF and readmission. They see those as the big block events that they're going after. And, you know, they come in and, Jay, to your point, they will present information on savings and change in trend. I think more the response is can you generalize it to the program more broadly. I think that's where we're saying we're not quite sure at this point.

DR. CARTER: And there is variation in PAC spending even if you take out LTCH and IRF spending, which are unevenly distributed, but even across home health and SNF there's lots of variation.

MR. HACKBARTH: And, Kathy, a corollary of the fact that the different types of facilities are not evenly distributed is that the capabilities of home health agencies and SNFs vary significantly across markets. So, you know, it's easy to fall into saying, you know, a home health agency is a home health agency or a SNF is a SNF when, in fact, the reality is more complicated on the ground.

Clarifying questions?

DR. CHRISTIANSON: Yeah, Evan, I know your interview methodology didn't -- wasn't structured to do

this. Do you have any sense of how common the benefit managers are as a model? And, also, is this a growing trend or not? Give us a sense of how big a deal this is, I guess, in the context of everything else going on in managing post-acute care?

MR. CHRISTMAN: I think it's new and growing. There's a few particular vendors in this world that are out there and reaching, you know, new plans and looking for entities to partner with. But it is a relatively recent development to have a PAC-only benefit manager, and so I think there are some plans who might have been doing this for one or two years, but I don't know that there's anybody who has a super long track record with it.

MR. HACKBARTH: Evan, the idea of an MA plan subcontracting, if you will, with a PAC benefit manager, is there -- it seems to me that that idea would be most logical for an MA plan that does not have a lot of business in a particular market, may have less experience, may have less leverage, and so they say, "I want to hire somebody who can manage this particular service in this particular market." In contrast to, you know, a Group Health of Puget Sound or a Kaiser Permanente where, you know, they're a huge player in

a given market and really known that market. Any evidence on whether that's how the MA plans are using them?

MR. CHRISTMAN: I don't get the sense that that was really what was going on.

What we heard again and again, really, was that SNFs were used to sort of providing care on the Medicare fee-for-service model, provided out at least 20 days, and I think there was a sense among some MA plans that some vendors kind of offered a system for basing patient stays more on what they believed was justified by the patient's characteristics. And bringing in somebody who had that specific expertise was valuable to the plan.

I don't think that they were doing this in areas -- it seemed like they were not focusing this in areas where they had less leverage or any kind of limitations. I got the sense it was more just that they felt that the SNF environment was so built around the 20-day length of say, that they really needed help, somebody with expertise, on how to tie those days better to patient needs.

MR. HACKBARTH: Clarifying questions?

MR. GRADISON: I don't think this was on your list, but did you get any insights into the experience with

the three-day rule? I gather from previous discussions here that the majority of MA plans don't have the same three-day requirement. I was, of course, wondering what might be learned from them in terms of why they don't follow it, and what the impact of their current practice may be with regard to quality, access, and cost.

DR. CARTER: We did hear a little bit about the three-day rule but not very much, but you're right. A lot of MA plans don't have that.

We did hear something interesting that some of the MA plans still contract on a discharge basis and would need to unravel those contracts in order to save money on the inpatient stay. So, in that sense, the three-day stay, if you are still going to be paying for a complete hospital discharge, you have less incentive to shorten that.

I was a little surprised to hear that, but we did hear that. But we don't have any numbers on how frequent that was or even the savings associated with that.

MR. GRADISON: Thank you.

MR. THOMAS: Did you come across in your interviews any issues around physician ownership of these entities, or do you see that having any sort of impact or

hearing that that had any sort of impact over utilization or usage of the facilities?

DR. CARTER: The one thing we did hear was that some of the systems that had an ACO were quite interested in aligning with SNFs where their physicians had a presence in that SNF in order to more fully align incentives across entities, but we didn't hear anything about physician ownership, per se.

DR. HOADLEY: When you heard about the educational strategies, obviously discharge planners and others always do some of that in any kind of situation. Did it feel like it was a real quantum leap above sort of normal practice when these entities would try to do more in terms of educating on choice of site?

MR. CHRISTMAN: In some cases, I think they were doing -- these vendors or discharge folks would have more information for helping and take a stronger role in trying to help beneficiaries steer their way through the system and make a decision about where to go, and there were a variety of different ones. In some cases, it was going to physicians and educating them about the alternatives.

I think what we didn't get a good sense of from

talking to these entities is sort of what the bottom-line impact was. In some cases, like the third-party vendor, there might be a financial arrangement where they are on the hook for the cost of PAC services and the cost of readmission, so there is some mechanism built in for that feedback.

But I think that the strongest -- I think the most important comments we heard were that in many cases where they were maybe having additional staff, like some sort of a transitional care staff, the beneficiaries often reacted very positively to that, to having someone who would work with them through the process and help them better understand the care that they are getting. And that was definitely, I think, a departure from regular practice.

DR. CARTER: I just wanted to add two things.

We did hear some providers were really developing scorecards and sharing that with providers in the hospital and helping them evaluate possible PAC referrals, so that is sort of the data side.

And then there was -- we go the sense there was more widespread dissemination of best practices, so how do you manage wounds, how do you identify early respiratory

infections, things like that, so trying to influence the way care was being managed in the facility to prevent rehospitalizations, mostly.

So it was two different strategies.

MR. HACKBARTH: Any other clarifying questions? Warner.

MR. THOMAS: Besides the third parties that seemed like they were taking kind of a global fee and then managing the utilization amongst various providers, did you come across any practices or areas where there was actually providers taking global payments and managing that on behalf of an MA plan or ACO, or was it really just kind of a third-party administrator that was taking that risk on?

DR. CARTER: No, probably not what you're referring to, but we did interview some entities there were participating in CMS's bundling initiative. So, in that sense, most of them were just entering the risk phase, but that, of course, would put them at risk financially.

MR. HACKBARTH: Any others?

[No response.]

MR. HACKBARTH: So let's turn to Round 2 comments. We will start with Mary. She is our transitions and care

expert.

DR. NAYLOR: So, Warner, I can tell you a little bit about some of those practices. That there is direct payment from MAs to a service line developed to feed all of these connections.

But, first of all, I think this is a really great example of where MedPAC's recommendations are having major impact, so the IMPACT Act and the use of, first, the identification of measures that we are going to be able to look at across, I think, is extraordinary, the tremendous efforts in alignment of readmission policies, both that which has been completed and that which is ongoing, and coupled with some of the work around payment deliveries, bundled payments, and the community-based care transitions program.

This is a really dynamic market, and I think what your report suggests is that people are responding. The interviews talking about the range of activities, I think, is really quite extraordinary.

So two things I would like to highlight, one is I think encouraging use of highest quality PAC environments is a really important area, and certainly, the data that we'll

get in terms of outcomes from these measures across sites will be very helpful, but wonder whether or not there are any more direct ways. And I think the use of comparative data, that we make those tools available to all involved in that entire journey would be great.

The second comment I'd make has to do with concerns about a third-party vendor, and wondering -- the review of all of the evidence around effective journeys for people moving from hospitals to PAC settings talks about not just knowing what are the best sites of care for quality, but the partnerships that need to exist between hospitals and post-acute settings, the collaboration between and among the providers, et cetera.

And to me, a third party adds a potential additional fragment to this entire journey, and this is a serious review of the evidence. That's one of the common grounds is when hospital clinicians talk directly and work directly with PAC clinicians, around Mr. Smith's plan of care. So I would really need to be convinced that the vendor model has real benefit and in fact might have some harm in our journey to make it more coherent, more together.

DR. CARTER: We didn't hear very much about that,

but we did hear a little bit of the mix, mixed reactions to having a third-party outsider who may not even be physically located in the facility or even the same market. So we heard a little bit about I think what you're talking about.

DR. MILLER: Also, to date those conversations -- and I don't know whether this changes your mind or your point -- they are taking place in the context mostly of MA plans. So it is not like a third party grafted onto kind of a fee-for-service environment, at least to the extent that we were talking to these folks, but maybe it doesn't change your --

DR. NAYLOR: No, I was just wondering about MedPAC's thinking about where.

DR. MILLER: Oh, I see. I see.

DR. NAYLOR: And I just think that's a direction we would want to really seriously evaluate.

MR. HACKBARTH: Round 2. Craig and then Kate.

DR. SAMITT: This was a great chapter. I learned a lot and enjoyed reading it.

I want to start with this slide, most specifically talking about ACOs and the additional flexibility. This is one area where I think our prior discussions about shifting

ACOs from being built on a fee-for-service chassis to be somewhat more in the middle between fee-for-service and Medicare Advantage is applicable, because I think we see the potential influence of ACOs in innovation and managing population health from the post-acute care perspective.

So I would encourage us to consider relaxation of some of the ACO rules to allow providers a more effective influence and steerage of choice of post-acute care, specifically also in the opportunity to create incentives for beneficiaries. I know that doesn't exist in ACO today. It does exist more in MA. What if that was an area where we targeted first? So the first thing that I would underscore is I think that opportunity exists in ACO.

But I also believe that there are some opportunities to modify existing fee-for-service policies. Most specifically, I very much encourage us to think about preferred provider networks, as well as creating incentives for beneficiaries to use those preferred provider networks, even in the fee-for-service space, which obviously is a departure from what we're used to.

The one caveat I would say is how do we address that in the area of Medigap coverage, and even if we create

incentives, do we bypass the influence of those incentives because of supplemental coverage?

The things that I was not very keen on would be COP as an influence, prior off, which I think adds a whole layer of complexity in fee-for-service, and similar to what Mary described, I have some concerns about a third-party vendor, and I think we would have to think carefully about that. I would rather the accountability to be closer to the provider as opposed to a delegated accountability for this.

MR. HACKBARTH: Craig, let me ask about your next-to-last idea. Within traditional Medicare fee-for-service, Medicare creating more opportunity for steering beneficiaries to particular providers, you referred to preferred provider networks. Would those be created by Medicare, or would those be preferred providers selected by a hospital, say?

DR. SAMITT: Well, I think it would potentially be a two-part process. One would be -- you know, I like this notion of the provision of data regarding post-acute care providers, so Medicare potentially may have a role in using -- and I even wrote a note to myself, "Can Medicare acquire some of these proprietary data analytic models to do

profiling on post-acute care providers and feed that information to communities to develop their own preferred provider network based upon the information that was generated?"

So I don't see why the local communities could not develop their own preferred provider networks, but Medicare modify policies to allow alignment of incentives for beneficiaries to use the preferred providers in the networks.

MR. HACKBARTH: Evan and Carol, this may be a good time for you to refresh everybody's understanding of what the rules are about hospitals trying to steer beneficiaries to particular PAC providers.

DR. CARTER: Well, they are not allowed to, but my sense is that soft steering goes on quite a bit, and you can do that by listing PAC -- I mean, the simple way would be to put up a list and put your favorites up top.

There can also be explanations about why you prefer certain providers. If your physicians are rounding at PAC providers, there would be clinical linkages between PAC providers and hospitals that would probably benefit the patient.

A couple of the places we talked to had integrated medical records or were working towards that, so that would be another reason.

Practitioners can also talk about good outcomes and just their experience, not hard data but just their experience of having worked at these places and not others.

So my sense is that there is some guidance, but bennies can always choose something else, and in the entities that we talked to, they -- like a place that had an NCO and then comparing that to the MA, there would be sort of 90 percent adherence with the MA use of working with it, using PAC providers within a network, but more like 50 percent in the fee-for-service world.

MR. HACKBARTH: What I'm trying to do here is identify at least a couple potential paths. One is sort of a rigorous data-driven identification of who are the best providers for different services, an information base that could be used. A second path would be simply to give hospitals more flexibility in terms of trying to steer, particularly in a world where hospitals have increasingly financial responsibility for like readmissions and things that happen outside the hospital. And I'm -- you know, try

to favor one or the other approach at this point, but I want to identify that there are a couple different paths that you can go.

MS. BUTO: Glenn, does that run afoul of the Stark rules in any way? I mean, if there is any ownership or share --

MR. HACKBARTH: Yeah.

MS. BUTO: Owner share between, say, the SNF and the --

MR. HACKBARTH: I won't pretend to know the answer to that, to those.

MS. BUTO: Yeah. I'm just thinking --

MR. HACKBARTH: But it would be things that we --

MS. BUTO: -- that that could be an impediment. Yeah.

MR. HACKBARTH: -- would need to examine if we go down that path.

Kate.

DR. BAICKER: So this seems like a great opportunity to potentially improve quality and slow spending growth, and we have talked about the PAC setting and all the different places patients might go, and the heterogeneity in

that is signaling this opportunity. To me, the presence of third-party managers in this highlights that there must be an opportunity for gains.

I am a little less concerned on the MA side or plan side. If they want to outsource this component of management, that doesn't strike me as an additional layer. That is doing something that the plan was doing, only it is a different insurance-type entity doing it. It is not somebody else between the doctor and the patient. There are clearly very different issues once you start getting the fee-for-service patients, or to ACOs where there are supposed to be physicians steering rather than an insurance entity steering. But, in some ways, the fact that there is a return to specializing in this kind of management to me is a signal of opportunity for us.

If only we had encounter data where we could trace all this out -- and I can't believe you didn't say it.

DR. SAMITT: I agree. I'm sharing the wealth.

DR. BAICKER: Thank you. Thank you.

So then what can we learn from these incredibly helpful stakeholder interviews as well as what we are seeing out in the field? We are worried about a couple of things.

We are always worried about the usual suspects of stinting, are people saving money by withholding valuable care or by cream skimming, selecting patients, and I think we can be less concerned about that in some cases than in others. And the goal would be to have the data and the analysis to let us know that this is truly seizing on opportunities to improve quality by getting the right patient to the right local and home, healthy sooner, which is good for everyone.

So I would love more information, if not from that data, then from what we can observe from these successful models about how much of the gain in quality and judicious use of resources can be accounted for by targeting the right patients, by sending patients to the right setting, by choosing the version of that setting the specific place that's the best -- you know, should they go to a SNF; if so, what's the best SNF? -- then managing their care once they are in that setting, and then coordinating their care throughout but also post-discharge.

Those are all different sets of policy levers for getting the use of resources targeted in the most efficient way to the most efficient people, and some of them seem more amenable to me to implementation through ACOs or through

some novel tools in the fee-for-service setting than others. So knowing where the gains are in that chain, I think would be really helpful in choosing the tools that we can implement to other settings.

Now, that just may not be possible with the data on hand, but it's a pretty different story if it's about picking the right patients versus if it's about discriminating among providers versus if it's among just getting everybody to the right setting that happens to be available to them in their community. That suggests very different policy levers to me.

MR. HACKBARTH: Continuing with Round 2, comments going down this way? Scott.

MR. ARMSTRONG: Yeah, I think I just briefly would affirm that the points that Craig and Kate made I would agree with. This just seems like an area where there's so much opportunity for us to do a better job. But I have to say I'm kind of stumped as to what, you know, the advice would be. I live in an MA world where we have teams of doctors and nurse practitioners rounding on very few facilities, and we're constantly evaluating those facilities against an incredible array of different criteria --

quality, service, ability to work with our care providers, and other things. And we're de-selecting facilities that actually don't stand up to our criteria. Clinical records are completely integrated. Our primary care practices know who these patients are.

Our use of the SNF is actually well beyond the normal use in that we will admit patients directly, and the acuity often is higher. And yet overall our length of stay is half of the Medicare program's length of stay in skilled nursing facilities. And it just seems, you know, those are some of the criteria that we want to judge fee-for-service by, but how do you get there? It's hard to imagine without a payment structure that is somehow creating the accountability for the overall cost and quality of care.

So short of Medicare Advantage, it just seems to me, you know, to Craig's point, something in ACOs, something in bundling, where we're able to clarify accountability for some of these kinds of outcomes is the best bet. And it just may be that, given how fresh the bundled payments for post-acute services are, that we give ourselves the opportunity to really discover, you know, what actually comes from that. But I wish I could offer more. I just

feel so influenced by a completely different world that I just think we should work hard to figure out how more fee-for-service patients have the benefits of it.

MS. BUTO: I had a question, a little bit of a clarification question, but it informs sort of the way I think, at least, about this issue. That is, is the cost and quality issue we're concerned about more on the readmission side? Or is it more on picking the higher-cost site of care for post-acute care? Because if it's on the readmission side, I would think we'd want to look at the readmissions penalty, because that ought to give hospitals, I think, a lot of incentive to want to manage to the best quality, best outcome post-acute care setting. But if it's more on the high-cost side, then I think what Craig was suggesting about preferred networks and so on would be, you know, something we'd really want to explore.

So I wondered, do you have a sense, is it both? Is it one more than the other? What's the exposure we're trying to get at here?

DR. CARTER: Just knowing the readmission rates, I would say that that's a piece of the problem, but it's not the whole problem. And it is finding the right setting.

It's finding the right providers within the setting. It's shoring up lengths of stay and loading people up with services they don't need while they're in the setting. So it's kind of all of those things.

MR. HACKBARTH: Before we proceed further down, Alice, I've been neglectful in asking people if there are any of these comments that they want to build on before we get too far away. So anything that Mary or Craig or Kate or Scott has said, does anybody want to pick up on that?

MR. THOMAS: I would just build upon Craig's comment around the fact that I do think there needs to be a relaxation of the ability for hospitals to do a better job, you know, set up a preferred provider network in directing folks. I think you're finding, especially around readmissions, but just the interest in this area that there is a -- more hospitals that are getting a better understanding of the types of facilities that they're sending patients to. And I think we ought to be providing guidance that hospitals ought to be understanding better about where they're sending patients to, and they should know the quality data and they should know the types of services that are being provided to their patients. And I

think going to Scott's point, they should be interfacing there more, and I think we ought to be providing guidance to hospitals that's an expectation. But in order to do that, you can't have a network that's, you know, as wide open and maybe it needs to be more narrow.

The other thing, it occurs to me that there's just such tremendous fragmentation in this area that if you think about an acute-care hospital, you have different levels of care, you know, through the entire facility, and it's not like there's a different facility -- you don't have separate ICUs, you don't have separate med/surg hospitals. I mean, they're aggregated together. But it seems like in post-acute we've actually created different types of hospitals based upon the type of care, and it just seems that fragmentation lends itself to additional waste and utilization.

MR. HACKBARTH: Anybody else want to pick up on one of these comments?

DR. HALL: I'll try not to be repetitious. I think the one aspect of this that we haven't discussed is what's in it for the patient and for the family. This is kind of my daily life, and just to give you a capsule, these

decisions are often felt to be some of the most important decisions a family makes during a hospitalization.

I can't emphasize too much how much pressure is put on the people to make a very rapid decision, pressures after three days in the hospital to move people out. And everybody does their job and checks it off, so somebody educates the patient, somebody explains the choices, but all of this is occurring largely in a 24-hour period of time, and the pressure is on constantly, usually with a veiled threat that if you don't do this, Medicare will not cover your extended hospitalization.

So I'll just stop there and say that this is a big deal for people, and they often feel like they've encountered FedEx or something and it's shipping and delivery. So I have a suggestion about that.

And I think the comments that have been made that a very common issue is fragmentation, nobody is responsible for the whole package. Everybody does their job excellently, and they check off all the process measures, and they're 100 percent. But the whole is rarely greater than the sum of the parts, which I think it probably should be.

So basically what I would suggest is that there are probably some best practices around the country -- I think Scott's place would be a good example of that -- and maybe we could learn a lot from interviewing them in some depth as to how they do this, particularly with the idea of what is the nature of responsibility that can be conveyed to the patient and the family, somebody is in charge here and is going to do the right thing.

The next thing that I would probably suggest is that one should look for some measures of patient and family satisfaction during the transition process, and there may even be members of the Commission who have some expertise in this. Put those two in the equation, and I bet you what that mix will come up with is that we need some kind of system, whether we want to call it fee-for-service, ACO, or MA, that basically is able to deliver this service with a high degree of patient satisfaction. Then I think at least our compass is pointed in the right direction here.

DR. COOMBS: So in terms of the question number one, I think we should consider the policies. Some of the policies, specifically the condition of participation, might add another level of administrative burden, so I'm not in

favor of that. But I think one of the greatest contributions -- this chapter was excellent. Excellent -- was speaking specifically about the tools and the tools that are provided to actually predict and model where patients might best be directed. The congestive heart failure, the COPD patients are really important to get them to places where you can set up a regimen where they can actually leave that facility, go home, and be successful, decreasing the readmission rate.

So I look at those tools as being really important, and I agree that there is accountability throughout the system, but the individual to point to for that accountability, that connection -- there's a misconnect for that whole process to actually happen. And I think the tool sets are very important, but there still has to be an entity that is in charge of that patient, navigating that patient from beginning -- from the admission to the hospital throughout the course until the patient gets home.

And so one of the discussions I didn't see was the patient-centered medical home. For instance, if the patient goes to the hospital and you really wanted the patient to go home with home health aides, well, wouldn't the primary care

doctor be very instrumental in navigating that whole piece? Because that transitional information needs to be communicated in order for it to be a successful entity. I've seen patients bounce back to the emergency room and wind back up in the ICU who maybe on the reconciliation had their lasix dose, not considered the extra doses that they were receiving in the hospital. And that's a piece of this whole thing with communication and transition of care.

And recently -- I talked to some of the Commissioners about this earlier -- we had a facility in our area that basically closed and accused an institution of not referring any patients to them and that's why they closed. They were unsuccessful because they had referrals that were directed away from their institution. And as a provider in the ICU, there are certain places that I know they wean people from ventilators, and they do a very good job of it. And I might be apt to send a patient to that institution because they're going to be successful.

So I think providers, knowing that and being able to communicate with the docs who are managing the vents at that place, at the other place, they're going to decide that. But does it happen for every patient? I don't think

so. And so that an overarching accountability has to happen. It happens in MA plans. I mean, it happens in some ACOs. And I think a third-party vendor is plus-minus, but the key thing, I think -- and this is some person, some entity being accountable from nuts to bolts, and the primary care -- the patient-centered medical home has to play some role in this, and I don't know what role they play, but I think they should be introduced somewhere along the line.

MR. GRADISON: Can I continue on that?

MR. HACKBARTH: Sure.

MR. GRADISON: Very briefly, I think Alice has pointed out the fact that when we speak of fragmentation, we're perhaps not necessarily talking about something that's negative, because fragmentation may be a reflection of specialization. And you pointed out, for example, that weaning people from ventilators, there may be a more fragmented system, but if certain of the facilities are better at that, there are gains to be shared.

So I just -- I don't know, some of the earlier discussion gave me the sense that fragmentation as such was a bad thing. I think it just depends on what we mean by that, because these entities are dealing with very different

patients, and I gather from what was mentioned earlier today that in areas which don't have certain facilities like long-term acute-care hospitals, nursing homes, in some instances maybe have developed and had to develop the capability of dealing with the ventilator patients that normally one might think would be going to a different type of institution if it were available.

MR. HACKBARTH: Anybody else want to pick up on this? Round 2 comments on this side? Jack? Oh, I'm sorry. I forgot Herb. Let's go back and catch Herb.

MR. KUHN: So I also want to kind of talk to this issue of the steering and the soft steering issue. I remember back in 2012 when we were looking at the issue of the rehospitalization recommendation for SNFs. I think, Carol, you had put up a map that showed the different states of how they were -- you know, in certain states, the opportunity, if you discharged to a SNF, the notion of a rehospitalization was greater in some states versus others, and that variation showed pretty clearly.

I know some hospitals have taken it down to their community levels and they know which SNFs, if you discharge to this SNF, you've got a 70 percent chance of

rehospitalization, or if this one, it's 40 percent, a little bit kind of what Scott was talking a little bit that's out there. And so I'm aware of at least one -- now, one is not a pattern, but I'm aware of at least one ACO that basically in order to combat that are actually taking their own staff, their own RNs, and have placed them in a skilled nursing facility in order to bolster their clinical expertise to avoid those rehospitalizations. So that's the work-around people are going through to make this happen. So this notion of steering is a big issue without a doubt.

So creating a more narrow network in the fee-for-service world that we have in traditional Medicare is going to be very tough, and I'm just wondering if there are additional augmentations that could be made to the Compare website that might share some additional information, because if you're a hospital and you're a discharge planner, you're probably not going to show your -- you may or may not. I don't know. It would be interesting to have those conversations with folks if they're going to share their own internal data that, you know, as you talked about, you put the ones you like the best at the front of the list, but how you have that conversation with a community. But if it's

CMS on their Compare website, if there is a new set of ways that they can augment the Compare website that you could then share with family members, it might help in terms of the soft steering equation that's out there, is one option.

The other thing I was thinking about, too, and I was really struck when I read the chapter, but particularly, Evan, when you put up Slide 3 which listed all the recommendations that we've made so far, I mean, there is a lot of stuff out there. And I'm wondering if there is in the upcoming chapter, when we put some of this stuff out there, create a new narrative around this conversation of -- the narrative of what all we've put out there and what more you can move forward, because pretty soon we start to layer on on these things, and do they really sync up that's out there? And I'm really getting worried that if we add more things out there, is that just more background noise out there? Is it effectively going to help us turn some things?

So I think a rerun of these things in a new narrative that kind of puts it in a context might be helpful. And then like I said, maybe something on the Compare website, if there's some more information that could be helpful to those hospitals or others to help instruct

families to help them make better choices.

MR. HACKBARTH: Herb, you've touched on a couple things that I'd like to come back to if we can get to a Round 3. Let's finish off Round 2.

DR. HOADLEY: So one thing I guess I should have asked in Round 1 was, Can you remind us just quickly the status of the bundling initiative? Because you talked in terms of some of the interviews of being only up to certain phases. How far ahead does that go?

DR. CARTER: So they have -- so I don't have the numbers right in front of me. There were a number of entities that entered phase one, which was basically getting data about yourself and your marketplace. When entities went to the risk phase, which was phase two, a lot of participants dropped out.

DR. HOADLEY: Okay.

DR. CARTER: I'm remembering 90 percent.

DR. HOADLEY: Wow. A lot.

DR. CARTER: A lot of attrition. But they have now also reopened entities that want to participate, and so there has been quite a bit of expansion of entities in phase one across all the models, and I can get you --

DR. HOADLEY: And for those handful of survivors from phase one, how far forward will they go?

DR. CARTER: I think they're just like in the first year.

DR. HOADLEY: Okay.

DR. CARTER: Yeah, so not very far along.

DR. HOADLEY: So it's still pretty early.

DR. CARTER: Right.

DR. HOADLEY: So my comment really is very similar to what Herb was talking about. I'm interested in this question of steering and the balance of how we could loosen restrictions without running afoul of the things that are legitimate problems. So if there's ownership and issues that are legitimate that we don't want to have happen, obviously, but trying to understand where that balance falls and -- I mean, it certainly makes sense in some of the things you describe just at the education level, before we even get to, you know, things that are more controversial like prior authorization or preferred networks. But just at the education level, you know, whether it's through Compare, whether it's through things that they can share. But where - so the question really that we ought to have on the table

is where are the rules that current law implies or current regulation implies, imposes, that we could think about loosening up without running afoul of other problems? I think that to me is a good place that we could offer something.

MR. THOMAS: Just real briefly to actually build on Herb's comments a little bit.

In our Medicare Advantage population, we have about 50,000 fully risk lives. We took a very hard look at this because we realized we did not have a good understanding of where we were sending our patients, and we were sending folks to about 60 different post-acute facilities. And through essentially an RFP process for Medicare Advantage, we asked them to fill out an RFP around quality measures and how they would interface with our discharge planners and our facilities, and reduce the network to 17.

Over the past couple years, we have seen a reduction in cost by about 10 percent year-over-year, and we have also seen an improvement in our readmission rate, and we have seen an improvement in the quality measures from those facilities, because we actually interface with them,

not dissimilar to what Scott is talking about with his staff.

Because of the limitations in traditional Medicare, it has been difficult to move that process forward there, but it certainly has worked in Medicare Advantage, so I think there are case studies out there that I think we could look at that show significant improvement in this area, especially when there is the right collaboration and integration between the acute, post-acute care.

MR. HACKBARTH: Any more Round 2 comments? Dave.

DR. NERENZ: I was also trying to think about how this looks and feels from the beneficiary point of view, and I am thinking if we imagine a discharge from hospital, the management of the post-acute process could conceivably be done by six different entities. It could be the hospital. It could be the primary care physician or patient-centered medical home. It could be the specialist, maybe. We haven't talked much about that. It's possible. It could be an MA plan if the beneficiary is in one. It could be an ACO. It could be a third party.

Now, in the worst case, it's all of them, and they all trip over each other, but in practice, it gets sorted

out.

So I am thinking as we look forward, one way to try to think about this is is there any evidence that any one of these management locations is better than the other, and if so, then we should try to design policies that favor that. My guess, though, is there may not be such evidence, and then I am thinking that within these different programs and domains, there may be ways to just make this management role and accountability clearer than it is now and also try to move to situations where, if it is present in one place, it then in some ways explicitly not present or not required in others.

Now, I realize this has some downsides perhaps when we think about the concept of aligning incentives, but just for discussion, we might say that if a patient belongs to an MA plan, if the MA plan is taking responsible for managing post-acute care, including prevention of readmission, perhaps in that scenario, the hospital should not be held accountable for the readmission, or if the hospital is taking on this role, then the MA plan is not responsible.

We don't typically do that, but I am just curious

for a discussion if perhaps we could.

MR. HACKBARTH: A couple reactions, Dave. I liked your -- there are a lot of potential, different potential actors here, and I think that's right.

My hunch would be that going to the evidence is fruitless. In fact, I don't think that there is an actor that will be inherently better at this or is proven better at this. I think it is dependent on who the actors are in particular models. It is very much a matter of performance as opposed to concept. It's how it's all executed as opposed to, "Oh, this is the single best model that works everywhere."

On your last point, specifically, just a question. So if it is an MA plan, the hospital is being paid by the MA plan. Whether there is any readmissions penalty in that case is a matter of contract between the MA plan and the hospital. The Medicare readmission roles don't apply in that case.

DR. NERENZ: Right. That would be fair enough.

That particular dyad may not be the best place to illustrate this concept, but I am just sort of exploring the idea that if any one entity explicitly is given the

responsibility and perhaps the resources, is there some way then to make it clear to everyone involved that that exists and then the others are not responsible?

MR. HACKBARTH: Right.

DR. NERENZ: I'm just curious.

MR. HACKBARTH: Rita, did you have any? Then John.

DR. CHRISTIANSON: I would like to go back to some of Craig's opening remarks.

I know you know from my previous comments that I am not in favor of giving ACOs all of the prerogatives that MA plans have. To the extent that ACOs add value to the Medicare program, I think it is sort of in between the traditional fee-for-service system and the MA plan.

But having said that, I think this is an opportunity for us to address some of our concerns about post-acute care and some of our concerns about how much ability should ACOs have to managed care, and putting those two sort of thoughts together, maybe this is a place where we would have our greatest effect if we focused our efforts on ACOs and talked about what is it that we think would be or should be allowable for ACOs in terms of managing post-

acute care and just try to focus our thoughts and efforts on that question.

It seems like we have kind of been -- had an interesting discussion where we have been all over the map about things, and I think to make progress here, that is the direction I'd like to see us go.

MR. HACKBARTH: So we have a few minutes left for a Round 3, a very few minutes. Now that I look at my watch, like five, so this will be a lightning round.

I want to sort of build on a point that John is making an refer back to Kate's comment early on. The comment had to do with creating a new type of entity that manages post-acute care, and I want to get people's reaction on that.

What caught my ear in Kate's formulation was she said, I think -- correct me if I am wrong -- that you are find with that if that is an MA plan deciding this is how we can best manage this, and I inferred from that, that you were not as interested in Medicare now creating a new type of entity, which it would contract and manage these services. And I think Mary made the same point, and I think John's comment implies that he would not favor that, the

creation of a new Medicare entity.

I just want to see if there is consensus around the table that that's a path that really we don't want to pursue.

I see a number of heads nodding that, no, they are not much interested in creation of still another new type of Medicare entity.

Is there anybody who wants to take the opposite side of that question, say let's not reach a judgment, we ought to explore that further?

[No response.]

MR. HACKBARTH: Okay. Seeing none, that is one path that we don't need to pursue further, right now at least.

A second issue that I wanted to focus on is this steering of patients. I think there are at least three different types of steering that happen. Carol used the term "soft-steering," and she said she suspects -- and I would agree -- that it's likely that there is a fair amount of soft steering that happens right now, even though, nominally, there is patient free choice of provider for post-acute services, as for all other Medicare coverage

services. But there is an opportunity for the hospital to try to influence that decision at discharge, so that's the soft steering, and it could happen through construction of lists or informal conversation about our past experience, et cetera.

A second type of steering would be the opposite end of the continuum, which would be to say, well, maybe we ought to rewrite the Medicare statute and say there's free choice of physician and hospital, but there is no longer free choice for post-acute services.

Because they need to be so integrated with other types of care delivery, we're going to eliminate patient free choice there and say that hospitals can direct Medicare patients to particular post-acute providers. That would sort of be the other end of the continuum.

In the middle is the notion that we might explore using incentives, and that's always appealing in concept because it involves still patients having some choice, but as we know from various other contexts, it is difficult in practice because of the prevalence of Medigap coverage that basically moots cost sharing as a potential tool.

But, conceptually, you could imagine that select

Medigap policies could be developed -- and we have talked about this in the context of ACOs -- that would provide for some steering but also some patient choice, with financial incentives used as the mechanism.

So we could stay on the current path, which is soft steering, and maybe we would do some clarification of the rules to say that is not against the law for clinicians to talk to patients about where they have the best experience in post-acute care in cases there is any anxiety about that, or we could go to hard steering and say, "No, this isn't a free choice area," or try to explore again this idea of using incentives.

Reactions between those three paths? Let me do it this way, in the interest of time. Is there anybody who thinks we really ought to look at hard steering and actually changing, eliminating free choice? I am stating this in the broadest way possible. Kathy and then Craig.

MS. BUTO: And, Glenn, you may be doing this for dramatic impact, but hard steering, I am thinking could mean a choice of like two or three preferred providers. It wouldn't need to be, "This is where you are going. End of discussion."

MR. HACKBARTH: Yes.

MS. BUTO: And I think that could make a difference.

MR. HACKBARTH: In fact, if I were a hospital and faced with this, in the interest of my patient satisfaction score, that is probably the way I would do it. As opposed to, "You're going to this particular nursing home," I would say, "We've got a range of choices for you, but these are all people that we work with really well." So I am doing it for effect referring to --

DR. BAICKER: I feel like this undermines the nice clear choice that you've made, so sorry, but I'll do it anyway.

The decision in some ways hinges on some of the other things, like bundling. I feel differently about the tools I want hospitals to have to steer patients, if they are also responsible for managing a bundled payment that includes post-acute care than if they don't have that financial responsibility.

So I think that the level of control or the tools available has to go with the level of accountability and financial responsibility that is in place.

MR. HACKBARTH: Yes. Excellent point, Kate.

Let me just ask Carol. In the bundling demonstrations, how do they address this issue? Are hospitals authorized? Is there a waiver of --

DR. CARTER: No. And it is an issue that came up in enrolling, and so they go through the same discussions we are having here.

MR. THOMAS: Glenn? And I would just say there actually is financial responsibility because, essentially, with readmission penalties, there already is a financial responsibility today.

MR. HACKBARTH: Fair enough. Craig?

DR. SAMITT: See, I don't think we should discount the notion of hard steering, but perhaps we consider it a Plan B. If our goal is to have a positive influence here in our policy recommendations and we feel that things like incentives, even if we try them, are ineffective, then the question is, What happens next? I don't think we should take hard steering or recommendation for hard steering off the table.

The other thing I would ask -- and I don't know if there's any information -- when Medicare beneficiaries

treasure choice in the benefit package, where does choice matter most? I would imagine it is primary care physician, specialist, and hospital. I would envision that it is less so in the post-acute care space. I certainly may be wrong.

But if we are going to want to make a difference and we need to start saying that Medicare isn't about free choice in everything, where do we begin to chip away? And post-acute care may be a good place to start.

MR. HACKBARTH: Scott.

MR. ARMSTRONG: So, just given a little bit of the context that Kate was creating, combine accountability with a payment structure that is aligned, I am all in favor of hard steering. I think that is how you make it work. That is what I do.

MR. HACKBARTH: Although let me just emphasize there is a distinction. Medicare beneficiaries choose to enroll in Group Health of Puget Sound. We are talking about the patients who have chosen not to enroll in an MA plan. They have opted for traditional Medicare whose hallmark is free choice of provider, and we are talking about for those patients who have chosen free choice to take away a piece of it.

MR. ARMSTRONG: And my own point of view is choice is overrated when the alternative is much better care and better outcomes.

MR. HACKBARTH: I have asked people to really economize here because I do want to get to one other point in this round. Bill?

DR. HALL: So advised, Glenn.

I think hard steering is a very slippery slope. I agree if someone decides that they want to be in an MA plan, that is part of the MA package, fine. But to apply that to the entire Medicare population when some simpler measure like good communication could solve that and then soft steering could work, we should exercise a little bit of caution on this.

MR. THOMAS: Once again, go back to the definition, Glenn. I think if you are talking about hard steering being to a network or a narrower network of defined facilities, I would all in favor of that, because there still is some choice there. It is just that you are narrowing the choice to a few places that you have actually done some diligence to make sure they are great places a patient could go.

DR. NERENZ: Well, a similar theme, that in the soft steering domain, the incentives would not necessarily have to be financial. You could just say to a patient, "If you go to one of these two, three places, we have a presence there. The records are integrated there. We know it's safe care there, and we will actually carry some accountability for what happens to you when you go there. If you go to a different place, those features don't occur, and then --

MR. HACKBARTH: And so you are saying you like the soft steering.

DR. NERENZ: With that kind of thinking, just pointing out that I think those are a certain sort of incentives to patients to then make that choice that are not financial.

MR. HACKBARTH: Yeah. Mary or Rita?

DR. NAYLOR: I think it really has it in to move to hard steering now until the market shakes out. I think right now we're seeing innovations and service lines where transitional services are delivering care in the home and skilled nursing and heading to hospice, the same service line delivering it.

So I think what we have now is hospital and post-

acute may not be what is the future in terms of how those services align with each other.

DR. REDBERG: I think hard steering could offer a lot of advantages in terms of what we are trying to achieve, in terms of better quality, better coordination, and I agree with Craig. I think patients -- matter of fact, Medicare beneficiaries are very interested in choice of provider, perhaps choice of hospital, but not so much in post-acute care.

DR. CHRISTIANSON: Yeah, I think we should focus on trying to determine what changes we would recommend in the present law or the way it's administered that allow the more aggressive soft steering that Dave has described as a starting place, and I think that helps -- would help address some of the concerns that ACOs have around managing.

We know the vast majority of variation in cost of care relates to post-acute care, and if you are trying to get your handle on that as an ACO, this would give them some more tools without at least initially restricting choice. So I think we should focus our attention on that.

MR. HACKBARTH: Last question then relates to trying to do some sort of financial incentive, select-type

supplemental product.

Let me build on John's earlier comment at the end of Round 2. If I understood John correctly, he might say here if we want to look at --

DR. CHRISTIANSON: Over here.

[Laughter.]

MR. HACKBARTH: If we want to look at select sort of products and creating the products that deal with the Medigap issue, let's do it on a vehicle like accountable care organizations as opposed to doing it in particular service lines. Am I reading you correctly?

Everybody agree with that? I will go out on a limb and say I agree with that. Does that make sense to everybody? Anybody want to argue the other side that we ought to try to look at a way to create specific financial incentive opportunities in post-acute care?

Kate is looking thoughtful.

DR. BAICKER: Well, I just want to make sure I understand when we say specific financial incentives, how big a shadow that casts.

We certainly, I think, continue to be interested in harmonizing payments in bundling, and that is a specific

--

MR. HACKBARTH: Patient incentives, cost sharing.

DR. BAICKER: Patient-side incentives.

MR. HACKBARTH: Yeah.

DR. BAICKER: Okay. So that does --

MR. HACKBARTH: Yeah, okay. I suspected that was the answer.

Jay.

DR. CROSSON: You know, just a question about that. I have been a proponent of ACOs for a long time, including the last time I was on the Commission, but there are not that many of them at the moment, and it isn't clear what the trend is going to be, and this problem, I think, as the slide shows, is one that we have been wrestling with six years or so.

While theoretically I agree with this direction, the question is how long would it take to resolve the range of issues we're talking about here, which include quality, care coordination, cost, readmissions, all those things, with the ACO approach as the solution. There's some question about that.

MR. HACKBARTH: I would say that it's not just

ACOs. It is also Medicare Advantage plans. They have the flexibility to do this, so that is a much bigger footprint.

DR. CROSSON: But we are not trying to solve that problem, or are we?

MR. HACKBARTH: Well, I thought you were saying we have got a great big national problem with utilization of post-acute services. ACOs are only this big, and they are not covering that. And my point is simply we have ACOs plus MA addressing this.

DR. CROSSON: Absolutely. I thought the field we're playing in here is not MA; it's what do we do outside of MA.

MR. HACKBARTH: Herb, last word, and then we need to move ahead.

MR. KUHN: Thanks.

One thing about this as we go forward, if we are going to look at the hard steering, soft, the financial incentives, whatever the case might be, as we continue this conversation, one think I would just ask is that if we could also, when we look at some policy options, look at how this impacts the rural areas, because you have more limited choices in rural areas, anyway. And so if we are going to

be narrowing what does that mean in terms of travel, distance, things like that, I think that will be something we just need to keep in mind and focus on, as well.

DR. CROSSON: Can I just make one quick -- just to reiterate what Herb said earlier, as we think through this next, it might be helpful -- I could almost see a table going back and looking at the key elements of all these prior recommendations, plus the choices we have now, against the values we are after. What improves care coordination? What improves quality in general? What reduces cost? What creates proper incentives? I know you are trying to narrow us down here, I think it is hard to do that with all these other things kind of still out there.

MR. HACKBARTH: Okay. Thank you very much, Evan and Carol. Good work.

[Pause.]

MR. HACKBARTH: Okay. So it looks like the shift change is almost complete, so in the interest of staying on schedule, Kevin, I want to go ahead and proceed.

So our next item pertains to the physician and other health professional fee schedule, Mary.

DR. NAYLOR: Thank you, Glenn.

MR. HACKBARTH: You're welcome. And specifically with calculation of relative values. Kevin?

DR. HAYES: Good morning. This session is part of the Commission's ongoing work toward reaching a balance in the payments for primary care relative to other services. The topic today is validating the fee schedule's relative value units.

Recall that you have considered this topic as part of repeal of the sustainable growth rate formula. And in the spring, you discussed this topic in the context of overpriced services as a possible source of funding for a per beneficiary payment for primary care. We will have more on that latter topic -- the per beneficiary payment for primary care -- at the November meeting.

The presentation this morning will address three topics:

First, concerns about inaccuracy of the fee schedule's relative value units. In particular, the presentation will focus on the relative value units for the work of physicians and other health professionals. Those RVUs account for over half of fee schedule spending. As we will see, much of the inaccuracy is due to assumptions about

the time professionals spend furnishing services.

Our second topic is the Commission's method for correcting the inaccuracies in a way that is streamlined and efficient.

And, third, we have data showing that it is feasible to use this method to correct RVUs.

The Commission has a longstanding concern about distortions in Medicare's fee schedule for physicians and other health professionals. Primary care services are undervalued relative to other services. This can occur because primary care is time-consuming with few opportunities for efficiency gains over time.

By contrast, other services lend themselves more to improvements in technique, technological advances, and other factors that make it possible to furnish more services in a given amount of time.

The Commission's other concern about the fee schedule is that it contributes to compensation disparities between primary care physicians and other physicians.

Based on data from the Medical Group Management Association that we will update for you at the December meeting, physicians in specialties such as orthopedics,

gastroenterology, and cardiology receive on average compensation that is more than twice the compensation of family medicine.

Previous work showed that this finding holds for compensation per hour. Some specialties receive compensation for every hour worked that is more than double that for primary care.

With the recommendation to repeal the SGR, the Commission recommended a replacement. The aim would be to rebalance the fee schedule with a sequence of legislated updates that are higher for primary care than for other services.

Specific to distortions in the fee schedule, the Commission made two additional recommendations: First, data should be collected to improve the relative valuation of services; and, second, overpriced services should be identified and priced appropriately.

In describing how the Secretary should undertake the data collection, the Commission recommended that the Secretary collect the data not from a sample of all practices but instead from a cohort of efficient practices.

Consistent with the Commission's recommendations,

the Patient Protection and Affordable Care Act of 2010 included two requirements:

First, the law directs the Secretary to periodically identify and review potentially misvalued services in categories such as those with the fastest growth, services established for new technologies, and other such criteria. If upon review services are found to be misvalued, the Secretary may make appropriate adjustments to their RVUs.

The second PPACA requirement is that the Secretary must establish a formal process to validate the fee schedule's RVUs. This validation may include elements of the work of physicians and other health professionals. The Secretary may also validate RVUs by conducting surveys and by other data collection activities, studies, or analyses she deems appropriate.

Efforts to date to identify overpriced services have consisted of review of individual services. CMS has established a process that includes input from the American Medical Association/Specialty Society Relative Value Scale Update Committee, or RUC. CMS identifies individual services that may be misvalued and requests recommendations

from the RUC. The RUC itself identifies potentially misvalued services through its own processes.

CMS has also awarded two contracts for work on data and methods that could be used to validate RVUs. Here again, the focus is individual services.

What would it take to validate the RVUs for individual services?

To being with, it is important to remember that there are 7,000 services defined in the fee schedule. For each one, there's an amount of time assumed that it takes to furnish the service. Commission analysis has shown that the fee schedule's work RVUs are mostly a function of these time assumptions.

It is important to validate these time assumptions. Studies by contractors working for CMS and for the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services have shown that the fee schedule's time assumptions are inflated.

The question is: What is the best way to do this? A service-by-service, or "bottom-up," approach would be costly and burdensome, especially if it involves a method such as time-and-motion studies. In addition, such methods

are subject to bias. Bias can arise from what is known as the Hawthorne effect. This effect would occur during a time-and-motion study if those observed alter their behavior because they are being observed.

The Commission's method is top-down. The unit of analysis is not the individual service. Instead, it would be the physician or other health professional. Data would be collected on:

First, each professional's service mix (that is, the number of services billed to all payers by billing code);

And, second, total time worked for each professional over the course of the same, say, week or a month, whatever the time period is for which the service mix data are collected;

And the third data element would be the fee schedule's time assumptions for the services furnished.

With that data, it is possible to identify services with fee schedule time allotted that is too low or too high. For example, the data collected might show that a physician works eight hours a day, but the time assumed in the fee schedule for the mix of services furnished is 12

hours a day. The difference would suggest that the fee schedule time for at least some of the services furnished is too high.

By going through this process for a number of physicians and other health professionals, it would be possible to identify services that are misvalued. The services so identified would then be candidates for further review.

This approach could be a desirable method for ensuring the accuracy of the fee schedule going forward and to do so in a way that is more efficient than trying to validate the RVUs for each individual service.

We have now worked with a contractor for a feasibility study on validating RVUs in this way. The contract was with researchers at the University of Minnesota. They were asked to collect data from a small number of practices on, first, the services furnished by physicians and other health professionals, and, second, hours worked in patient care for these professionals. The contractor also compared the fee schedule time assumed for the services furnished and reported hours worked.

The specialties represented among the

participating practices were those you see listed here -- family medicine, medical oncology, and so on. In all, seven practices were recruited and interviews conducted on issues of staffing, use of technology, and other factors influencing the services furnished.

Four of the practices submitted data that were complete for purposes of conducting the feasibility study. Reasons for the absence of three of the practices from the feasibility stage of the project ranged from incomplete submission of data to use of out-of-date billing codes in the data submitted.

Here we see the comparison of fee schedule time and hours worked for the physicians in the four practices. Fee schedule time is derived by just adding up the time assumptions for the services furnished. The average for each practice is compared to average hours worked. For example, in the cardiology practice, the average fee schedule time is 20 hours per day, but the average hours worked is 12 hours per day.

With this top-down perspective on the fee schedule's time assumptions, the results are highly dependent on service mix within the practices. In other

words, the types of services furnished will make the difference in whether the fee schedule time is close to or far from hours worked.

With the family medicine practice shown here, the vast majority of fee schedule time for the physicians in the practice is time furnishing office visits. And, yes, the fee schedule time exceeds hours worked.

However, the difference between fee schedule time and hours worked is greater in the other three practices, both in absolute and percentage terms. The reason is that the fee schedule time in these three practices is distributed across a broader mix of services that includes office visits and other E&M services but also imaging, procedures, and tests.

While limited to data from four practices, these data are consistent with the Commission's concern that primary care services are undervalued in the fee schedule and other services are overvalued.

Let's now take a detailed look at the data for the 21 physicians in the cardiology practice. Hours worked for all physicians were reported by the practice to be 12 hours per day. The fee schedule time for each, depending on the

service mix, ranges from 7 hours to 31 hours.

The physicians furnish a diverse mix of services. For example, all of them have volume in evaluation and management services; some of this volume is visits to hospital inpatients, but most is office visits.

Almost all the physicians interpret echocardiograms.

From there, they differentiate themselves according to whether they specialize in services such as cardiac catheterization or imaging stress tests.

To reinforce what I have been saying about using a top-down approach to identify services that may be misvalued, let's look at service mix for some of the physicians in the practice.

The two physicians with the lowest fee schedule time -- physician #5 and physician #7 -- are somewhat different from the others. Both are heavily invested in furnishing E&M services.

By contrast, the two physicians with the highest fee schedule time -- physician #15 and physician #21 -- do more imaging than most other physicians in the practice.

The point of all this is to show that it is

feasible to use a top-down approach to sort out where in the fee schedule there may be service that are misvalued.

In this case, the data say to focus on imaging. Now imagine a database with such data for hundreds of physicians. It would then be possible to conduct a statistical analysis to sort out which services are most associated with differences between fee schedule time and hours worked. Those services would then be candidates for a more detailed review.

To summarize, the Commission has made recommendations on validating the fee schedule's RVUs. Data collected by a Commission contractor confirms the feasibility of a top-down approach to validating RVUs with a goal of ensuring the accuracy of the fee schedule on an ongoing basis.

The alternative is a bottom-up approach. This is the approach that has been followed under CMS' work on a misvalued codes initiative started in 2009. Meanwhile, services furnished by physicians and other health professionals have continued to change.

But to maintain the fee schedule from here with a bottom-up approach would mean going to methods such as time-

and-motion studies that would be cumbersome and costly.

CMS has a statutory mandate to validate the fee schedule's RVUs. Under a provision in the Protecting Access to Medicare Act of 2014, the agency now has $2 million annually for this purpose. The Commission has advised CMS that a top-down approach is the best direction to take.

Over the next few meetings, we will be returning to the issue of the accuracy of the fee schedule. For example, at the November meeting, we anticipate further discussion of a per beneficiary payment for primary care. Recall that, in the spring, when you considered options for funding such a payment, some of you expressed interest in a funding option that would reallocate funds from overpriced services to the per beneficiary payment.

That concludes the presentation. If you have questions, I'll do my best to answer them. Thank you.

MR. HACKBARTH: Thank you, Kevin. Good job.

I'd like to say just a few additional things about the context of this work, in particular for our new Commissioners. Broadly speaking, our work, which now spans a lot of years on this, has been down two separate paths. One path is the one that we're discussing today, which is:

How do we make the resource-based relative value schedule, the relative values, more accurate? And this time issue, which we've talked about for years now, is an important part of that, and figuring out strategies to get better, up-to-date data on time, that's today's topic.

But we've done other things in the broad area of relative values, for example, proposing changes when multiple things are done at the same time in the same session and there may not be duplication of the work, and so the relative values in that context should be lower. So there's this body of work, and we'll advance it some more today and subsequently.

Still in this area of how do we make the relative values more accurate, we've also made some institutional sort of structural suggestions. As I think everybody knows, an important source of information for CMS in reaching decisions about relative values is the RUC, which is a private entity. It is not a government entity. And by law, CMS is not bound to take their recommendations. They are just that: They are recommendations from a private entity.

Over the years we've raised some questions about the work of the RUC, in particular their dependence on

medical specialty-sponsored surveys as a key piece of information in developing relative values. And we've suggested that CMS would do well to, A, be somewhat more directive in their relationship with the RUC, which, in fact, I think they've done in recent years; but, B, also develop an in-house, within the Department of Health and Human Services, source of expert advice that they could also use in making their final decisions on relative values.

So that's one path of work, and it all has to do with how do we improve this system of relative values.

The second path is based on the recognition that there are things that you care about in setting prices that we're willing to pay that go beyond the inputs that go into producing the service. The resource-based relative value system is very much focused on what are the inputs, in particular, you know, time, intensity of service, intensity of the activity, et cetera. But in markets, they don't just price services based on the inputs that go in. The value of the product to the ultimate consumer is a very important part -- in fact, the ultimate consideration in how a market prices. And so from time to time we have said, you know, we ought to at least have an opportunity to break out of the

resource-based, input-focused way of calculating prices for physician services to include considerations of value.

And, of course, part of that is paying for performance, which, you know, has turned out to be much more complicated for physicians for a variety of reasons I won't go into. But another path is exemplified by the primary care bonus. So this is an add-on to the fees calculated through the resource-based relative value based on an assessment of value, but also mismatch of supply and demand or concerns about a potential mismatch of supply and demand, which is another important market factor in determining prices.

Then when the primary care bonus, as you know, we've actually looked at that now. You could do that either as a percentage add-on to the fees for primary care services or do it as a PMPM payment, break out of the fee-for-service mentality.

So we've had a lot of work going on in physician payment, and this is like, you know, one piece of a much bigger puzzle, which I wanted to emphasize in particular for Warner and Kathy.

Now let's turn to the issue at hand, which is very

much focused on how we can improve the relative values and open it up for Round 1 clarifying questions. I think we started on that side last time. We'll start on this side.

DR. HOADLEY: So I have two questions. One, given what you said about CMS already has these contracts out, to what extent is that changeable? If we made a recommendation or made a statement, how far are they down the track already?

DR. HAYES: The contractors are working. In the case of RAND, this is a contract that is focusing on surgical services, primarily, and looking at alternative ways of validating the time for the duration of surgical procedures. They are pretty far along and anticipate having some results pretty soon, from what I gather. So they are pretty far along, and that's pretty much where that is.

The other project is a joint venture involving the Urban Institute, RTI International, and Social and Scientific Systems. They issued an interim report on that project about the time that the proposed rule came out this summer, and that's where they talked about some of the challenges that they have encountered in proceeding with that project. I don't believe that they have moved into the

data collection phase yet, or if they have, they have just started, but they are along too.

DR. HOADLEY: There is some room on that one.

The other question, on Slide 12, the hours worked is uniform across the physicians.

DR. HAYES: Mm-hmm.

DR. HOADLEY: I assume that's the way it was -- was there one average collected for the practice?

DR. HAYES: Well, this was a case where the contractor had different methods for doing it. I am not sure exactly what was done with this particular practice, but let's say that it was a consultation with the practice manager, and the practice manager would have said, "Well, our physicians are doing like 12 hours a day," and so that was a fee. So it would have been an average across.

DR. HOADLEY: Essentially group --

DR. HAYES: Yeah, within a range, but it's -- yeah.

DR. HOADLEY: Because on the previous slide, you had different levels across the different practices. It just opens up some questions about the methodology, that we don't have to spend more time on, but --

DR. HAYES: Yes. Right.

MR. HACKBARTH: Warner? Bill?

MR. GRADISON: On the bottom of page 2, there is that last sentence of the document you sent out ahead of time: With regard to 15 percent lower than average compensation based upon this matter of projection. I think I got this, but I am very puzzled over it. I think what it says is that the actual compensation is 15 percent, whatever, higher than if all the services were provided the Medicare rate, simply because the private, the non-Medicare fee schedules, actual payments from non-Medicare sources are higher than Medicare.

DR. HAYES: That's right. Yes.

MR. GRADISON: Briefly, somewhat tongue in cheek, I just would like to observe that philosophers for several thousand years and even to today are still trying to figure out how to define time. I think they would have a great time -- I would love to have a conference in which we brought together the physicians who, based upon this schedule, are working more than 24 hours a day because it might solve a riddle that has troubled people for many, many years.

[Laughter.]

MR. HACKBARTH: Cori?

MS. UCCELLO: I am just trying to get a sense on whether there is a concern at all that data from three of the seven practices couldn't be used. The practicality of using this approach moving forward, how big of a deal is this?

DR. HAYES: Well, the problems ranged from they just used some out-of-date billing codes to just didn't submit complete-enough data.

So if we think about this issue in the context of what the Commission has said in this area, the Secretary, CMS, might have more leverage to say, "Well, okay, we are going to identify practices, and we can provide some financial kind of compensation for the time and effort it takes to collect the data," but otherwise, those who are selected would participate, and there would be a structured data protocol and so forth that they would follow in order to do this.

Whereas, with this project, it was more voluntary. It was more, "Well, you agreed to participate. We had this research project and is going to guarantee anonymity," and

so forth, and that is about as far as we could go within the constraints that we were operating under.

DR. NERENZ: Thanks, Kevin. That is very good.

Slide 9, and then we are going to flip to Slide 11.

This is the more concrete version of Bill's time question. The phrase "inpatient care," I am just curious if we could have a little more fine-grain meeting.

If you could flip to 11, in the yellow bars, it is interesting that family practice in this example is lower than cardiology. I'm curious. Are the workdays just simply different, or in family practice, is the workday 12 hours, but there are things going on that the clinician would think of work but don't meet the criteria of inpatient care? Is it one or the other?

DR. HAYES: Yeah. The time reported is shorter for the family medicine practice, and as far as we know, it is all-inclusive of what they did. The hours worked were defined to include not just the time with patients, but also the time in any kind of follow-up activity, documentation, phone calls to referring, consulting, the whole thing. Yeah.

DR. MILLER: And I think clear from the conversation, but I wouldn't take all of this -- this is very small, a few practices. We are trying to work through the proof of concept, I think, at this stage, so I wouldn't get -- and I know you know that, but I also want the rest of the room not to think we are hung up on these.

DR. NERENZ: I just wanted to make sure we know what we are looking at.

DR. MILLER: Yeah.

DR. CHRISTIANSON: I guess, just to reinforce that, the strategy Kevin has outlined, if I understand it right, wouldn't involve every practice in the country providing this kind of data. It would involve, as you suggested, a subset of practices, presumably with some financial incentive. So thinking about data problems and stuff like that would be more relevant if you were doing all practices and what percentages would respond and so forth.

MR. HACKBARTH: Okay. Clarifying questions? Craig, then Kate and Kathy.

DR. SAMITT: Staying on Slide 11, Kevin, in the reading materials, you show a similar slide, but for the nurse practitioners and physician assistants -- and it looks

very different. Did you ever -- did you do a calculation that added the two by practice? The reason I ask is it suggests that perhaps in some of these disciplines, nurse practitioners and physician assistants may be serving more of a support function, and the question is should you look at them together as opposed to separate.

DR. HAYES: I did not look at them together. It might be worth doing that.

The one thing that we have from the contractor's report that tells us that maybe there is still going to be a difference has to do with the interviews that were conducted, which suggested that particularly nurse practitioners and PAs were used for activities such as chronic care, management of patients with chronic diseases. As we discussed in the context, say, of the PMPM, payment for primary care, but may be relevant to other types of services, too, that there are a number of activities accompanying that are not billable. And so we just may not have a fee schedule time for much of what they do, so the disparity could continue, but I have not done that.

MS. UCCELLO: So it certainly seems like a much more manageable problem to get an accurate assessment of

hours worked than a unit-by-unit hours worked, so I acknowledge these problems are likely to be much smaller, but you still need a really accurate measure of hours worked to implement the whole approach.

So what's the vision for how you would -- not for this subset that we've just looked at as a case study, but in general, how do you envision sort of quality-controlled measures of hours going forward?

DR. HAYES: There are different ways to try and nail that down. I mean, you could imagine something fairly cumbersome, like the physicians and others, professionals working in the practice who keep logs, a daily log of their activity, but then we wonder, just as with time and motion studies, if maybe some biases would creep in or some cumbersome things would.

With this -- and I got a third point to make, but with this, you could see why the contractor went in the direction of, say, consulting with practice managers, and that is because those individuals are often involved in recruitment of new physicians, and so the question in that process is going to be what can I expect my workday to look like. And they are going to hear about it if they are

wrong. There is that kind of quality control, if you will, that tells me at least that that's why they went where they did.

The other point to make here I think would be that, well, there is a certain amount of work that could be done just with the data. I mean in the sense that you could imagine some kind of -- I am losing the word here, but kind of simulations to say, "Okay. What happens if these hours worked are off by 20 percent?" and we are talking about 12 hours a day when the reporting had been 10 hours a day. With some of these differences, we are still -- even at that, we are still not looking at -- we are still looking at quite a disparity.

So it would kind of become a question of how important is it to really hone that hours-worked number, and so I think with some experience doing this kind of thing, the answer to that question might emerge. But that is the extent of my thinking on the topic to this point.

DR. BAICKER: Yeah. The problem would be if there is systematic difference errors that are related to the types of things that people are doing. You will still get the overall picture, but you have planted some intriguing

seeds about you could just run a regression and see how many minutes each thing bangs in at, if you had a reasonable measure.

I was hoping you were going to say something like implant chips in people, and we could just follow them.

[Laughter.]

DR. BAICKER: As long as it's not me.

But then I wondered about the possibility of supplementing self-reports with external things. OR time. There must be some booking of OR time and things like that, but I don't know what other sources are available.

MS. BUTO: So I have three questions. They are all factual. Maybe you can just help me on this.

One is, these are total hours worked, not necessarily Medicare hours worked, so a question of whether we know if there is a difference, because that could make a difference. And if the measure we're using that Medicare is now using is total hours worked, then it is apples to apples, but I would just lay that question out.

The second one is how much of a fee that a physician receives is driven by time, and I guess the question that follows on that is, Is that different for E&M

services versus procedural? In other words, my sense of procedural services is -- was that more of the fee was driven by complexity, skill, and so on, but maybe it's time. So that is question number two.

And the third one is really from the paper on page 2 where you say the volume of procedurally based services can be increased more readily than the volume of primary care services. I think in an earlier exchange, granted, it was a while ago, but that was not the experience I remember, which was when there were two separate updates, it was actually E&M that really looked like it was easier to increase because, even the proceduralists could bill consultations and short visits and check in at the hospital. That ended up growing much faster.

So those are the three questions. I don't know if you have any comments on those.

DR. HAYES: Okay. On the first question, this is all services furnished all payers, so the goal here is to get a representation of total hours worked and total fee schedule time.

MS. BUTO: Total fee schedule time is all hours worked; it's not just Medicare hours?

DR. HAYES: That's correct. That's correct, yes.

So the idea was to take the volume of services by CPT code, match that with the hours worked for those -- or for fee schedule times for those codes, total all that up, and compare it to total hours worked and thereby capture everything.

It would be kind of an interesting thing. One could imagine doing this where you do sort of keep track of what proportions of the volume are Medicare versus other patients. I could see where maybe that might be an interesting thing to do.

MS. BUTO: And just to comment on that, I think for primary care, that could be hugely important. In other words, a Medicare beneficiary receiving primary care may have more requirements than, say, a working-level person or a child. So it is just something to think about as we get to the next step.

DR. HAYES: Mm-hmm.

DR. MILLER: But I thought within the fee schedule, you have levels of E&M in terms of time --

DR. HAYES: Sure. Yeah, yeah, yeah.

DR. MILLER: -- and intensity.

DR. HAYES: Right.

DR. MILLER: At least so far, to her first-line question, it is apples to apples.

DR. HAYES: That's right. That's right.

Your second question had to do with the extent to which time drives the fee, and our work on that has shown that if we focus just on the work RVUs for a minute that the time assumptions in the fee schedule are the most important factor. They are highly correlated with the RVUs. If we were to use some statistical language here, they explain 70 to 90 percent of the variation in the -- so it is the lion's share across the board.

And I am just not recalling which one is closer to 70 percent. Is it E&M, or is it the procedures? Then, of course, as you know, the work RVUs account for over half of total spending under the fee schedule, so we are talking about that 70 to 90 percent driving half of the fee on average, but that depends on the service, of course.

So intensity -- you mentioned the word "intensity" or the complexity. It is a factor, but it is not huge.

And there's some feedbacks in here in terms of the work RVUs that influenced other parts of the fee schedule

indirectly, but we won't get into that. So, in any case, this is important. If you want to validate the RVUs, this is one place where you want to be.

The last thing you mentioned had to do with volume growth and how that has changed over the years and how service volume has grown by different types of services, and it is true that, say, in the '90s, we did see some fairly low growth in some procedural services, and under the old expenditure target method, that led to higher payment updates for those services and a growing disparity in fees between primary care and special -- you know, and other services and so on.

I would say that subsequent to that, with changes that happened in the health care marketplace starting around the year 2000 or so, we saw in our work on volume growth, very rapid increases in three categories of services, imaging, tests, and procedures, not of a major type, not the kind of ones that require hospital stays and so forth, but other services of a less invasive nature.

The services that seemed to be behind that, that seemed to be growing slowly in the '90s, some portion of those were major procedures, and they have continued to grow

at a fairly low rate, kind of in a pattern consistent with what we saw with E&M. The high flyers were in those other categories.

MR. HACKBARTH: So, Kathy, one place that you may want to look is each March in our chapter related to the physician update, we have a table that provides trend information on the rate of growth with a fairly detailed service breakdown, and you can see. You can look at the trends there.

MS. BUTO: Just to comment on that, so as we look at using this methodology, which looks very promising, it would be good to know how that lines up with those --

DR. HAYES: Right. Yes.

MS. BUTO: -- high-growth procedures, if you will --

DR. HAYES: Right.

MS. BUTO: -- and does it really get at the issue.

DR. HAYES: Yeah.

MR. HACKBARTH: Clarifying questions? Still, I have Alice, Herb, and Bill.

DR. COOMBS: Kevin, on page 3, the Commission selecting efficient processes -- or practices, how do you

define efficiency in that term?

DR. HAYES: Yes. I did wonder whether we would get a question like that, and the touchstone, of course, in this area would be our March report where we do talk about how the Commission is exploring ways to define relatively efficient providers, and much of the discussion there in the March report, as you know, involves institutional providers, submitting cost reporters, and identifying efficient providers with the data that are available there.

Of course, that is not this sector, and so if we think about how one might go about this, there is some research. This is all to be determined. This is part of how the data collection, the Secretary chooses to structure the data collection.

But we do know that there has been some research on economies of scale in physician practices, and so that would be one way to -- one consideration perhaps.

Another would be to say that it is probably going to vary by specialty. We are all familiar with how the information technology can influence the efficiency, but that is going to vary. There was an interesting thing in one of our newsletters the other day about the impact of

technology on radiology, and digital sources. So that would be a consideration.

And then the third point I would make would be with the work of this contractor, we saw a lot of what is driving efficiency has to do with the construction of teams and who does what and all that kind of thing.

DR. COOMBS: So one basically when using practices and there were patients in a given time period, so it becomes a circular argument. That's my point.

DR. HAYES: We are not necessarily defining efficiency in that way.

DR. COOMBS: In time, okay.

And then on page 13, when we talk about the impact of NPs and PAs with global payment and how do we allocate time specified when we have a collaborative team working together, I was wondering if there was any way that you deciphered that. Was that looked at?

DR. HAYES: Yes. That was a big part of the contractor's work, was to just make that distinction, and so, in this case, the volume of services was attributed to a practitioner, depending upon who had actually furnished the service, not necessarily how the billing had worked. So

even if a nurse practitioner or PA was working with a physician in a collaborative arrangement and what we call "incident-to billing," that work was allocated or assigned to the nurse practitioner or PA and not to the physician.

DR. COOMBS: Even though there might have been the supervision in one capacity or the other.

DR. HAYES: Right.

DR. COOMBS: Last question. Page 16 and 17, there are graphs that are comparing E&M services with imaging service, with a correlation of .3 and minus .57. Can you just summarize in like a couple of sentences what you glean from that?

DR. HAYES: Yes. That if we were to try and select or identify the services that are most associated with a difference of fee schedule time exceeding actual hours worked, we would not expect that a high volume of evaluation and management services would produce that result. Instead, if we look at the positive correlation between imaging volume and that difference between fee schedule time and hours, there we do see a positive. So the delivery of, the furnishing of imagine services is more predictive of a difference, of that kind of a difference.

MR. KUHN: So, Kevin, as the paper shows and as you mentioned here, the contractor CMS -- or I'm sorry -- MedPAC engaged has looked at non-physician providers. Has the two contractors that CMS has engaged also looking at non-physician providers when they are doing their validation process?

DR. HAYES: Let's think. The RAND project is mostly focused on surgical procedures, and so there may be some acknowledgement, some consideration of the collaboration of surgeons with PAs and nurse practitioners, but it is not going to be them specifically and how much time it takes for them to do their -- to perform a service.

But with the other project, it is just not far enough along for me to say. I could see where they could be, should be able to do that, but I don't know enough about it to say.

MR. KUHN: And the second quick question is the RUC. So, obviously, CMS has this validation process. How is CMS still engaged with the RUC in terms of reliance on their recommendations for rulemaking during this process? What kind of transition is going on there?

DR. HAYES: During the first 10 or 15 years of

experience with CMS working with the RUC, there was a very high, what we will call, acceptance of RUC recommendations, 90 percent or better.

In recent years, CMS has been more willing to question RUC recommendations, has been more willing to revise downward time estimates, time assumptions that have come out of the RUC, RVU recommendations and so on, and the percentages have varied in recent years, but they are below 90 percent. In some years, as I remember it, it was more in the 70 percent area, and then it came back up again. So there's been certainly less dependence or less acceptance of RUC recommendations.

As far as how big the difference is, that I can't tell you, but I --

MR. KUHN: And then, finally, on the RUC, I am just real curious. Are there any non-physician providers that have seats on the RUC, or is it all physician groups?

DR. HAYES: There are 31 members, and there are non-physicians with seats on the RUC, and then there is an advisory committee to the RUC, which is made up of professionals other than physicians. There are opportunities, but the vast majority, almost all of the

seats on the RUC are occupied by physicians.

MR. HACKBARTH: And I think we started with Jack, right? This was still Round 1, by the way, and we are down to our final 12 minutes here.

I am going to ask Mark just to say a little bit more about the context and why we brought this to you, and then I will offer a word about what we are looking to get out of this. And then we will have a brief opportunity for people to make a final comment, if they wish.

DR. MILLER: In some ways, the fact that we are down to -- at least from my point of view, but you can judge yourselves. It is not that much of a problem. The way I view this is the Commission took a position a few years back, the SGR package, that had a lot of elements of it, among them relooking at the validation process and also trying to get away from some of the old, very cumbersome methods that were hard to replicate, expensive to do, those types of things.

I think what we are up to here is the HHS and CMS are engaged in efforts now, and I mean legitimately, and all trying to do the right thing. I think we wanted to -- we had this concept. We wanted to get a little bit of a proof

of concept out there, and we don't think that this is big science, but we think it is a bit indicative. We want this thought to not get lost, and at least that they consider this approach alongside others and look at the relative merits of it relative to other strategies, and I think at least some sense among the staff here that there may be things to recommend this one, given that all of them have their problems.

So, really, what we are trying to just extract is almost some visibility for the process to say, "Look, there might be something here. Don't lose track. At least don't lose track of this," and maybe we're trying to push this for us out in front a little bit, but, of course, you guys may have views on that too.

MR. HACKBARTH: So as opposed to asking you to say this is the right methodology and we feel we have examined exactly how hours are calculated and everything and we bless it, that is not what we are looking for here. I don't envision that we are moving towards a formal recommendation on which everybody is asked to vote on this. As Mark says, we think that this is a method that certainly ought to be considered.

Now, Kevin, my recollection is that there is an existing statutory charge to CMS to do revalidation of our views. My recollection is further that in pending SGR legislation, there are even provisions setting specific numeric targets for readjustment of RVUs, but the dollar targets are not in current law. That is in pending legislation as opposed to --

DR. HAYES: There is in the SGR override bill that was passed in the spring.

MR. HACKBARTH: Oh, that's what it was.

DR. HAYES: Yes.

MR. HACKBARTH: Okay.

DR. HAYES: It's the Protecting Access to Medicare Act of -- right.

MR. HACKBARTH: Yeah.

So in terms of how this will be communicated with CMS, of course, would be through personal interactions with CMS staff and potentially also in our public comment letters. Those would be the vehicles as opposed to formal MedPAC voted-upon recommendations.

So that's what we're up to here. We've got nine minutes left for any concluding comments or questions about

it. Let me just see how many hands we have got. One, two, three, four, five. So you have got a minute and 40 seconds or something to go, and since we started Round 1 over there, we will start this over here.

Alice. Go ahead, Alice, and then Jay.

DR. COOMBS: Okay. First of all, thank you very much, Kevin, for this presentation. My concerns is over efficiency and how you define it, because it becomes a circular discussion in terms of efficient providers, and I will give you an example. In surgery, you can have a difference of two or four hours for one procedure, so that an efficient surgeon, we say is the one who gets the patient out with the same quality indicators. It will vary, depending upon if you are in private answer versus academic practice. It becomes very, very hard, and it's very complex in looking at the different clinical sites for defining efficiency.

So that piece in terms of E&M, I was a resident many years ago at MGH, and there was one doctor who could see 40 patients in a day. And I looked at awe in that because that was truly efficient, and all of the patients loved him, and they seemed to get good care.

But I think that the variation is complex not only because of the different clinical sites, but also the combination of support infrastructure, whether or not you have an NP working with you, whether or not you have a patient navigator who does most of the work beforehand. So this whole notion of time, I think is really complex.

Bottom up or top down, either way you do it, I think it has to be validated with a real time, so that whatever the real time, if it correlates, then I think you can extrapolate from that how well it correlates in terms of going forward for time allocations.

I have many more comments to make, but I won't.

MR. HACKBARTH: And thanks for economizing, Alice.

I would say the points you are raising are, of course, valid ones. Those sorts of issues really pop up under all of the competing methodologies for doing this. There is no sort of a clean shot to get these relative values calculated, challenges in all the paths.

Jay.

DR. CROSSON: Yeah. I feel a little bit like Rip Van Winkle because, in my previous time on MedPAC, we went through this issue, and we came up with what we thought --

here's the problem always -- what we thought was a fairly simple approach. Let's go look at efficient physicians, in this case, who were either on salary or in some other situation where they were not in fee-for-service. We are talking about time now. Let's look at how long it takes to do certain procedures. It seemed like a simple idea. "Bottom up," we're now calling it.

Obviously, it wasn't. That's sort of disappointing to me. So now I woke up, and the dream I had seems to have evaporated into the mist, and we are looking at this again. As I look at this top-down approach, I think two things. Number one, it validates that there is an issue here that needs to be worked on, and it potentially points to some areas where there may be problems.

But then -- and I think -- I forget the term Kevin used. What would follow after this would be a detailed review of those areas. Now, it seems to me that that detailed review would take you right back full circle to trying to figure out, to quantitate what that real difference was in order to then create some change in the payment system.

I wonder whether or not, as we go further down the

line if we're going to do that, we examine some of those problems that made the bottom-up approach not workable and whether those are addressable or not, because, ultimately, I think to get to a solution, we probably find ourselves back there again.

MR. HACKBARTH: Let's see. Round 2. Hands? Cori, Warner, and Jack.

MS. UCCELLO: I just want to say that I think this is fabulous work, and despite my kind of data concern in Round 1, I do not want the thought to be that I had a negative reaction to this, because I really think it's great, and I think it is a really good way of -- even with some maybe data in precision, it is still going to point us in the direction of services that need to be looked at further.

Now, whether Jay is right that still at the end of the day we are going to have some issues, well, maybe. But I think this is really a fantastic way to be identifying that kind of triaging what services we need to be looking at in more depth, so thank you.

MR. THOMAS: I will be brief. Just a couple of comments. I think the top-down approach could be utilized.

I am suspect of all the physicians in the cardiology group working exactly the same in hours. It just doesn't seem like that would work, but who knows?

The other comment I would make it even though there are different levels of E&Ms, I think the idea of taking care of a Medicare patient versus a commercial patient, different age group, is different. There's different time associated with those, and I think we need to be careful of that as we look at this situation. Even in the same level type of visit, I think you are going to see a time differential based upon those two different patients.

DR. HOADLEY: I think my Rip Van Winkle moment is thinking that these same issues we were talking about in the 1990s at the PPRC, before MedPAC was even done. But like Cori, I think we could really debate the details of the methodology on the hours and whether the same measurement across all the doctors is the right way. But I think the real point is it's a really interesting approach. It is a really, I think, useful approach, and I think your point really is that we are trying to think about how to not focus on 7,000 services but to focus on 700 or 70. Then we can have the time to really define methodology within that

little family of services and be much more efficient in how we analyze this issue.

MR. HACKBARTH: Even the method that you used, let's say you get it down to 700 or 70 and you need to do some sort of bottom-up approach, the method that you use, the bottom-up method you use could be dependent on which services you're talking about, I would think.

For example, an obvious example is if it's a surgical service, then OR logs or something may become a source of information that wouldn't be available for E&M services.

Kathy and then Craig, you've got --

MS. BUTO: Twenty seconds.

MR. HACKBARTH: Yeah.

MS. BUTO: Okay. So I just wanted to add my voice to Cori's and Jack's and others. I don't know whose idea this was but fairly brilliant approach or insight that someone had to go down this path. At the very least, I think it will provide a good cross-check against what CMS is doing, and it raises important questions whether or not we have a good path to resolve them. I think it's still a very important contribution.

DR. SAMITT: So, very quickly, I also support the methodology. It will be a welcome complement to RUC's work, but the only caveat that I would say is that we have to remember that an RVU-based methodology and achieving equilibrium here works in today's world, but as we begin to think about more value-based care delivery, paying especially primary care on an RVU basis, especially when there are many services we want primary care to provide that do not have RVU values, quickly becomes an unsustainable compensation model. So we are always going to need to be cognizant of the fact that in a value-based world, we are going to want clinicians to provide different types of services than we are reimbursing through an RVU model today.

MR. HACKBARTH: And we will return to that in December.

Okay. Thank you very much, Kevin. Good work.

We will now move to our public comment period.

Hold on just one second, Sharon. Let me see if there's anybody else. If you would like to make a comment, would you please get in line behind Sharon, so I have the sense of how many people we are talking about.

MS. McILRATH: They can go in front. I don't

care.

MR. HACKBARTH: Sharon chooses her seat strategically, right by the microphone.

[Laughter.]

MR. HACKBARTH: Okay. You know the ground rules, Sharon. Please introduce yourself and your organization. When the red light comes back on, that's the end of your time.

MS. McILRATH: For those of you who have poor memories, I'm Sharon McIlrath with the American Medical Association.

I just wanted to say the RUC has basically indicated that any kind of time data, any data that anyone has, so long as it meets certain criteria, they would be willing to look at. And I think that they would. They've had a lot of screens that they've used to identify misvalued services. I think they would be willing to consider this as one of the screens.

It would have to meet a certain number of criteria. One would be, Is it current? And this is particularly a problem right now because they have been moving so rapidly on the misvalued codes issue that things

are changing in terms of the disparity between different services as well as what time is in those services.

So between the last time that I talked to you about what the RUC has done and sent the paper around, they now have done $39 billion worth of redistribution or recommended the last bunch of this -- or the most recent will be coming out. We'll see what CMS does in the final rule in November.

Some of the other things, there are some other issues, some of which I think might have been involved in the services that you were looking at that are up for review in the end of January.

For instance, since 2012, the services of urology, orthopedics, and cardiology have -- generally the times in those services have dropped between 20 and 30 percent. So what you're looking at in 2012 as a comparison is different than what exists today.

In addition to that, because of the new chronic care management and the transitional care management codes that are expected to be billed by the primary care physicians, that would add in some time that is now available to them. So, bottom line, for the RUC to be able

to use it, it needs to be the same year that you're looking at currently.

Another issue would be whether it's the same -- whether it fits with the methodology that they have and that is required by the law, and what they're looking at is the typical patient, not the efficient practice. So you would have to take that into consideration as well.

And then, finally, I just wanted to say there is potentially the data collection problem. It was a problem for us when we tried to do it with the PPIS. It was the Abt survey way back in the beginning that had to be ditched because they couldn't do it. And it is hard for a practice to know exactly what is needed.

There's also the issue of interpreting what the codes meant and what you have collected. So on this score, I would just say if you're going to go in this direction, it would be a good idea to be working with the RUC right along. So an issue -- Dr. Coombs mentioned this. The global surgical codes, without knowing exactly what they did in the study, it's hard to see how they would have known what part of a global surgical code was being provided by a nurse practitioner or a physician assistant, because the bill is

for the surgical procedure. It doesn't distinguish between who did an E&M within the follow-up visits. So that would be one issue.

Another issue would be where you had multiple procedures and, you know, the time within those would be difficult to sort of suss out. You'd really have to think about how to do that.

So, you know, with the caveats that I think the RUC would like to be involved sort of up front in this sort of effort, it is something that could be used as a screen.

MR. HACKBARTH: Okay. Thank you all. See you next month.

[Whereupon, at 12:06 p.m., the meeting was adjourned.]