

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, April 2, 2015
9:24 a.m.

COMMISSIONERS PRESENT:

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P R O C E E D I N G S

[9:24 a.m.]

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3 MR. HACKBARTH: So this is my last public meeting
4 as MedPAC Chair, today and tomorrow, so if you'll indulge
5 me, I just want to say a couple things at the outset.

6 So I've been on MedPAC for 15 years now, and
7 during my tenure as Chairman, we've voted on over 300
8 recommendations. So with 17 Commissioners, that
9 represents, you know, roughly 5,100 individual votes cast.
10 Over that period, there only have been 32 no votes on those
11 more than 300 recommendations, over 99 percent yes votes.
12 And I take great pride in that. I think that's a
13 remarkable degree of consensus for generations of
14 Commissioners coming from very different backgrounds,
15 different life experiences, different political
16 perspectives. And to achieve that level of consensus I
17 think is a great tribute to Commissioners, past and
18 present, and to our wonderful staff, because I think the
19 two key ingredients to getting to that level of consensus
20 have been that Commissioners accept their responsibility to
21 put the interests of the Medicare program and its
22 beneficiaries first. They come to the task not as

1 representatives of a particular profession or a particular
2 type of health care provider or a particular geographic
3 region but, rather, they bring their experience and
4 knowledge to the table and put the goals of the program
5 first and foremost.

6 Our staff have contributed hugely to this through
7 both the quality of their analysis and their responsiveness
8 to the questions raised by Commissioners. And I can't
9 overstate the importance of that in forging consensus on
10 these issues.

11 And the issues haven't always been easy issues to
12 deal with. I want to just quickly tick off a list of some
13 of the things that we've made recommendations on in the
14 last 15 years.

15 Of course, one of our basic responsibilities to
16 the Congress is on annual updates and the various Medicare
17 payment systems. I think we have applied a fairly
18 rigorous, some would say demanding approach to that,
19 resulting in updates that are certainly lower than many
20 provider groups would have liked, using as our guidepost
21 efficiency providers. And I think our work in this area
22 has set the stage for Congress to arrive at update

1 recommendations that are lower than they might have
2 otherwise, including in the Affordable Care Act, where they
3 set lower statutory updates pretty much across the board.
4 And they've done that again in the pending SGR legislation.
5 Providers may not like that, but I take pride in our role
6 in supporting Congress in that area.

7 We've made a variety of recommendations to
8 improve the equity in Medicare's payment systems, and by
9 their nature, these adjustments redistribute dollars, and
10 there are winners and losers. Yet the analysis supporting
11 the work has been strong, and some difficult changes have
12 been made: severity adjustment for inpatient hospital
13 services, improvements in RVU accuracy in the Physician
14 Payment System, changes in how rural providers are paid,
15 improved payment equity between rural providers and urban
16 providers.

17 We've made recommendations on site-neutral
18 payment. To this point, Congress has only adopted them at
19 the margin, but those have been difficult, challenging
20 issues I know for many Commissioners, and I'm proud of the
21 work we've done in that area.

22 We made very important recommendations on GME

1 reform and Medicare's role in financing graduate medical
2 education.

3 We've made recommendations on benefit
4 restructuring that I'm hopeful still will find their way
5 into legislation because I believe the current benefit
6 structure, with all of its peculiarities, dating from 1965,
7 really isn't in the interest of Medicare beneficiaries. I
8 think, frankly, it's more in the interest of people who
9 sell Medigap insurance than it is in the interest of
10 Medicare beneficiaries.

11 Long ago, in fact, one of the very first
12 recommendations we made after I became Chairman was to move
13 towards financial neutrality in Medicare Advantage, namely,
14 that we ought to pay the same amount for a beneficiary
15 regardless of whether he or she was in traditional Medicare
16 or enrolled in an MA plan. Congress took a big step in
17 that direction in the Affordable Care Act.

18 We laid the groundwork for a lot of the Medicare
19 payment reforms that are now under consideration -- some in
20 law, like ACOs; others being tested in CMMI.

21 We were one of the early advocates of a public
22 database on physician financial relationships, the so-

1 called Sunshine Act, which is part of law now.

2 We were one of the early advocates of a major
3 federal investment in comparative effectiveness, which is
4 now embodied in PCORI.

5 And last, but certainly not least, we were very
6 early advocates of SGR repeal. Again, that was something
7 we recommended in 2001 when it wasn't nearly as popular as
8 it has become in recent years, and hopefully in the next
9 couple weeks that will become law as well.

10 So to deal with difficult, complex issues like
11 these and achieve the level of consensus that we have I
12 think is a record that all of us should be proud of. I
13 know I am.

14 And to those of you in the audience, there are a
15 lot of familiar faces. Some of you I see sort of month
16 after month after month and year after year after year. I
17 know that doesn't signify that you necessarily agree with
18 what you're seeing. In fact, maybe it means the opposite,
19 that you're here because you don't agree with it. But I do
20 welcome and I'm grateful for the interest that you've shown
21 in MedPAC's work, so thank you for that.

22 So, with that, let's turn to our agenda--

1 [Standing ovation.]

2 MR. HACKBARTH: Thank you.

3 Can we go on now?

4 [Laughter.]

5 DR. MILLER: You're the Chairman.

6 MR. HACKBARTH: Right, for a little while longer.

7 Okay. So, Zach, are you going to lead the way on
8 hospital short stay?

9 MR. GAUMER: Yes, sir, that's right.

10 MR. HACKBARTH: And, incidentally, I don't want
11 anybody to feel any pressure about votes.

12 [Laughter.]

13 MR. HACKBARTH: But I do count.

14 Zach?

15 MR. GAUMER: Okay. Good morning. Today we'll
16 discuss the five draft recommendations you've assembled
17 concerning short hospital stays. Based on your discussion,
18 the Chairman will initiate the voting process.

19 To review from the Commission's four previous
20 discussions, the origins of this issue lie in both the
21 complexity of the admissions process and the payment
22 differences between similar inpatient and outpatient stays.

1 These factors led RACs to focus their audits on short
2 inpatient stays, and in response, hospitals increased their
3 use of outpatient observation.

4 CMS took action to resolve these issues by
5 implementing the 2-midnight rule. The rule has been
6 controversial, and its full implementation has been delayed
7 repeatedly.

8 For beneficiaries served in outpatient
9 observation, there is fairly broad concern that they are
10 occasionally surprised to learn that they are in
11 observation status. In addition, while liability is
12 generally lower for beneficiaries served in observation
13 status, these beneficiaries can be exposed to higher
14 financial liability with regard to SNF coverage and self-
15 administered drugs.

16 The five draft recommendations we will discuss
17 are listed on the slide above. They have been slightly
18 modified from what you've read in the mailing materials you
19 received last week.

20 The first recommendation pertains to the RAC
21 program, and the withdrawal of the 2-midnight rule has been
22 incorporated in this recommendation.

1 The second recommendation concerns the hospital
2 short-stay penalty concept.

3 The last three recommendations focus on improving
4 beneficiary protections for those served in observation
5 status.

6 The first recommendation we will consider today
7 concerns specific changes to the RAC program. In its work
8 this year, the Commission has identified three concerns
9 about the program:

10 First, that it has significantly increased the
11 administrative burden of hospitals;

12 Second, that the exception of losing payment when
13 their claim denials are overturned -- excuse me. Second,
14 with the exception of losing payment when their claim
15 denials are overturns, RACs are not held accountable for
16 their auditing determinations;

17 And, third, that hospitals are unable to rebill
18 RAC-denied claims as outpatient claims due to the
19 misalignment of the three-year RAC lookback period and the
20 one-year hospital rebilling window.

21 As you will recall, at our last meeting Herb
22 suggested we give consideration to crafting a

1 recommendation about removing CMS' 2-midnight rule. We
2 have discussed this rule publicly on several occasions, and
3 we have built this topic into the draft recommendation
4 pertaining to the RAC program because the rule is a
5 directive to auditors. Retaining the 2-midnight rule may
6 be redundant in the context of our larger package of
7 recommendations on this topic.

8 For a moment, let's review what the 2-midnight
9 rule is. CMS established the 2-midnight rule for fiscal
10 year 2014 to alleviate concerns about admission criteria,
11 long observation stays, beneficiary liability, and
12 hospitals' concerns about RAC audits. This rule instructs
13 auditors to presume that stays longer than 2 midnights are
14 appropriate for inpatient status and should be exempt from
15 audit, with some exceptions. It also instructs them to
16 presume stays shorter than 2 midnights are more appropriate
17 for outpatient status and, therefore, are subject to audit.
18 This rule does not directly alter Medicare admission
19 criteria, but it will alter providers' admitting behavior.

20 Congress and CMS have placed RAC enforcement of
21 the 2-midnight rule on hold several times since its
22 implementation. The most recent hold expired this past

1 Tuesday, March 31st, but legislation to extent the hold is
2 included in the active SGR legislation, H.R. 2.

3 The 2-midnight rule may have successfully
4 achieved a few of the goals that it was designed to
5 address. It alleviates a portion of the RAC-related
6 administrative burden hospitals face, and it will reduce
7 the use of long observation stays. In addition, some
8 hospitals have been pleased with the fact that it
9 essentially creates the time-based standard for inpatient
10 services.

11 However, the 2-midnight rule raises a number of
12 concerns. It largely exempts stays longer than 2 midnights
13 from RAC oversight, and it provides hospitals with the
14 incentive to increase the length of stays beyond 2
15 midnights in order to avoid RAC scrutiny. The lengthening
16 of the stays may result in an increase in the use of short
17 observation stays and, therefore, exacerbate concerns about
18 SNF coverage eligibility. Overall, the incentive to
19 increase the length of stays may act to eliminate 1-day
20 inpatient stays entirely.

21 Stakeholders have also noted that the rule
22 detracts from the current admissions criteria based on

1 physician judgment, increases burden on physicians to
2 document admission, and causes significant shifting of
3 cases between the inpatient and outpatient settings.

4 For these various reasons, the Commission is
5 considering the complete rather than partial withdrawal of
6 the 2-midnight rule.

7 Based on our evaluation of the RAC program and
8 the 2-midnight rule, the Commission's four-part draft
9 recommendation reads as follows:

10 The Secretary should direct Recovery Audit
11 Contractors to focus reviews of short inpatient stays on
12 hospitals with high rates of this type of stay; modify each
13 RAC's contingency fees to be based, in part, on its claim
14 denial overturn rate; ensure that the RAC lookback period
15 is shorter than the Medicare rebilling period for short
16 inpatient stays; and withdraw the 2-midnight rule.

17 We expect this recommendation will increase
18 program spending because it will cause RACs to take a more
19 cautious approach to auditing, resulting in fewer claim
20 denials and a lower level of recoveries. It will also
21 increase rebilling opportunities and allow hospitals to
22 gain partial reimbursement for services that were otherwise

1 denied.

2 We do not expect this recommendation will
3 adversely affect beneficiary access. However, the effect
4 on beneficiary cost sharing may be mixed due to stays
5 shifting between the inpatient and outpatient settings.

6 For hospitals providing a high rate of short
7 inpatient stays, this recommendation will increase RAC
8 scrutiny of short stays and administrative burden.
9 However, for the remainder of hospitals this recommendation
10 will either reduce or eliminate RAC scrutiny and the
11 associated administrative burden. Also, we expect this
12 recommendation will benefit hospitals financially because
13 it will enable more rebilling of denied inpatient claims
14 and reduce administrative costs associated with RAC record
15 requests and physician documentation requirements.

16 Our evaluation of the RAC program has also led
17 the Commission to consider the potential for a formula-
18 based payment penalty on hospitals with excess levels of
19 short inpatient stays to replace RAC reviews of these
20 stays. Interest in this concept is derived from concern
21 that the RAC program is administratively burdensome for
22 hospitals and CMS, and oversight of hospitals could be made

1 more efficient.

2 Therefore, the Commission is recommending:

3 The Secretary should evaluate establishing a
4 penalty for hospitals with excess rates of short inpatient
5 stays to substitute, in whole or in part, for RAC review of
6 short inpatient stays.

7 The penalty concept may reduce administrative
8 burden on hospitals and CMS and make oversight more
9 efficient. However, the Secretary will need to address
10 several design elements in evaluating this concept, such as
11 how to define short stays, identifying an appropriate
12 penalty threshold and penalty amount, and risk-adjusting
13 the measure to make it equitable for all hospitals.

14 Because this recommendation is for the Secretary
15 to evaluate rather than implement this concept, we expect
16 this recommendation will not increase Medicare program
17 spending or adversely affect beneficiaries or providers.
18 While we are asking the Secretary to evaluate this concept,
19 we will also be conducting our own evaluation.

20 Stephanie will now discuss the Commission's
21 beneficiary protection recommendations.

22 MS. CAMERON: Turning now to our draft

1 recommendations on beneficiary protections, you'll remember
2 that beneficiaries with an outpatient observation stay who
3 are then discharged to a skilled nursing facility without
4 qualifying for Medicare's SNF benefit are at risk of
5 substantial financial liability for their post-acute care.
6 In addition, these beneficiaries are at risk of incurring
7 out-of-pocket expenses for self-administered drugs, as
8 these drugs are not covered by the outpatient payment
9 system.

10 The Commission has considered recommendations
11 with regard to revising the SNF 3-day prior hospitalization
12 policy, beneficiary notification requirements, and
13 beneficiary financial liability for self-administered drugs
14 which I will review today in turn.

15 First, the 3-day prior inpatient hospitalization
16 requirement for SNF coverage.

17 A small group of beneficiaries incur high out-of-
18 pocket costs because their 3-day hospital stay did not
19 include three full inpatient days, leaving them without SNF
20 coverage. As you may recall, time spent receiving
21 outpatient observation care does not count toward the 3-day
22 requirement for SNF coverage.

1 In an attempt to find a balance between expanding
2 SNF eligibility to include beneficiaries receiving
3 observation care and preserving the SNF benefit as strictly
4 a post-acute-care benefit, the draft recommendation reads:

5 The Congress should revise the skilled nursing
6 facility three inpatient day hospital eligibility
7 requirement to allow for up to two outpatient observation
8 days to count towards meeting the criterion.

9 The Commission anticipates that this policy will
10 increase program spending for the beneficiaries who will
11 now qualify for SNF coverage. The overall impact of this
12 policy on spending is dependent on the behavioral response
13 of beneficiaries and providers. For example, a lower
14 threshold for Medicare SNF coverage could provide a greater
15 incentive for nursing facilities to send beneficiaries to
16 the hospital in order to requalify for the SNF benefit.

17 The Commission anticipates that this policy will
18 have a positive impact on the beneficiaries who are
19 discharged to SNFs without Medicare SNF coverage currently.
20 Beneficiaries such as these will see their out-of-pocket
21 post-acute-care liability reduced dramatically. This
22 recommendation would also increase Medicare use of and

1 payments to freestanding and hospital-based SNFs.

2 The Commission has discussed beneficiary
3 uncertainty about the differences between inpatient status
4 and outpatient observation care. Medicare currently does
5 not require hospitals to notify beneficiaries of their
6 outpatient observation status regardless of the time these
7 beneficiaries spend in the hospital. Medicare
8 beneficiaries and beneficiary advocates often cite this
9 lack of notification as a source of confusion for
10 beneficiary SNF eligibility and cost-sharing liability.

11 Several states have laws or are considering law
12 that require hospitals to inform patients about their
13 status in observation. Earlier this month, the House of
14 Representatives passed legislation addressing this issue on
15 the federal level in what is called the NOTICE Act.

16 I would be happy to discuss this further on
17 question.

18 In the meantime, the draft recommendation to
19 address beneficiary notification reads: "The Congress
20 should require acute care hospitals to notify beneficiaries
21 placed in outpatient observation status that their
22 observation status may affect their financial liability for

1 skilled nursing facility care. The notice should be
2 provided to patients in observation status for more than 24
3 hours and who are expected to need skilled nursing
4 services. The notice should be timely, allowing patients
5 to consult with their physicians and other health care
6 professionals before discharge planning is complete."

7 When CBO evaluated the NOTICE Act, they
8 determined that, as passed by the House of Representatives,
9 the legislation would not have significant budgetary
10 effects over the 2015 through 2025 period. We expect that
11 hospitals will need to make administrative adjustments to
12 accommodate this change and, thus, likely incur an
13 administrative cost to implement this policy.

14 Lastly, we will discuss self-administered drugs
15 in outpatient observation care.

16 Beneficiaries who receive outpatient observation
17 services may be in the hospital for an extended period of
18 time, for example, 24 hours or more, and require some of
19 their oral medications that they would normally take at
20 home. As you'll recall, oral drugs and certain other drugs
21 that are considered usually self-administered are not
22 covered by Medicare for hospital outpatients. The extent

1 to which beneficiaries are affected by this issue varies by
2 hospital. Some hospitals reportedly do not charge
3 beneficiaries for self-administered drugs. Other hospitals
4 contend that they must charge beneficiaries for self-
5 administered drugs because of laws prohibiting beneficiary
6 inducements. These facilities may bill the beneficiary at
7 full charges, which equals approximately \$200, on average,
8 which is substantially higher than the cost of providing
9 the drug, which equals about \$40, on average.

10 The draft recommendation to package self-
11 administered drugs in the outpatient payment rate reads:
12 "The Congress should package payment for self-administered
13 drugs provided during outpatient observation on a budget
14 neutral basis within the hospital outpatient prospective
15 payment system."

16 Under this approach, the Secretary would increase
17 outpatient payment rates for all beneficiaries receiving
18 observation care to reflect coverage of self-administered
19 drugs, while payment rates for other outpatient services
20 under the OPSS would decrease slightly to offset it,
21 resulting in no additional Medicare spending.

22 Overall, this option would also reduce

1 beneficiary liability for self-administered drugs.
2 Beneficiaries receiving observation care would no longer be
3 liable for non-covered self-administered drugs at full
4 charges. In addition, this option would also make cost
5 sharing for self-administered drugs uniform across
6 beneficiaries and hospitals paid through the OPPS.

7 We expect that hospitals would experience a small
8 decrease in revenues from no longer receiving full charges
9 from beneficiaries. However, this policy may reduce
10 hospital administrative burden associated with cost sharing
11 collections and beneficiary complaints concerning self-
12 administered drugs.

13 We have reached the end of our presentation
14 today. For your reference, here's a quick summary of the
15 draft recommendations we've discussed, and with that, I
16 will turn it over to Glenn.

17 MR. HACKBARTH: Okay. Thank you, Zach and
18 Stephanie.

19 So, we'll have two rounds, our usual clarifying
20 questions, strictly defined, and then a second round where
21 each Commissioner may, if he or she wishes, state their
22 overall view on the package of recommendations before we

1 vote.

2 So, let's start with clarifying questions. Are
3 there any clarifying questions from Commissioners? Jack.

4 DR. HOADLEY: I just wanted to clarify, I think
5 it's in the text, but on the recommendation on the RAC,
6 when we talk about the denial overhead rate as a basis, you
7 say in the text that the Secretary should have latitude to
8 define the rate. So, we're not setting any particular
9 definition for the rate in our recommendation.

10 MR. GAUMER: That's correct. There is some, I
11 think, debate generally in the policy community, in the
12 weeds, anyway, about what rate should be used and how it
13 should be defined. So, we're not being specific in the
14 text about which rate should be used, and the Secretary
15 should have some latitude.

16 DR. HOADLEY: And, then, a similar question on
17 the rebilling thing. There obviously are different ways to
18 define exactly what the time period should be and we're not
19 taking any particular position. I know there's language in
20 the text about principles on hospitals not being able to
21 fully exhaust appeals and a clear window for rebilling.

22 MR. GAUMER: That's right. So, the

1 recommendation that we have up there is a principle-based
2 recommendation and, you know, the Secretary should be able
3 to define the right balance between appeal and rebilling
4 and it's a complicated decision.

5 DR. HOADLEY: Great. Thank you.

6 MR. HACKBARTH: Clarifying questions. Bill.

7 MR. GRADISON: Thank you. In the mailing
8 material on page 13, the text box refers to a list of
9 changes that CMS announced with regard to the RACs, that
10 CMS announced in December of last year. I just wonder what
11 the status of this is. My impression is that that issue
12 ended up in court in some manner or other, and could you
13 just tell us the facts there, please.

14 MR. GAUMER: Yes. So, that issue did end up in
15 court. Let me go back. CMS released a list of 18
16 different changes that they wanted to make to contracts
17 going forward, and I believe that happened late in
18 December. The first contract that got signed, there was a
19 lawsuit, and it had to do with -- it had to do with the
20 provision that said, after which point the hospitals will -
21 - after which point in the appeal process the money would
22 exchange hands again. And, that lawsuit, I believe, is

1 still in kind of an appeal process, and it's in limbo, I
2 think is the way to leave that.

3 And, CMS has informed us that they have some
4 leeway to begin to do these changes, these 18 changes
5 incrementally as this occurs. And, so, some of these
6 things are being implemented slowly with the RACs before
7 the contracts are being -- the new contracts are being
8 signed. And then the new round of contracts, they hope --
9 CMS hops to get these components, these 18 components, into
10 the new contracts.

11 MR. GRADISON: Thank you.

12 MR. GAUMER: Okay.

13 MS. BUTO: Two clarifying questions. On the
14 issue of the 2-midnight rule, there was an 0.2 percent
15 reduction made to compensate for what CMS was projecting
16 would be additional costs associated with it. Did we look
17 at or address -- I'm trying to -- I was looking in the
18 text, but couldn't find whether we addressed whether we
19 think that should be restored, whether there ought to be
20 any, you know, compensating calculation made there.

21 MR. GAUMER: So, there's not a broad discussion
22 of the 0.2 in the text.

1 MS. BUTO: Mm-hmm.

2 MR. GAUMER: I think our general position has
3 been that it should be restored if it was implemented with
4 the 2-midnight rule. If the 2-midnight rule were to be
5 withdrawn, the 0.2 should come back in --

6 MS. BUTO: Okay.

7 MR. GAUMER: -- and that's where we --

8 MS. BUTO: And then my second clarifying question
9 is, the recommendation is for self-administered drugs to be
10 folded into OPPS just for observation stays, or days,
11 rather, observation days. Dave and I were talking about
12 stays, and stays is an inpatient concept. What would the
13 additional cost be of including self-administered drugs for
14 all OPPS services? Do we have a number on that?

15 MS. CAMERON: We do not have a number on
16 including the cost for all OPPS services. We had done some
17 preliminary look at some of the ER visits and surgery, and
18 if we added those in, we expect, based on our calculations,
19 that to cost about \$100 million a year. But, that hasn't
20 been something we've thought through in terms of the
21 implementation or the appropriateness for all of ER or all
22 of surgery to be included.

1 MS. BUTO: Okay. So, \$100 million on top of the
2 estimated \$50 million that we think goes with observation,
3 or just a total of \$100 million?

4 MS. CAMERON: A total of 100.

5 MS. BUTO: Okay. Great. Thank you.

6 MS. CAMERON: So, it just about doubles it.

7 DR. SAMITT: Great work yet again on this
8 chapter.

9 I think this is probably a question for
10 Stephanie. On Slide 14, you talk about the administrative
11 burden on providers of this recommendation. I was
12 wondering if you had some discussion and dialogue about
13 whether you thought that this recommendation would increase
14 in any way substantively length of stay. So, if
15 beneficiaries are now made aware of the implications of the
16 SNP eligibility rule, would it then lead to longer stays,
17 potentially?

18 MS. CAMERON: We had -- in thinking about this,
19 we wanted to ensure that this remained a discussion with
20 beneficiaries and their physicians or other health care
21 professionals. It's unclear to us how that will play out
22 and what the ultimate behavior will be. There could be a

1 situation where a beneficiary may have been recommended to
2 be discharged to a skilled nursing facility, but because of
3 a subsequent conversation, they decide that maybe home
4 health is a better option. In that case, I don't think we
5 would expect length of stay to be increased. However,
6 there could be circumstances where that may happen.

7 DR. SAMITT: Thank you.

8 MR. KUHN: So, a quick question about the appeals
9 backlogs and the announcement last year of CMS to enter
10 into a settlement agreement with hospitals at 68 cents on
11 the dollar if they were to drop their appeals. That
12 process is now closed, and I know we referenced it in the
13 reading material, but do we know what the take-up rate and
14 how much that decreased the backlog?

15 MR. GAUMER: Let me just ask a clarifying
16 question to your question.

17 MR. KUHN: Yes.

18 [Laughter.]

19 MR. GAUMER: The backlog, in terms of how much
20 the 68 percent settlement has resolved the 800,000 appeals?
21 Is that what you're asking?

22 MR. KUHN: That's correct. Yes.

1 MR. GAUMER: Okay. We don't have a sense yet for
2 the result of that settlement. Just the other day, the
3 three of us were talking about this. CMS's most recent
4 information on this came out in March, I believe, and what
5 they've said is that the process of filing for the
6 settlement, in other words, the hospitals initiating that
7 they would like to take advantage of the 68 percent deal
8 they can get, that has closed and, I think in October,
9 hospitals had to let everyone know -- let CMS know that
10 they were interested, and as a result, CMS is supposed to
11 release a report on what occurred fairly soon. But, we
12 haven't seen anything yet. So, they're probably ironing
13 out how this all works.

14 MR. HACKBARTH: Any more clarifying questions?

15 [No response.]

16 MR. HACKBARTH: Okay. Let's move, then, to round
17 two. As I said, this is an opportunity for Commissioners
18 to state their views about the overall package of
19 recommendations. I don't think we need to go through them
20 one by one. Just treat it as a package. And, as I say,
21 don't feel obliged that everybody's got to talk, but this
22 is your chance if you want to go on record with a view of

1 the overall package.

2 Cori, and then Herb, and we'll come around this
3 way.

4 MS. UCCELLO: Well, I support the entire package
5 of recommendations, but I just want to call out my
6 particular appreciation for the notice recommendation
7 wording that, I think, changed a little from last time to
8 specify more the timing of that notice, and I think it's
9 really important that this be done before people are
10 walking out the door, or being wheeled out the door. So, I
11 think -- so, I just really appreciate this new wording, so
12 thank you.

13 MR. KUHN: I, too, want to say that I support the
14 package of recommendations. There's a lot of
15 recommendations here, as we all know, and we've been
16 through a lot of material here. But, it's just a challenge
17 to think that clinical judgment, and physicians have been
18 admitting people to hospitals in the Medicare program since
19 1965, and who would think that we're here in 2015 still
20 struggling with what that admission criteria kind of looks
21 like, to a degree. So, the fact that we're trying to get
22 some clarity here and looking at a fairly complex set of

1 recommendations, hopefully, we'll give some predictability
2 and stability for folks as they think this through.

3 But, also, I think some of the other
4 recommendations here dealing with the rebilling issue, the
5 2-midnight rule, the three-day prior hospitalization with
6 SNF benefits are all improvements to the program.

7 So, overall, I think it's a terrific package, and
8 I want to compliment the staff for bearing with us, because
9 we have been back and forth on this issue so much over many
10 sessions, and I think the write-up of the material is
11 extraordinarily well done.

12 DR. CHRISTIANSON: Yeah, I also support the
13 package as a whole, but I want to -- I mean, a lot of the
14 discussion around this has been around hospital payments
15 and issues with respect to hospital payments, but I am
16 particularly pleased that the recommendations regarding the
17 beneficiaries became part of this package. I thank the
18 staff for working on that.

19 DR. CROSSON: Thank you. I support the five
20 recommendations. I think it's a good package.

21 I'd just like to make one comment on the 2-
22 midnight rule. I think, based on our conversations on this

1 issue, a lot of people in the health care industry are
2 going to be happy to see in the recommendation that we
3 withdraw the 2-midnight rule. On the other hand, it does
4 provide a safe harbor and a clear line for hospitals in
5 what is a very complex clinical judgment arena, and I think
6 it's important to emphasize, as we will, that that
7 recommendation does not actually stand alone. It is, in
8 fact, linked to the other recommendations with respect to
9 reform of the RAC process. And, to the extent that people
10 -- and there will be some who are concerned about this
11 recommendation -- they need to understand that our
12 intention has been that this withdrawal would be in the
13 context of overall reform of the RAC process.

14 DR. NAYLOR: I also support the recommendations.
15 I want to reinforce Jon's comments. I think that the
16 collection of recommendations just places the centrality of
17 the beneficiary in this program front and center, with
18 self-administered drugs, with attention to what is a SNF
19 stay, and with the efforts to really make sure that
20 beneficiaries understand their rights in this program. So,
21 I really think that this reinforces your earlier -- your
22 introductory comments about everybody stepping out of

1 themselves and really placing the program and the
2 recipients front and center.

3 DR. HALL: I, too, wanted to commend you on not
4 only this particular material, but all the material that's
5 been prepared on this issue. I think it's the best
6 explanation available anywhere. This is a very, very
7 confusing literature.

8 For example, we talk about the 2-midnight rule
9 creating a safe harbor. It's a safe harbor for
10 administrative issues. It's not a safe harbor for
11 patients. And, if we look at our Medicare recipients as
12 our primary responsibility, there are many instances where
13 strict adherence to the 2-midnight rule could adversely
14 affect patient care. Some of these individuals who are put
15 in observation status are considered sort of not very sick,
16 when, in point of fact, they often have very serious
17 illnesses.

18 It also assumes that health care providers are
19 superior and infallible diagnosticians, and that's not a
20 true statement. One thing one learns over time in clinical
21 medicine is to be very humble about decision making.

22 So, any kind of sort of unofficial restraints,

1 artificial restraints on getting the right care at the
2 right time can really harm people. And, so, I think we
3 would do well to eliminate the 2-midnight rule. But, as
4 everyone else, I am sure, will be saying, it has to be in
5 conjunction with some of the important reforms we've put
6 into the RAC process. And, I think we're really -- this is
7 a very, very exciting initiative that we're embarking on
8 now. I'm in favor of these recommendations.

9 MR. GRADISON: My support for eliminating the 2-
10 midnight rule goes to the desire to put nothing in the way
11 of shortening lengths of stay, which have been shortened
12 dramatically over the years. We have no way of knowing
13 what changes may come about in the future that might
14 lengthen or shorten stays, but I hate to have something on
15 the books which would stand in the way of having a very
16 intense one-day and then sending people on to some kind of
17 post-acute care rather than staying longer.

18 DR. NERENZ: Yeah. I'm happy to support the
19 recommendations, and I appreciate the great work on what's
20 really a complex issue, in part because it's not just one
21 problem. It's at least two, maybe more related problems.
22 And, the things that we've talked about here, I think, are

1 things that can be achieved in relatively short term and
2 sort of that's the scope of the discussion.

3 I think once we put that behind us, going
4 forward, I'm still going to be concerned about, from the
5 beneficiary point of view, these really long outpatient so-
6 called stays. That's not the right word. And, I think we
7 ought to continue for ways to avoid what we hear from our
8 physician colleagues is an essentially arbitrary
9 distinction for people who are under a hospital roof,
10 they're in a bed, they're surrounded by nurses, they're
11 having things done to them, but yet we still maintain this
12 dichotomy. So, I'm perfectly happy with what we're doing
13 here, but I think we still have perhaps a little work to do
14 going forward.

15 MS. BUTO: I want to just say this is incredible
16 work on the Staff's part because this is probably the most
17 complex issue I can remember dealing with, and I've been
18 dealing with Medicare issues for a long time. So I want to
19 just commend you for the work.

20 I fully support all the recommendations. I want
21 to just express worry about the formula-based penalty, and
22 it goes a little bit to what Bill Gradison was just saying

1 about standing in the way of trying to shorten unnecessary
2 length of stay.

3 I worry on two fronts. One is that an across-
4 the-board penalty where if its threshold is sent for
5 hospitals having one-day stays, disregards whether or not
6 those stays are medically necessary, and once you get into
7 trying to sort of slice and dice and only look at the not
8 medically necessary ones, it gets into a very convoluted
9 process. So if you keep it clean and it's across the
10 board, you're going to catch medically necessary one-day
11 stays, and hospitals will face a penalty for those as well.

12 And then the other point that Bill was making
13 about just -- I fear it is a little bit like the 2-midnight
14 rule. You could sort of be setting up a situation where
15 two inpatient stays creates a safe harbor against this
16 penalty.

17 So I just register that. I realize what we're
18 recommending is an evaluation, but I just want to say that
19 I think there are some potential pitfalls there.

20 Lastly, the only other thing I would love to see
21 us at least call out is the possibility of folding in self-
22 administered drugs for all OPPS into the rates, if it's

1 \$100 million or so. The idea that beneficiaries are going
2 to be charged full charges for these drugs in everything
3 except observation stays or days, I think would be -- the
4 burden is going to remain there, and I think it's kind of
5 unnecessary. So I'd like to see both of those changes or
6 at least call out the possibility of those issues.

7 DR. COOMBS: Thank you very much for an excellent
8 chapter, and I really appreciate the whole process of this
9 discussion on appeals.

10 I support the recommendation. I just want to
11 echo just my concern again about the penalty and the
12 recommendation regarding evaluate. I think that one of the
13 things that we have talked about is just this whole notion
14 of looking at different critical access hospitals and also
15 the DSH hospitals.

16 One of the experiences -- I was discussing with
17 one of the hospital executives, and one of the experiences
18 they talked about was the whole notion of the probe and
19 educate and what they have experienced with the 2-midnight
20 rule and their denials. And they got into a deep
21 discussion when they did their case reviews about, okay,
22 why was this considered, why was this denied. When they

1 asked about clinical criteria, they were fraught with very
2 disappointing answers. That piece of it, the probe and
3 educate, is not internally consistent, I think, from one
4 region to the other.

5 Hopefully, with the RAC reform, there is also
6 this discussion about what's the criteria for denial that
7 goes beyond the 2-midnight rule. I strongly agree with the
8 withdrawal of the 2-midnight rule, but the whole piece with
9 probe and educate, I think is something else that going
10 forward the RAC will have to deal with as well.

11 Thank you.

12 DR. HOADLEY: Yeah. I want to join others in
13 thanking the staff. Teaching us on a very difficult issue
14 how to think about this and answering a lot of sometimes
15 naive questions has shown a lot of great work from the
16 staff and also join others in support of these
17 recommendations, and I think it's a great example of the
18 sort of consensus process. We might not all have written
19 every one of them exactly the way they came out, but we're
20 all seemingly very comfortable with the package as a whole.
21 I also join Jon, Mary, and some others in really
22 appreciating that we have addressed some of the particular

1 beneficiary issues that came up in this, and I think that's
2 a really helpful thing.

3 MR. HACKBARTH: Any others?

4 Oh, Warner.

5 MR. THOMAS: Just a couple of comments. Number
6 one, as we all understand, this is a very complex issue,
7 and patients are all different, quite frankly.

8 I suppose the recommendations. I just want to
9 make a few comments, not to change recommendations, but if
10 they could be in the verbiage as this is put forth.

11 First of all, the issue around the RAC reform, I
12 think is extremely important in this whole rule. I know
13 that in the chapter, it talked about a 1 percent reduction
14 for RACs that see high overturn rates. I would just
15 encourage us to make sure it is a material impact to the
16 RACs because depending upon the rates you look at, between
17 65 to mid-70 or high 70s of appeals, essentially overturn
18 the RAC review. So that is, I think, a big issue for
19 providers and certainly puts the beneficiary in the middle
20 as that whole process is being considered.

21 I know in the recommendation, it talks about
22 making sure the period is long enough to allow the rebuild.

1 I just think it's important that we take into consideration
2 the appeal time frame as we go through that. I know that
3 there's a one-year limitation. I'm not sure in the
4 recommendation if that would be modified to make sure that
5 a provider has enough time to go through the complete
6 appeal process and then be able to rebuild. I would just
7 make sure that that's something we have an opportunity to
8 comment on.

9 I would agree with Kathy on the formulaic
10 approach. I would just encourage us to be careful if we go
11 down that road. Given the nature of this, I think that can
12 be a challenge.

13 Then, finally -- and I had asked this clarifying
14 question earlier about the rate of one-day stays. If we're
15 going to look at percentages, which I think is important,
16 because otherwise you could potentially penalize large
17 organizations that see lots of Medicare patients. On the
18 flip side of that, if you have a very small provider that
19 has very few cases, a percentage could be a challenge as
20 well. So I think we just need to balance those two and
21 maybe look at some sort of threshold of number of cases and
22 then look at percentage. I just would make that small

1 comment.

2 Then, lastly, just in the comment of -- I know in
3 the 2-midnight rule, we talk about the issue that there is
4 a safe harbor after a 48-hour period, going to David's
5 point. I mean, these patients are inpatients. I just
6 think if there could be a comment about -- or some guidance
7 to RACs about how they are going to look at these patients,
8 if they are an observation in for a couple of days, I just
9 think that's an important component of the 48-hour rule or
10 the 2-midnight rule. I agree we should revoke that, and I
11 support the recommendation. I just think there ought to be
12 a comment that is made in the verbiage.

13 But with those comments, I certainly approve the
14 recommendations and think it's been great work. Thank you.

15 DR. REDBERG: First, I want to add my thanks to
16 the Staff for an excellent chapter on very complex issues,
17 and I support all of the recommendations.

18 Just building on what others have said in terms
19 of the appropriateness, I think in the future, it's
20 important to also look at the appropriateness because a lot
21 of these inpatient observation stays happen to be in the
22 cardiac area, like chest pain, cardiac arrhythmia, and the

1 question is whether they should be held at all or whether
2 these really should be outpatient, because a lot of data
3 shows in the low-risk chest pain, which mostly these are
4 people with funny kind of symptoms, normal EKGs, negative
5 enzymes, 90 percent of them don't even have cardiac disease
6 and have a very low event rate. So overall, the question
7 to me isn't so much observation or inpatient, but should
8 they be held at all, or should they just be more
9 appropriately kept in the outpatient and sent home to
10 follow up with primary care doctors, which we hope are
11 easily accessible?

12 But I support the current recommendations at this
13 time.

14 MR. HACKBARTH: Any other Commissioner comments?

15 [No response.]

16 MR. HACKBARTH: This goes to your point, Rita.
17 All of this is an artifact of Medicare-siloed payment
18 systems, and in particular, having the inpatient system
19 with its large and high-priced bundle lodged alongside an
20 outpatient system, it isn't as bundled as much and has
21 lower dollar values, and that creates the potential for an
22 incentive to inappropriately hospitalize patients.

1 I think there is a broad consensus in the
2 Commission that we all long for the day where we're focused
3 less on how we manage the siloes and the problems that the
4 siloes create and we have payment systems where there are
5 better incentives for high-quality care for Medicare
6 beneficiaries done in the most efficient way possible with
7 the appropriate resource use.

8 We have a ways to get there, but I trust that you
9 folks, once I'm gone, will finish the work very, very
10 quickly. Yes, six months.

11 Okay. So we are ready to vote now. Draft
12 Recommendation No. 1 is up on the screen. All in favor of
13 Recommendation 1, please raise your hand.

14 [Show of hands.]

15 MR. HACKBARTH: Opposed?

16 [No response.]

17 MR. HACKBARTH: Abstentions?

18 [No response.]

19 MR. HACKBARTH: Okay. No. 2. All in favor of
20 Recommendation 2, please raise your hand.

21 [Show of hands.]

22 MR. HACKBARTH: Opposed?

1 [No response.]

2 MR. HACKBARTH: Abstentions?

3 [No response.]

4 MR. HACKBARTH: Okay. No. 3. All in favor of 3?

5 [Show of hands.]

6 MR. HACKBARTH: Opposed?

7 [No response.]

8 MR. HACKBARTH: Abstentions?

9 [No response.]

10 MR. HACKBARTH: Four? All opposed to four --

11 [Laughter.]

12 MR. HACKBARTH: All in favor of Recommendation 4?

13 [Show of hands.]

14 MR. HACKBARTH: Opposed?

15 [No response.]

16 MR. HACKBARTH: Abstentions?

17 [No response.]

18 MR. HACKBARTH: And No. 5. All in favor of No.

19 5?

20 [Show of hands.]

21 MR. HACKBARTH: Opposed?

22 [No response.]

1 MR. HACKBARTH: Abstentions?

2 [No response.]

3 DR. SAMITT: So, Glenn, does that count at 85
4 additional votes to your tally?

5 MR. HACKBARTH: It does. It does.

6 [Laughter.]

7 DR. SAMITT: Or just 17?

8 MR. HACKBARTH: I have a calculator set up to do
9 a new percentage rating.

10 Okay. Thank you, Zach and Stephanie and Kim and
11 everybody who has contributed to this work on the staff.

12 Very well done.

13 [Pause.]

14 MR. HACKBARTH: Okay. Polypharmacy is up next.
15 Welcome home again, Joan. Good to see you. Shinobu,
16 whenever you're ready.

17 MS. SUZUKI: Good morning. Today Joan and I are
18 here to talk about potentially inappropriate use of opioids
19 -- a topic we discussed last fall, and the related but
20 broader polypharmacy issues that affect the quality of
21 services provided under the Part D program. We went
22 through a lot of clinical literature, but neither of us

1 have clinical expertise, and we are hoping for inputs from
2 Commissioners, particularly from the clinicians. We plan
3 to include this material in our June report to the
4 Congress.

5 Here's the roadmap.

6 First, I'll provide a quick summary of the
7 patterns of opioid use in Part D. It reflects more recent
8 data, but the patterns are similar to the data presented to
9 you last October. I'll also go over the concerns raised by
10 the patterns we see in Part D. Next, Joan will go over
11 broader polypharmacy concerns for the program. We'll
12 conclude the presentation with both clinical and policy
13 approaches that could be taken to address polypharmacy and
14 potential overuse of opioids.

15 In October, we presented to you data on opioid
16 use among Part D enrollees in 2011. The patterns we
17 observed for 2012 were pretty much the same. Here's a
18 quick snapshot of some of the key findings.

19 About 36 percent of Part D enrollees filled at
20 least one prescription for opioids.

21 Use of opioids varied widely across states, with
22 higher prevalence of opioid use in many Southern states.

1 Most opioid use was not for beneficiaries in
2 hospice or beneficiaries who had been diagnosed with
3 cancer, but use of opioids for other types of pain can be
4 clinically appropriate.

5 Some conditions were more prevalent among
6 beneficiaries who had opioid prescriptions compared to
7 those who didn't. For example, we found a higher
8 prevalence of conditions such as osteoporosis, bipolar
9 disorder, and depression among those who used opioids.

10 About 10.7 million beneficiaries with no hospice
11 stays or cancer diagnosis used opioids in 2012. Compared
12 to beneficiaries who did not use opioids, these
13 beneficiaries were more likely to be disabled under 65 and
14 receive the low-income subsidy.

15 Some beneficiaries used a lot of opioids. About
16 500,000 beneficiaries with spending (for opioids) in the
17 top 5 percent accounted for \$1.9 billion in gross spending,
18 or about 70 percent of the total amount spent on opioids in
19 2012.

20 Those beneficiaries filled, on average, 23
21 prescriptions at a cost of over \$3500. Sixty-five percent
22 of the beneficiaries in the top 5 percent were under-65

1 disabled beneficiaries receiving the low-income subsidy.

2 Those in the top 5 percent were more likely to
3 have obtained opioid prescriptions from four or more
4 prescribers and were more likely to have filled those
5 prescriptions at three or more pharmacies.

6 These patterns of opioid use raise both clinical
7 and program integrity concerns.

8 First, there is a real concern about effects on
9 beneficiaries' health. Opioid use is often associated with
10 polypharmacy in the elderly population. In 2012,
11 beneficiaries who used opioids filled an average of 52
12 prescriptions per year from about 10 different drug
13 classes.

14 Second, opioids have addictive properties with
15 high risk for abuse and are most often connected to
16 unintentional overdose. A recent study by AHRQ showed
17 inpatient stays related to opioid overuse by Medicare
18 beneficiaries rising by 80 percent between 1999 and 2012.

19 Finally, findings from government reports suggest
20 that some of the opioid prescriptions filled under the Part
21 D program may not be clinically indicated and potentially
22 fraudulent, increasing program costs without providing

1 health benefits.

2 The issue of polypharmacy is not limited to the
3 use of opioids. Now Joan will discuss broader polypharmacy
4 concerns for the Medicare population.

5 DR. SOKOLOVSKY: Elderly Medicare beneficiaries
6 with multiple chronic conditions frequently take many
7 drugs. More than one-third of beneficiaries fill more than
8 six prescriptions each month. Although there is no
9 consensus definition of polypharmacy, researchers generally
10 call it polypharmacy when a person takes six or more drugs
11 concurrently. Alternatively, polypharmacy exists when a
12 patient is prescribed more drugs than is clinically
13 warranted or when all drugs are clinically appropriate but
14 there are too many for a patient to manage or ingest
15 safely.

16 For the past few years, Commissioners, as well as
17 many other researchers, have been studying the question of
18 whether adherence to medications reduces the use of medical
19 services and medical spending. Our results were mixed.
20 But as you've seen, many beneficiaries are taking a lot of
21 medicines. So this year we wanted to start looking at the
22 effect of a lot of drugs or polypharmacy on the use of

1 medical services. Somewhat to our surprise, we found
2 little connection between the studies of adherence and
3 those about polypharmacy.

4 The literature on medication adherence is quite
5 different although both that and polypharmacy are concerned
6 with patients taking appropriate drugs as prescribed.
7 Researchers ask different questions, use different
8 methodologies, and rarely cite studies from the other body
9 of work.

10 Studies of adherence typically use administrative
11 data with large data sets. They measure adherence in terms
12 of possession of study medications. And they measure
13 outcomes in terms of use of medical services and medical
14 spending.

15 Polypharmacy studies require medical records and
16 sometimes patient interviews. Since data collection is
17 labor intensive here, sample sizes are usually smaller.
18 Researchers also focus on adherence, but they define it
19 much more broadly. Adherence means taking drugs as
20 prescribed, not continuing to take drugs against doctors'
21 orders or despite adverse events, taking the correct
22 dosage, not sharing other people's medicine. And the

1 research is less focused on cost effects. Outcome measures
2 tend to be adverse drug events, ED visits, or
3 hospitalizations.

4 Although it may seem contradictory, polypharmacy
5 is associated with nonadherence to appropriate drug
6 therapy. Patients, especially older patients, often have
7 difficulty managing complicated drug regimens, e.g., taking
8 some drugs in the morning, some before bed, some with food,
9 some without.

10 It is especially difficult when patients transfer
11 from one site of care to another, like going from a
12 hospital to home. They may not understand their
13 physician's instructions. Some medications may be added,
14 others stopped. And patients also may not tell their
15 provider about over-the-counter drugs and dietary
16 supplements that can interact with many other medications.
17 They may also find the total cost of the drugs too
18 expensive and stop some without telling their physician.
19 Patients also may be unwilling to stop some drugs even when
20 recommended by their physicians, for example, sedatives and
21 sleeping pills.

22 Although adverse drug events are not necessarily

1 linked to polypharmacy, the association between the number
2 of drugs a person is taking and adverse drug events is
3 consistent across multiple studies using different data,
4 sites of care, and research designs. It is a statistically
5 significant predictor of hospitalization, nursing home
6 placement, decreased mobility, cognitive decline, and
7 death. It's frequently the only factor that is
8 statistically significant in many of these studies.

9 A study of ambulatory care, for example, found
10 that the number of adverse drug events per patient
11 increased by 10 percent for each additional drug.

12 One study estimated that over 4.3 million health
13 care visits were associated with adverse drug events, as
14 well as 10 percent of all emergency department visits.

15 There are a number of mechanisms through which
16 polypharmacy can lead to adverse drug events. One of them
17 is therapeutic competition, which occurs when the treatment
18 for one condition worsens another concurrent condition.
19 For example, some medications used to treat heart failure
20 can exacerbate urinary incontinence. More medications may
21 result if a physician prescribes a drug to treat the
22 incontinence rather than changing the heart failure

1 medication, leading to a prescribing cascade and more
2 potential drug interactions.

3 Secondly, therapeutic duplication is defined as
4 the use of multiple medications from the same therapeutic
5 class at the same time. It can occur when a physician
6 replaces one drug with another but the patient does not
7 discontinue the first drug. This often can occur when a
8 patient is using multiple pharmacies. One common example
9 is NSAIDS, painkillers which can result in gastrointestinal
10 distress including ulcers and bloody stools.

11 Finally, toxic combinations where the interaction
12 between two drugs leads to serious complications. An
13 example here is warfarin, a blood thinner, and simvastatin,
14 a cholesterol-lowering drug, which together increase the
15 risk of bleeding.

16 Some of the literature discusses how clinicians
17 can reduce polypharmacy. Most frequently, they advise
18 reducing the number of medications prescribed. Secondly,
19 simplifying the drug regimen, for example, how and when the
20 drugs are taken. Other suggestions are to limit the number
21 of prescribers, avoid treating adverse drug events with
22 more drugs if at all possible. Finally, patient and

1 provider education is necessary to ensure that patients
2 understand the purpose of the drugs they are taking, how
3 they should take them, and why it's important to only take
4 them as directed.

5 Now Shinobu is going to list some policy options
6 designed to address opioid overuse and other polypharmacy
7 issues.

8 MS. SUZUKI: Part D provides limited incentives
9 and tools for plans to address clinically inappropriate use
10 of drugs, such as overuse of opioids and polypharmacy.

11 Policies to address these issues must balance access to
12 needed medications with prevention of inappropriate uses.

13 For opioids, there has been a lot of discussion
14 around lock-ins. But before we discuss lock-ins, I wanted
15 to draw your attention to another tool that has been used
16 in Part D.

17 CMS has been encouraging plans to use point-of-
18 service edits, such as limits on quantity, for
19 beneficiaries with opioid use above a certain threshold.

20 There seems to be some reluctance among plan
21 sponsors for this policy. One reason may be that there is
22 no FDA-approved maximum dosage limit, and some plans have

1 expressed concerns because of this. Another reason may be
2 because POS edit alone is unlikely to resolve all cases.
3 Determining clinical appropriateness requires
4 communications with prescribers, which can be time-
5 consuming and may be particularly difficult for stand-alone
6 PDPs because they don't have a contractual relationship
7 with prescribers.

8 These kinds of issues may be behind the recent
9 interest on the Hill and among plan sponsors for the lock-
10 in policy. The idea is to prevent doctor or pharmacy
11 shopping, which are often associated with overuse and abuse
12 of opioids. They are already being used by state Medicaid
13 programs and by some commercial insurance.

14 While the use of lock-ins may allow for an easier
15 tracking of opioid prescriptions, identifying a potential
16 overuse would still have to rely on some safety threshold,
17 such as an MED limit, or morphine equivalent dose limit.
18 In addition, determining the clinical appropriateness would
19 require prescriber involvement, just as in the case of POS
20 edits.

21 Finally, lock-ins may not work for LIS
22 beneficiaries because they can change plans month to month.

1 Some have raised concerns about access. These
2 policies could be combined with an allowance for temporary
3 supplies while the case is being reviewed.

4 For broader polypharmacy and inappropriate use
5 issues, we may want to consider ways to provide a stronger
6 incentive to improve the quality of pharmaceutical service.
7 For example, a performance measure could be added that is
8 based on prevalence of inappropriate or appropriate use of
9 drugs by their enrollees. That could be tied to payments.

10 Constructing an appropriate measure and
11 determining the appropriate cutoffs would likely be a
12 challenge. And such policy would need to be combined with
13 more flexibility for plans to manage drug use.

14 Some in the commercial sector have reported
15 success using medication synchronization. By dispensing
16 all medications on the same day, pharmacists may be able to
17 identify possible polypharmacy risks more easily and
18 improve adherence to appropriate medications. It may also
19 mean fewer trips to the pharmacy for the beneficiaries.

20 Finally, there has been some activity around
21 provider and pharmacy profiling at CMS' Center for Program
22 Integrity. We could look into this and see if more could

1 be done in that area.

2 So, to summarize, the patterns of opioid use by
3 Part D enrollees raise both clinical and program integrity
4 concerns. Goals of improving medication adherence for this
5 population must be balanced against the risk of
6 polypharmacy.

7 Policy options to prevent opioid overuse may be
8 applicable to broader polypharmacy issues and issues
9 related to inappropriate medication use. And, finally,
10 potential policy changes would need to provide plans with
11 appropriate incentives and tools.

12 And, with that, I'll turn it over to Glenn.

13 MR. HACKBARTH: Thank you, Shinobu and Joan.

14 So we will now have Round 1 clarifying questions,
15 beginning with Warner.

16 MR. THOMAS: Did we or has there been any
17 information looked at for the beneficiaries that are the
18 high utilizers of opioids, other kind of underlying medical
19 conditions or the medical costs of those beneficiaries in
20 total?

21 MS. SUZUKI: We've looked at conditions. There
22 were some that were more prevalent in those populations

1 than others. We have not looked into the medical spending
2 side to see what that looks like, but the top 5 percent are
3 disabled, under-65 beneficiaries -- or two-thirds of them
4 are. That likely means higher spending than average.

5 MR. THOMAS: So two-thirds of the users are under
6 65 and disabled. Is that correct?

7 MS. SUZUKI: Two-thirds of the high users are
8 under-65 disabled beneficiaries.

9 MR. THOMAS: Because, I mean, you would likely
10 think that there's other underlying issues. I think we're
11 targeting the pharmacy issue, but it's probably a much
12 broader clinical issue, frankly.

13 MR. HACKBARTH: We'll go around this way.

14 MS. BUTO: This is somewhat related to Warner's
15 question. A lot of this work is obviously focused on Part
16 D plans, right? And yet how easy is it for Part D plans to
17 track adverse drug events? Because they show up in
18 emergency rooms and other providers, how much of that gets
19 collected back? Isn't that an area of vulnerability here
20 in terms of really being able to track polypharmacy and
21 some of the events that come out of it? And I think it
22 just -- you know, Warner's point about the underlying

1 conditions is very much related to that.

2 DR. SOKOLOVSKY: It is a problem if it's a stand-
3 alone drug plan, especially if they have no way of tracking
4 that. And even those who are tracking it, sometimes it's
5 still subjective.

6 DR. NERENZ: I wonder if you could go to Slide 5,
7 please, first bullet point. If you can just clarify for us
8 a little bit what you mean here, what you want us to be
9 thinking about here in two specific ways. The term
10 "polypharmacy," as you pointed out, has two or three very
11 different meanings and concepts, and I'm not sure here
12 which one of those we're supposed to be thinking about.
13 And also "associated with" can mean either just pure
14 empirical correlation, or it could mean cause and effect,
15 either one way or the other, or both caused by some third
16 thing.

17 So what do you want us to be thinking about here?

18 DR. SOKOLOVSKY: We both have to answer this
19 question. I think where Shinobu is using really large data
20 sets, it really here means taking a lot of medicine.
21 That's the only one that could be incorporated in that kind
22 of a thing. But in terms of what you want, David, to be

1 thinking about, that's up to you.

2 MS. SUZUKI: Well, there are a couple policy
3 options that we sort of showed at the end of the
4 presentation, and opioid use, you know, could be dealt with
5 with lock-in or other policy options.

6 DR. NERENZ: I don't even want to go there. I
7 just want to know -- this really is purely clarifying.

8 MS. SUZUKI: Oh, okay.

9 DR. NERENZ: I think when you said this, you said
10 people who use opioids fill, what, 52 prescriptions? So
11 how does that compare to people who don't use opioids? I
12 am just trying to understand this phrase associated with
13 what -- why do you want me to -- what does that mean?

14 MS. SUZUKI: Well, one of the things we are
15 finding in the literature is that opioid itself interacts
16 with other drugs, so having 52 prescriptions from 10
17 different classes of drugs -- and some of them, we listed
18 in the mailing material -- they could interact with each or
19 that we were displaying that there could be polypharmacy, a
20 lot of polypharmacy issues occurring in this population who
21 are using a lot of opioid medications.

22 DR. NERENZ: [Speaking off microphone.]

1 MS. SUZUKI: Okay.

2 DR. MILLER: Well, I, too, would have struggled
3 answering without thinking of policy, and I know, David,
4 you were very clear to take that off the table for them.
5 But I'm going to redefine the question.

6 I struggle trying to think through how we would
7 answer your question, which I do whenever these guys are on
8 point. I mean, the way I'm kind of thinking about this
9 whole discussion is there is a lot of noise in the
10 environment around polypharmacy and even more intense focus
11 on opioid use and the concerns about the negative effects
12 of those two things.

13 The way I'm thinking about our conversation here,
14 it's harder for me, even though I think it's very
15 insightful to sort of lay out the literature between
16 adherence and polypharmacy and how they kind of, in some
17 ways, don't talk to each other -- it's harder for me to
18 think about polypharmacy because I think it's still harder
19 to define and more complex to focus on the problem.

20 But opioid use, I think even in isolation and in
21 connection with other drugs, I think for myself, speaking
22 only for myself, that strikes me as a bit of a brighter

1 line. So the way I think about this conversation is, as a
2 tool to think about how you manage drug use, should we look
3 at opioid and think about policies that might make sense in
4 that context? Next sentence. Maybe that will lead us
5 close to something that on the broader issue of
6 polypharmacy, we pursue down the line.

7 So the way I see it in the lineup is opioid sort
8 of first in line and are there steps we would take there to
9 look at that issue and perhaps address it from a policy
10 perspective and then learn from that to go to polypharmacy.

11 But I'm not sure that's still your question.
12 Your question seemed very narrow about association, and I'm
13 not sure how I would have answered.

14 DR. SOKOLOVSKY: Can I try again?

15 DR. MILLER: My point was to give you some time.

16 [Laughter.]

17 DR. SOKOLOVSKY: And I appreciate it.

18 DR. NERENZ: Nicely done.

19 DR. SOKOLOVSKY: If you think about the different
20 kinds of polypharmacy that were discussed in the paper,
21 opioid is really a very good example of all of them and
22 taking it. First of all, of all drug classes, it's the one

1 most associated with unintentional overdose, and part of
2 that is therapeutic duplication. There are lots of
3 different kinds of opioids, and people are getting
4 prescriptions for different ones and taking them at the
5 same time.

6 Another issue is a therapeutic competition
7 because they're not just taking opioids. They're taking a
8 whole range of other painkillers, and some of them have
9 additive effects.

10 So it's kind of many of the worst features of
11 polypharmacy you see with opioids, and the more drugs
12 you're taking, the more likely that is to happen.

13 DR. NERENZ: That's okay. What you just said at
14 the end is helpful because I wasn't picking up that
15 particular implication from that phrase.

16 MR. GRADISON: In the material you sent out in
17 advance, on page 17, you refer to CMS creating the
18 overutilization monitoring system. How long has that been
19 -- I realize it's too early from what you say in here to
20 get much in the way of useful information, but how long has
21 that been underway, about?

22 MS. SUZUKI: I believe it's been used since 2013.

1 MR. GRADISON: And do you have any guesstimate in
2 terms of how long it would be before we could gain useful
3 information? Because that's really right on point.

4 MS. SUZUKI: In the past couple of years, CMS has
5 been providing their progress report, so to speak, on
6 opioid utilization, and last time, they presented data from
7 2011 or '12 back in the fall. They may come back and
8 revisit this issue and present more data on this.

9 MR. GRADISON: Okay. Not sure when.

10 I wanted to ask your thoughts with regard to some
11 of these state registries that have been created. While
12 our focus is on Medicare beneficiaries, the more I think
13 about this issue, the more I think that we've got to take a
14 look at the broader issue for a whole lot of reasons,
15 people aging into Medicare and in particular the younger
16 people who are disabled. Could you as a general matter
17 share with us your thoughts with regard to these
18 registries? And then I've got a few very specific
19 questions related to those that I'll ask in a moment.

20 MS. SUZUKI: HHS has recently issued a brief
21 talking about the PDMPs and the Prescription Drug
22 Monitoring Program that states run and how some states have

1 had some success with using the use of opioid. It is
2 difficult to measure how effective PDMPs are generally
3 because each state has different rules and structure, but I
4 think run in the right way, you could get some reduction or
5 change in behavior by prescribers and beneficiaries.

6 MR. GRADISON: Are there any restrictions under
7 the Medicare rules that would prevent participation in
8 these state programs and in sharing this information with
9 regard to specific patients?

10 MS. SUZUKI: My understanding is it's a state-by-
11 state program. States determine who can access the
12 information.

13 MR. GRADISON: No. I'm talking about what
14 information they would require to be sent to the state.
15 Are Medicare beneficiaries, that is, the prescriptions for
16 opioids for them treated just like prescriptions for
17 opioids for non-Medicare beneficiaries --

18 MS. SUZUKI: I believe so.

19 MR. GRADISON: -- under these state programs?

20 MS. SUZUKI: Yes. I think so. It is usually the
21 states may require all prescribers who prescribe controlled
22 substances to report all medications they prescribe, for

1 example, in states' different rules, but it doesn't
2 distinguish between what coverage that person has.

3 MR. GRADISON: All right. Well, in that
4 connection, how about VA? I thought I read somewhere that
5 VA was not sharing that information, and I think it may be
6 relevant because that would perhaps be an important
7 component of the disabled under the Medicare program.
8 Perhaps you could enlighten us on that at another time.

9 Finally, with regard to admission to SNFs, it's
10 been a while, but at one point, I did some work with
11 consulting pharmacies, and I was struck by the data, which
12 may be out of date, but as I recall, it was that it went
13 like that. On admission to a SNF, there was requirement to
14 assess the utilization of drugs for each admission, and
15 that on the average, each person coming into the SNFs was
16 on nine or ten medications, order of magnitude, and that on
17 the average, they were reduced by two on admissions to
18 duplications and other factors.

19 The question is, have you talked to the
20 consulting pharmacist folks to see the extent to which what
21 their observations are with regard to opioid use that they
22 may be able to measure very specifically at the point of

1 admission to a SNF for Medicare beneficiaries?

2 Thank you.

3 DR. HALL: Two very important and somewhat
4 related topics to polypharmacy and opioid abuse. I'm just
5 curious, as a clarifying question, why you chose only
6 opioids as kind of the single drug class to concentrate on
7 in the setting of polypharmacy in a Medicare population.

8 DR. MILLER: Want me to do this, apparently?
9 Again, I don't know if this answer is really satisfactory .
10 There is a lot of attention on this out in the environment
11 right now, both in the states and at the federal level.
12 Our sense in traveling through the world and the people
13 that we talk to, there's been a lot of focus on this, and
14 so I think that's part of the reason we've kind of started
15 there -- and again, I didn't do a very good job -- and see
16 ourselves working out from that point, but a lot attention
17 right now.

18 DR. HALL: So the only reason I bring it up is
19 they are both very important topics. It is not a surprise
20 -- and maybe this is creeping into Round 2, but it's no
21 surprise that much of the presumed abuse is in a population
22 below age 65, representing a very different demographic

1 that what might be called the average Medicare patient.

2 And if we're going to look at opioids, we might
3 want to just consider as we go through this that it might
4 be better to consider opioids in the context of pain
5 control because that's where I think there's some very
6 important issues for Medicare population. It doesn't make
7 this such a moralistic issue if we combine these two
8 together, but maybe I'll have more to say later on that.

9 MR. HACKBARTH: Okay. I think the barrier
10 between 1 and 2 has been well breached, so you don't need
11 to feel apologetic about that.

12 Other Round 1 clarifying questions? Jon, did you
13 have your hand up? Herb and then Jack.

14 MR. KUHN: If I can ask you to go to Slide 12. I
15 am just curious about the first dot point where you talk
16 about the point-of-service edits. I just wanted to
17 understand a little bit more about the challenge CMS was
18 having. You said FDA didn't have clear guidance here, but
19 I know at least on the Part A and Part B side, CMS has a
20 tool, a national coverage determination tool, where even if
21 they disagree with FDA or have additional information, they
22 can put a recommendation out, get public comment, and make

1 a change in that program. Do they not have a similar tool
2 in the Part D side?

3 MS. SUZUKI: We don't think so. Having said
4 that, they have issued sub-regulatory guidance on this
5 topic.

6 MR. KUHN: That may be something that the policy
7 world, we could look at, is what works in the Part A, Part
8 B side when they see these kind of issues. As you say,
9 they do have sub-regulatory guidance opportunities, but if
10 there is something more, not necessarily discrete, but more
11 overt that they could use, that might be something to look
12 at somewhere in the future.

13 DR. HOADLEY: Just thinking about Herb's
14 question, it strikes me that the plans under prior
15 authorization or things like that would have -- could use
16 things as much softer kinds of things. The issue might be
17 whether Medicare in overseeing Part D could do certain
18 things. That's where I think the question was being asked
19 and answered, but there still would be flexibility on the
20 plan side.

21 My clarifying questions are on Slide 3. When you
22 talk about statistics such as the opioid users were more

1 likely to be disabled or receive LIS, did you do any risk
2 adjustment in relation to that? Does any of that go away
3 if you risk-adjust?

4 MS. SUZUKI: What exactly do you --

5 DR. HOADLEY: So I mean since LIS beneficiaries
6 are overall sicker, is the level more likely, therefore, to
7 have pain-related kind of conditions -- I mean, in an
8 extreme case, you could say that their opioid use is only
9 appropriate to their otherwise level of health.

10 MS. SUZUKI: It's not a risk-adjusted figure. We
11 did look at comorbid conditions from the risk-adjustment
12 model to see if you could see whether they had more of
13 certain conditions that could be related to opioid use, and
14 it's not a rigorous study, but we did not see anything
15 jumping out at us saying that this explains why someone
16 would be using opioid compared to other populations.

17 DR. HOADLEY: Even, for example, to look at
18 people with X number of chronic conditions, is their opioid
19 use within LIS or within under-65 comparable to the other
20 populations with the same number of chronic conditions?
21 Just see if there's any way in which these categories are
22 just surrogates for other kinds of health status.

1 And on the next slide, Slide 4, when you looked
2 at the top, the high users, you were looking at high users
3 defined by dollars?

4 MS. SUZUKI: Mm-hmm.

5 DR. HOADLEY: Did you also take a look at high
6 users defined by volume? I just wonder whether the --
7 since a lot of the opioids are generics and inexpensive,
8 whether there's anything unique about -- and maybe this is
9 a different kind of question, but is there anything unique
10 about the high-cost ones that would say the high-cost users
11 might actually be a somewhat different subset than the
12 high-volume users? It's a thought to try to further dig
13 into the numbers on this.

14 MR. HACKBARTH: Round 2 comments. Why don't we
15 just come back the other way and start with Warner and then
16 Jack and Scott and Rita.

17 MR. THOMAS: Just a comment. I mean, I think,
18 certainly, we could look at a policy of trying to limit or
19 put more regulation in. I tend to think that -- I mean,
20 it's probably not effective long term because I think
21 probably what you have here is you have a lot of other
22 conditions that are happening with the patients. It would

1 be interesting to think about a broader policy where we try
2 to identify folks that have this type utilization that are,
3 one, in ACOs and can we incent them to try to manage the
4 patient population better or, ones that are not, could
5 there be care management or coordination fees that go with
6 these patients that would incent primary care physicians to
7 really manage what I would anticipate as probably more
8 chronic disease issues that the patients have more
9 effectively, because I think this is a symptom of a
10 problem, not the actual problem, in my opinion.

11 It would be interesting to kind of look at that
12 more to just see for these users, how many have -- if
13 they're using multiple medications, how many have multiple
14 chronic diseases, and then, once again, what does their
15 other medical utilization look like?

16 DR. HOADLEY: I mean, this is a really useful
17 starting point for discussions about how to address this in
18 policy, and the problem is it just feels like it's hard.

19 I've got sort of four thoughts, which I'll just
20 say briefly. One that you did a little more of in the
21 chapter and didn't spend much time on in the presentation
22 was the MTM program, the Medication Therapy Management

1 program, and I know, Joan, you have talked about this over
2 the years. It's been very frustrating to sort of see the
3 lack of any real results or even sometimes activity. It
4 still feels like if a lot of these people were given the
5 kind of comprehensive medication reviews, if somebody,
6 primary care doctor, pharmacist, somebody sat down and sort
7 of said, "Does this patient really need all these drugs?"
8 that that would help to address it. MTM doesn't seem to
9 have caused that to happen, or when it has, it doesn't seem
10 to necessarily lead to a lot of results.

11 Second observation. I think you mentioned doing
12 ratings, star ratings, as one potential tool. It does seem
13 like a potential tool. On the Part D side, of course, it
14 has the potential to set priorities. We don't have the
15 payment linkage that we do on MA. So how much does it do?
16 Again, all the usual complications with star ratings, it
17 does feel like it's a potential tool to use in this,
18 although I don't necessarily have super high hopes for it.

19 Third, you talked about some of the utilization
20 management flexibility, and certainly, that feels like one
21 way to sort of go at some of these cases. We want some
22 kind of stops to be made, potentially. The opioid use is

1 maybe the easier one to say if somebody has got the nth new
2 prescription, let's stop and make sure somebody has looked
3 at that before we dispense what the possibility of things,
4 like the temporary supplies and stuff like that.

5 I do think -- and we have said this before in
6 other contexts -- that we really have to think about
7 getting some of the appeals procedures right because too
8 often to patients, the UM process, these are just sort of
9 unthinking barriers to appropriate use as well as a means
10 of slowing down inappropriate use, and we need to figure
11 out how to get that right.

12 The fourth is just to be careful as we go through
13 this that we're not sort of blaming the low-income patients
14 and we do see -- and that was sort of the source of my
15 question -- you do see the higher levels, and if that holds
16 up after we look at other kinds of factors. And we know
17 there are some differences in how things like copayments
18 and other kinds of things are done, that maybe there is a
19 factor there, but it does feel like sometimes we could fall
20 into the trap of saying, "Well, this is a problem for those
21 patients." It's clearly a problem for a broad array of
22 patients, and I think we should be wary about folks -- and

1 you didn't push the focus so much on this, but it comes up
2 in these discussions, so I just want to be wary about that.

3 MR. HACKBARTH: If I could, I just would like to
4 go back to Warner's comment for a second, and I think a
5 piece of what you said, Warner, was, given the nature of
6 these problems, better mechanisms for care coordination
7 like ACOs could be a part of the solution, which I agree
8 with in principle. But I just want to remind people,
9 that's sort of our stock answer to a lot of problems, and
10 here we've got the particular challenge that Part D
11 expenses are not part of ACOs. And the logistical
12 challenge of somehow incorporating Part D expenses, given
13 that they are managed by separate insurers, into ACO
14 assessments, calculations, and the like, there's some real
15 barriers there. I don't know how easy it is to surmount
16 them, but it would require a major effort to try to bring
17 Part D into ACOs and have that part of the medical bundle
18 that is managed by an ACO.

19 So I just wanted to highlight that again.

20 MR. THOMAS: So just to comment on that, I would
21 say it's an "and" not an "or." So I would say if there's
22 regulation we want to put in for Part D to try to manage

1 the utilization of opioids or try to limit access to, I
2 think that could be -- that's one approach that could be
3 taken. And at the same time, let's identify who these
4 folks are and see if there is a way we could, you know, on
5 the other side of the program provide incentives or care
6 management fees that could effectively manage them better
7 from a total medical cost separate from Part D.

8 Does that make sense, or --

9 MR. HACKBARTH: To be clear, I didn't -- I'm not
10 trying to disagree with what you're saying --

11 MR. THOMAS: No.

12 MR. HACKBARTH: -- but just to highlight that
13 there is this challenge about how Part D expenses integrate
14 with ACOs. Obviously, in terms of Medicare Advantage, the
15 mechanisms for management of drug expenses exist already.
16 But ACOs are somewhat more problematic and challenging.

17 MR. ARMSTRONG: Yeah, actually my comments are
18 really in the middle of the dialogue the two of you have
19 just been having.

20 First, I do want to affirm I think this is a very
21 important topic for us to be giving attention to, the
22 overuse, the misuse, the harm caused by the avoidable costs

1 associated. Opioid use in particular is an enormous issue,
2 and I'm really glad we're trying to figure this out.

3 I wish I had a better translation of my own
4 experience into policy options or ideas, given the Part D
5 program, just as you were describing. But the point I
6 wanted to make was that there are organizations that are in
7 MA or, you know, with this kind of accountability that have
8 done some spectacularly effective things to change the use
9 of opioids and to improve care and health for these
10 populations of patients.

11 In my own system, for example, I know every
12 beneficiary in my system who is prescribed an opioid, and
13 we have a care plan for every one of those members. And
14 the outcomes that have resulted from this attention has
15 really been quite spectacular.

16 I guess my only suggestion would be let's make
17 sure we know what systems that are doing this well are
18 doing and ask how that might inform or begin to, as Warner
19 was saying, you know, complement, if you will, some of the
20 payment policies that we might be able to speak
21 specifically to within Part D.

22 DR. REDBERG: First, thanks, Joan and Shinobu,

1 because it's a really excellent chapter and a really
2 important problem because it certainly illustrates another
3 example of more is not better, and, in fact, more is worse
4 when it comes to a lot of the polypharmacy and opioid use.

5 And I want to start out by reminding us that
6 there really isn't data that this increasing use of opioids
7 is addressing any clinical problem, and, in fact, people
8 have continued pain and continued suffering and just are on
9 escalating doses of opioids and other medications with new
10 problems like addiction and other -- there was just in the
11 paper, I think a town in -- I'm not going to say the state
12 because I can't remember -- where they were having an
13 epidemic of HIV use now because of IV use of these opioid -
14 -

15 MEMBERS: Indiana.

16 DR. REDBERG: It was Indiana, yeah. And there's
17 a lot of problems associated with it, and not getting where
18 the trouble is. So I think sort of a recognition of that
19 is important, and then the resolve to try to address it on
20 a policy level and on a cultural and medical level, because
21 there are many reasons why we have gotten to this point,
22 some of it being more use of it, but a lot of it being use

1 of opioids now to medicate sort of pain that, when I was
2 training, you know, 20, 30 years ago, we didn't use opioids
3 for non-terminal patients or else post-op, and now it's
4 used for a lot of sort of maladies that it really doesn't
5 treat.

6 And I think the suggestions, you know, like the
7 care management and other non-medical approaches, like
8 physical therapy, occupational therapy, counseling, you
9 know, other ways to deal with -- because a lot of this is
10 treating depression. I mean, it's not -- that was the most
11 prevalent condition you identified, and opioids don't treat
12 depression. They kind of numb it.

13 And the association with low income, it's not
14 even clear to me if it's a cause or effect because it's
15 very hard to work when you're on opioids, and it's very
16 hard to work when you're on a number of medications. And
17 so certainly it can contribute to a nonproductive state as
18 well.

19 In terms of the policy solutions, you know,
20 things that we could strive for, you know, having one
21 doctor who is in charge of your medications, because a lot
22 of the problem is, as you noted, that you have doctor

1 shopping. You can go to multiple doctors in multiple
2 states and get multiple prescriptions, and this is not
3 really in anyone's best interest. And also the single
4 pharmacy and the states, I don't know how effective it has
5 been. I'd be interested in hearing the states that have
6 monitoring programs now. I mean, we have -- and I think
7 other hospitals do. We have little alerts for patients
8 that come back into our emergency room repeatedly, you
9 know, asking for narcotics. But you can just go to the
10 hospital across the street, the hospital across town, and
11 so we really need sort of a single pharmacy where we can
12 track medications and know what people are getting and what
13 they're doing to protect them and also because of all the
14 fraud and abuse problems there are with narcotics.

15 DR. COOMBS: Thank you very much. The chapter
16 was excellent.

17 A couple of ideas I have. As I read the chapter,
18 some things dropped in my head just because of my clinical
19 involvement with patients who are on both the post-
20 operative, the pain side, and the ICU. And one of the
21 things, as I think about it, the increase in the regulatory
22 requirements for CMEs related to pain control, the Joint

1 Commission, some of the items that we've actually promoted,
2 the pain control is a good thing and we should try to get
3 to optimal pain control, coincide with that, in addition to
4 intersecting with CPOE and what that means for the rollover
5 for prescriptions, where, when I was in internal medicine,
6 prior to going into anesthesia, partners would actually
7 come into the office, pick up a prescription. That's no
8 longer necessary.

9 And the other piece of it is I think how patients
10 start on narcotics, how do they get on narcotics. I don't
11 think the provider one day wakes up and says, "I'm going to
12 give you Percocet, hydrocodone." Many times there's an
13 event. It doesn't even have to be a surgery event. It
14 could be a fall. It could be a sprain. And for whatever
15 reason, that gets put in the patient's panel of
16 medications.

17 So I'd be interested -- I don't know how that
18 could be done, but if possible, looking at the initiation
19 of narcotics, because I think once a medication is
20 initiated, unless there's someone doing ongoing review, the
21 patient's visit may not transpire more than twice a year,
22 and so that becomes an issue, because the medications are

1 rolled over and there's a 30-day rollover period. And so
2 sometimes it's not even done by the physician necessarily.
3 It may be the NP in the office, or it may be the physician
4 assistant that's rolling it over. And, you know, the cross
5 coverage is another issue which I don't think we could ever
6 get at.

7 And so the monitoring program in the states vary.
8 Massachusetts has a very good monitoring program. But I
9 would actually look at champions in the area of
10 prescription monitoring exterior to the prescription plans
11 and looking at states that have monitoring as a part of
12 their Board of Registration in Medicine, Board of
13 Registration in Nursing, looking and seeing whether or not
14 that correlates with your crescents from your map and, you
15 know, the map that you had, the Southern crescent, we call
16 it, of the greatest opioid use, and see if there's some
17 correlation with that, because I think if you can pick the
18 champions, you can pick the factors that make a big
19 difference, I think it's a huge issue with drug overdoses
20 and drug-drug interactions. And I think about patients who
21 are on benzos and narcotics at the same time, that's when
22 we get into a lot of trouble.

1 If I were to pick -- you know, you've got a long
2 list of concomitant medications. I would look at those
3 kind of things, the patients who are on some of the mood
4 disorder drugs, some of the mental health disorder drugs,
5 and if those could be tweaked, because I think those kinds
6 of innovations can actually help practitioners, help
7 providers. And all the other things you've outlined have
8 been really great. It's a great chapter, and I appreciate
9 it.

10 MR. KUHN: So I want to also talk just briefly
11 about the issue of medication therapy management. I recall
12 when the Medicare Modernization Act was being debated and
13 ultimately adopted in 2003. There were so many people
14 talking about this new benefit, this MTM benefit that was
15 going to be available. And I remember member of Congress
16 after member of Congress talking about these brown-bag
17 audits, that for the first time Medicare beneficiaries
18 could take all their pill bottles, put them in a brown bag,
19 take them to their doctor, take them to their pharmacist,
20 and have an audit done, and life would be great. I mean,
21 things were going to change for the better.

22 And so there was all this talk 12, 13 years ago

1 about this. This program now, Part D, has been in place
2 for nearly a decade, but yet we continue to talk about
3 enrollment is low and the program's not effective.

4 So I guess I just need to understand a little bit
5 more why the enrollment is low and why it is not effective,
6 and part of it is kind of -- I don't know if I fully
7 understand how the MTM is paid for. Is it a Part B
8 benefit? Is it a Part D benefit? Does it have CPT codes
9 that are not well valued? You know, just kind of what are
10 some of the barriers that we're seeing and why we're having
11 this low takeup rate.

12 DR. SOKOLOVSKY: Well, to answer the last
13 question first, the payment comes out of the funds of the
14 plan. It's not a separate -- Medicare doesn't pay them.
15 The plan pays them, and they have different methods of
16 doing that. Some of them -- sometimes it's an on-staff
17 pharmacist. Sometimes they contract with a third party
18 whose job it is to do this for plans. So that's an easy
19 answer.

20 Why it's not effective, part of it is that the
21 plans don't have much of a real incentive to do it.
22 Whoever is managing it is not likely to be a geriatrician

1 pharmacist, because there aren't that many to do all of
2 this. And when I look for -- I haven't been able to find
3 the numbers, but when I look through the reports that have
4 come out, they seem to be more focused on, well, these are
5 drugs that you need and you're not taking them rather than
6 these are drugs that you don't need and why are you taking
7 them. It's more about increasing adherence than
8 eliminating most drugs, unless there are -- you know, they
9 may find duplicate drugs, but they're not going the other
10 way, because they're looking at the guidelines for, say,
11 cholesterol and they want to make sure you're taking a drug
12 for that. They're not really looking so much as
13 interactions between drugs.

14 So, I mean, at least that's my theory looking at
15 the reports. I haven't done work specifically on it, just
16 that it bothers me.

17 As far as the enrollment being low, at first it
18 was -- CMS changes the enrollment pattern each year, what
19 the requirements are. But they've tried to get more and
20 more people by making more people eligible for it. The
21 plan has to reach out to the beneficiary, but how hard they
22 have to reach out is not clear. But even if they reach the

1 beneficiary, the large majority say, "No, I don't want to
2 participate."

3 So I don't know how it's sold to them that they
4 find it something they don't want, but that seems to be
5 what the evidence indicates.

6 MR. HACKBARTH: Joan, could you go back to your
7 first statement that the plans don't have a very strong
8 incentive to do this and just say more? Why don't they? I
9 would think if one of their enrollees is using drugs that
10 they really don't need, the plan would want them to use
11 fewer drugs. They're at risk for drug utilization. Why
12 don't they have an incentive to do this?

13 DR. SOKOLOVSKY: Well, I think this is something
14 that you all have been talking about this year, that when
15 you're taking really a lot of drugs, not too far along, the
16 plans have only 15 percent risk; whereas, paying for the
17 clinicians or whoever it's going to be that personally
18 reviews the drugs and has a meeting with the beneficiary
19 and so on is not going to be cheap.

20 MR. HACKBARTH: Okay.

21 DR. MILLER: Well -- go ahead.

22 DR. HOADLEY: I was just going to -- a quick

1 follow-up. My impression is that most of these reviews,
2 when they're done, are done by pharmacists rather than
3 doctors, and that they're often done by pharmacists that
4 work for the plan maybe on a telephone line rather than the
5 kind of scenario of walking in with the brown bag to your
6 doctor and saying, "Here it is. What should I be using?"
7 Is my impression correct on that?

8 DR. SOKOLOVSKY: At the beginning it was any
9 which way, and some plans chose to do it that way, and
10 others didn't. My understanding now is that it's more and
11 more companies, third-party companies who are pharmacists
12 and their job, after they're contracted with by the plan,
13 is to do it personally.

14 But when we look at what they do, even the annual
15 review of all the medications mostly doesn't happen, even
16 for the people who are participating and who are getting
17 something.

18 DR. HOADLEY: But they're not working through
19 like the patient's, the enrollee's primary care physician
20 or something like that?

21 DR. SOKOLOVSKY: No. No, absolutely not.

22 DR. MILLER: And that's one thing I just wanted

1 to inject into this, triggering off of his question and
2 what you were saying, and also to be sure that you
3 understood when you talk about participation. I mean, you
4 can reach out, but the beneficiary can or cannot
5 participate. If you're a PDP -- and you know this better
6 than I do -- you know, a PDP, your relationship with the
7 prescribers and the other physicians that are involved in
8 that patient's life is very distant, and we hear a lot of
9 the PDP says I think there might be an issue here, fax
10 stuff over, call up. And it just is kind of waved off by
11 the providers.

12 You would think in an MA plan, in addition to the
13 drug use and the AB use, the MA plan would have an
14 incentive. But, remember, the MA plan has also other
15 tools, like, you know -- or a greater ability to kind of
16 reach to the beneficiary through a lot of mechanisms. And
17 so I think there's a lot of things that explain your
18 triggering question.

19 MR. KUHN: And has CMS ever thought or talked
20 about putting thresholds in there that, you know, plans,
21 every year they need to at least do MTM with 30 percent or
22 40 percent? Do they have targets that they have to hit?

1 DR. SOKOLOVSKY: Yes, and every year they raise
2 the target in an effort to get more people to participate.
3 But I think, you know, now you only have to be taking two
4 drugs to qualify. But I think that the result of that has
5 been that would be even more expensive, and, therefore, if
6 you're not willing to triple the amount of money you spend
7 on the program, you're working less hard to reach those
8 people.

9 MR. HACKBARTH: So does anybody else want in on
10 this particular point?

11 [Laughter.]

12 MR. HACKBARTH: Okay, Craig and Dave and Kathy,
13 it's on this point?

14 DR. SAMITT: Yeah, I mean, it's actually on, I
15 think, a bunch of the points, and I end with MTM. I have
16 two perspectives, and they stem from Slide 13, if we can go
17 there.

18 You know, in my experience, I'm always much more
19 in favor of extrinsic motivators as a means of driving
20 change as opposed to administrative controls, which is what
21 you see on Slide 12. And so I think that the power of the
22 opportunity is very much on this slide, and I think it

1 falls in two dimensions. One is we need to concentrate
2 very much on this profiling notion. I'm a big believer in
3 this notion of profiling, and I think we should be
4 profiling physicians, I think we should be profiling
5 hospitals and health systems, because we should be looking
6 at who truly is driving high opioid use and polypharmacy.
7 I think they're highly interrelated.

8 I also completely agree with Alice's views on
9 this because we all should be profiling where the starts
10 are happening. I had mentioned in one of the prior
11 discussions about this that some health systems do an
12 evaluation of what drives patient satisfaction with
13 hospitalizations, and pain control is a big part of it. So
14 we may find that a lot of the starts are hospitalizations,
15 because in many respects they may correlate with patient
16 satisfaction. And I think we should study that. So I very
17 much believe in the notion of looking at incentives for
18 Part D plans and profiling to really look at where the
19 outliers are.

20 The second concept is really about the need to do
21 both, which is that we need alignment between the payer and
22 the provider. We can't think of extrinsic motivation of

1 one versus the other. And to Scott's point, I think we
2 look at those organizations that do this very well, what
3 we'll likely find is that exact alignment whereby the plan
4 and the provider both have interests in educating the
5 patient, the beneficiary -- and I would even argue that
6 it's aligned with the beneficiary's interest because
7 management of polypharmacy, management of opioid use
8 produces better outcomes for the beneficiaries, reduces
9 risk, ADEs, and total cost of care.

10 So I think we need to find alignment between
11 these two parts, and I would guess that what you'd find is
12 where you see that alignment, you see high use of MTM, that
13 these systems maximize it. So we need pressure from both
14 directions to encourage that.

15 And then the final thing that I would say is I
16 want to comment on the ACO notion, because I'm not sure to
17 create alignment between PDPs and ACOs you need the ACO to
18 be at risk or accountable for the cost of drugs. I would
19 say think of another type of incentive for ACOs. Maybe we
20 should be profiling opioid use in ACOs, or maybe we should
21 be profiling polypharmacy in ACOs, and that is a component
22 of a quality metric. It doesn't have to be the cost

1 elements of Part D. One would argue they already should be
2 looking at polypharmacy anyway because management of
3 polypharmacy improves the health of the overall population
4 and reduces the total cost of care.

5 But on top of that sort of natural incentive
6 anyway, I don't see why we wouldn't think of a quality
7 measure that taps to this, plus the incentive for Part D.
8 Those two together, with the ACO population, should offer
9 some policy recommendations to help manage this.

10 DR. SOKOLOVSKY: I just want to make one comment.
11 I thought about mentioning it before, but now you've pushed
12 me that I have to mention it. There was some literature in
13 the last year about one ACO that requires a clinical
14 pharmacist on all of its Care Coordination Teams, and they
15 have registered quite a bit of success in their MTM
16 program, which is linked to this pharmacist on the team.

17 MR. HACKBARTH: So, we're still on this same
18 point. I have Dave and Kathy, and Mary, you want in on
19 something else or on this? On something else. Okay.
20 Dave, and then Kathy, and then --

21 DR. NERENZ: I'll pass. Craig made the point.

22 MS. BUTO: I'm going to come in on something

1 else.

2 MR. HACKBARTH: Oh, okay. Then we're back to
3 Jon.

4 DR. CHRISTIANSON: So, I thought this was really
5 an interesting chapter, and lots of interesting statistics
6 that kind of jump off the page at you that were surprising
7 to me, and a lot going on. So, you had the polypharmacy
8 stuff, which we've been talking about. We've had the
9 opioid use sort of as an issue in itself, but also as an
10 example of polypharmacy.

11 But, also in the chapter, you had a really quite
12 long text box that you used to address fraudulent -- I
13 would characterize -- fraudulent use of opiates, and you
14 present some data that suggests it's going on. You
15 describe some of the CMS programs that have tried to
16 identify where that might be occurring. And then you
17 actually propose or raise some issues around policy things
18 that we could consider or recommend.

19 And, I think the text box was useful in terms of,
20 for me, separating out the issue of there's potential fraud
21 in the use of opiates from the general stuff we've been
22 talking about, like appropriate medical use of this in

1 treating patients.

2 So, from the Commission's point of view, I think
3 we at some point will kind of need to make a decision about
4 whether we want to focus attention on the policy issues
5 that you raised and take stands on things related to how do
6 you ferret out and what should you do about fraudulent use
7 of opiates versus the general issues that we've been
8 talking about today. And, I'm not sure that we want to do
9 that. That's what I'm saying. It's a general question
10 about, is this something we want to take on, or do we want
11 to focus more on general issues related to polypharmacy and
12 what most of the discussion has addressed today.

13 DR. CROSSON: Thanks. I just want to make one
14 comment, and that's about the write-up itself. I don't do
15 this much, because the general quality is so high, but I
16 just found this one particularly well researched, clear,
17 and concise, all of which I value in write-ups. So, thank
18 you, both of you, for that.

19 I'll talk -- you know, with respect to
20 polypharmacy, I think one of the problems I have in
21 thinking about this -- and this is similar, I think, to
22 something Mark said earlier, is, first of all, the term

1 itself is fairly non-specific, because it seems to me it's
2 describing at least three different situations.

3 One is a situation where an individual, a
4 beneficiary -- and as we know, many beneficiaries are on a
5 lot of drugs because of their age and conditions and things
6 -- it describes a situation where, for one reason or the
7 other, the complement of drugs is inappropriate because of
8 drug-drug interactions or all the other things that you've
9 written about.

10 Another situation is where a beneficiary is on a
11 large number of drugs and they're appropriate for that
12 individual and those conditions, but the management of it
13 by the beneficiary is very difficult, potentially because
14 of confusion that comes with older age. That's a separate
15 issue.

16 And then the last situation is where
17 beneficiaries are on a large number of drugs and they're
18 perfectly appropriate.

19 And, I think -- so, I just wonder in terms of how
20 we think about this down the line if we might not get more
21 specific about what we're talking about rather than using a
22 general term, which I think can cause some confusion.

1 I do believe, based on the data -- I was really
2 shocked to see that close to 25 to nearly 50 percent of
3 Medicare beneficiaries across the age spectrum are on
4 opioids in any given year. I mean, I knew there was an
5 issue. I didn't realize that. I think that screams for
6 some work and intervention.

7 I think the policy in this regard, the policy
8 options that we should look at, similar to Scott, I think
9 there is an experience out there, particularly in MAPD
10 plans -- and delivery systems are at risk, in general, for
11 pharmaceutical services -- that we could tap to look at
12 mechanisms. Not all of these are going to be applicable to
13 the PDP situation, but some may be.

14 My thought would be to look at what, in fact,
15 physicians do or don't do, because I think, although I
16 think the MTM thing holds promise, in the loose environment
17 of PDP plans, for reasons already stated, it may not turn
18 out to be that effective, whereas working with the
19 physicians and the physician-patient relationship might
20 well be.

21 And, so, I would be thinking about looking at
22 this issue of limitation of providers in some way and

1 focusing on those providers particularly. I think that's
2 what we do in some of the programs I talked about a minute
3 ago. It just struck me in the data that where individuals
4 were accessing opioids from large numbers of providers, it
5 tended to correlate with what appeared to be abuse.

6 So, I don't know how to do the limitation of
7 providers. I realize the issue of LIS individuals being
8 able to change plans on a monthly basis is a potential
9 objection. I would imagine that an individual, LIS or not,
10 who is changing plans -- who is on opioids and changing
11 plans every month or with some frequency would be a
12 suspicious situation to begin with.

13 So, I think looking at limitation of providers,
14 exploring the pros and cons of that, policy issues around
15 that might be fruitful.

16 MR. HACKBARTH: I have Mary, Dave, and Kathy, and
17 Bill. Anybody else on the list? Okay. Mary.

18 DR. NAYLOR: So, I want to echo Jay's comments
19 about this work and how extraordinarily important it is, I
20 think, for the Medicare program today and well into its
21 future. I think we are talking about a very big issue here
22 around effective and efficient and appropriate use of

1 medications and all the -- you used the word "cascading" --
2 implications when we're ineffective and inefficient.

3 So, I think this might be a case where we would
4 want to -- we talk a lot about bundling, but we might want
5 to unbundle this work, and it's all stimulated by your
6 terrific chapter. I think we might want to unbundle, as
7 you clearly stated that we are talking about different
8 target populations here, and maybe looking at this from the
9 standpoint of -- and, not only to get back to bundling, but
10 of the older adult versus the younger or disabled.

11 I also think that, as Warren [sic], Alice, and
12 others have said, we might want to look back more to the
13 root cause. Multiple chronic conditions contribute to
14 polypharmacy because clinical guidelines dictate that so-
15 and-so with diabetes needs to be on X, Y, and Z
16 medications, and so on and so forth, and with cancer, and
17 so on. But, as people live longer, they get more of those
18 clinical guidelines and we now know that they don't all --
19 we know from science that they don't interact. So, I think
20 that that's a really important, kind of going back, the
21 polypharmacy maybe root cause is multiple chronic
22 conditions.

1 As Bill has, and others, suggested, opioids, if
2 you look at the root cause, has been a societal problem in
3 mismanagement of pain, and we began to think about solving
4 that by adding more and more medications and now it's a big
5 problem, including for the older adults.

6 I think we then have to think about what are the
7 common facilitators and barriers, and medication management
8 can't be thought of outside of looking at individualized
9 care plans, chronic care management, palliative care,
10 mental health, and teams. We constantly refer to the role
11 of the physician when, in this case, it is a team approach.
12 Pharmacists, nurse practitioners, and others all need to be
13 on the same page with this.

14 I think, then, finally figuring out what are the
15 best practices and from that deriving policy implications.

16 The perspectives on which we have to look at this
17 are the beneficiaries, the physicians and other health
18 professionals, the plans, but, most importantly, society
19 and how it views the almighty pill as the way to solve all
20 of our health problems.

21 DR. HALL: Well, as usual, I agree very much with
22 Mary's sentiments.

1 The way I would parse this out -- first of all,
2 it's a very, very important area and I think we can really
3 do a lot through our mechanism here. So, I would say that
4 the issue of opioids, just for the record -- I don't know
5 that you mentioned this in the chapter, you might have --
6 but, there was a huge uptake in the opioid use in the
7 Medicare population starting about 1992, coincident to a
8 clinical guideline that the American Geriatric Society put
9 out, suggesting that opioids might be the drug of choice
10 for pain in older people because the alternative,
11 nonsteroidals, had such serious problems with cardiac and
12 renal function.

13 So, basically, this was sort of designed to move
14 to a greater use of opioids. Now, that's been modified
15 since then, but -- so, I think the opioids are kind of a
16 special area.

17 So, it's that area and then there's the use of
18 opioids for people -- seniors who are addicted. That's
19 another -- it's a special problem.

20 But, then, that leaves -- as a geriatrician, when
21 I think of polypharmacy, it's the large mass of Medicare
22 patients, probably 30 or 40 percent, who are on not just

1 three or four or five drugs, but are on ten or 12 drugs.
2 This is a commonplace occurrence. This is a disease of
3 medical progress. When Medicare was instituted in 1965,
4 there were about six drugs that may or may not have worked.
5 now, we have a lot of drugs that have improved the quality
6 of life, and particularly in the area of cardiovascular
7 disease, so that we're now left with people on legitimate
8 reasons in the abstract for taking individual pills. But,
9 we know that when we put it together, it can become a
10 disaster.

11 So, I think the approach of MedPAC might be to
12 say, here is a perfect opportunity to call attention and
13 maybe give some serious thought to interventions that will
14 do two things that are important to us. One is improve the
15 quality of life of older people, no question about that.

16 But, secondly, vastly reduce the cost of medical
17 care, because as you cited in your chapter and has been
18 noted elsewhere, as many as ten percent of all acute
19 Medicare admissions are due to an adverse drug event.
20 Imagine a situation where one out of every ten admissions
21 to the hospital are related to a misadventure in a common
22 medical practice, amenable to education, amenable to

1 electronic medical records, prescribing that's electric,
2 which is starting to really catch on around the country.

3 So, we get a big whammy on this, two good
4 benefits, quality of life and reduction, potentially --
5 it's not the cost of the drug that's the issue here. It's
6 really the sequelae of adverse drug events. That's how I
7 look at this.

8 DR. CHRISTIANSON: Dave, I think you were next,
9 and then Kathy.

10 DR. NERENZ: No, actually, Craig said a long time
11 ago what I was going to say.

12 MS. BUTO: Okay. I just have a few comments.
13 One is, I really like this slide. I would suggest we think
14 about adding two more bullets to it. One would be
15 something about finding a way to increase or actually
16 create a feedback loop between Part D plans and primary
17 care physicians or prescribers. There's got to be a way.
18 There's been a tremendous amount of money spent on
19 electronic records. Isn't this one of the best test cases
20 for activating that electronic communications pathway? So,
21 I would just say, I think that's a challenge, but we really
22 should urge that that be done, and we might have some ideas

1 as to how we could achieve that.

2 A second one, or another bullet I would suggest
3 we look at is beneficiary engagement, so -- especially in
4 the opioid area. That's an area where there is a lot of
5 engagement by law enforcement authorities looking to
6 prosecute physicians who are big prescribers of opioids and
7 abusers and so on, and, I think, Jon, this is where it
8 intersects your issue or your note.

9 There's a whole area of protocol development
10 about the appropriate use of opioids that I think could
11 both -- could be sort of a bridge between appropriate
12 medication management and the issue that you're raising
13 about should we be even talking about fraud and abuse.
14 There's an intersection there. Without good communication
15 about protocols, I think we do lend ourselves to a lot of
16 fraud and abuse in this area of prescribing.

17 And, you know, CMS may have done this. I don't
18 know. But, I don't think it's well understood what the
19 appropriate protocols are. And, again, plans don't seem to
20 have a strong incentive to put these forward and actually
21 to follow them.

22 So, back to your, which I really like, your

1 bullet point on quality and performance measures tied to
2 payment, those are -- that authority obviously exists, but
3 hasn't been really used. Or, maybe it's being used, but
4 not for the kinds of things that we think are -- it could
5 be sort of ratcheted up to do.

6 I think this is an area, whether it's, you know,
7 Part D plans, we know, collect data. Surely, they are
8 tracking for their individual subscribers how many
9 physicians are prescribing. They must know who the
10 physicians are. They must have a way of tracking that. It
11 just seems to me we're not holding them accountable for
12 this whole polypharmacy area, and if we want to focus on
13 opioids, on that area, and that there's more ability to tie
14 that to performance measures and payment that might make
15 this a more kind of robust requirement.

16 So, I really like that one, and I would look at
17 what we could do with beneficiaries and also with feedback
18 loop to doctors.

19 MR. HACKBARTH: Okay. Jack, last word.

20 DR. HOADLEY: A quick follow-up to a couple of
21 questions. People have mentioned electronic records and
22 electronic prescribing. It might be useful in some future

1 presentation on this or some of the other related issues to
2 sort of get an update on where things stand on e-
3 prescribing. There's been a lot of talk about all the
4 things it can do for formulary adherence, for other kinds
5 of things, and yet I keep hearing rumbles that it doesn't
6 quite do the things that we've kind of hoped it will and it
7 might be something where we could just sort of see, what's
8 the state of play? Is there anything we can do to help if
9 it's not where we want it to be?

10 MR. HACKBARTH: Okay. Thank you, Shinobu and
11 Joan. Well done, as usual.

12 We'll now have our public comment period.

13 [Pause.]

14 MR. HACKBARTH: And, before you begin, let me
15 just see -- just two people wanting to make comments?
16 Okay.

17 Let me just quickly repeat the ground rules. So,
18 begin by identifying yourself and your organization. When
19 the light comes back on, that signifies the end of your two
20 minutes.

21 MS. RILEY: How long is the time? I'm sorry.

22 MR. HACKBARTH: Two minutes.

1 MS. RILEY: Two minutes, okay. Great. Thank you
2 very much. Good afternoon. My name is Cindy Riley. I am
3 a pharmacist and Director of the Prescription Drug Abuse
4 Project at the Pew Charitable Trusts. Pew is a nonpartisan
5 research and policy organization with a number of drug and
6 medical device initiatives. Thank you for addressing the
7 topic of polypharmacy today.

8 Doctor shopping, or visiting multiple prescribers
9 and pharmacies, is one mechanism to obtain excess
10 quantities of opioids and other controlled substances.
11 This practice, which often results in polypharmacy, may be
12 addressed through the use of patient review and restriction
13 programs, or PRRs. These programs identify, as we've heard
14 here today, patients suspected of abusing prescription
15 opioids and designate a single pharmacy or prescriber. The
16 result is improved care coordination that ensures patient
17 access to needed medications while lowering the risk of
18 overdose.

19 In January, Pew submitted a letter to MedPAC that
20 recommended that Congress provide Medicare Part D plan
21 sponsors the authority to implement PRR programs. I won't
22 go into the details of that letter here, but I will tell

1 you that you will hear we've described in that letter some
2 statistics that were outlined in reports by CMS and GAO
3 that are similar to the statistics that were presented by
4 Ms. Suzuki here today, as well as at your earlier meeting
5 in October of 2014.

6 As you've heard, there are other tools that can
7 address inappropriate opioid use in Medicare Part D. CMS
8 recently proposed an expansion of its current
9 Overutilization Management System, or OMS. While OMS has
10 demonstrated some effectiveness in addressing overuse of
11 opioids, a recent analysis that was contained in their 2016
12 Advance Notice and Call Letter demonstrated that there was
13 a high frequency at which beneficiaries repeated exceeding
14 the established threshold, even after following an
15 intervention. This indicates that currently available
16 mechanisms have limited effectiveness. While the proposed
17 changes to the OMS may enhance identification of patients
18 at risk, this change would continue to rely predominately
19 on retrospective interventions.

20 A PRR can prospectively improve opioid use while
21 applying safeguards that ensure beneficiary access to
22 needed pain therapies. An evaluation performed by the CDC

1 expert panel found that PRRs used in State Medicaid
2 programs have generated savings and reduced narcotic
3 prescriptions, abuse, and visits to multiple doctors and
4 emergency rooms. About 45 States currently have PRRs in
5 place, and they are also widely used in private plans.

6 Current law does not allow the use of PRRs in
7 Medicare Part D plans, despite the fact that officials from
8 CMS have indicated a willingness to explore their use.
9 There is significant bipartisan momentum building for
10 change with legislation that has been considered by Ways
11 and Means as well as the Energy and Commerce Commission in
12 the House.

13 Is that my light?

14 MR. HACKBARTH: Yes, it's your light.

15 [Laughter.]

16 MS. RILEY: Okay. Again, I'd like to thank you
17 for your time here this afternoon. Pew has additional
18 comments in our letters that we'd be willing to share.

19 Thank you very much.

20 MR. HACKBARTH: Thank you.

21 MS. COHEN: Good afternoon. My name is Allison
22 Cohen and I'm with the Association of American Medical

1 Colleges. The AMC appreciates this opportunity to share
2 our views on the recommendations related to short-stay
3 payment issues.

4 The AMC commends MedPAC for acknowledging the
5 challenges associated with the 2-midnight rule and for
6 recommending withdrawal of this flawed policy.

7 At the same time, the AMC supports leaving in
8 place the part of the 2-midnight rule pertaining to stays
9 longer than two midnights, because this part of the rule
10 alone effectively reduces longer observation stays that
11 this policy was adopted to correct.

12 We also strongly support MedPAC's recommendation
13 to hold recovery audit contractors accountable by modifying
14 RAC contingency fees, to subject RACs to a penalty if their
15 overturn rate exceeds a certain threshold. For important
16 policy reasons, the AMC has serious concerns about the
17 recommendation directing RACs to focus on hospitals with
18 the highest rate of short-stay cases because it may
19 improperly target large hospitals and major teaching
20 hospitals and disincentivize innovating to efficiently
21 treat complex patients.

22 The Association's data analysis demonstrates that

1 hospitals do not vary substantially in their share of
2 short-stay cases as a percentage of all cases. Instead,
3 hospitals' average number of short-stay cases increases for
4 larger hospitals and hospitals with more Medicare inpatient
5 volume. The AMC is concerned that targeting hospitals with
6 higher average number of short stays would merely target
7 larger hospitals that treat more Medicare patients.

8 If MedPAC chooses to adopt this recommendation,
9 the AMC strongly encourages the Commission to require a
10 risk adjustment to ensure that hospitals that take care of
11 the most Medicare patients and have innovated to treat the
12 most complex patients efficiently are not improperly
13 targeted.

14 For the same reasons, the AMC is also opposed to
15 evaluating replacing the RAC program with a formulaic
16 hospital penalty imposed on hospitals with a higher volume
17 of short stays than other hospitals.

18 Thank you for the opportunity to present our
19 views.

20 MR. HACKBARTH: We are adjourned until one.

21 [Whereupon, at 11:47 a.m., the meeting was
22 recessed, to reconvene at 1:00 p.m. this same day.]

1 AFTERNOON SESSION

2 [1:00 p.m.]

3 MR. HACKBARTH: Okay. It's not everybody who
4 gets to do sharing Part D risk after lunch. Do you know
5 how -- this is like an actuary's dream, right?

6 [Laughter.]

7 MS. UCCELLO: Every day.

8 MR. KUHN: It's the highlight of our day.

9 MR. HACKBARTH: Okay. We are off. Rachel and
10 Shinobu.

11 DR. SCHMIDT: So, Cori, this is for you?

12 [Laughter.]

13 DR. SCHMIDT: Good afternoon. Today we'll pick
14 up where we left off last month in your conversations about
15 how Medicare shares risk with plans in the Part D program.
16 We plan to include this material in our June report to the
17 Congress.

18 In this presentation, I'll review some of what we
19 talked about last month in terms of patterns we've observed
20 in Medicare's payments to plans and what we think may be a
21 financially advantageous way for plans to bid. Next we'll
22 look in more detail at what might happen if Medicare were

1 to lower the amount of individual reinsurance that it
2 provides to Part D plans. An alternative to Medicare's
3 reinsurance might be for plan sponsors to purchase private
4 reinsurance, so we'll discuss that option. We'll also
5 discuss options for changing Part D's risk corridors and go
6 over Medicare's new requirements for medical loss ratios to
7 see if they serve a similar purpose as the risk corridors.
8 I'll end with our plans for going forward.

9 This slide is a reminder of the ways in which
10 Medicare shares risk with private plans. The direct
11 subsidy is the name of the payment that Medicare makes to
12 all plans each month to lower the cost of premiums for all
13 Part D enrollees. Since it's a capitated amount, the plan
14 sponsor bears insurance risk. If their plans' enrollees
15 spend more than the direct subsidy they get from Medicare
16 and enrollee premiums combined, the plan has to cover the
17 cost. Second, Medicare risk-adjusts the direct subsidy to
18 offset the incentives for plan sponsors to avoid higher-
19 cost beneficiaries.

20 Medicare pays individual reinsurance for each
21 plan enrollee with drug spending above Part D's
22 catastrophic threshold. And if, across all a plan's

1 enrollees, the plan's aggregate benefit costs are a lot
2 higher or lower than what it bid, Medicare shares in the
3 plan's losses or profits through risk corridors.

4 Remember last time we talked about CMS' process
5 for reconciling Medicare's prospective payments to plans
6 with their actual benefit spending. We talked about how
7 we've noticed a pattern in the payments that come out of
8 the reconciliation process. In recent years, for a growing
9 majority of sponsors, Medicare ends up paying out more
10 individual reinsurance money to the plans when they
11 reconcile the payments. The positive amounts (in yellow
12 bars) mean Medicare paid the plans. In other words, the
13 plan sponsors have been underestimating how much of their
14 covered benefits would fall in the catastrophic part of the
15 benefit.

16 The reconciliation data also show us that in each
17 year since Part D began, plan sponsors have, in the
18 aggregate, paid Medicare back through risk corridors.
19 Negative amounts (in the green bars) mean the plans paid
20 Medicare because sponsors overestimated all the other
21 covered benefits in their bids except for catastrophic
22 spending. So plan sponsors have had to pay back Medicare

1 in the risk corridors because they were overpaid in their
2 prospective payments. They made additional profits through
3 the risk corridors above and beyond the margins that they
4 had already included in their bids.

5 So just to summarize the pattern, at
6 reconciliation, Medicare paid most plans more for
7 reinsurance because they bid too low on catastrophic
8 spending, and then the plans paid Medicare through the risk
9 corridors because plan sponsors bid too high on the rest of
10 benefit spending other than catastrophic coverage.

11 Last time, we told you that we had interviewed
12 plan actuaries to get their take on why this pattern might
13 be happening. They told us that there is a lot of
14 uncertainty about key assumptions when they have to submit
15 bids to CMS and the way in which some plan sponsors project
16 future spending growth could lead to underestimates of
17 catastrophic spending. However, we've seen a persistent
18 pattern rather than randomness in payments that we might
19 expect to see in the face of general uncertainty. The
20 persistence of the pattern led us to ask whether there
21 might also be financial advantages to bidding in certain
22 ways.

1 In March, Shinobu walked you through a numeric
2 example of how underestimating the catastrophic spending in
3 bids could potentially help a plan's financial position.
4 Bidding this way could help the plan keep a competitive
5 premium and yet the plan would still be guaranteed to
6 recoup any higher actual amounts of catastrophic spending
7 from Medicare through reinsurance reconciliation payments.
8 In addition, with the risk corridors, if a plan's benefit
9 costs are 5 percent lower than its bid, the risk corridors
10 let the plan keep all of that difference as additional
11 profit above and beyond the margin that was included in its
12 bid. If the plan's actual benefit costs are even lower, it
13 has to return some of that to Medicare, but it gets to keep
14 some. A downside of this bidding approach is that the plan
15 would have somewhat less cash flow because its prospective
16 reinsurance payments would be lower.

17 So as we consider policy options for risk
18 sharing, one approach might be to lower the amount of
19 individual reinsurance that Medicare provides. I won't go
20 over this slide of the standard Part D benefit in detail
21 again, other than to call your attention to the white area
22 at the top. Medicare pays 80 percent of benefit spending

1 above the catastrophic threshold, while the plan pays 15
2 percent and the enrollee pays 5 percent. That cap is
3 currently at about \$7,000 in total covered drug spending.
4 Because Medicare pays for 80 percent of covered benefits
5 above that amount, it's taking a lot of the risk for the
6 highest spending enrollees.

7 Here's the same slide, except that to demonstrate
8 one option, I've changed the top. Notice that Medicare's
9 individual reinsurance (again, in white) is now just 20
10 percent of catastrophic spending. It doesn't have to be 20
11 percent. This is just an example. We've used this example
12 because now the plan is responsible for covering 75 percent
13 of benefit spending above the catastrophic threshold just
14 as it covers 75 percent of spending between the deductible
15 and the initial coverage limit. The idea behind this
16 change is to give plan sponsors greater incentive to manage
17 benefit spending even among high-cost enrollees who reach
18 the catastrophic portion of the benefit.

19 You might be concerned that lowering Medicare's
20 reinsurance would lead to much higher enrollee premiums.
21 Let's look at that for a minute. Here I'm using the same
22 hypothetical example that we provided in your mailing

1 materials, with a simplified benefit structure that's
2 different from Part D's actual benefit. The middle column
3 shows current policy in which Medicare pays plans for 80
4 percent of benefit spending above the catastrophic limit.
5 In the right column, we've got what might happen if
6 Medicare only paid 20 percent reinsurance. This is a very
7 simple example that assumes there would be no behavioral
8 changes, so it's just cranking through the formula for Part
9 D subsidies. For the same \$50 that a plan expects as
10 catastrophic spending in its bid, Medicare would pay \$40 to
11 the plan under current policy, but only \$10 with the lower
12 reinsurance rate. That means the plan sponsor would be at
13 risk for more of the benefit spending -- \$37.50 in benefits
14 above the catastrophic limit compared with \$7.50. When you
15 add the rest of benefit spending in, the plan would now be
16 at risk for \$90 of the benefit rather than \$60. The
17 expected cost of the total benefit would be the same in
18 both cases (\$100); it's just that the plan would be at risk
19 for more of it.

20 Part D law says that enrollees must pay 25.5
21 percent of benefits, so in this case, that's a premium of
22 \$25.50 per month. In the example, the enrollee premium

1 wasn't affected. Even though Medicare reduced its
2 reinsurance, it had to keep its overall subsidy at 74.5
3 percent, so it would pay plans more in monthly capitated
4 payments: \$64.50 instead of \$34.50. Now, again, this is a
5 very simple example assuming no behavioral changes.
6 However, requiring plan sponsors to bear more of the risk
7 would likely affect their behavior. On the one hand, there
8 might be downward pressure on benefit spending because
9 bearing more risk would give sponsors more incentive to
10 manage drug spending. At the same time, there might be
11 some upward pressure on benefit costs because plan sponsors
12 might need to purchase private reinsurance or otherwise
13 recoup a premium for bearing more risk.

14 If Medicare had lower reinsurance, would that
15 affect the bidding incentives that Shinobu described to you
16 last time? We suspect that so long as Medicare guarantees
17 to make the sponsor whole for some of its actual benefit
18 spending as they do currently through reinsurance, there
19 will still be an incentive to bid in a financially
20 advantageous way. However, by giving more of Medicare's
21 subsidy through capitated payments, the relative amount of
22 dollars provided through reinsurance would be smaller --

1 which would temper the incentive somewhat.

2 One concern about lowering Medicare's reinsurance
3 might be that plan sponsors might not have the capacity to
4 bear more risk. However, about 80 percent of Part D
5 enrollment is in plans operated by nine large insurers.
6 Most of those same companies also offer Medicare Advantage
7 plans and commercial health plans. We believe most would
8 have the capacity to develop internal systems for
9 reinsuring themselves. However, if Medicare provided less
10 reinsurance, smaller regional sponsors might need to
11 purchase private reinsurance. We asked representatives of
12 the reinsurance industry whether they would be interested
13 in extending coverage to the Part D market. Now, this is a
14 different group of actuaries with private reinsurers than
15 the interviewees I described last month who were with Part
16 D plans. The reinsurance actuaries told us that they
17 already have contracts in place with some insurers that
18 offer Medicare Advantage plans, and yes, they'd be willing
19 to offer reinsurance. They see drug spending as having no
20 more variation than medical spending and, for Medicare
21 Advantage plans, they could probably roll drug spending
22 into their existing reinsurance contracts. They would also

1 be willing to offer private reinsurance for stand-alone
2 drug plans. Among the contracts reinsurers offer to health
3 plans today, it's more common to use an approach like
4 individual reinsurance than risk corridors (where they
5 provide one-sided protection in the event of large plan
6 losses). Reinsurers do offer both kinds, but it would look
7 different from what Medicare's risk sharing looks like.
8 For individual reinsurance, private reinsurers tend to set
9 the point at which they provide coverage higher so that
10 maybe 1 percent to 3 percent of a plan's enrollees hit that
11 level of spending. By comparison, in Part D, currently
12 about 8 percent of enrollees reach the catastrophic
13 threshold. And if private reinsurers were to offer
14 coverage similar to a risk corridor, it would likely be
15 wider than what Medicare provides today. So Part D plan
16 sponsors wouldn't be able to offload as much of the risk
17 through private reinsurance as what Medicare takes on.
18 Most reinsurers were unwilling to estimate what their
19 premiums might cost without more specific details, but one
20 consultant suggested that premiums could be in the range of
21 20 to 25 percent of covered benefits, where covered
22 benefits would be smaller than what Medicare covers today.

1 A separate set of options would be to remove or
2 change Part D's risk corridors. This slide shows the
3 corridors that were used in 2006 at the start of Part D at
4 the top when plans may have needed extra help with risk to
5 get this market up and running. The current structure of
6 the corridors is in the middle, and one option for wider
7 corridors is at the bottom. After the end of the benefit
8 year, CMS compares each plan's actual benefits paid with
9 what the plan sponsor bid. In the original risk corridors,
10 the sponsor had to pay for all benefit spending that was up
11 to 2.5 percent higher than what they bid, and they got to
12 keep any profits up to 2.5 percent lower than their bid.
13 Those were additional profits above and beyond the margin
14 that they had already included in the bid.

15 If actual benefit costs were between 2.5 and 5
16 percent more or less than the bid, then Medicare and the
17 plan split losses or profits 75/25, with Medicare having
18 the bigger share.

19 If actual costs were more than 5 percent
20 different from bids, then Medicare paid for 80 percent of
21 larger losses -- or got 80 percent of the gains.

22 After 2008 the corridors widened, meaning that

1 plans had to bear more risk -- which is what the law
2 intended. The middle bar shows the corridors that we still
3 have today. The point at which Medicare starts sharing
4 losses or profits is wider -- plus or minus 5 percent
5 around what the plan bid instead of 2.5 percent. Given
6 that plan sponsors have been returning overpayments to
7 Medicare each year through the risk corridors, one
8 perspective may be to tighten the corridors again so that
9 Medicare can recoup more of the overpayments. On the other
10 hand, if the plan knows that Medicare will cover a lot of
11 its losses, it may be less motivated to manage its
12 enrollees' drug spending. In the third bar at the bottom,
13 plan sponsors would be on the hook for all losses up to 10
14 percent higher than its bid. However, with the payment
15 patterns we've observed, the sponsors would likely be
16 keeping additional profits beyond what they're getting
17 today.

18 In isolation, you might think that removing the
19 risk corridors is a good idea because plan sponsors would
20 have a lot more incentive to manage their drug benefits.
21 This is in line with the approach used in Medicare
22 Advantage, which doesn't have risk corridors.

1 However, in practice, Part D's risk corridors
2 aren't just operating in isolation. Medicare is also
3 providing a guarantee to pay individual reinsurance based
4 on enrollees' actual benefit spending. Given the approach
5 to bidding that we think we're seeing in Part D, the risk
6 corridors have acted as a constraint on Medicare's
7 overpayments to plans. Because Medicare has been
8 collecting funding back from plan sponsors each year, we
9 also think that removing the corridors would likely be
10 scored as a cost in legislation.

11 One idea, then, is to keep the corridors in place
12 for the near term, but potentially make other changes to
13 Part D's risk sharing -- perhaps lowering Medicare's
14 individual reinsurance -- and then revisit the idea of
15 removing the corridors in the longer term.

16 Cori asked us to look into another issue that's
17 related to Part D's risk corridors: new rules as of 2014
18 that Part D (and MA) plans meet an 85 percent medical loss
19 ratio requirement. Her question to us was whether the new
20 MLR requirement serves the same role as corridors.

21 First, let me tell you about the requirement. We
22 don't yet have any data for you because it just went into

1 effect with the 2014 benefit year, and CMS hasn't yet
2 reconciled claims for that year. But the idea is that each
3 Part D contract's spending on benefits and quality-
4 improving activities must be greater than or equal to 85
5 percent of total contract revenues. If the contract's MLR
6 is less than 85 percent, then the sponsor has to return the
7 difference between that and 85 percent to Medicare. If the
8 sponsor's contract is out of compliance for three
9 consecutive years, it becomes subject to enrollment
10 sanctions. If it is out of compliance for five consecutive
11 years, CMS will terminate the contract.

12 MLR requirements act in the same way as a one-
13 sided risk corridor because they try to limit
14 administrative costs and profits to 15 percent of contract
15 revenues. However, the specific definitions of what goes
16 in the numerator and denominator matter, and it's not yet
17 clear how binding a constraint the MLR requirement will be.
18 For example, we're unsure about what will qualify as
19 quality-improving activities or how thoroughly those will
20 be checked. We'll keep our eye on how the MLR plays out
21 and report back to you about what we find.

22 This slide points out that as we consider changes

1 to risk sharing, it's important to bear in mind that low-
2 income subsidy enrollees are not distributed evenly across
3 Part D plans. Among all Part D enrollees, about 30 percent
4 get the low-income subsidy. If you look at the 20 stand-
5 alone drug plans that had the most enrollment in 2012, ten
6 of those only had 25 percent or fewer of their enrollees
7 with the LIS and six plans had 75 percent or more with the
8 LIS. So plans tend to either have a small share or a large
9 share of LIS enrollees.

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

16 If there are changes to Part D's risk-sharing
17 arrangements, it will be very important to recalibrate the
18 risk adjusters. Otherwise, some sponsors may decide that
19 changes to risk sharing may make it less desirable to
20 enroll beneficiaries with the low-income subsidy.

21 As for next steps, we're very interested in
22 hearing your comments related to individual reinsurance,

1 risk corridors, bidding incentives, and the direction of
2 policy options for risk sharing in Part D. We plan to
3 incorporate your comments and turn this material into a
4 chapter in the Commission's June report to the Congress.

5 For the next cycle, we will bring back to you
6 potential policy options and their implications for
7 beneficiaries, plan sponsors, and Medicare. We may also
8 want to revisit our recommendation on low-income subsidy
9 cost sharing from 2012, as one of several policy options
10 focused on the LIS.

11 MR. HACKBARTH: Okay. Thank you.

12 So would you put up Slide 3, Rachel? So if you
13 look at the middle two rows -- risk adjustment and
14 individual reinsurance -- the objective, broadly stated, is
15 the same in each case. So for me, decidedly, as you well
16 know, not a numbers person, that raises the question, well,
17 in judging what we should do with individual reinsurance,
18 we may want to know how good the risk adjustment is, that
19 the two are related to one another.

20 So analytically how can we assess how good the
21 risk adjustment is and then use that to help guide the
22 decision about whether lessening the individual reinsurance

1 is a good idea?

2 DR. SCHMIDT: Well, we haven't done a sort of
3 analytical work like Dan Zabinski has done for the Medicare
4 Advantage program, although we could, you know, think about
5 doing some of that going forward.

6 I can tell you, in the past, the risk adjustment
7 for low-income subsidy enrollees has been an issue. We've
8 done some work in the early years of Part D where it seemed
9 to be a concern. It seemed that some plan sponsors did not
10 want those enrollees.

11 CMS subsequently redeveloped its RxHCC model, and
12 I can tell you anecdotally, in the interviews that we
13 conducted plan actuaries, none of them voiced that as a big
14 concern at this point in time, with the possible exception
15 going forward of some of the high-priced specialty drugs,
16 that those -- you know, given that they're entering the
17 market quickly, the expense is large, they won't be
18 reflected in claims very quickly. There's a lag between
19 the recalibration of the risk adjusters and the
20 incorporation of those expenses.

21 MR. HACKBARTH: Clarifying question? Let's go
22 with Jay and then Bill.

1 DR. CROSSON: Thank you, Rachel and Shinobu.

2 Another good chapter. Appreciate it.

3 I will stick with this slide because one of the
4 things I wonder about in the presentation is whether in
5 fact in the future we're going to see more variability in
6 payments and cost and risk from drugs than, for example,
7 the experience in MA plans. At least the recent experience
8 with hepatitis C drugs suggests that, and if any of you
9 watched the wonderful series this week on cancer and the
10 presentation of future potential treatments, immunologic
11 and otherwise, for cancer, it does tend to suggest that
12 downstream costs for biopharmaceuticals are going to add to
13 the unanticipated and potentially unplanned-for risk,
14 anyway.

15 In looking at individual reinsurance and risk
16 corridors, you introduced this notion for risk corridors
17 that, in fact, one feature is protection against
18 unanticipated spending due to the introduction of expensive
19 drugs, but reinsurance would do that as well, correct, or
20 not?

21 So is there a reason to believe that the risk
22 corridor is a better protection, either financially or from

1 a policy perspective, for that problem than individual
2 reinsurance, or did you just choose that to put that
3 example there for the heck of it?

4 DR. SCHMIDT: Probably more of the latter, I
5 would say.

6 [Laughter.]

7 DR. MILLER: I was just going to say, do you want
8 to get a lawyer before you answer?

9 DR. SCHMIDT: Please.

10 You're right. They both can serve in that
11 capacity. I don't know. If you start tinkering with the
12 individual reinsurance, one could argue that maybe that
13 might change the incentives again for the plan sponsors to
14 be a bigger part of the negotiation of the price or to
15 think through when it's best to use those high-priced
16 medicines to be more involved in all of that decision-
17 making. I don't know if that might sway you towards
18 keeping the risk corridors in place for just picking up the
19 risk associated with doing that.

20 Do you have something else?

21 MS. SUZUKI: The one thing I would add is risk
22 corridors right now covers a different portion than what

1 the individual reinsurance covers, and if you remember the
2 benefit graph, the 80 percent, that white part, is the
3 individual reinsurance, and risk corridor is around the
4 benefit that's not the white part.

5 DR. SCHMIDT: [Speaking off microphone.]

6 MS. SUZUKI: Right.

7 Right now, only 15 percent of the high cost is
8 actually under the risk corridors.

9 DR. MILLER: The way I -- not at the technical
10 level -- kind of thought about that is the two devices and
11 particularly at the construction of the program way back in
12 the day were you can have a patient, individual patient
13 experience go south on you, and you want to ensure against
14 that, and because this industry was so new and these things
15 didn't exist in nature, there was real worry about you
16 could just get the whole thing wrong, your whole bid and
17 estimate over time.

18 What Shinobu is saying is that the individual
19 insurance piece isn't really part of the corridor
20 calculation, and it was thought through that way at the
21 inception of the program.

22 DR. CROSSON: Can I state it one other way?

1 Let's say in any given year, any given plan had \$100
2 million additional expense due to the introduction of some
3 high-cost biopharmaceuticals, and we had a world where we
4 either had removed the risk insurance or reinsurance or
5 removed the risk corridors or weakened them, but let's just
6 for the argument's sake say we only have -- we have got
7 belt and suspenders now. We won't have either a belt or
8 suspenders. Either financially or conceptually, what would
9 the difference be to that plan in that situation if we had
10 only reinsurance or if we had only risk corridors?

11 MS. UCCELLO: Can I just add something in here?
12 I think part of the difference maybe between the -- after
13 the introduction of something that was unexpected, that
14 reinsurance and risk corridors are going to act differently
15 over time. So you can think of in the first year is when
16 there is the surprise, and that the risk corridors kind of
17 take precedence in a way. Over time, plans should be
18 incorporating those costs into their expectations, and now
19 it's coming out in the long term on the reinsurance side of
20 things.

21 DR. MILLER: I hate to say this in public, but I
22 thought that was really well put, Cori.

1 [Laughter.]

2 DR. MILLER: You're an actuary, right? I think
3 she nailed that well.

4 To his example --

5 MS. UCCELLO: Can I leave for the day then?

6 [Laughter.]

7 DR. MILLER: Oh, you don't understand how the
8 prizes work. You have to stay. You get it wrong; you get
9 to go.

10 But just to deal with this question a little bit
11 in isolation, I feel very adrift here. So all three of you
12 are on point.

13 I mean, I would say to the extent that the
14 introduction of this new drug, if that was your example --
15 I'm a little bit distracted -- and it hit the non-
16 catastrophic portion of the benefit in a systematic way, so
17 that even a person who didn't hit the catastrophic was
18 taking the drug, the corridor might accommodate that.

19 So, in your example, if the corridor were
20 eliminated, the plan might be running into some heavy water
21 at the lower end of its benefit where it assumed a bid and
22 that bid turned out to be wrong because this thing showed

1 up.

2 But then, of course, you would have -- if this is
3 an expensive drug, taking an expensive drug is going to
4 make you more likely to hit the catastrophic cap, and so
5 you could have people who drive into a catastrophic cap
6 because of the introduction of the drug, and the other one,
7 the catastrophic cap takes place.

8 To go to your example, if you had a catastrophic
9 cap but not corridor and this thing had an effect and it
10 had an effect on the non-catastrophic portion of the
11 benefit, the plan might be losing money because it bid at
12 one level, and it turned out that was wrong. But to the
13 extent that individuals were hitting it, they would be
14 indemnified or at 80 percent or whatever the right word is.

15 The reverse is also true. So if this drug hit
16 and I had the corridor, I would be indemnified about the
17 fact that I was surprised. I didn't anticipate it, but to
18 the extent that beneficiaries are hitting the catastrophic
19 cap, I wouldn't be indemnified, individual beneficiaries.

20 MR. HACKBARTH: I think Cori was clearer. So she
21 says and you go.

22 [Laughter.]

1 DR. MILLER: Actually, that's fine.

2 MR. HACKBARTH: Are we good?

3 Okay. Still on this same issue, I have Jack, and
4 then anybody else want in on this topic?

5 Jack.

6 DR. HOADLEY: To some extent, experience -- and
7 we don't have the data on it yet except for what CMS has
8 sort of said publicly -- for 2014 and the hepatitis C drugs
9 is that because those drugs were very expensive for a
10 relatively small set of people, they mostly pushed people
11 into the catastrophic, and most of that additional cost is
12 picked up on the reinsurance side. Speculatively, the risk
13 corridors weren't called in, and both using sort of
14 Shinobu's example from the last meeting and the way you
15 sort of play those numbers through and just the numbers
16 that have already been reported, it would look like that
17 played out.

18 If what you had was a new drug that was a new
19 cholesterol drug, not a big blockbuster or many thousands
20 of dollars, but a new Lipitor that was at the brand level
21 that was going to affect a lot of people, that might play
22 out differently. But if you take one or the other out,

1 you've got some ability for whichever one was left in place
2 to pick up the slack of which -- whatever one wasn't there.
3 So that is the sort of reinforcing, you know, if you don't
4 have the belt, the suspenders will do more, and if you
5 don't have the suspenders, the belt will do more. So I
6 think that's -- but the design is a little bit different,
7 and the incentives creates, which we can come back to in
8 the broader discussion, will be different.

9 MR. HACKBARTH: Is it on this point, Kathy?
10 Yeah. Okay.

11 MS. BUTO: I think so.

12 We're still on clarifying questions, right? So
13 the question I have is whether Medicare Advantage plans,
14 when a new procedure comes along that's really expensive,
15 say liver transplant, does CMS still -- I'm looking at
16 Carlos -- still provide sort of a bump-up payment to
17 account for that? In other words, what I'm trying to get
18 to is not only the MLR, but I think CMS Medicare uses other
19 mechanisms to account for the high-cost procedure in the
20 context of Medicare Advantage, and you could imagine that
21 even if they did away with the risk corridors, you could do
22 something like that for an expensive new drug.

1 DR. SCHMIDT: And Carlo sis nodding yes.

2 MS. BUTO: Yes. Okay.

3 MR. ZARABOZO: [Speaking off microphone.] --
4 national coverage.

5 DR. SCHMIDT: Right. Yeah. This actually came
6 up last meeting as well. If there is a national coverage
7 decision, then, yes, CMS does make accommodation for that.

8 MR. HACKBARTH: Anybody else on this point?

9 [No response.]

10 MR. HACKBARTH: No? So we're doing clarifying
11 questions, and we'll go down this row. Bill.

12 MR. GRADISON: On Slide 11, I have a question,
13 please. Looking at the 2006 and now the current division
14 of the cost, has the shift during that period, which as I
15 understand it has increased the risk taken by the plans,
16 caused them to purchase more or any private reinsurance?
17 Have they felt that necessary with that shift so far?
18 That's a question.

19 DR. SCHMIDT: With the private reinsurers that we
20 spoke with, no, they generally haven't felt the need to
21 purchase private reinsurance, even with that change in the
22 corridors. The provisions within Part D itself were

1 sufficient, and they're large insurers to begin with, so
2 they had the capacity at that time.

3 MR. GRADISON: Thank you.

4 DR. NERENZ: I have a big clarifying and a little
5 clarifying question.

6 It seems like last time we talked about this --
7 I'm looking at Scott -- I think Scott was the one who
8 asked, "What's the problem here?" So I'm feeling that same
9 question again. As we go through this discussion, is the
10 issue somehow that the Medicare sharing of risk is too
11 high, relative to the plan? Is it the other way around?
12 Is it wrongly configured even though the balance is right?
13 How do you want us to think about that big thing?

14 DR. SCHMIDT: I didn't include the slide that we
15 had in the last presentation that was supposed to be more
16 of the motivation behind this whole thing, but we have seen
17 such rapid growth in Medicare program payments associated
18 with risk sharing and particularly for individual
19 reinsurance, that that has been a motivation behind this
20 work.

21 DR. NERENZ: Okay. Well, that's a perfect
22 transition then to my little question, which was going to

1 relate to Slide 4, and I think -- and maybe you just
2 answered what I was going to ask. Is the difference in up
3 height versus down height a problem? Is that a restatement
4 of what you just said?

5 DR. MILLER: I would say this. What Rachel was
6 just referring to is the yellow bars where we can see this
7 ramp-up of individual reinsurance payments, and we're
8 wondering what's going on and then asking the question to
9 your first bigger question. Is the risk structure properly
10 between the Federal Government and the plan? Because the
11 Federal Government is paying out increasingly more
12 insurance dollars, and this could be corrected. We're not,
13 but our intuition is, "Well, wait a minute. The actuaries
14 and the people who think about this should, after 10 years
15 of experience, have some sense of that." But there's also
16 noise, so we're trying to be balanced about it.

17 The way I think about the risk corridor side of
18 things is almost the same intuition. The plans are paying
19 out under the corridors on net, and once again, if you had
20 10 years of experience or about 10 years of experience, you
21 might think you could get your bid in such a way that you
22 wouldn't have to pay that, and so we're just sort of asking

1 -- and this goes on the yellow bars against the government.
2 It goes on the green bars to the government, and we're just
3 sort of saying, "What's the risk structure here? Maybe we
4 need to rethink this."

5 Remember way back in the day, it was belt and
6 suspenders because nobody had a really good sense of what
7 was going to happen.

8 DR. NERENZ: Okay. And actually on that
9 metaphor, are the pants actually falling down, or are they
10 not?

11 [Laughter.]

12 MR. HACKBARTH: So for me, Dave, it's not so much
13 the net difference between the two. It's the trend on the
14 two lines respectively, the individual reinsurance with
15 this sharp upward bend and then the flatness and the one-
16 sided nature of the green bars.

17 DR. SCHMIDT: Right. I was going to say these
18 are -- this is kind of a little complicated because there
19 are reconciliations to prospective payments, not the
20 absolute amount of spending.

21 DR. NERENZ: Well, okay.

22 DR. SCHMIDT: But yes.

1 DR. NERENZ: Again, thank you. This is a
2 wonderful answer to my question because that's where I was
3 also going to go. If this is reconciliation, so that
4 really we're just talking about a matter of who guesses
5 what at the beginning of the year and are they up or down,
6 we may conclude that even though one bar goes up and
7 another bar goes down, there's no really net flow of funds
8 or a funny sharing of risk. It's just a matter of how
9 people guess at the front end.

10 But on the other hand, you could look at it and
11 say, "Well, there's effectively a subsidy going on here."
12 Again, your answers are helping here.

13 DR. SCHMIDT: Right. And we hope to come back to
14 you with more information looking at the absolute dollars
15 of program spending.

16 MR. HACKBARTH: So we're continuing on clarifying
17 questions, and we'll go around this way. Cori is next.

18 MS. UCCELLO: So I've gotten some feedback that I
19 think you've gotten as well about the example and about
20 bidding strategy with respect to the reinsurance and how
21 base premiums are set nationally, and so the ability of any
22 particular insurer to influence that.

1 I just kind of want to hear your reaction to that
2 with respect to the strategy.

3 DR. SCHMIDT: Right. So Cori is characterizing
4 accurately a reaction we've gotten back. How can anyone
5 plan sponsor affect things very much, given that it's a
6 bid, a nationwide average bid?

7 One thing that we heard in the course of doing
8 interviews with plan actuaries is that a lot of them are
9 using the same consulting actuaries who have the same
10 models for projecting growth and spending. Here is one
11 hypothesis, that they kind of fell into a pattern maybe of
12 understating catastrophic coverage, those benefits, and
13 overstating the rest by using a smooth assumption about
14 projecting trend. But over time, maybe there is a
15 financial advantage that becomes obvious to doing it. So
16 that's one hypothesis.

17 MR. HACKBARTH: Clarifying questions? Jay.

18 DR. CROSSON: Just on redirect, so Cori --

19 [Laughter.]

20 DR. CROSSON: I'm probably getting this wrong
21 again, but does that slide there, with a relative
22 consistency of the risk corridor and the spiking

1 reinsurance numbers, does that suggest, based on what you
2 said earlier, that this is indicative of relatively
3 unpredictable but short-term changes in unanticipated risk
4 or not?

5 MS. UCCELLO: The risk corridors have been
6 payments for plans to the government. So, I mean, that
7 kind of makes things a little more difficult to answer
8 this, but I think that the surprise that -- maybe if you
9 want to call it -- this surprise is that spending has been
10 lower, generics or whatever, that was not anticipated.

11 DR. CROSSON: I may not have been clear. No.
12 That's a larger question about whether Part D is in trouble
13 or is actually doing quite well, but what I thought I heard
14 you and Jack saying was that -- maybe just Jack -- the
15 reinsurance belt was most effective for short-term
16 unpredictable losses, whereas the development --

17 MS. UCCELLO: It's the other way around.

18 DR. CROSSON: Okay. What did I say?

19 DR. MILLER: Corridor.

20 DR. CROSSON: I'm sorry. The risk corridor was
21 more effective. Whereas, if you had a new cholesterol drug
22 and virtually every male over the age of 45 was taking it

1 and it was high cost, that then the risk corridors would be
2 more effective for that. Whereas, reinsurance -- or did I
3 get it completely backwards? Help me.

4 DR. MILLER: Here's what I would have said, okay?
5 And you guys see if I am following any of this along. What
6 I heard Jay saying is you have set this up, and I am pretty
7 sure it was Cori who said just because we want -- well, we
8 want to have the defendant, you know, identified for the
9 Court.

10 [Laughter.]

11 DR. MILLER: The corridors might be -- and, Cori,
12 in all serious now, back to your comment, I think what you
13 were saying is the corridors might play a role in which
14 there is a short-term shock, and then -- and I realize
15 there's many different ways, but just to say -- and so he
16 then was asking do you see a pattern there that suggests
17 short-term shocks or some other pattern. And what I would
18 have said is, "No, I don't see a short-term shock kind of
19 pattern," because I would have guessed more noise in the
20 corridor if it's really about I didn't anticipate something
21 in the market and it showed up versus what -- there's a
22 little noise there at the beginning, and then it kind of

1 flattens out, and then year over year, you just get -- and
2 then again -- well, I'll stop there.

3 MS. UCCELLO: And I'll continue.

4 DR. MILLER: Thank you.

5 [Laughter.]

6 MS. UCCELLO: Yes, that's -- I agree with you,
7 and I think on the reinsurance side, maybe the evidence
8 that backs up my statement is that the reinsurance payments
9 have been increasing over time, and so it's a cumulative
10 effect.

11 DR. HOADLEY: And, in fact, the -- I mean, here,
12 you're showing the reconciliation part. But, if you showed
13 the base thing, it would be a similar pattern. It's been
14 high and getting higher and that's presumably reflecting
15 something more about the overall pattern of high use that
16 we would expect.

17 So, it's one thing to say what happens when a new
18 drug comes in that year and it was too quick to anticipate.
19 It's another thing to say a new drug comes in that's
20 expensive for a small subset of people and it's going to
21 continue to be there.

22 So, there's both the how do you react to it the

1 first year, which ultimately is what you sort of think of
2 the risk corridor as being about, but in the long term, if
3 there's more people that are up over the catastrophic cap
4 continually over a period of time, that's going to be
5 comparable to that sort of yellow line, saying high and
6 growing higher.

7 MS. BUTO: I just -- I think this question is
8 actually for Cori, but Rachel or Shinobu, and that is if we
9 eliminated -- if Medicare were to eliminate the risk
10 corridors altogether but MLR has gone into effect,
11 essentially, would those bars kind of look the same? In
12 other words, what they suggest is that the plan is having
13 to pay back Medicare. Do we think that plans without a
14 risk corridor and an MLR would be a little more close to
15 that horizontal line and be more likely to hit it on the
16 mark or be closer to it? I'm just wondering, because they
17 do seem like those two things are very much aligned, given
18 that they're paying the government back. MLR suggests that
19 you might have to pay the government back if you haven't
20 hit the medical loss correctly.

21 MS. UCCELLO: I'll just respond because you asked
22 me, but this was actually my question to Rachel, and I

1 think that there are dissimilarities between the MLR and
2 the risk corridor --

3 DR. SCHMIDT: It's only one-sided, for example.

4 MS. UCCELLO: -- getting different things, it's
5 one-sided, but we care about this one side, but it will
6 have -- it could have behavioral consequences for bidding
7 that also would need to be considered. But, I mean, I
8 think that's what you're going to be looking into a little
9 bit more --

10 DR. SCHMIDT: Yeah. I think -- so, it doesn't --
11 if you get rid of the risk corridors and there is this, you
12 know, the new cholesterol drug that everyone over 45 --
13 every man over 45 is taking, there isn't that protection
14 anymore, right, if you get rid of the risk corridors,
15 because the MLR would be one-sided. It's only recouping on
16 the profit side.

17 We have a concern that I tried to say in the
18 presentation. These things can be a little porous, you
19 know, with the definitions of what qualifies as quality
20 improving activities, for example. So, we're not sure how
21 binding a constraint on profits MLR will ultimately be, but
22 --

1 MS. UCCELLO: And, I think something that was
2 brought up in the paper is that MLR can be criticized
3 itself for not really being focused on the right thing.
4 It's trying to squeeze the admin and the profit, but one
5 way to increase your MLR is not to manage care as well and
6 just to have higher costs. So, there's kind of some weird
7 incentives here.

8 DR. MILLER: Shinobu, I keep remembering, when we
9 had this conversation, you would always make a point about
10 what the MLR applies to.

11 MS. SUZUKI: So, the denominator includes the
12 reinsurance portion, which is that white box, 80 percent,
13 and when you're allowed 15 percent on the basic benefit
14 plus reinsurance, that's a much bigger profit margin than
15 the five percent allowed for the basic portion of the
16 benefit within the risk corridor.

17 MS. BUTO: So, it's not just -- so, we're
18 actually going to count the government's 80 percent in
19 computing the MLR, not just what the plan is at risk for.

20 DR. SCHMIDT: It's in both the numerator and
21 denominator, yes.

22 MS. BUTO: Yeah. Hmm. That seems to be a

1 mistake. I don't know --

2 DR. MILLER: It seems to be something we should
3 look at, and I think that's why every time we have this
4 conversation, Shinobu goes, "Remember --"

5 [Laughter.]

6 DR. MILLER: So, I think you're on to something.

7 MR. HACKBARTH: Any other clarifying questions?

8 [No response.]

9 MR. HACKBARTH: Let me just get one other thing
10 out on the table. So, some months ago, there was some
11 controversy around the Affordable Care Act and the
12 financial protections provided to insurers under the
13 Affordable Care Act for some of the same broad policy
14 reasons, trying to get people to play, et cetera. Could
15 you just refresh our recollection on why some people
16 thought, well, those are really problematic, but the ones
17 in Part D are okay? How were they different?

18 DR. SCHMIDT: I'm not sure I have a good answer
19 to that one. Do you happen to know, Jack?

20 DR. HOADLEY: I mean, both Cori and I have done
21 testimony where that's essentially been the question. I
22 mean, in a simple way, you can say the answer is that in

1 Part D, plans that pay back to the government, and the
2 expectation by those who are worried about the ones in the
3 Affordable Care Act is that the government will rescue,
4 will pay back the plans. I mean, so, I think in the very
5 short sort of simplistic way, that's been the concern.

6 MR. HACKBARTH: But the design is similar.

7 DR. HOADLEY: The design is similar. The biggest
8 difference is that the Affordable Care Act ones phase out
9 completely and these, while they -- as these guys showed --
10 they widened, and there is statutory authority built into
11 the MMA to either further widen them or actually make them
12 go away? Both?

13 DR. SCHMIDT: Yeah, as long as it's at least as
14 wide, you could conceivably get rid of it.

15 DR. HOADLEY: They can do more. I mean, the law
16 built in the opportunity to do more. CMS has not opted to
17 do that. But, they are permanent in the sense of there's
18 no phase-out created.

19 MR. HACKBARTH: I think we're ready to go to
20 round two. Who wants to lead on round two? Jack.

21 DR. HOADLEY: So, it seems to me that a lot of
22 this is driven by sort of thinking about the kinds of

1 questions we've already been talking about, of sort of
2 where cost pressures come from and what's the best way to
3 sort of design the program to address those pressures in a
4 useful way.

5 You know, right now, the best guesses are that
6 the cost pressures on Part D are going to come from
7 specialty drugs, from expensive drugs, whether they are the
8 Hepatitis C kind of example, which is a relatively small
9 number of people at a very high price, or the potential
10 coming cholesterol drug that could be also expensive, not
11 at the same level as Hepatitis C, but with a much larger
12 set of people, potentially. Obviously, lots of questions
13 about the clinical judgments that will be made at that.

14 And, I mean, I think part of where I try to think
15 about this is where is the burden in that cost? Where are
16 the incentives to manage those costs? So, on the one hand,
17 you've got some burden on the individual beneficiary, even
18 in the current design. I mean, if you put that 80 percent,
19 the white box figure, back up, there's still that five
20 percent that the beneficiary is responsible for, so they
21 are going to bear some of the burden, and that's -- I said
22 at the last meeting, if we start doing some changes, we

1 might want to think about out-of-pocket maximums for Part D
2 or otherwise messing around with that five percent.

3 But, we've sort of divided up the impact on the
4 plan and the program in a particular way through this so
5 that, as I said before, the 2014 experience in Hepatitis C
6 seems to put most of the cost on the government through the
7 reinsurance and doesn't put a lot of burden on the plans to
8 manage.

9 And, so, I think, thinking through those trade-
10 offs, where do we think that would -- and to me, it kind of
11 comes back almost to our last session. It's what are the
12 tools -- you know, then, we were talking about opioids and
13 polypharmacy. Here, we might be talking about new drugs
14 coming on the market. What are the tools -- clearly, the
15 government doesn't have a lot of tools, although the
16 government, because it has to do it indirectly through the
17 plans, the government can't negotiate prices. The
18 government can allow or disallow some of the management
19 tools for utilization, and we might want to think about
20 some of those.

21 But, if we are going to change these mechanisms
22 to try to put -- if we think part of what this structure

1 creates is not a lot of incentive for a plan to manage a
2 new Hepatitis C drug or a new cholesterol drug that will
3 kick a lot of people into catastrophic coverage, do we want
4 to change the risk rules so that there's more incentive on
5 the plans to manage, but do the plans have the tools in a
6 sort of stand-alone Part D environment to do that
7 management.

8 MR. HACKBARTH: And, sort of the flip side of
9 that is, so, take the Hep C drugs. A lot of that spending
10 is going to be in the individual reinsurance, and, oh, by
11 the way, there's a prohibition on the government
12 negotiating with the insurers about the price of those
13 drugs. So, the risk is shifted from the plan to the
14 government and the government, by law, is prohibited from
15 doing anything about it.

16 DR. HOADLEY: And, even if the burden was more on
17 the plans, there's the question of whether some of the
18 rules around formularies and management, so the kind of
19 things you heard about in the private sector, where Express
20 Scripts and some of the other PBMs came in and negotiated
21 lower prices, could implement them right away, for good
22 reasons, we don't necessarily allow plans -- or, we don't

1 allow plans to change their formularies in mid-year, so
2 there's a lag before they could trade a more favorable
3 formulary position. There are questions of what CMS would
4 allow in terms of formulary treatment of these drugs and
5 other kinds of things, all of which have some good reasons
6 behind them. But, they'll intersect. So, the government
7 can't do certain things, as you point out, like negotiate
8 prices. The private plans can negotiate prices, but they
9 have some hands tied in doing that.

10 And, so, I think the point is we should be
11 thinking about these issues, and I've said before some
12 thoughts on how we might do that. But, I think it's
13 dangerous to do that in isolation of, okay, what's the
14 second order effect on the beneficiary? What's the second
15 order effect on the plans' tools to manage? And, do we
16 make sure -- should we be looking at a package of things to
17 say, okay, we want to do this here, but in turn, we either
18 want to recognize that the plans' tools are limited,
19 recognize that the government's tools are limited, change
20 the limits on either side and think about how to do all
21 those things in tandem.

22 MR. HACKBARTH: Round two. Cori.

1 MS. UCCELLO: So, every time we have discussed
2 risk sharing in Part D, I have complained that risk
3 corridors make no sense at this stage of the program.
4 That's all theory. In the real world, I think I'm kind of
5 waving the white flag now, notwithstanding what we find out
6 about how the MLR shakes out. It just doesn't make sense
7 to make changes to that now, given that the government is a
8 net receiver of payments. It just doesn't make sense. So,
9 I think we do need to focus more on kind of the reinsurance
10 side along with some of these ideas Jack has about, well,
11 tools plans have and those kinds of things. But, I think
12 in the short term, that's where we need to be focusing.

13 MR. ARMSTRONG: Two very brief points. One, I
14 just want to affirm Jay's point earlier. I always get Jack
15 and Cori confused.

16 [Laughter.]

17 MR. ARMSTRONG: So, I understand that.

18 But, more seriously and not too specifically, and
19 I'm repeating a point I've made before, drug spending in
20 the Medicare program is a huge emerging problem. It's only
21 going to get bigger. And, I think that the risk sharing in
22 Part D is a component part of that, and I think there are

1 some real issues we've identified here. I'm not an expert.
2 I can't speak like these guys can to some of these issues.
3 But, I think at some point, we do need to just check to
4 affirm that we're dedicating the limited resources of
5 MedPAC and our staff on those variables that will have the
6 biggest impact in the next decade on overall costs to the
7 Medicare program of pharmaceuticals.

8 And, I haven't taken the time to kind of step
9 back and just check on that, but I just would really
10 encourage us to do that as we get ready to gear up and
11 really dive into some of these specific questions.

12 DR. REDBERG: Just a comment, maybe. It's
13 related to Scott's. And, picking up on what you said, but
14 it does concern me that Medicare has this rapid increase in
15 costs and reinsurance at the same time that Medicare can't
16 negotiate prices, at the same time when there are a lot of
17 very expensive drugs coming on the market that are priced
18 really in ways that are inexplicable, I would say, at best,
19 and certainly not related to any kind of benefit for
20 Medicare beneficiaries, and clearly we're headed that way
21 and that's a situation we need to really do something about
22 quickly, because we're looking at billions of dollars for

1 unclear outcomes and, no market operating in Medicare right
2 now, being very seriously at risk for those costs, and not
3 just Hep C.

4 DR. COOMBS: I'd be interested in what the low-
5 income subsidy looks like with and without risk corridors,
6 if there's a difference, based on how often you hit the
7 catastrophic, the sub-catastrophic, numbers, and what a
8 more tailored approach might look like. You know, we've
9 talked about getting rid of the risk corridors altogether,
10 but what if there was a hybrid where you had a certain
11 benchmark for LIS within a population and, you know, just
12 looking at how proportionality makes a difference with
13 combinations of non-LIS versus LIS.

14 DR. SCHMIDT: Let me make sure I understand, or
15 maybe I can ask you to speak a little bit more. So, right
16 now, I think it's on the order of 80 percent of the people
17 who hit the catastrophic have LIS. So, are you asking to
18 have kind of a different level at which their reinsurance
19 would kick in, or what --

20 DR. COOMBS: What would happen if you had a
21 different rule applying to both, in other words, risk
22 corridors with LIS versus none with non-LIS.

1 DR. SCHMIDT: Well, the thing with the risk
2 corridors, that's a plan's overall spending --

3 DR. COOMBS: Right. Correct.

4 DR. SCHMIDT: -- for all enrollees.

5 DR. COOMBS: Right.

6 DR. SCHMIDT: So, you're saying --

7 DR. COOMBS: So, for instance, with the Hepatitis
8 C, at the rate of \$84,000 or how much ever for the
9 treatment plan, you're going to hit catastrophic in non-LIS
10 populations, presumably. And, with the literature from ID
11 saying we want Baby Boomers to be tested and the estimation
12 from the house of ID saying that somewhere between 50 and
13 75 percent of people who are Hep C positive don't know that
14 they're Hep C positive, and whatever percentage of that
15 that has chronic active Hepatitis.

16 So, I'm being futuristic and thinking that it's
17 not just the LIS that's going to drive costs in the future.
18 There will be this new group that's not necessarily LIS,
19 and so how do we look at changing the paradigm in the
20 future, or looking at this new cohort that's not
21 necessarily LIS and what they look like without risk
22 corridors versus LIS going forward.

1 DR. MILLER: So, I think we're going to have to
2 take what you said and think about it and come back. But,
3 I want to make sure that I at least carry out of the room
4 what you were asking. So, in the end, what I took away
5 from it was you might want to think about a different
6 corridor, or you're asking whether it makes sense to have a
7 different corridor structure -- I'm leaving reinsurance out
8 of it for just a half-a-second -- for different
9 populations. Okay. I think we can think about that and --
10 I wouldn't want to try and take that on the fly, although
11 we could ask Cori to do it. But, I want to make sure I
12 followed your question.

13 MR. HACKBARTH: Is there a relationship between a
14 plan's enrollment of LIS beneficiaries and its likelihood
15 to exceed the risk corridor?

16 DR. SCHMIDT: We've just recently gotten data to
17 be able to answer that, but I don't have that analysis
18 completed, but I can try and do that and come back to you.

19 MR. HACKBARTH: Okay.

20 DR. COOMBS: And I just have an important point,
21 Glenn, and that's where we're going. The other thing I
22 wanted to say is in terms of medical loss ratios, I don't

1 have a whole lot of hope in medical loss ratios and how
2 they're done. We had -- as you know, in Massachusetts, we
3 had that as a benchmark many years ago and still there are
4 ways around it, and I think that medical loss ratio, the
5 way it's calculated, gives us a little leeway into how we
6 can change the paradigm for Medicare.

7 DR. HOADLEY: Yeah, I wanted to follow up on the
8 LIS thing. I mean, clearly, we need to think about how
9 this plays out, and the kind of data you're talking about
10 would help on that.

11 There are also some policy levers, however, we
12 could think about on the LIS side that sort of otherwise
13 don't have to do with this, but as we're talking about how
14 they intersect. So, some of the ways you get that
15 lumpiness of LIS has to do with basic versus enhanced
16 plans. But, some of it has to do with the things that
17 sponsors have been allowed to do in terms -- that have
18 encouraged them, in a sense, to segregate their LIS
19 enrollees into one plan as opposed to another. And, so,
20 some -- and some of those CMS has addressed in rules and
21 then not gone forward with. But, we might want to think
22 about some of those policies to lessen the amount of

1 complete isolation of LIS in certain plans and not, because
2 if you have a more mixed plan, at least, it might change
3 some of those bidding incentives that Rachel and Shinobu
4 have talked about.

5 DR. CHRISTIANSON: Yeah, I was going to comment
6 on that, too, Jack. I think one of the things we haven't
7 talked about much today, but we did previously, is the sort
8 of bidding incentives and how they might relate to what
9 we're seeing in that graph that everybody's commenting
10 about. I think that's important to keep in mind.

11 But, I also think one of the things that this
12 chapter really does, and this work does, that's very
13 important is it focuses attention on sort of the full
14 picture in terms of the Part D program instead of what I
15 think is kind of the naive focus on just the bid prices and
16 looking at the bid prices and saying, here's how the
17 program is functioning. And, I think, just by having this
18 chapter, laying all of this out and saying to people, look,
19 it's not just the bid prices. You have to look at the
20 whole picture, and here's how it relates, is a really
21 important thing that we can bring to the policy discussion.

22 I thought the chapter was just fabulous, by the

1 way. It was just great. But, that's me. I wanted to be
2 an actuary.

3 [Laughter.]

4 DR. CHRISTIANSON: In high school -- and you'll
5 appreciate the irony of this -- the local medical society
6 gave me a scholarship to go to college to study to be an
7 actuary.

8 [Laughter.]

9 MR. HACKBARTH: [Off microphone.]

10 DR. CHRISTIANSON: Well, I didn't. Actually, I
11 didn't, because I found out in the course of my study that
12 I didn't have a good enough personality to be an actuary --

13 [Laughter.]

14 DR. CHRISTIANSON: -- so I became a health
15 economist instead. It's an old joke, Cori. I know you've
16 heard it before.

17 DR. SAMITT: So in our last session, we talked
18 quite a bit about learning lessons from best practices or
19 from other sectors in the industry, and, you know, what I
20 haven't heard us talk about -- and I'd be curious to get
21 other folks' perspective on it -- is the fact that, you
22 know, I'm not sure why we're so worried about risk bearing

1 by these plans, especially because these same plans, many
2 of the MAPD plans and the PDP plans, already do bear global
3 drug risk in the commercial sector. So they already do
4 have to take accountability and responsibility for under 65
5 in managing full risk without reinsurance for the most part
6 from Medicare or some other body other than their own
7 independent reinsurance. They already experience this
8 whole world for a large subset of their patients.

9 So I don't know to what degree we've actually
10 looked into the commercial world, the private world, to
11 really understand whether there are any lessons learned
12 here from a risk-sharing, risk management perspective for
13 drugs, and taking some of those lessons and making them
14 applicable to some alternatives here in Part D.

15 DR. CROSSON: So in thinking about narrowing the
16 work, would it be reasonable to say -- I did listen to
17 Cori.

18 DR. SAMITT: Or Jack.

19 DR. CROSSON: Yeah, I know. I listened to both,
20 but with respect to taking a look at the risk corridors,
21 maybe not, taking a look at reinsurance, maybe that's what
22 we should be doing, it seems to me that it might be helpful

1 to get more granular, if that's possible, about what's
2 actually going on with respect to that spike in reinsurance
3 payments. And I don't know what I'm saying, whether I'm
4 talking about the clinical issues, the emergence and rate
5 of emergence of new drugs, or some of the incentive
6 dynamics, or all of those things. But it seems to me that
7 if that's where we want to go and that's where we want to
8 focus, maybe if we understand at a more granular level
9 what's actually going on there, it would tend to point to
10 some solutions.

11 MR. HACKBARTH: Round 2 comments [off
12 microphone].

13 MS. BUTO: So I don't know at what point we think
14 about making recommendations, and maybe -- this feels like
15 it's too soon, but at least on the area of reinsurance, it
16 seems to me we're moving toward a set of recommendations,
17 or at least a direction that we -- at least my sense is
18 that we think we might want to go, because if you relate
19 this piece of work to the work that you all have done on
20 LIS and generic drugs, I think the same issue -- there is a
21 related issue, which is, if you've got Medicare bearing 80
22 percent of the risk on reinsurance, then it's a lot less

1 likely that the plan is going to put pressure during the
2 coverage gap in other places on trying to substitute
3 generics for brand-name drugs.

4 So it just strikes me that we are probably moving
5 in the direction of trying to move the plan into more of
6 that risk on the reinsurance side. I could be premature in
7 saying this, but if we're doing that, I'm just wondering
8 when would we do that. In the next go-round next year? Or
9 would we just basically talk about it this year and then
10 take it up in more detail next year?

11 DR. SCHMIDT: Right. I think the plan was to
12 kind of introduce the topic notionally -- and go ahead, you
13 can jump in, Mark -- and then next year come back to you
14 and, you know, as we get feedback from you, to kind of
15 develop some policy options to take forward.

16 DR. MILLER: And the only thing I was going to
17 say is, you know, this is not atypical for this part of the
18 cycle. We're putting up a lot of topics, as you think
19 about them, that are kind of open-ended, and, hey, we did
20 some data analysis, what do you think about this? Trying
21 to draw you out. We write it up in the June report. This
22 will bring out other actors in the environment who will

1 come in and tell us what they think about these ideas.
2 Then we'll come back into our regular cycle in the fall and
3 start coming through this again. And if your opinions
4 start to gel, then we start to move into recommendations.
5 But we're not trying to do this before the June report.

6 MR. THOMAS: First, a clarifying question. Do we
7 look at the margin on this, these products, with the
8 insurers?

9 DR. SCHMIDT: We took a tentative look at it from
10 bid information, but the data in that were not -- were
11 before reconciliation, so I didn't bring that to you
12 because we need to use the reconciled data to do that. But
13 that's another piece of data work that we hope to develop
14 further and come back.

15 MR. THOMAS: So just building on Craig's point, I
16 kind of sit here and am curious as to why we have
17 reinsurance at all, given the size of the program. We can
18 understand in the beginning when we wanted to get people
19 interested and in the program. But today, given the size
20 of the insurers that have this and the scale of this
21 program, to me it just doesn't seem like it would make a
22 lot of sense that the Medicare program would be taking any

1 of this risk. I mean, I can't imagine that there's going
2 to be folks that back out of this program significantly
3 given that it has been so successful.

4 So I think as part of the analysis we ought to be
5 looking at what do the margins look like, do we really
6 think there's risk that people would pull out of the
7 reinsurance goes away? Because my sense is that that was
8 important early on, but it's probably not as important
9 today. It would be interesting to just kind of ask
10 ourselves that question as we go through the process.

11 MR. HACKBARTH: Okay. Anybody else?

12 DR. HOADLEY: Just a follow-up to that and
13 Craig's comment. I mean, I think Warner's point is well
14 taken. I think it's -- I generally tend to agree with it.
15 The difference in sort of looking at private sector
16 experience is the stand-alone drug plans don't really have
17 a private sector, and that's the kind of point Mark has
18 made a couple of times. There's not really a private
19 sector equivalent to those. So, I mean, that's the sort of
20 thing you always have to keep in the corner of your mind.
21 That is a different kind of product.

22 But to Warner's point, it's now ten years in.

1 They are the big companies. They seem very into doing it.
2 You know, it works in the market. You know, risk adjust
3 still -- you know, the more we drop some of the other
4 things, we have to keep our eye on risk adjustment. That's
5 certainly also true. And we have to think about that, you
6 know, in deciding which of these things, to sort of Kathy's
7 point, as we try to gel towards a recommendation, what's
8 the right combination and what are its second-order effects
9 so we can kind of be ready to do it right.

10 MR. HACKBARTH: This will provide further
11 evidence that I am not an actuary. Is risk adjustment
12 easier or more difficult in Part D versus Medicare
13 Advantage, you know, when you're dealing with a narrower
14 group of expenditures versus full range of services? Is it
15 maybe lumpier in Part D, you know, more variation at the --
16 Cori's laughing at me.

17 DR. SCHMIDT: Do you mean overall variation in
18 spending or the development of the -- I mean, a
19 complication that CMS has in developing the risk adjusters
20 is that there is this individual reinsurance piece that
21 Medicare's paying, so they have to estimate plan liability.

22 MR. HACKBARTH: Right.

1 DR. SCHMIDT: But in the text box, we tried to
2 get at the question of whether there's a different
3 coefficient of variation underlying variability.

4 MR. HACKBARTH: Yeah, right. That kind of stuff
5 is what --

6 DR. SCHMIDT: And we found that, you know, the
7 overall coefficient of variation for A-B spending has been
8 pretty constant over time and is wider than it was for Part
9 D at the start of the program. But now the overall
10 liability of Part D has gotten to be the same. We'll
11 probably come back with some further analysis at a future
12 point that's showing that the plan liability, however, may
13 not have the same degree of variability as the total spend
14 because of the individual reinsurance.

15 MR. HACKBARTH: Right, right. Well, I'm sort of
16 going back to the original point from Slide 3 about one of
17 the strongest reasons for the individual reinsurance is to
18 make sure that if the risk adjustment system isn't good
19 enough to prevent skimming, that this is sort of a backup
20 on that. And that's why I'm -- and, of course, in MA we
21 feel like the risk adjustment is good enough -- not
22 perfect, but good enough to prevent -- along with market

1 regulations, good enough to prevent wholesale skimming.
2 And if the rationale for individual reinsurance is to
3 protect against skimming, again, I'm trying to think about
4 how good is the risk adjustment here versus MA. It seems
5 to me that's sort of a central question. I haven't heard
6 any reason to think that -- to back up the case that, oh,
7 we need individual reinsurance here, but we don't need it
8 in MA. I have yet to see that evidence.

9 DR. HOADLEY: In fact --

10 DR. MILLER: And the thing I was trying to
11 remember was -- and this will cut both ways. I thought the
12 explanatory power of the risk models in D were higher, and
13 you said easier, but my mind went to which side is the
14 explanatory power higher. But I think the other caveat
15 that has to follow right on to that is they're not
16 explaining the whole risk in that model, right? They're
17 not -- right, that's --

18 MR. HACKBARTH: As the reinsurance [off
19 microphone].

20 DR. MILLER: Yeah, so I think we're back to I'm
21 not sure.

22 DR. HOADLEY: But individuals -- I mean,

1 individuals' drug use in general is more stable year to
2 year than -- even if total spending is sort of what they
3 show in their text box, individual -- I mean, that's more a
4 matter of, okay, for every person that gets more sick on
5 the A-B kind of expenses, somebody else doesn't; whereas,
6 in D it's a lot more the same people having similar levels.
7 And you do have the shocks to the system with new drugs.
8 So that's a sense in which, you know, risk adjustment at
9 least is no harder in D than in A-B.

10 MS. UCCELLO: But you could argue that it's more
11 important when spending is more predictable --

12 DR. HOADLEY: Yea.

13 MS. UCCELLO: -- and somebody knows more and the
14 insurer might be able to know more, then the risk
15 adjustment is even more important because you care more
16 about the predictable costs as opposed to the random costs.

17 [Comments off microphone.]

18 MR. HACKBARTH: Okay. Next is measure low-value
19 care.

20 [Pause.]

21 MR. WINTER: Good afternoon. I want to begin
22 first by thanking John Richardson for his help with this

1 project as well as Aaron Schwartz and Dr. J. Michael
2 McWilliams of Harvard Medical School, who helped with our
3 analysis, as I'll talk about later.

4 We'll start by talking about our motivation for
5 exploring this issue. There has been increased interest in
6 recent years in measuring and reducing the use of low-value
7 services. There is a growing literature that explores this
8 topic, including the studies cited here as well as several
9 others.

10 For example, analyses sponsored by the Commission
11 found higher-than-expected rates of repeat diagnostic
12 testing among Medicare beneficiaries.

13 In addition, practitioners are making efforts to
14 identify and reduce low-value services through the Choosing
15 Wisely campaign, an initiative of the American Board of
16 Internal Medicine Foundation.

17 Thus far, over 60 medical specialty societies
18 have identified more than 300 tests and procedures that are
19 often overused.

20 As part of our recommendation in June 2012 on
21 redesigning the Medicare benefit, the Commission supported
22 value-based insurance design in which CMS could alter cost

1 sharing based on evidence of the value of service. Under
2 this approach, cost sharing would encourage beneficiaries
3 to use high-value services and discourage the use of low-
4 value services.

5 And finally, last year, we measured potentially
6 inappropriate imaging services, such as MRI scans for low
7 back pain using Medicare claims data, and published the
8 results in our June report.

9 For today's presentation, I will be talking about
10 the development of 6 claims-based measures of low-value
11 care by a team of researchers. With their help, we applied
12 their measures to 2012 Medicare claims data. I will
13 describe the results of our analysis of these measures and
14 then finally describe some potential next steps.

15 So, first, it's important to define what we mean
16 by low-value care. Researchers define low-value care as
17 services with little or no clinical benefit or when the
18 risk of harm from a service outweighs its potential
19 benefit.

20 Another term for this type of care is "overuse."
21 Low-value care is a concern for two reasons. First, it
22 increases health care spending, and second, it has the

1 potential to harm patients, both directly by exposing them
2 to the risks of injury from the service itself and
3 indirectly when the initial service leads to a cascade of
4 additional tests and procedures that contain risks but
5 provide little or no benefit.

6 A group of researchers that included two
7 physicians developed 26 measures of low-value care and
8 published their findings last year in JAMA Internal
9 Medicine. Sixteen of their measures were based on Choosing
10 Wisely guidelines. Other measures came from the U.S.
11 Preventive Services Task Force recommendations, the medical
12 literature, and other sources.

13 The authors applied these measures to Medicare
14 claims data from 2009. They developed two versions of each
15 measure, a broader one with higher sensitivity and a
16 narrower one with higher specificity.

17 Increasing the sensitivity of a measure captures
18 more potentially inappropriate use, but is also more likely
19 to misclassify some appropriate use as inappropriate.
20 Increasing a measure's specificity means that it is less
21 likely to misclassify appropriate use as inappropriate, but
22 it is more likely to miss some instances of inappropriate

1 use.

2 To explain these concepts, will look at some
3 examples of specific measures, and the full list of
4 measures is in your mailing paper.

5 The first measure on the slide detects
6 inappropriate back imaging for patients with a nonspecific
7 low-back pain. The broader version of this measure
8 includes all patients who received imaging for low back
9 pain and therefore captures more inappropriate use but also
10 some appropriate use.

11 The narrower version of this measure excludes
12 certain diagnoses, such as cancer and trauma, and is
13 limited to imaging that is provided within the first six
14 weeks of the diagnosis of low back pain. Although the
15 narrower version identifies fewer cases of inappropriate
16 imaging, it is less likely to misclassify appropriate use
17 as inappropriate.

18 The second measure identifies inappropriate use
19 of colon cancer screening for older patients. The broader
20 version of this measure includes all beneficiaries older
21 than age 75, and the narrower version is limited to
22 beneficiaries older than age 85 with no history of colon

1 cancer.

2 The third measure detects inappropriate use of
3 head imaging for an uncomplicated headache. The broader
4 version includes CT or MRI imaging of the head with a
5 diagnosis of headache that is not a thunderclap or post-
6 traumatic headache.

7 The narrower version is limited to beneficiaries who don't
8 have a diagnosis on the claim that warrants imaging, such
9 as epilepsy or cancer.

10 We contracted with the authors of the JAMA
11 Internal Medicine article to obtain their measures and the
12 algorithms used to calculate them. So here are some
13 differences between our analysis and theirs.

14 We used a later year of claims data than they
15 did, 2012 versus 2009; a larger sample size, 100 percent of
16 beneficiaries versus 5 percent; and a larger population.
17 We included both aged and disabled beneficiaries, whereas
18 the authors of the study only included aged beneficiaries.

19 In addition, the authors made small changes to
20 some of the measure specifications after publication of the
21 article, and we incorporated these changes in our analysis.

22 So here are the aggregate results from our

1 analysis of all 26 measures. Based on the broader versions
2 of the measures, there were 65 instances of low-value care
3 per 100 beneficiaries in 2012, and 37 percent of
4 beneficiaries received at least one low-value service.

5 Medicare spending for these services was about \$6
6 billion, and that includes beneficiary cost sharing. Based
7 on the narrower versions of each measure, there were 28
8 instances of low-value care per 100 beneficiaries, and 21
9 percent of beneficiaries received at least one low-value
10 service in 2012. Total Medicare spending for these
11 services was about \$2 billion.

12 We also grouped the measures into six larger
13 clinical categories, using the same categories as the
14 authors of the article. We found that imaging and cancer
15 screening measures accounted for about 70 percent of the
16 volume of low-value care in 2012, under both the broader
17 and narrower versions of the measures.

18 However, cardiovascular testing and procedures
19 and imaging accounted for most of the spending on low-value
20 care, between 60 percent and 72 percent, depending on the
21 version of the measures.

22 So to take an example, based on the broader

1 measures, the cardiovascular testing and procedures
2 category accounted for 9 percent of the total volume of
3 low-value care but 56 percent of spending on low-value
4 care. Although these services occur less frequently than
5 other low-value services, they receive much higher payment
6 rates per service.

7 Here are results for some of the individual
8 measures. Results for all of the individual measures are
9 in your paper.

10 The first row on the slide shows back imaging for
11 patients with nonspecific low back pain. Based on the
12 broader version of measure, the number of cases per 100
13 patients in 2012 was 12.0 and spending was \$224 million.
14 Based on narrower version, number of cases per 100 patients
15 was 3.6, and spending was \$67 million.

16 Looking at the second measure on the slide, colon
17 cancer screening, the number of cases per 100 patients
18 ranged from 8.7 under the broader version to 0.4 under the
19 narrower version.

20 And if we look at the third measure, head imaging
21 for uncomplicated headache, there was less variation in the
22 number of cases per 100 patients, 3.8 to 2.6. These

1 results show that the volume of low-value care that we
2 detected can vary substantially based on the measures'
3 clinical specifications. For other measures, however, ere
4 is much less variation between the broader and narrower
5 versions.

6 I also want to point out that the measures on
7 this slide account for a relatively high share of low-value
8 care. There are other measures that we looked at that
9 account for very small shares.

10 Our results may understate the volume and
11 spending on low-value care, and thus, they represent a
12 conservative estimate of the actual amount of low-value
13 services. This is for following reasons. First, there are
14 limited number of measures of low-value care that use
15 claims data.

16 As I noted earlier, this project used 26
17 measures, while the specialty societies in the Choosing
18 Wisely campaign have identified over 300 tests and
19 procedures that are often overused.

20 It can be challenging to identify low-value care
21 with claims data because claims may not have enough
22 clinical detail to distinguish appropriate use from

1 inappropriate use. Thus, we are unable to measure the full
2 extent of low-value care with claims data.

3 In addition, our spending estimates for the 26
4 measures probably understate actual spending on low-value
5 care because they don't include downstream services that
6 may result from the initial low-value service. For
7 example, if an imaging study has incidental findings, the
8 patient may have several follow-up tests and procedures to
9 explore these findings.
10 So we include spending on the initial imaging study but not
11 spending for any follow-up tests or procedures.

12 Before I conclude, here are some potential next
13 steps for your discussion. First, we or CMS could track
14 and publish rates of low-value care on a regular basis.
15 This could highlight the prevalence of low-value care for
16 policymakers and the general public.

17 Second, CMS could alter Medicare's coverage and
18 payment rules to be consistent with evidence of low-value
19 care.

20 Third, Medicare could increase beneficiary cost
21 sharing for low-value services, which is the concept I
22 mentioned earlier.

1 This concludes my presentation, and I'd be happy
2 to take any questions.

3 MR. HACKBARTH: Well done.

4 So Round 1 clarifying questions beginning with
5 Herb.

6 MR. KUHN: Quick question on Slide 9, and I'm
7 just curious about the first dot point when you put it in
8 these categories. You mapped these to the BETOS
9 categories. Is that what occurred here?

10 MR. WINTER: The authors of the JAMA Internal
11 Medicine article created their own categories. So imaging
12 would include things like back imaging for low back pain,
13 CT scans for sinusitis, cancer screening measures including
14 the colon cancer screening, cervical cancer screening, PSA
15 testing, those sorts of things. And the full list of -- if
16 you look at the appendix to your paper, it tells you -- it
17 shows you which measures are in which categories.

18 MR. KUHN: Okay. Thank you.

19 And then on the image and cancer screening
20 measures, obviously, you said that counted for 70 percent
21 of the volume here of low-value care. Does that correlate
22 also with where we're seeing the highest growth in spending

1 of the Medicare program?

2 So imaging is growing very fast. So we're seeing
3 -- would this be more correlated -- are those two
4 correlated at all, or have we looked at that yet?

5 MR. WINTER: That is a good question. I have not
6 looked at that, although it is correct that imaging has
7 been growing rapidly over the last decade or so. Within
8 the physician fee schedule, the volume has plateaued or
9 begun to decline a little bit, but in the outpatient
10 department, as you know, it's been still increasing pretty
11 rapidly. So that's something we could look at going
12 forward.

13 MR. KUHN: All right. Thanks.

14 DR. COOMBS: So in the reading material on page
15 16 and page 17, I like the way you display that and
16 combining that with Slide 10. For the cardiac services,
17 the volume itself, you demonstrated that it's lower. The
18 cost is higher, but what would be interesting is if you
19 took the total bottom number, volume of the total bottom
20 number cost and showed to what degree, to what extent are
21 these true outliers within their total denominator. I
22 don't know if that's possible, but it sounds like it is

1 possible, going from -- say, for instance, an example would
2 be using the broader version definition of imaging for low
3 back pain, total cost for low back pain, and what
4 percentage outliers if you do by volume or what percentage
5 increase in spending is attributable to that entity in and
6 of itself.

7 And the reason why I asked that question is
8 because later on, it might prioritize services that are
9 true outliers based on the volume that is normally
10 prevalent for true indications.

11 I don't know if that data exists, and I'm asking
12 you if it does.

13 MR. WINTER: So are you asking for measures that
14 are outliers; that is, they have high volume or high
15 spending, like imaging for low back pain, for example, what
16 percent of the imaging category does it account for? Is
17 that what you mean by denominator?

18 DR. COOMBS: Yes.

19 MR. WINTER: Okay. Yeah, we can do that. We
20 haven't done it for that analysis. We have the numbers to
21 do that, and it would account -- I can tell you right now
22 it accounts for a lot of the total imaging category is in

1 that first measure on the slide, the low back pain measure.

2 DR. REDBERG: Great job, Ariel. It was a really
3 interesting chapter and work.

4 Certainly, this area of low-value care seems like
5 a win-win because we're spending a lot of money, and people
6 are being harmed. So we could be spending less money, and
7 people would be better off. That seems pretty good
8 combination.

9 I just wanted to ask in particular about the PSA
10 screening. I suspect maybe you took over 75 because that's
11 what the authors did in their 2009 data, but in between
12 2009 and 2012, when you analyzed the task force actually
13 revised and said no PSA screening of any age was not
14 beneficial. So I'm just wondering whether we should revise
15 that to PSA screening of any age.

16 MR. WINTER: You're correct. We took the
17 definite -- their measure, which was from 2009, and they
18 used the information or the recommendations that were
19 available in 2009, and I guess the PSA measure was updated
20 after that.

21 DR. REDBERG: Yeah.

22 MR. WINTER: We can talk to them about revisiting

1 that, or we can think about doing it ourselves, looking at
2 all PSA testing. It doesn't matter -- the age doesn't
3 matter anymore.

4 DR. REDBERG: Just to add on -- and you did note
5 that, but I would just note that means the cost of the test
6 is kind of minuscule compared to all the additional
7 treatment that Medicare pays for based on those unnecessary
8 tests, and so that's a lot of chemotherapy, radiation
9 therapy, proton beam therapy. I mean, that's huge, and to
10 look at that where clearly the test score has stated the
11 harms outweigh the benefits.

12 I have more comments that I'll save for Round 2.

13 MR. WINTER: And just to follow up on that, in
14 the article by Schwartz that we talked about, they do cite
15 a different study which says that the total cost associated
16 with PSA testing, when you include all the downstream
17 services -- the cost of the test itself is only 2 percent
18 of the total spending that is associated with the test.
19 That's probably a very extreme example, but it does
20 illustrate the upper end of the range.

21 DR. REDBERG: Maybe not that extreme.

22 MR. HACKBARTH: When we publish this, it seems

1 like the point about this not capturing downstream costs
2 and the fact that this is just 26 services, not the 300
3 low-value services identified by specialty -- those points,
4 they ought to be like flashing in a new report feature that
5 we have lights that go off, because if you miss those
6 points, you look at this and say, "Boy, these are small
7 numbers relative to the size of the Medicare program."
8 Making those points very prominent, I think is important.

9 Further clarifying questions? Jack.

10 DR. HOADLEY: Okay. My question was right along
11 the lines we were just talking about. You didn't use it on
12 this slide, but in the chapter, you talked about the share
13 of all Medicare spending that these dollars on Slide 8
14 represent, and I think it was 2 percent on the bigger one
15 or something like that.

16 MR. WINTER: Right. 1.7 percent.

17 DR. HOADLEY: 1.7 percent. And my follow-up to
18 that was, in a sense, the question we've just been talking
19 about is what we don't know, and obviously what maybe we
20 could know in some further analysis is how much total
21 spending this could involve if you sort of did all the
22 caveats on Slide 11. Obviously, you can't do that, except

1 to put the caveats in flashing lights.

2 Then to Alice's kind of point, it seemed like it
3 also might be interesting whether in some of these specific
4 areas that do the same kind of percent -- and you were
5 alluding that on imaging, what percent of these particular
6 imaging numbers out of all imaging, and that would help us
7 bracket, again, with the same flashing lights, that it
8 doesn't necessarily cover all of the downstream costs, et
9 cetera.

10 MR. WINTER: Yeah. Those are both good points.

11 I just want to caution us about trying to
12 identify the full downstream cost associated with an
13 initial service will be quite difficult, as you can
14 imagine. We can cite the literature, like the study that
15 talks about the total cost associated with the PSA test.
16 There is also literature that looks at the downstream costs
17 associated with an MRI scan for low back pain that looks at
18 the downstream surgical and procedure cost. So we can look
19 at the literature and see what's already been researched.

20 MR. HACKBARTH: Okay. Clarification questions?
21 Dave.

22 DR. NERENZ: Just a semantic question. I guess

1 we could go to Slide 4, although it's right in the title.

2 A couple of bullet points suggest that "low
3 value" is actually kind of a kind and gentle term. The
4 real term is "no value." But the question is, Are there
5 elements of this discussion where the proper term really is
6 "no value" or even negative value, harmful? I think it
7 matters because the policy options, I think might be chosen
8 differently if we're talking about some small positive
9 value, which is my sense of what the word "low" means, and
10 literally no. In my own mind, I would take those in
11 different directions.

12 MR. WINTER: Right. I think because we're using
13 definitions that are from the literature and specifically
14 from this paper, and I think you want to be a little bit
15 cautious when you're defining or measuring these services
16 just with claims data because there might be diagnoses that
17 are not on a claim or that are not in the patient's
18 history. There might be symptoms that are not reported in
19 a claim that could qualify it as recommended or having some
20 value.

21 But there are also services like the Preventive
22 Services Task Force that said above this age, colorectal

1 cancer screening provides no benefit. There's higher
2 moderate certainty it provides no benefit.

3 What you're saying could apply for certain
4 services, but perhaps not for others that we've looked at.

5 DR. NERENZ: Right, and I wasn't suggesting that
6 we change the term across -- what I'm just wondering, if
7 for definable subsets, it would actually be appropriate of
8 it to think as no value. Okay.

9 MR. HACKBARTH: Clarifying questions?

10 [No response.]

11 MR. HACKBARTH: Okay. Round two. Alice.

12 DR. COOMBS: I just wanted to start with
13 something, and that has to do with this specific task
14 forces and the various specialties who take a stand on
15 value and choosing wisely. And, recently, actually, last
16 week, a New England Journal article came out regarding
17 early goal-directed therapy for sepsis management, and it
18 has been the 11th Commandment in sepsis management to go
19 early goal-directed therapy. This article came out and
20 there is a cacophony of sounds from all areas of ICU across
21 the country about not being aggressive, being equivalent to
22 the aggressive measures of putting lines in and treating

1 people aggressively.

2 And, so, with the advent of this article, we're
3 right now at an impasse between the specialty societies and
4 what the literature has said, and it takes probably about,
5 I'm going to say probably another two to three years before
6 literature catches up with practice. We saw this with
7 activated protein C in sepsis management, a very
8 extraordinarily expensive therapy, and it actually happens
9 that within two to three years, you don't see activated
10 protein C for sepsis management any more.

11 So, I wanted to speak specifically to the
12 prostate issue and the PSA. There is a group and a
13 population that may be more at risk, and the task force
14 comes out with a strong statement regarding PSA. They came
15 out with breast screening. We have to be cognizant,
16 there's a large proportion of individuals -- a black male
17 who comes in at 45 years old who's got a positive family
18 history and may or may not have symptoms, people will argue
19 that that person needs to be screened because he will die
20 of prostate cancer quicker than a white male. And, it is
21 said that if a white male gets diagnosed with prostate
22 cancer, he is going to die of anything else but the

1 prostate cancer.

2 So, I think that it takes a while before the
3 practice of medicine actually catches up with some of the
4 recommendations. But, even in that, before we say it's a
5 no-value service, realize that if you had proportionate X
6 population, 25 percent of the population between blacks and
7 Latinos that may be at increased risk of death from
8 prostate cancer, you would say, before I make a global no-
9 value statement, if it's valuable in one out of four
10 patients, then you might retract that and say, let me give
11 a narrower -- and I like the fact that we did the narrow --
12 according to the article, you might do a narrower
13 definition in terms of specificity, the high sensitivity
14 versus the high specificity.

15 And, that's all my point is, if we go forward
16 with policy or go forward with recommendations, to bear
17 that in mind.

18 And, each one of the categories, with the
19 exception -- I agree with the imaging, because, you know, I
20 had experience a few years ago where a patient came into
21 the ICU, had 27 CTPA grams for rule out pulmonary embolism
22 and one radiologist says, the buck stops here. We're not

1 doing this anymore. I mean, that's extraordinarily
2 expensive, plus it exposes the patient to radiation.

3 So, I agree with Rita that there's a lot of
4 therapy that's done that's harmful. But, let's not forget
5 that when you have a proportion that's pretty significant
6 that benefits from a certain service, you have to be very
7 careful before we say it's no value or low value. To that
8 entity, it might be valuable.

9 DR. NERENZ: Just to follow up on that, if I
10 could, I think I agree with you, although it would seem
11 like you could say, well, it's no value in this population,
12 but it might be of some value in that population, rather
13 than trying to force yourself to say it's got the same
14 label everywhere.

15 MR. HACKBARTH: Part of the challenge here, using
16 claims-based analysis, as I understand it is, the claims
17 information won't always allow you to discriminate between
18 the population where it might be clinically appropriate and
19 the one that isn't, because there's no clinical
20 information. I know I'm not telling you anything new here.

21 Let me ask you this, Alice. To the extent that
22 this relied on the choosing wisely recommendations which

1 were developed by specialty societies, it seems to me that
2 that also adds an element of conservatism in this. I would
3 think that specialty societies, to some degree, they're
4 political organizations and they have constituencies within
5 them that need to be satisfied and addressed. I would
6 think that they are not necessarily the boldest in terms of
7 saying, oh, this is low-value services. These are low-
8 value services within our specialty.

9 So, when a specialty society is saying, this is
10 low value in our specialty, it's probably way out there on
11 the continuum. Is that a fair guess, Rita?

12 DR. REDBERG: [Off microphone.] A very fair
13 statement.

14 MR. HACKBARTH: Yeah. So, this is, in that
15 sense, a very conservative measure.

16 Rita.

17 DR. REDBERG: Continuing on these fair
18 statements, because cancer screening was such a big pot, I
19 just want to note that I think it's going to get even
20 bigger, because, as I think everyone here knows, CMS
21 recently approved -- added another cancer screening
22 benefit, lung cancer screening, which had, I think, a

1 fairly unusual history in that the U.S. Preventive Services
2 Task Force gave it a Grade B recommendation on the basis of
3 the National Lung Screening Trial. But, the Medicare
4 Evidence Development Coverage Advisory Committee, which I
5 chair, met last April -- so, I don't vote as the Chair, but
6 the Committee voted overwhelmingly that the harms exceeded
7 the benefits for lung cancer screening in the Medicare
8 beneficiaries after reviewing the data very carefully.

9 And, I'll just, for example, 96 percent of the
10 nodules identified were false positives, and so that really
11 amplifies the harms, because when you have a false positive
12 -- and they didn't have quality of life data from the
13 National Lung Screening Trial, so we don't know, but I
14 can't imagine that being told that you might or might not
15 have lung cancer after a screening CT, people, I think,
16 have a decrement in quality of life, but they also have
17 more procedures and those are procedures at significant
18 risk, like lung nodule biopsies or thoracotomies. And, the
19 rates of surgical procedures were much lower in the
20 National Lung Screening Trial than they are in real world
21 practice, both in terms of complications and just in terms
22 of rates. And, so, that was why the Committee, among other

1 things, like there's a lot of variability, it's very
2 difficult to read lung CT scans, very hard to read those
3 nodules.

4 If you don't stick to the low-dose protocol,
5 there were estimates from radiologists that the chance of
6 getting cancer from the actual CTs was greater than the
7 chance of getting cancer from your history of smoking.

8 And, so, I would suspect that lung cancer
9 screening is going to be in this low-value care for
10 Medicare beneficiaries, certainly, based on the -- and that
11 is just about to start, and certainly there was a lot of
12 concern about the harms from that screening test.

13 MR. HACKBARTH: Okay, round two. Scott.

14 MR. ARMSTRONG: So, briefly, I just would like to
15 comment on this topic. I benefit from being unencumbered
16 by the clinical evidence that Rita knows, but I just would
17 endorse strongly the merits of advancing this evaluation
18 and MedPAC's attention to this.

19 Frankly, the use of value-based insurance design
20 is old news. We've been doing this for a long time. The
21 evaluation of the impact on the Medicare program is, as we
22 just acknowledged, very conservative, which I think it

1 should be. And, this whole argument that this is not just
2 about getting control over investments that we can't afford
3 in the future, but this is actually avoiding harm to
4 patients. It is an incredibly powerful argument. I just
5 wonder why we are so slow. I mean, what is it that's
6 taking us so long to roll out the kind of proposals that
7 we're talking about here?

8 And, so, that's the point of view I'm going to
9 bring into the work that we have in front of us and I'm
10 very enthusiastic that we're taking this on.

11 DR. HOADLEY: So, I also like this work a lot,
12 and I think it's real promising. I can imagine a number of
13 ways to extend analytically. I mean, you could look at
14 geographic variations. You could look at provider-level
15 kinds of things and just go different ways to try to see --
16 to understand better what's going on.

17 But, I also tried to think -- and I could also
18 imagine drug data, thinking about drugs that we know to be
19 of low value, and it sort of ties back to the polypharmacy
20 discussion and other kinds of things.

21 But, I also tried to think a little bit about,
22 so, how you might eventually address this from a policy

1 perspective, and I could imagine measures that ranged from,
2 ultimately, making a different coverage decision and just
3 say some of these things aren't eligible for coverage, to
4 something that involved some kind of prior authorization or
5 screening, and I know we've been down the route in some of
6 the imaging areas with prior authorization and in the fee-
7 for-service world it can be complicated, and prior
8 authorization is always complicated in terms of doing it in
9 a fair way, to profiling and ratings and publicizing sort
10 of rates of use at a provider level or something to try to
11 help to amplify it more as a point of public discussion,
12 but, obviously, would have a less direct effect on changing
13 behavior.

14 But, it seems like at some point over time, we
15 should -- and I probably haven't thought of several other
16 options -- begin to think about sort of what do you then do
17 and what are the measures that could allow you to reduce
18 these levels of use.

19 MS. BUTO: Yeah, I want to totally agree with
20 Jack. I think the issue that we can tackle next is -- the
21 issues we can tackle next are how might you use this
22 information to revisit coverage? How do you

1 institutionalize this kind of review? So, is it MedPAC
2 that does 100 percent claims data analysis every so many
3 years? Is it Cori? Is it AHRQ? Whoever it is, there
4 ought to be some way to make this a more regularized part
5 of the Medicare program.

6 And then, I agree. I think prior authorization
7 is one where people have given up. But, it seems to me
8 that is one of the areas, one of the tools that is used
9 occasionally, and only by statute, in the Medicare program.
10 But, where we clearly see low-value care, it's at least one
11 way to look at the care without making an all or nothing
12 decision that we never cover this. I think Medicare is
13 always nervous about that, because there is somebody out
14 there who may meet the criterion, but who actually would
15 benefit from whatever it is. So, prior auth is definitely
16 one thing to look at.

17 But, I would also say, I think we have to look at
18 the beneficiary, where generations of beneficiaries now
19 getting much more used to dealing with complex information,
20 information on the Internet. They would -- I think there
21 is a hunger for this kind of information, and again, I
22 think it's a matter of how do you get it out to them in a

1 way that they will actually receive it and take it in and
2 do something with it.

3 MR. HACKBARTH: Just to pick up on Kathy and
4 Jack's, so another approach to potentially reduce the
5 provision of low-value services is bundled payment of
6 various types. And, I wonder whether there's analysis that
7 we can do there.

8 For example, are there some low-value services
9 that are outside bundles, and we could look at the rate of
10 use there versus services that are incorporated in a
11 Medicare bundle, for example, the inpatient DRG system? I
12 guess, now that I say that, we won't -- if it's in a
13 bundled payment, we wouldn't necessarily have the
14 information about the rate at which the services are used.

15 MR. WINTER: Well, you probably -- you would if
16 there's a physician claim involved --

17 MR. HACKBARTH: Well, that's true. Right.

18 MR. WINTER: But, most of these, just as an
19 aside, most of these are outpatient services. There are
20 only a couple that are predominately performed --

21 MR. HACKBARTH: Yeah.

22 MR. WINTER: -- on an inpatient basis.

1 MR. HACKBARTH: Yeah. Well, anyhow, you get the
2 point. Jon and I were talking about the other day and the
3 standard of whether a service is appropriate or not, it
4 used to be the finding that high cost sharing reduced
5 utilization but did not really significantly alter the
6 proportion of appropriate versus inappropriate utilization.
7 I think at one point, Joe Newhouse had a similar finding
8 within HMOs. Utilization was lower, on average, but the
9 mix of appropriate versus inappropriate was not
10 significantly different in his analysis.

11 All those studies, the ones that I know of, are
12 quite old now, and I wonder whether there's some way to
13 sort of update that analysis. As incentives are changed,
14 do we, in fact, find less use of low-value services than in
15 unconstrained fee-for-service?

16 So, other round two. Bill, and then Mary and
17 Jay.

18 DR. HALL: Well, I really like this analysis. I
19 think we may be on the brink of -- to have some optimism
20 about the dissemination of these kinds of guidelines to
21 inform care. There now, over the last five or six years,
22 is a whole series of studies that have used Medicare claims

1 data and then merged these data with lots of other data
2 sets, such as, for instance, in older people, functional
3 state in the hospital, at home, things that are very, very
4 important. And, this is all quite relatively new.

5 And, then, virtually all societies in medicine
6 now have put out these Choose Wisely guidelines, but we
7 don't share them very much among ourselves. For example, I
8 was involved in the 20 that the American Geriatric Society
9 put forward, such things that we talked about today as how
10 to deal with polypharmacy, for example. But, I don't think
11 we disseminate them very well, so a little experiment that
12 we tried was to say, in our society, which is a very small
13 group of physicians, relatively speaking, rather than just
14 send our guidelines out to everybody else, why don't we
15 take everybody else's guidelines and say, how do they apply
16 to us? And, it was an absolute revelation, embarrassing
17 kind of revelation for me. So, we don't mine that database
18 very well.

19 So, now that we have these data and there's going
20 to be a lot more of this, I think the thing you were
21 getting at, Kathy, is how does this inform what we define
22 as health literacy in the future for Medicare patients. I

1 think that's really what has to happen. It means that
2 Medicare might become much more vocal about using these
3 kinds of data in terms of value of services, and even in
4 terms of potentially payment for these services. But, this
5 is another area where I think MedPAC can make an enormous
6 contribution. I mean, this is really exciting stuff that
7 you put together. I hope we do a lot more of this.

8 DR. NAYLOR: So, I just wanted to respond to your
9 recommended next steps. I think that to the extent that we
10 can unbundle low value to be little value, no value,
11 harmful, and to the extent that we can define for whom and
12 bring more clarity to this, I think that would be really,
13 really of great value.

14 On the issue of altering coverage and payment
15 rules, I noticed that in your terrific report there has
16 been a reduction since 2009, and given all the design
17 differences, five percent versus 100 percent and
18 modifications, so, we're seeing, witnessing reductions in
19 low value -- your analysis did, in 2012 relative to 2009.
20 And, so, one of the things I think would be important to
21 track is the extent to which all of the work on the
22 Preventive Task Force and campaigns, Choosing Wisely and

1 other, are really accomplishing what might be a positive
2 change in the use of these services without going into the
3 issue of -- especially given the challenges you've outlined
4 in getting low-value services from claims data without
5 getting to changes in coverage.

6 And, I also think beneficiary cost sharing -- I
7 would be concerned about moving there. I think there is a
8 hunger for information about what is a valuable service for
9 lots of reasons, especially because people are paying out
10 of pocket. But, before we would get to asking them to pay
11 more for low value, I think they need to know that this is
12 a low-value service.

13 MR. WINTER: If I could just make one point about
14 the comparison between their results and ours, as you
15 noted, our results were lower, but there were several
16 methodological differences between the analyses, in
17 addition to the fact that they did change some of the
18 measures after the publication -- after their publication -
19 - that we used in our analysis. So, I'd want to look at
20 another year of data or two using the same method, and also
21 talk to them about concerns they might have about how noisy
22 some of the measures are.

1 So, I think longitudinal analysis is really
2 interesting. Potential step to go next. But, I just want
3 to think about that some more and I just want to caution
4 you about using the same -- about drawing conclusions about
5 the comparison of their results to ours. But, it could be
6 there were declines. And, in fact, vertebroplasty, which
7 was one of the surgical procedures, they do agree that
8 there's been a decline in use over the last three years.

9 DR. NAYLOR: Just in sum, I share the enthusiasm
10 of all the Commissioners about continuing this work. I'm
11 wondering what signals we might have and where we might be
12 able to rely on others rather than changing claims coverage
13 services.

14 DR. CROSSON: I'll start with standard comment
15 number one. In terms of the, you know, potential avenues
16 to explore to deal with low-value care, and that's delivery
17 system and payment reform, and I think although that
18 doesn't necessarily point directly at additional work,
19 because there's a lot of work that we've done before and
20 work that's ongoing and new ACO models and the like, I
21 think it may have relevance in the sense that we still see
22 difficulty in people actually believing this, and

1 particularly those who are doing scoring, that down the
2 line, there are avenues for both improvements in quality
3 and cost saving by making some of the changes that are
4 underway right now. I think we saw that and we discussed
5 it earlier today with respect to the SGR reform.

6 So, to the extent that we could, by broadening
7 the number of low-value care and low-value services that we
8 look at, maybe some larger subset of the 300, and then
9 calculating not just the direct cost of that, but as we
10 mentioned earlier, the downstream costs of that, both from
11 the perspective of adverse impact on patients as well as
12 financial costs, it might help build up the evidence base
13 and the policy base down the line for a better
14 understanding of the value of delivery system and payment
15 reform.

16 DR. SAMITT: This chapter was fantastic, almost
17 as exciting for me as risk sharing in Part D.

18 [Laughter.]

19 DR. SAMITT: I'm kidding. So what I would say is
20 I think --

21 DR. CROSSON: Are you picking on Cori?

22 DR. SAMITT: I think it's about time that we

1 actually have this discussion. You know, I think for me
2 it's the beginning of the retirement of the flawed paradigm
3 that more services leads to better health. And so let's
4 please move forward with more analysis. This is critical.

5 The one thing, though, that I kept thinking about
6 was how do you sell this, because even though I think
7 beneficiaries are recognizing the importance of this, I
8 think there also is still an expectation around the receipt
9 of certain services, and so I began to think about how do
10 you explain this, how do you articulate it? And what
11 immediately came to mind is I'm not sure we should think
12 about this in isolation. You know, from my point of view,
13 they're two sides to the same coin. While there are a
14 whole bucket of services that we provide that are of low
15 value or no value, I think there are also an equal number
16 of services that we should be providing that we don't, that
17 we don't consistently provide services that are grossly
18 underutilized that if they were utilized would improve
19 quality and improve outcomes. And in many respects, the
20 notion of identifying these services is really a
21 reallocation of resources from things that are not
22 improving health to those that should be reallocated to

1 improve health.

2 So I don't know if there's a way to tie this
3 notion of overutilization with underutilization, because in
4 many respects the two parts of that conversation need to go
5 hand in hand.

6 DR. CHRISTIANSON: I think what I was thinking
7 about saying is a little bit repeating what Bill and Craig
8 said, so I'll keep it short.

9 I think if we're going to depend on beneficiaries
10 to be one of the mechanisms by which this will all work, we
11 need to really keep focusing on and keep a spotlight on the
12 negative effects on beneficiaries. I don't think there's
13 going to be many beneficiaries who are going to say, "I
14 don't want this service because it's going to cost Medicare
15 more money."

16 So I think it's important to see, you know, what
17 these services do cost Medicare. But I think it's just as
18 important to highlight what the potential adverse effects
19 are going to be on beneficiaries if they consume, because I
20 think that's what's going to be salient to beneficiaries.
21 So if that's one of the mechanisms that is going to promote
22 change in this area, we need to make sure that stays front

1 and center as we go forward.

2 MR. HACKBARTH: Any further questions or
3 comments?

4 DR. NAYLOR: I just had one idea, which was
5 raised by others, but if there's a way -- I know you can't
6 do it with many of these, but if you were to take one or
7 two, such as PSA screening or something, and see if you
8 could almost in a qualitative way track what happens to
9 people, I think that could be really powerful. Obviously
10 you can't do it for many, but one or two cases of the
11 consequences of the unnecessary test on the long -- it
12 would be -- or if research tells us -- and there are
13 studies that have done that, you know, just a lit review of
14 one or two of them, I think it would be really powerful.

15 MR. HACKBARTH: Just a thought on the issue of
16 beneficiary cost sharing as a mechanism. I have no doubt
17 that that would be unpopular, and because it would be
18 unpopular, probably very politically difficult to do. And
19 so I get all that. And I also agree that for many
20 beneficiaries, this would be a tough choice that we're
21 framing for them, and there could be inequities by income;
22 you know, higher-income people can afford to pay the higher

1 cost sharing, lots of issues like that.

2 But the argument on the other side is that I have
3 a real problem using the taxpayer dollars to pay for
4 services that are proven to be of low value. And it's not
5 just because of the first-order effect on the taxpayers; it
6 also means that there are fewer public resources available
7 to provide some of those high-value services that Craig was
8 alluding to, fewer resources to provide appropriate
9 subsidies to low-income people under the Affordable Care
10 Act.

11 And so I think that there's a real ethical
12 argument on the other side that we shouldn't be paying a
13 lot of money, Medicare dollars, for low-value services,
14 even though I recognize the inherent political and other
15 difficulties involved in that.

16 DR. COOMBS: One last thing. One of the things I
17 was thinking about as we were talking around the table is
18 if there was a way to get the low-hanging fruit of the 26,
19 or you could categorize these ones as overwhelmingly low
20 value and there's really uniform consensus -- not that
21 there's not uniform consensus with the others, but target
22 an area that there's absolutely clarity on going forward,

1 and there was a corresponding communication that is as
2 strong as well. And I think that would help in kind of
3 phasing in this whole new chapter in our goals of looking
4 at low-value and saying that this is going to be an ongoing
5 report card from year to year that, you know -- that
6 literature is changing and results research is being done,
7 and going forward I think it makes it stronger that people
8 look at it as this is a cost in transition. And for
9 medicine, it's not a hard science, and that's what the
10 problem is. I think if it was a hard science, it would be
11 easy to do. But because it's not really a hard science, it
12 makes things hard. But I think it's not impossible to deal
13 with it just as it's actually happening, new literature is
14 coming out, new research is there, and to see it as we're
15 being transformed to better information as we go on, and I
16 think that's very helpful. It's helpful not just for
17 beneficiaries but providers as well.

18 MR. HACKBARTH: Okay. Thank you. Great work.

19 We'll now move on to our concluding session for
20 today on using episode bundles to improve the efficiency of
21 care.

22 [Pause.]

1 DR. STENSLAND: All right. Good afternoon.
2 Today we're going to talk about incentives to reduce
3 spending during episodes of care, which is not unrelated to
4 the discussion we just had. The goal is to encourage
5 better quality while reducing unnecessary care within an
6 episode.

7 As we have discussed in the past, the fee-for-
8 service system lacks incentives to improve quality and to
9 eliminate unnecessary services.

10 In an effort to improve value within the fee-for-
11 service system, CMS developed the value-based purchasing
12 program which ties a small share of each hospital's
13 payments to how well they do on quality metrics and episode
14 spending metrics.

15 First, we'll review how the VBP program works,
16 and then we'll discuss whether the magnitude of the VBP
17 incentives are at the right level to encourage improvements
18 in value.

19 The program started in 2013 and by law is
20 scheduled to slowly increase the share of hospital payments
21 that are tied to value-based purchasing metrics.

22 The hospitals' performance in 2015 on certain

1 performance metrics will be evaluated and then will affect
2 their 2017 payments under the VBP program. In 2017 and in
3 future years, 2 percent of hospital inpatient operating
4 payments were at risk and tied to value. This essentially
5 acts like a 2 percent withhold. Hospitals that have high
6 VBP scores will receive more than 2 percent back, and those
7 with low scores will receive less than 2 percent back.

8 Recall that value refers to both quality and
9 spending metrics. The current weighting of the VBP program
10 has a 25 percent weight placed on Medicare spending per
11 beneficiary and a 75 percent weight placed on quality
12 metrics. The quality metrics include the AHRQ patient
13 safety composite measure, three process measures such
14 pneumonia vaccinations, some outcome measures which are
15 currently mortality rates, and patient experience measures.

16 Today we are focusing on the incentive within the
17 VBP program to reduce episode spending.

18 The MSPB measure examines all spending that takes
19 place starting three days before admission and ends 30 days
20 after discharges. The spending is standardized to adjust
21 for differences in payment rates across regions.

22 Therefore, it is essentially a risk-adjusted measure of

1 service use within a 30-day episode. For each discharge
2 CMS computes an actual and expected spending. Hospitals
3 are then informed on the 30-day episode spending for each
4 category of discharge. For example, the hospital would
5 then know if their respiratory cases or their orthopedic
6 cases had high spending relative to the expected level.

7 As we explained in more detail in your mailing
8 material, hospitals with below expected levels of spending
9 per discharge will see an increase in their payment rates,
10 and those with above expected spending will see a decrease,
11 if quality is equal. A top-performing hospital will expect
12 to receive roughly 0.5 percent higher payments due to the
13 MSPB program and a poor-performing hospital will be
14 expected to receive roughly 0.5 percent less than they
15 would have without the MSPB program.

16 We examined the variation in episode spending
17 use. In this chart, we standardize spending so the
18 expected level of spending given a hospital's case mix is
19 1. So numbers less than 1 in this chart refer to hospitals
20 where the average spending is below expected levels given
21 their case mix; numbers above 1 refer to hospitals where
22 the spending is above the expected level. We find that at

1 the 10th percentile hospitals have spending that's about 7
2 percent less per episode than expected, and hospitals at
3 the 90th percentile had episode spending that was roughly 9
4 percent higher than expected.

5 This tells us that there is about a 16 percent
6 difference in service use between the 10th and the 90th
7 percentiles, and this is equivalent to roughly \$3,000 per
8 inpatient episode.

9 One question that arose in the readmissions
10 reduction program is whether hospitals that serve poor
11 patients will have a harder time achieving low readmission
12 rates, and in that case we said that was true and there
13 should be an adjustment. There may also be a similar
14 question as to whether episode spending tends to be higher
15 for hospitals with high shares of poor patients.

16 We find that socioeconomic status, as measured by
17 income, does not appear to be a material issue in the
18 Medicare Spending Per Beneficiary measure. In this slide
19 we show a scatter plot examining how the Medicare
20 beneficiary income, as measured by the share of the
21 hospitals' patients on SSI, is related to episode costs.
22 We see a small positive correlation of 0.13. Many high-

1 episode-cost hospitals that we saw, though, were in the
2 South where post-acute care was high. And a question is
3 whether the higher use in the South is due to having a
4 higher share of poor beneficiaries or was it due to certain
5 practice patterns in some of those communities.

6 To test this, we examined the correlation between
7 SSI and episode spending in just Northern states -- in
8 essence, a split sample. Let's look at the South, and then
9 let's look separately at the North. If patient income is
10 what's driving the differences across hospitals, then we
11 would expect to see that same relationship in both the
12 Northern and Southern states. We found that in the
13 Northern states the relationship between SSI levels and the
14 MSPB measure was statistically insignificant, and the sign
15 of the coefficient actually flipped to represent a negative
16 correlation.

17 So given that the magnitude of the correlation is
18 small very small and that the sign of the correlation can
19 flip depending on what part of the country is being
20 examined, we can conclude that patient income is not
21 driving the differences in episode costs. We also looked
22 at this using DSH shares and found a similar result.

1 So the bottom line is that socioeconomic status
2 does not appear to have a material effect on the
3 differential in spending per episode across hospitals.

4 Now Carol is going to talk about what does appear
5 to be driving the differences.

6 DR. CARTER: This slide compares the components
7 of episode spending (that's the pie chart on the left) to
8 the source of the variation in episode spending (which is
9 on the right). On the left, I know the numbers are small,
10 but the two to focus on are: the hospital stay accounts
11 for 45 percent of the episode spending and post-acute care
12 makes up 26 percent. On the right, we display the
13 variation by comparing hospitals with the highest (those
14 are in green) and the lowest (those are in yellow) average
15 episode spending, and those are the top and bottom
16 quartiles (after controlling for wages and add-on
17 payments.)

18 In the first pair of bars, SNF spending averaged
19 \$3,400 for the top quartile hospitals and \$2,400 for bottom
20 quartile hospitals, or about 40 percent higher. The
21 differences between top and bottom quartile hospitals were
22 over threefold for IRF spending and over sixfold for LTCH

1 spending. The differences in home health spending were
2 about 40 percent higher for the top quarter hospitals.

3 Combined, the four PAC settings make up three-
4 quarters of the difference between hospitals with high and
5 low episode spending. The variation in spending on
6 readmissions (that's the last pair of bars) is smaller than
7 the variation in any single post-acute service. We don't
8 show the variation in inpatient hospital spending because
9 with DRG pricing, there is little variation. Controlling
10 PAC use will, therefore, be key to increasing the
11 efficiency of hospital episode spending.

12 The MSPB is a simple way to effectively achieve
13 the goals of bundled payment, and it has the advantage that
14 hospitals are familiar with it and are currently operating
15 under it. Some of you may remember our Commissioner Peter
16 Butler once commented about bundled payments: We already
17 have a mechanism, and it accomplishes the same goals and
18 the hospitals are used to it. It's the MSPB. Yet, as Jeff
19 mentioned, the structure of the VBP program creates a
20 pretty small incentive for hospitals to lower their episode
21 spending.

22 We've identified three ways to strengthen the

1 incentive to lower episode spending: we could amplify the
2 current MSPB; we could develop an MSPB measure for post-
3 acute-care providers; and we could increase the clarity for
4 hospitals to guide beneficiaries to high-value PAC
5 providers. These options are not mutually exclusive. Some
6 combination could be considered, and we're going to discuss
7 each one in turn.

8 The most basic way to strengthen the incentive to
9 lower episode -- I mean to increase episode efficiency is
10 to amplify the current MSPB. CMS has the authority to
11 change this, and it could be done quickly. Because the
12 MSPB is a 30-day spending measure, it's a direct way to
13 infuse the incentives of bundling into fee-for-service
14 Medicare.

15 The impact of the MSPB measure is determined by
16 the amount that's withheld and its weight in calculating
17 each hospital's score.

18 Therefore, to increase the pressure on hospitals,
19 we could either increase the amount that's withheld from
20 the 2 percent in 2017 to 3 or 4 percent. In addition, the
21 weight of the MSPB measure within the value-based
22 purchasing could also be increased from the 25 percent

1 share to up to 50 percent.

2 Another way to increase the pressure to increase
3 episode efficiency would be to put hospital PAC providers
4 at financial risk for episode spending in the same way that
5 hospitals are at risk for episode spending. A PAC measure
6 would begin with an admission to the PAC setting and
7 continue for 30 days after discharge, just like the
8 hospital measure. CMS could implement value-based
9 purchasing for all PAC providers and include a PAC MSPB
10 measure as a performance measure. A PAC MSPB would more
11 closely align hospital and PAC providers since post-acute-
12 care providers would be at financial risk for their own
13 episode spending. SNFs, for example, would have an
14 incentive to shorten their stays, and all PAC providers
15 would have an incentive to more carefully refer
16 beneficiaries to a second and subsequent post-acute-care
17 use.

18 Just as hospitals get feedback on their episode
19 spending, PAC providers could get comparative information
20 on their episode spending, including information by
21 condition. The IMPACT Act requires the Secretary to
22 specify and for PAC providers to report on resource use

1 measures, including total estimated Medicare spending per
2 beneficiary. And a PAC MSPB measure could be one of those
3 measures.

4 Another way to lower episode spending would be to
5 provide hospitals with more clarity on how they can guide
6 beneficiaries to high-value PAC providers. Although
7 hospitals are at risk for post-acute care, they have few
8 tools to guide beneficiary decisionmaking regarding
9 placement in a post-acute-care setting. Typically,
10 discharge planners work with their physicians and provide
11 information to beneficiaries about their PAC options, and
12 beneficiaries have the final say.

13 In our conversations with private sector entities
14 last fall about how they manage post-acute care, we learned
15 that some establish partnerships between hospitals and
16 high-value PAC providers. In shaping a preferred network
17 of providers, they evaluated potential partners in terms of
18 their geographic coverage, quality, and cost. Fee-for-
19 service beneficiaries were not required to use a preferred
20 partner, but the advantages of using one were explained:
21 receiving more coordinated care, tighter integration of
22 medical staffs, and higher quality of care. We could

1 explore how such "soft steering" could work in fee-for-
2 service that would retain freedom of choice and strong
3 physician input while, at the same time, ensuring that the
4 networks are adequate and include high-value providers.

5 As we think about strengthening the incentives of
6 the MSPB, it is helpful to think about how its incentives
7 are aligned with those of ACOs, the other policy that's
8 attempting to control spending. Both policies encourage
9 providers to minimize unnecessary services within the
10 episode, including unnecessary PAC use, physician consults,
11 and readmissions. The policies are mutually reinforcing.

12 The big difference between the two is that the
13 ACO policy includes an additional incentive to control the
14 volume of episodes. This is because ACOs are at risk for a
15 population. In contrast, the MSPB does not discourage the
16 volume of episodes. In fact, hospitals may have a small
17 incentive to admit the marginal, most likely lower-
18 complexity case as a way to lower their average spending
19 per episode.

20 Scott and other Commissioners have commented that
21 we spend a lot of time focused on how much Medicare spends
22 for units of service and less time on how to control units

1 of service. In addition to the existing ACO program, one
2 way to discourage episodes is to develop an admission
3 policy. The idea here would be to penalize providers with
4 high rates of potentially avoidable hospital admissions,
5 similar to the readmission policies for hospitals and soon
6 for SNFs.

7 An admission policy requires calculating a rate
8 of expected admissions for a given population. Rates for
9 nursing homes would be relatively straightforward to
10 develop because we could use their long-term-care residents
11 as the population. Some of the avoidable admissions from
12 nursing homes are beneficiaries who are admitted to
13 hospitals to recertify them for their Part A coverage, the
14 churning that we've talked about before.

15 Hospital rates would be trickier to develop and
16 administer. We would have to define the geographic area
17 and then calculate a rate, and that's the easy part. The
18 harder policy questions are, first, how to hold multiple
19 providers in an area jointly responsible for the rate and,
20 second, which providers to hold accountable. We know that
21 policies that involve joint responsibility are not very
22 effective at changing the behavior of individual actors.

1 In terms of which providers, patiently avoidable admission
2 rates reflect the adequacy of the ambulatory care system
3 and hospitals' inclinations to admit the marginal patient.

4 Past Commission discussions have indicated a
5 reluctance to hold fee-for-service providers jointly
6 responsible when the entities have little relationship to
7 each other. Another complication is that changes in volume
8 could reflect beneficiaries seeking care at better quality
9 providers, which the program would want to encourage. So
10 while a hospital admission policy might be possible, these
11 issues would need to be worked through.

12 This concludes our presentation. We'd like to
13 hear your thoughts on how to increase the pressure under
14 fee-for-service to lower episode spending. Options
15 identified include amplifying the current MSPB, developing
16 an MSPB for post-acute-care providers, guiding
17 beneficiaries to high-value PAC providers, and ways to
18 discourage the volume of episodes.

19 MR. HACKBARTH: Okay. Thank you.

20 Clarifying questions, please.

21 DR. NAYLOR: So I'm wondering if you could
22 clarify how the PAC MSPB is different from the bundled

1 payment model 3?

2 DR. CARTER: It's pretty similar in that they
3 both start with the beginning of a post-acute-care use, and
4 they follow a beneficiary through either 30 or 60 or 90
5 days. So in that sense, the risk and sort of the services
6 that are include are similar.

7 The big difference is that the bundling
8 initiative is voluntary. Those that are opting in are
9 putting, I think, relatively few numbers of conditions at
10 risk. And, finally, the time frame of that is pretty long
11 in the sense that the bundled initiative, providers have to
12 decide to be at risk by July, and then finalize the
13 conditions that they're going to be at risk for by October.
14 And then there's a three-year evaluation -- performance
15 period and then an evaluation.

16 So in broad gauge, they're similar. What we were
17 thinking is that the MSPB we could sort of do pretty soon.
18 And so in that sense, I think they're on different time
19 frames for actually implementing something relatively soon.

20 MR. GRADISON: In our earlier work on payment
21 updates for three of the silos, including hospitals, we
22 came up with a definition of efficiency, which was based

1 upon, of course, cost and quality. The question is:
2 Specifically with regard to hospitals, are we using the
3 same measure here that we used in doing the chapter on --
4 which was in our March report, on hospitals?

5 DR. STENSLAND: In the March report on hospitals,
6 we're using just the hospitals' costs. But we could shift
7 to using episode costs or a combination of the two.

8 MR. GRADISON: I just was wondering about the
9 consistency of the -- trying to see whether we might, if we
10 haven't already done so, move to a consistent measure. And
11 perhaps we've already done that. That's all.

12 DR. STENSLAND: Yeah, the questions are a little
13 bit different, and the hospital one is: Is the hospital
14 able to deliver their services for a lower cost? And we're
15 really looking at the hospitals' costs. In this measure,
16 it's really looking from the Medicare spending, so it's
17 really looking from the Treasury's perspective. Can we get
18 this done without the Treasury putting a lot of money out
19 the door, which is different than the provider's cost? But
20 I think you have a good point.

21 MR. GRADISON: Thank you.

22 DR. NERENZ: Slide 11, please. The first bullet

1 point where it says hospitals are at risk, is this
2 referring to anything other than the current MSPB and the
3 readmission?

4 DR. CARTER: No.

5 DR. NERENZ: Okay, good. So the actual amount at
6 risk is really small here, right? Fractions of a percent?

7 DR. CARTER: [Nodding head.]

8 DR. NERENZ: Okay.

9 MS. BUTO: So just two quick questions. One is
10 about the increase we're seeing in hospital admission
11 rates. So if we're looking at one possible factor of
12 identifying what measures or what appropriate admissions
13 rates might be and how to set a threshold for that, you
14 know, what do we know about what the rate of growth is in
15 admissions? Are we seeing that to be a real problem?

16 And then, secondly, isn't there a difference
17 between the MSPB versus bundling in that bundling would be
18 sort of an ongoing prospective payment versus MSPB is more
19 of a reconciliation after the fact? I'm just curious. Do
20 we think the payments would flow in the same way? And the
21 reason I ask is my sense of bundling is if, in fact, it is
22 given prospectively, there's more of an opportunity to be

1 for active management versus waiting until, you know, the
2 episode has long passed, and then looking to see what
3 happened, and then sort of trying to take that on board.

4 DR. CARTER: So most of the bundling initiatives
5 actually are not, prospectively. The money flows fee-for-
6 service, and then there's reconciliation done at the end.

7 MS. BUTO: So they are basically identical in the
8 flow of money is what you're saying?

9 DR. CARTER: Yes.

10 MS. BUTO: Admission rates. Are they growing
11 fast?

12 DR. STENSLAND: No. The admission rates
13 generally have been declining. So the question is not the
14 trend, but the question is, Is the level as low as we would
15 like? We still think that there is maybe some excess
16 readmissions, and one of the concerns is while the
17 admission rates are generally declining across the country,
18 there still is a fair amount of regional variation with
19 some places having a lot higher readmission rates than
20 others, and there is a question is all those other
21 admissions necessary in those regions.

22 DR. MILLER: The only other thing I would add,

1 Kathy, is, I think, if I followed your comment about how is
2 it different than bundling, there may be some view down the
3 road in the bundling demonstration that you actually get to
4 and up-front payment that then the person manages -- or
5 whoever the actor is manages over time.

6 And another way to think about this is, well, at
7 least you can inject some feeling into how much you amplify
8 it in the existing measures, of managing on that basis
9 before the real thing comes along, if you want to think
10 about it that way.

11 I think that's what we kept hearing from
12 hospitals. Hospitals were saying, "I'm already starting to
13 think about this. Why when everybody talks about all this
14 bundling stuff does nobody come back to this thing that
15 actually arrives in my office once a month and sort of
16 tells me what's going on over a 30-day period.

17 MS. BUTO: And I was just reacting to this notion
18 of you find out later whether or not, you know, versus
19 potentially if you -- more like capitation or some kind of
20 up-front payment where you're trying to make tradeoffs,
21 that's happening at the time the money is flowing, but that
22 may just be a distinction without a difference.

1 MR. HACKBARTH: Clarifying questions, anybody?

2 [No response.]

3 MR. HACKBARTH: Okay. Round 2. Craig.

4 DR. SAMITT: So focusing on the discussion
5 topics, I am glad you said that these aren't mutually
6 exclusive because, as I began to think about which one
7 would be most effective, I recognize that at least the
8 first three, in my mind, they're at least equally
9 effective, and in fact, the way that I am thinking about
10 it, is amplifying the current MSPB highlights why this
11 should matter -- the hospital developing a PAC MSPB
12 underscores why this should matter to the PAC. And the
13 third, in terms of guiding beneficiaries, is an avenue by
14 which to engage and persuade the beneficiary to utilize the
15 high-value services, so I think one without the other two
16 is somewhat less effective. So I would advocate for all
17 three.

18 I guess we could process the pros and cons of
19 each individually, but I think that together, it's the most
20 powerful solution.

21 The one that I am not comfortable with is the
22 last. I mean, as I heard you discuss sort of how does one

1 go about achieving joint accountability for reducing
2 inappropriate hospitalizations, it made me think, well,
3 isn't that what we are trying to accomplish with the ACOs,
4 and should we -- with either the next-generation ACOs or
5 the existing ACO models give that program an opportunity to
6 work, to see if it works, before developing yet another
7 option to achieve community-wide joint accountability for
8 population health.

9 MR. HACKBARTH: Just say a little bit about the
10 relationship between this and the readmissions penalty. It
11 seems to me readmissions are a subset of what this
12 potentially gets at.

13 DR. STENSLAND: I have a little slide here that
14 helps a little bit.

15 The readmission penalty is what you see on the
16 right, and that is really the bottom part of this slide.
17 Hospitals that have high readmission rates, their inpatient
18 payment rates decline slightly up to a 3 percent maximum
19 reduction for those conditions that are covered by the
20 readmission penalty.

21 Now, for the 30-day episode, that generally
22 increases your rates, meaning you get some money back from

1 your withhold as you have lower and lower 30-day episode
2 costs, and part of that 30-day episode cost is the
3 readmissions, but the readmissions is really a small part
4 of it. It doesn't really move the needle too much.

5 So the incentive to reduce your readmissions is
6 really driven by the readmission penalty, and the amount of
7 the incentive that flows through the MSPB program is really
8 small. It adds a little bit of extra incentive on top of
9 what we are getting through the readmission penalty, but
10 not a whole lot.

11 MR. HACKBARTH: Let me just be the devil's
12 advocate for a second. If readmissions are such a small
13 portion of the added cost, maybe that means there's too
14 much weight put on readmission penalty here, and it ought
15 to be just subsumed under a total measure of 30-day post-
16 discharge performance.

17 DR. STENSLAND: I think if I was going to be the
18 counter to the devil's advocate, I would say one thing you
19 could argue is that the readmissions are something
20 different from a lot of this extra spending. Like the
21 extra spending might include an extra consult while you're
22 in the hospital or an extra home health visit, and you

1 could say those things are not particularly bad. They
2 might be wasteful, but they're not particularly bad.

3 On the other hand, a readmission represents a
4 really bad outcome for the patient, and we merely might
5 want some stronger incentives to reduce those readmissions,
6 and it looks like so far it's working. That would be one
7 thing. It's a different animal. It may be something we
8 really want to put some more emphasis on.

9 The other thing is that the readmissions are --
10 the variance of the readmissions is not super huge between
11 hospital to hospital, and it's that variance that looks at
12 the variance in the MSPB 30-day measure.

13 MR. HACKBARTH: Okay.

14 DR. SAMITT: Correct me if I'm wrong, but isn't
15 it conceivable that these work in opposition? If you are
16 seeking to avoid a readmission penalty, you may very well
17 drive up the post-admission cost because you're more than
18 likely going to want to use a post-acute care facility to
19 assure a non-readmission to the hospital, and so I would
20 imagine that they definitely work in opposing directions.

21 MR. HACKBARTH: Is that a good design or a bad
22 design or indifferent?

1 DR. SAMITT: Well, I think we'd want to compare
2 and contrast the total costs in each scenario. So while
3 you would want to avoid readmission, in some respects,
4 neither is good. You wouldn't either want frequent
5 readmissions nor would you want an excessive use of post-
6 acute. So what is the combination of those incentives to
7 really get to the optimal admission and post-admission
8 outcome?

9 MR. HACKBARTH: I'll let you go in just a second,
10 but I do worry about a proliferation of bonuses and
11 penalties for readmissions and HACs and now this, and I
12 really think that if another one is going to be added, it
13 really needs to be thought of strategically. How does this
14 fit with the others? Are they mutually reinforcing? Are
15 they conflicting? What are the right proportions? Should
16 they be penalties and bonuses in all cases as opposed to
17 just throwing one more thing in an already-complicated mix
18 of payment incentives?

19 Other -- Herb.

20 MR. KUHN: So I would agree with that comment. I
21 think these payment systems do need to work seamlessly and
22 they don't appear to be layering one another as part of

1 that.

2 I am glad you mentioned the HAC, the hospital-
3 acquired condition, because if you look going into 2015,
4 you've got now with the three of them -- that is, the
5 readmissions or the rehospitalizations, the value-based
6 purchasing, and the HACs -- you've got 5.5 percent, and
7 that is going to grow next year to 5.75, and the year after
8 that in 2017, it will be up to 6 percent. So it's
9 continuing on a scale moving forward.

10 All these things that we have up here, I think
11 they're worth continuing to explore and to look at, with
12 the caveat, as we talked about, how they can seamlessly
13 work together.

14 The one thing that would be helpful for me,
15 though, as we continue to review on this is what the
16 literature shows or how much of either an incentive or
17 penalty really motivates the changes in provider type
18 that's out there.

19 So, on the hospital side, there are some who have
20 made the arguments, at least I've heard and read, that
21 maybe 2 percent, 3 percent is enough to change that
22 behavior because that translates into around \$100 to \$150,

1 I think, per discharge, and that's enough to get people's
2 attention and change behavior.

3 On the physician side, I've heard people say that
4 it's got to be something north of 5 percent, maybe even as
5 high as 10 percent -- even more than that. So it would be
6 nice if we could in the future understand what does the
7 literature show in that and what's kind of the range that
8 we're talking about as we move there.

9 And the final thing I would just say is that as
10 we look at the Medicare spending per beneficiary component,
11 that really only is beginning this year, and I don't want
12 this to be an impediment for our work going forward, but
13 historically, in the Medicare program, you've let programs
14 kind of start, get a chance to look how they're working,
15 evaluate, and then you start the refinement process. To
16 start a refinement process, the year one, and begin
17 tinkering with it, I don't know whether that's a good thing
18 or bad thing, but it goes against historic norms. I just
19 think we need to take that into consideration and
20 understand. Do you start tinkering with something before
21 it's even really begun?

22 MR. HACKBARTH: Round 1. Any more Round 1

1 clarifying questions?

2 [No response.]

3 MR. HACKBARTH: Round 2. Go ahead, Cori, and
4 then Jay.

5 MS. UCCELLO: So I'm attracted to this idea of
6 the soft steering and that kind of thing, but I'm
7 wondering, just stepping back, how much freedom or choice
8 or control do beneficiaries actually have now in terms of
9 post-acute care use. How much are they already relying on
10 the hospitals to steer them to where they should be going?

11 DR. CARTER: We did talk with private sector,
12 both systems and ACOs, so they're running in fee-for-
13 service, and so benes have freedom of choice. We heard
14 things like they had a preferred network, but they had a
15 lot of leakage, and so even though they were recommending -
16 - and so that was doing better than not recommending, they
17 had leakage of like 50 percent. Those were just the
18 handful of people we talked to. Obviously, in the MA
19 world, it's totally different.

20 I think what I'm hearing in your question is it's
21 true there's a lot of guiding going on now, but there also
22 is a lot of leakage and for good reasons. Patients want to

1 be close to their families, and so they may opt to not go
2 to a recommended facility or for whatever reason. But I
3 think even with current guidance going on, benes are still
4 making choices that may not align with where they are being
5 recommended to go.

6 DR. HOADLEY: I'm intrigued by both of these last
7 two lines of conversation. It does seem like it's hard to
8 figure out what beneficiaries are using information, and
9 you've obviously got some insight, which you just offered,
10 and then what different kinds of tools could do to do it.
11 But let me go back to Herb's comment, because I've had the
12 same thought about these financial incentives. I know at
13 one point, doing some interviews with physicians and asking
14 them about -- I have no idea at this point what the
15 particular example was, but about the effect of some kind
16 of bonus system, and you often got the answer, "Well, I
17 don't even know what's coming in. It's sort of lost in the
18 midst of lots of payments that come in."

19 On the other hand, we hear a lot about the impact
20 of the Star ratings bonus in MA, that it does seem to
21 become quite a focus, and you see lots of -- again, it's
22 anecdotal, but a lot of trade news stories that suggest --

1 and I think folks here have talked about it too -- that
2 once you've got these things, they're going to really pay
3 attention, how can we up our score on this particular
4 thing, because there's some money at the other end and
5 maybe less of that in Part D plans because there's no money
6 at the other end, although even there, even before the
7 money was attached to MA, there was that sense of some
8 value and sort of having certain Star levels and just for
9 the public view of it.

10 But it does seem like if there's some ways to
11 better understand how these different kinds of bonuses and
12 withholds and things translate, how they're perceive, how
13 they're received, in other words, what form do they come,
14 do they come with labels, do they come in advance, to
15 Kathy's point, where you can say, "Okay. Here's money.
16 It's contingent on these things," versus it's a little
17 fuzzier in terms of you're getting something and somebody
18 is going to reconcile later. It seems like if we could
19 understand that and how that differs across sector and
20 across some of these different programs, that might help us
21 get a better sense of how to set these things up going
22 forward.

1 MR. HACKBARTH: One of the things that I like in
2 the pending SGR bill is that at least they made some effort
3 to take what had been totally sort of unrelated bonuses and
4 penalties and put them into a more integrated system with
5 an overall score and a single payment or a penalty, up or
6 down, and I think maybe some of the same sort of work could
7 be useful in the hospital world as well as opposed to just
8 piling new things on top, as has been the practice to this
9 point.

10 Warner.

11 MR. THOMAS: I would agree with your comment,
12 Glenn, and I think there is a lot of kind of disparate
13 measurements, incentives, penalties. I guess, as I read
14 through this, certainly, there's things that can be
15 improved. I was just trying to get to what are we trying
16 to accomplish. Are we making recommendations to the whole
17 bundled program? Are we talking about how this fits in
18 with other programs? I was trying to figure out where we
19 were going with the discussion.

20 DR. MILLER: I think there's a couple of
21 different ways to talk about this here.

22 I don't think there is any inherent resistance to

1 the notion of looking across a set of incentives and saying
2 how could we rationalize across them, and if that's the
3 direction you wanted to go on this, we could certainly --
4 and would certainly be willing to do that.

5 I think the motivation here -- and I swear to
6 God, this is true. A lot of this came out of talking to
7 hospital people who said there's a lot of other things out
8 in the area, and I would just add to Jack's list, there are
9 certain things that get people's attention. The Stars
10 clearly have people's attention. The readmission penalty
11 clearly has people's attention. There's also some other
12 noise out there that people are less clear, and what was
13 kind of striking to us is we would go to these rooms to
14 talk to different hospital people and that kind of thing.
15 This incredibly geeked-out measure, they were all aware of,
16 and actually, many of them were using it and then sort of
17 asking -- to questions that occurred over on this side of
18 the conversation, there is all this churning unbundling,
19 and it doesn't sound like it's going to happen anytime
20 soon, and I'm not sure how to even get involved in it. Why
21 aren't policy people talking about this? This creates the
22 same kinds of incentives.

1 And then the third thought that I linked it to is
2 something you brought up in our conversations a few times
3 back, which is why don't you give me more tools to manage
4 what happens outside my hospital? And I'm sure I'm not
5 doing your comments justice, but that type of thought, and
6 so we started looking at this and thinking about whether
7 this gave a platform to pull many of those thoughts
8 together. No resistance to the thought that, look, if we
9 have too many bells and whistles, put them in one place, or
10 get rid of them someplace, and put something else in place,
11 no resistance to that.

12 But those were the thought processes that kind of
13 brought us to this.

14 MR. THOMAS: I think that's helpful because I
15 would agree that the -- I mean, people talk about bundles,
16 but as far as the traction it has compared to readmissions
17 or compared to the Stars program and MA, it's a much lower
18 priority. It's not getting the same sort of traction. So
19 I think the idea is to try to get more traction there, to
20 try to make it more attractive and contain a modifier, that
21 could be interesting for some hospitals that are not going
22 down the road of more of a global payment of the ACO model.

1 MS. BUTO: On this same point, to me the
2 difference is who you think actually has control. So, if
3 suddenly, Medicare says to hospitals, we're giving you the
4 bundle for post-acute care, up to 30 days, that's a whole
5 different game than saying we are going to tweak your MSBP
6 and hope that you have more drive to influence that
7 decision, or even second bullet, which is PACs, whoever
8 your governance is, you're going to get a certain reward,
9 depending on how that's managed.

10 So, to me, it's sort of back to who controls
11 this, and then the mechanism for getting the money to them
12 is maybe less important, and maybe you try to do it in the
13 least disruptive way possible. But if we had a better
14 sense of who we think is in control, I think that helps a
15 lot in figuring out how powerful any of these things
16 actually are.

17 MR. HACKBARTH: I agree with that, Kathy, and to
18 me, in an ideal world, the financial responsibility is
19 aligned with the control, as you put it. And, to say, oh,
20 we are going to penalize you for something that happens
21 outside your four walls, hold you accountable for something
22 that happens outside your four walls, is -- that's been a

1 point of controversy around the readmissions penalty from
2 the beginning.

3 And, one way that we dealt with that and the
4 world has dealt with that is to say, well, it's a
5 relatively small penalty and what we're trying to do is
6 nudge hospitals towards accepting more responsibility for
7 what happens outside their walls. But, because the dollars
8 don't match up with the accountability, there's only a
9 limited amount of penalty that you can apply, and that
10 means the limited amount of effect that you're likely to
11 have.

12 If you want a much bigger effect on what happens
13 post-hospital admission, I think you need to go to a true
14 bundle and say to the hospitals, you're accountable, but
15 you also control the dollars. And, so long as the
16 accountability and control over the money is separate,
17 there's going to be a limit on what you can expect of them.

18 DR. MILLER: And, I just want to add, I agree
19 with all that. And, the other point that you touched on,
20 and I would just draw it out a little bit further, there's
21 this ongoing dilemma, and you hear it here all the time,
22 which is why can't we move people to taking truly more

1 risk, you know, move people to an ACO, just to use it as an
2 example. And, as long as fee-for-service -- and, I'm not
3 saying make it unnecessarily and just arbitrarily
4 complicated.

5 But, as long as fee-for-service is a fairly
6 comfortable place to be, people aren't going to move, and
7 you can sort of think of these changes, too, because even
8 in your exchange where you say, you know, what really
9 matters here is giving them the money tomorrow and giving
10 them the responsibility. We also know the monumental
11 resistance to that idea, both on where the fact that
12 certain actors would lose control of their money and
13 certain actors are not ready to take control of that money.
14 This kind of thing can represent a bit of a bridging step
15 if it is done in a rational way where a few things are put
16 together.

17 MS. BUTO: Yeah, and I'm not disagreeing with
18 that, Mark. I just don't want to lose sight of the fact
19 that life would be simpler, and we would get to where we
20 want to go -- so, let's not lose sight of the bigger kind
21 of impact that a big change could have, albeit we're not
22 ready to go there yet, but --

1 DR. MILLER: [Off microphone.] I hear you.

2 DR. NERENZ: I was going to make a similar
3 comment to the one Kathy made, so I'll try not to just
4 duplicate it, but I was struck in reading the materials
5 about how hospital-centric this whole presentation was,
6 starting with the selection of the episodes, that they are
7 defined by an admission, even though there are many other
8 clinical episodes that are not necessarily so. But, I
9 understand that you've just taken this as a frame for
10 discussion.

11 But, as I went through the chapter, in reading
12 it, I was looking for the point where we'd say, well, how
13 about having physicians accountable or physicians somehow
14 in this picture somewhere, or even a little more precisely,
15 how about patients who are formally aligned with Certified
16 Medical Homes. How about having the medical home -- and it
17 was never in there.

18 So, I think the line of this discussion -- again,
19 I'll just call very hospital-centric -- and I'd echo
20 Kathy's question. Is that really now the way the scope of
21 responsibility and authority really runs? Do hospitals
22 really control this whole set of things that drive costs,

1 including the fee schedule element? Meaning, do hospitals
2 control payments to doctors? That seems a little odd.

3 And then looking forward, is that how we want the
4 world to be? In this set of episodes, do we want hospitals
5 running the show? Now, maybe we do, but there may be other
6 alternatives.

7 DR. NAYLOR: So, I just want to echo those
8 points. I walked away reading this chapter with the same
9 kind of sense of what is the goal? Is the goal to get to a
10 more efficient spending for a given episode, or is it -- I
11 actually like point four, trying to figure out ways to
12 discourage unnecessary acute care episodes that result in
13 unnecessary hospitalizations and so on.

14 I mean, much of our conversation has been to
15 think about how it is that -- where our energy should be in
16 terms of enabling community-based providers to guide the
17 care of Medicare beneficiaries, and I think that this is
18 where we should be placing our attention going forward.

19 MR. HACKBARTH: Other questions, comments?

20 [No response.]

21 MR. HACKBARTH: Hearing none, I think we're done.
22 Thank you all.

1 Okay. We will now have our public comment
2 period.

3 DR. MILLER: Carol, can you put up the public
4 comment slide? Thanks.

5 MR. HACKBARTH: Seeing nobody go to the
6 microphone, we are adjourned.

7 [Pause.]

8 MR. HACKBARTH: It's over, George.

9 [Laughter.]

10 MR. HACKBARTH: Go ahead, George. You're
11 special, so we'll --

12 MR. GEORGE MILLER: Thank you. I just stood up
13 to thank Glenn for his great service to MedPAC on behalf of
14 all the Commissioners and the public. This is the first
15 time I've had this opportunity to be on this side of the
16 microphone, and I'll try to keep it under two minutes, but
17 --

18 [Laughter.]

19 MR. HACKBARTH: [Off microphone.]

20 MR. GEORGE MILLER: But, Glenn has been a great
21 Chairman. On behalf of all the Commissioners, I wanted to
22 stand and rise and thank you for your great, great service

1 and your great leadership over MedPAC over these 12 years.

2 [Applause.]

3 [Whereupon, at 3:53 p.m., the proceedings were
4 adjourned, to reconvene at 8:30 a.m. on Friday, April 3,
5 2015.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, April 3, 2015
8:30 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, JD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
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

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Synchronizing Medicare policy across payment models	
- Julie Lee, Carlos Zarabozo, Jeff Stensland.....	78
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P R O C E E D I N G S

[8:30 a.m.]

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MR. HACKBARTH: Good morning. Nancy and Katelyn are going to lead this morning with bundling for oncology services.

MS. RAY: Good morning. Medicare's payment policies for Part B drugs do not always provide beneficiaries and taxpayers the best value because the policies do not consider evidence on a drug's comparative clinical effectiveness compared with its alternatives.

Physicians have raised this concern. In one instance, physicians from a cancer hospital announced that a new cancer drug would be excluded from the hospital's formulary because the new drug offered the same survival benefit and a similar side effect profile as its alternative but was twice as expensive.

At the fall Commission meetings, we discussed policies that aim to improve the value of Part B spending for drugs and biologics.

We discussed Medicare's application of least costly alternative policies between 1995 and 2010. For two or more drugs that clinicians prescribe for the same

1 condition and produce a similar health effect, the policy
2 bases the payment rate on the least costly product.

3 We also discussed bundled approaches under which
4 Medicare would establish one payment for Part B drugs and
5 other medical services furnished across one or more
6 settings and by one or more providers during a defined
7 period of time for a given condition.

8 Some have reservations about Medicare's role in
9 developing LCA policies, about Medicare grouping drugs and
10 deciding which drugs result in similar health effects.

11 In contrast to LCA policies, bundled approaches
12 permit clinicians rather than Medicare to decide on the
13 value of a service covered by the bundle -- for example,
14 drugs. In addition, bundled approaches, depending on their
15 design, might lead to improved care coordination.

16 Based on Commissioners' request, today Katie and
17 I are going to focus on bundling oncology drugs. We focus
18 on oncology drugs because Medicare spending for oncology
19 drugs -- that is to say, products that treat cancer and its
20 side effects -- accounted for about half of total \$11.7
21 billion in spending for Part B drugs furnished in
22 physicians' offices and paid based on the average sales

1 price in 2013. To put it in another way, 45 percent of the
2 total \$11.7 billion in Part B drug spending was paid to
3 oncologists in 2013.

4 So first I will present preliminary findings from
5 an exploratory analysis that examined Medicare spending for
6 oncology services. Then I will review key design elements
7 to consider when bundling services. Katie will then
8 present case studies on bundling approaches used by
9 commercial payers and Medicare.

10 The goal is to include the material we are
11 presenting today and our earlier work on LCA policies in
12 the June 2015 report.

13 So we analyzed 100 percent claims data so we
14 could begin to learn about the spending patterns of
15 oncology care and to assess the spending that oncologists
16 can affect. To be clear, our goal here was not to create a
17 bundle. Our study population of about 61,000 beneficiaries
18 consists of newly diagnosed beneficiaries with three major
19 cancer types -- lung, breast, and colon -- who were
20 diagnosed in 2011 or 2012 and who received a Part B
21 oncology drug between January 2011 through June 2012.

22 The mean length of an episode, the mean length of

1 time we followed a beneficiary on average was 162 days.
2 About 20 percent of the study population died during the
3 180-day follow-up.

4 Here are our preliminary findings: 180-day
5 spending for Part A and Part B services averaged nearly
6 \$41,000 per beneficiary. This total includes: outpatient
7 oncology drugs and their administration furnished at
8 physician offices and hospital outpatient departments, that
9 is the red slice; other physician/supplier services, that
10 is green; institutional outpatient services, yellow;
11 inpatient hospital services is orange; and home health and
12 hospice is lavender. At the 25th percentile, total
13 spending averaged about \$21,000 per beneficiary while at
14 the 75th percentile spending averaged \$54,000 per
15 beneficiary during the 180-day follow-up.

16 From this slide, oncologists directly manage the
17 46 percent of spending for outpatient oncology drugs and
18 their administration costs. In addition to spending on
19 oncology drugs, there is a block of dollars here that
20 oncologists may also have opportunities to affect -- for
21 example, the 20 percent on inpatient hospital services.

22 So here we show you our preliminary findings that

1 look at spending for outpatient services:
2 physician/supplier services and institutional outpatient
3 services. This is a subset of spending from the previous
4 slide. It includes spending for services furnished in
5 physicians' offices and hospital outpatient departments.
6 These two service types account for 76 percent of total
7 spending.

8 This slide shows 30-day outpatient spending for
9 oncology drugs and their administration, that is the red
10 bar; radiation oncology services, that is green; and all
11 other outpatient services, that is yellow. So I'd like to
12 highlight three points here.

13 The first point is that spending during the first
14 30 days is intense, and then it drops between periods 2
15 through 6.

16 The second point is the substantial spending for
17 radiation oncology services; that's the green bar. During
18 the 180-day follow-up period, radiation oncology services
19 accounted for 9 percent of total spending. This is another
20 service type that oncologists can influence.

21 The last point concerns the group "all other
22 outpatient services." This group also includes some

1 services that oncologists can affect, including imaging and
2 laboratory services, and services associated with
3 furnishing major procedures and other procedures.

4 Developing bundles that include Part B oncology
5 drugs and biologics might help address the incentive under
6 Medicare's current Part B payment method for providers to
7 furnish more costly regimens when therapeutic equivalent
8 drugs exist. It might also lead to improvements in care
9 coordination. I'm going to summarize six key design
10 elements to consider when bundling services. In our June
11 2013 report, the Commission examined these elements with
12 respect to bundling PAC services.

13 The first element is deciding on the services
14 included in the bundle. Bundles that include more services
15 require providers to be accountable for a wide range,
16 thereby creating greater incentives for care coordination
17 than a narrowly defined bundle. Katie will be discussing
18 oncology approaches that range from the narrowest approach
19 covering the cost of oncology drugs and their
20 administration to the broadest approach which would cover
21 all services.

22 The second element is deciding on the duration of

1 the bundle. The oncology case studies show approaches that
2 range from one month to one year.

3 The third element is selecting the trigger event.
4 Some of the case studies start the bundle at cancer
5 diagnosis while others start the bundle at the oncology
6 treatment -- for example, chemotherapy.

7 The fourth key design element is deciding on the
8 type of payment. Several of the case studies pay providers
9 prospectively while others maintain fee-for-service
10 payments and adjust payments retrospectively.

11 The fifth key element is adjusting for risk. The
12 case studies use measures on disease severity and cancer
13 type and stage.

14 And, finally, the sixth element is countering the
15 incentive to stint, which the case studies address by
16 including outcome measures such as patient survival.

17 Now Katie will take you through several of the
18 case studies we included in your briefing paper.

19 MS. SMALLEY: So you may recognize this slide
20 from previous meetings. In a 2011 Health Affairs article,
21 Peter Bach and colleagues outlined a bundling proposal for
22 cancer care in Medicare. The bundle would be relatively

1 narrowly defined. They discussed covering the costs of
2 chemotherapy drugs and their administration during an
3 oncology episode, but mention that more services could be
4 incorporated into the bundle over time. The design of the
5 bundle would be informed by evidence-based guidelines for
6 cancer care, and payments would be periodically readjusted
7 to account for the cost reductions associated with
8 bundling.

9 The goal of this type of bundle is to incent the
10 use of low-cost, but effective, drug therapies. This would
11 be managed by adherence to standards of care for each
12 condition, which Bach envisions that Medicare would
13 certify. Bach noted that financial structures like risk
14 corridors or shared savings could also be built into the
15 model to strengthen the incentives.

16 An advantage to this approach is that, because
17 the scope of the bundle is limited, the oncologist is in
18 control of the treatment regimen, and few others would be
19 involved. This situation would make the bundle more
20 straightforward to implement. On the other hand, the
21 narrow scope of the bundle gives the oncologist fewer
22 options to realize efficiencies in the delivery of care.

1 While they were not detailed in the paper, Bach
2 also acknowledged the importance of addressing issues such
3 as cost shifting, upcoding, and stinting in designing a
4 successful bundle.

5 In contrast to Bach's proposal of a narrow
6 bundle, UnitedHealthcare and MD Anderson have collaborated
7 on a relatively broad bundle for head and neck cancer. MD
8 Anderson is responsible for the total cost of cancer-
9 related care for that patient, including complications, and
10 is paid with a prospective payment, which they describe as
11 similar to a DRG. Based on historical data for similar
12 cases, United and MD Anderson negotiated a prospective
13 payment amount for eight different bundles, based on the
14 type of cancer therapy being provided.

15 A multidisciplinary oncology team decides if
16 surgery, radiation, chemo, or some combination is the most
17 appropriate treatment for a particular patient. The
18 diversity of the members of the team encourages a choice of
19 treatment that is consistent with the evidence of the best
20 treatment for the particular patient.

21 From the patient perspective, there is the added
22 benefit of only one bill to pay. They know the amount that

1 they are responsible for up front, and there are no
2 surprises as they go along.

3 Another UnitedHealthcare pilot, which we
4 discussed in detail at previous meetings, specifically
5 targets drug treatment for oncology episodes. The insight
6 is that paying for oncology drugs via ASP plus some add-on
7 provides a revenue incentive to prescribe a particular
8 (more expensive) drug, without much regard to quality.
9 They wanted to remove that incentive and strengthen the
10 incentive to evaluate drugs based on their effectiveness
11 and prescribe on that basis alone.

12 To do this, they separated the drug add-on from
13 the drug and repurposed it as a fee that could be used to
14 provide services like in-hospital care or hospice
15 management if the patient and oncologist decide to
16 discontinue treatment.

17 Provided that the survival rate improved over the
18 cycle, the oncologists were also eligible for shared
19 savings. From 2009 to 2012, spending was reduced overall
20 by about \$33 million, \$11 million of which went back to the
21 practices. Interestingly, however, drug spending during
22 that time increased. It seems that total spending went

1 down because of decreases in hospitalizations and
2 radiology. It's not clear what drove the large increase in
3 drug spending; however, because this is a larger bundle and
4 the benchmark holds providers accountable for all services,
5 not just chemotherapy, if a more expensive chemo regimen is
6 appropriate, oncologists have the opportunity to prescribe
7 it.

8 CMMI has also proposed an oncology episode
9 payment. In the oncology care model (OCM), participating
10 practices will agree to practice transformation efforts
11 such as 24/7 access to the EHR, adherence to nationally
12 recognized clinical guidelines, and providing patient
13 navigation and comprehensive care plans, with the intent to
14 improve coordination and quality of care for beneficiaries
15 initiating chemotherapy. CMS plans to initiate the model
16 in spring 2016.

17 The episode is six months in length, but can be
18 renewed for as long as chemotherapy is administered during
19 the five-year model. Quality monitoring is composed of 39
20 measures, which fall into domains including care
21 coordination, patient experience, population health, and
22 adherence to practice requirements. A subset of the

1 measures is used for the purposes of performance-based
2 payment.

3 On the next slide, we will discuss the payment
4 arrangement in more detail.

5 The episode maintains most aspects of fee-for-
6 service payment, including paying ASP+6 percent for Part B
7 drugs, but with the addition of a \$160 dollar per
8 beneficiary per month payment to support practice
9 transformation and care coordination efforts. The PBPM is
10 paid to the oncologist who first orders chemotherapy and is
11 paid for the duration of the six-month episode, regardless
12 of whether chemotherapy ends before six months or if the
13 beneficiary chooses to go to another provider. The PBPM
14 can be renewed for beneficiaries on chemo for longer than
15 six months, until the end of the demonstration.

16 Performance in the model is determined every six
17 months by combining the participant's actual expenditures
18 over the period with a benchmark, or target price. The
19 actual expenditures include all fee-for-service A and B
20 spending and some Part D, plus the per beneficiary per
21 month payments. The target price is calculated from
22 historical fee-for-service A, B, and D expenditures --

1 which are trended forward to the performance year, and then
2 risk adjusted -- minus a 4 percent discount rate. If the
3 practice achieves actual spending below the target price,
4 then they are eligible to share in savings. The amount of
5 savings that they are eligible for depends on performance
6 on a subset of the quality metrics.

7 While the PBPM may lead to better care management
8 among participating practices, the size of the payment
9 relative to practices' drug administration costs may lead
10 to increased total Medicare spend that is not met with
11 gains in quality or access.

12 Similarly, the shared savings arrangement may
13 provide an incentive to lower costs, but the lack of a
14 requirement for a two-sided risk arrangement lowers that
15 incentive.

16 In conclusion, bundled approaches allow
17 clinicians to provide high-value services to their
18 patients. Our exploratory analysis found that, for the
19 three cancer types we looked at, oncology drugs and
20 administration account for a significant portion of
21 spending on oncology over a six-month episode. However,
22 oncologists have the opportunity to make judgments that

1 affect their patients' treatment regimen, hospitalizations,
2 and other utilization, making this an area amenable to
3 bundling and other episode-based approaches.

4 We welcome Commissioner feedback on the design of
5 bundled oncology approaches in this session, and we are
6 happy to answer any of your questions.

7 MR. HACKBARTH: Thank you. This is really
8 interesting.

9 Could you put up Slide 5 -- or, actually, I guess
10 it's 6, the graph. Or, no, put up 5. That is easier to
11 talk about. Thanks.

12 So this is the pattern for lung, colon, and
13 breast cancer. Do we know whether the pattern is
14 significantly different for other types of cancer?

15 MS. RAY: I did not look at the other types of
16 cancer yet. That's something that we can do moving
17 forward.

18 MR. HACKBARTH: Okay. And then we've used the
19 first administration of an oncology drug as the beginning
20 of the episode. Do we know anything about what the
21 expenditures look like before that?

22 MS. RAY: That is something I can get back to you

1 on. I don't have that material here, but that is knowable.

2 MR. HACKBARTH: Okay. So Round 1 clarifying
3 questions. We'll come down this way, starting with Kathy.

4 MS. BUTO: So I wondered if you could give us
5 just a thumbnail of the difference between the two
6 UnitedHealthcare demos or pilots. I couldn't figure out
7 exactly what elements were different. And if you could
8 also comment on whether -- I think one of them is a
9 prospective payment. Was the first one also a prospective
10 payment, or was that something else? So both the payment
11 design and also what are the key differences?

12 MS. SMALLEY: Sure. So the first one that I
13 talked about, this is for a very small subset of cancers.
14 It's just for head and neck cancer. And it's also limited
15 to patients that are being treated for cure, and so they
16 kind of have a different set of services, and MD Anderson
17 worked to create a true bundle around those services, so
18 they get a prospective payment on that.

19 The other model is kind of broader, and it's not
20 necessarily a bundle in the way that we typically think
21 about it in that there's no prospective payment. It's kind
22 of the change is that the drugs are paid at ASP plus zero,

1 and then that contracted add-on that used to be attached to
2 the drug payment is paid in an episode fee.

3 MS. BUTO: Just one follow-up. On the first
4 UnitedHealthcare demo, you've got a team deciding on best
5 course of treatment. So were there different bundles or
6 different -- for surgery, radiation, and chemotherapy?

7 MS. SMALLEY: There are eight different bundles
8 based on the different mix of services.

9 MS. BUTO: Okay. So that's -- there wasn't an
10 overall bundle or an overall amount.

11 MS. SMALLEY: Right.

12 MS. BUTO: Gotcha.

13 DR. NERENZ: On Slide 6, please. The first 30-
14 day period obviously is more expensive than the others, and
15 I just want to make sure I'm understanding why that might
16 be. These are, again, people -- only those people who got
17 at least one Part B drug, so we're not seeing an effect of,
18 say, surgery only here, and it's outpatient, it's not
19 inpatient. And the red thing is higher. Is there just an
20 obvious explanation of why that first 30-day period,
21 particularly for drugs, is so high?

22 MS. RAY: Well, everybody is in that first

1 period. By definition, you have to be in that first period

2 DR. NERENZ: So then it gets lower because people
3 fall out of it?

4 MS. RAY: Well, 20 percent of the study
5 population died in the 180-day period, in the six months.

6 DR. NERENZ: Okay.

7 MS. RAY: So clearly -- well, I don't know yet,
8 but if the trigger point was cancer diagnosis instead of
9 the first administration of an oncology drug, that could
10 give a different pattern.

11 DR. NERENZ: Well, that's just what I want to
12 make sure we understood.

13 MS. RAY: Right. It could, yes.

14 DR. NERENZ: But it was not that. The trigger
15 point is the first claim for a Part B drug.

16 MS. RAY: Yes.

17 DR. NERENZ: Okay.

18 MR. HACKBARTH: So, Nancy, could I just make sure
19 I understood that? For this calculation, the denominator
20 for the per beneficiary calculation includes throughout the
21 period all of the beneficiaries who were in the initial
22 denominator --

1 MS. RAY: Yes.

2 MR. HACKBARTH: -- even if they've died during
3 the period.

4 MS. RAY: If you died in Period 2, you're
5 included in Period 2, but you're not included in 3, 4, 5,
6 or 6.

7 MR. HACKBARTH: Okay. So --

8 MS. RAY: The only way you drop out from the
9 denominator is if you died.

10 MR. HACKBARTH: So when a patient dies, it can
11 reduce the cost per beneficiary within that period.

12 MS. RAY: Right.

13 MR. HACKBARTH: But then they don't influence the
14 subsequent period calculation.

15 MS. RAY: Right.

16 MR. HACKBARTH: Okay.

17 MR. GRADISON: There are two pilots, Case Study 3
18 and 4, which started quite a while ago. The Florida one
19 was in 2011, and the other united one was between 2009 and
20 2012. Have these been incorporated? Have the results of
21 those been incorporated in the ongoing way in which the
22 Florida Blues and United managed these programs?

1 MS. RAY: So that's a good question. I can't
2 speak for the Florida Blues or United. What I can tell you
3 is Florida Blues, they are -- in addition to using the
4 approach that we included in the paper, which was a
5 prospective payment for a prostatectomy, they're also doing
6 an oncology -- I would characterize it as an oncology
7 shared savings program. So I think they are using a
8 variety of approaches as well as United.

9 MR. GRADISON: Okay.

10 MS. RAY: Yeah.

11 MR. GRADISON: I'm not sure whether you are
12 telling me that you know all that you would like to know
13 about what they are doing. That's all right. I just
14 wondered whether they've learned something that they have
15 applied. That is really what I'm trying to -- perhaps you
16 could look further into that, if you don't mind.

17 MS. RAY: Okay.

18 MR. GRADISON: This other thing, it's very minor,
19 but at the top of page 2, there is a sentence which refers
20 to the percentage of Medicare spending and the top ten and
21 so forth. I have read this over and over. Can it both be
22 52 percent?

1 MS. RAY: It is. Yes. Yes, it is.

2 MR. GRADISON: Okay.

3 MS. RAY: But perhaps I should have taken it to
4 the tenth digit because that's where the difference was.

5 MR. GRADISON: Oh, no, no, no. That's okay.

6 [Laughter.]

7 MS. RAY: I know. I got a lot of comments about
8 that. It really is 52 percent.

9 MR. GRADISON: All right. I don't want to add to
10 them. Thank you.

11 MR. HACKBARTH: Further clarifying questions?
12 Mary, Jay, and Craig.

13 DR. NAYLOR: Two brief ones. On the 21 percent,
14 in this study, 21 percent died in the first 180 days; is
15 that right?

16 MS. RAY: 20 percent.

17 DR. NAYLOR: 20 percent.

18 MS. RAY: We updated the results after the paper.

19 DR. NAYLOR: Okay.

20 And on the earlier slide, 4 percent of spending
21 was on home health and hospice; is that right?

22 MS. RAY: Yes.

1 DR. NAYLOR: The other, I thought this was great.
2 I loved the case studies. I'm wondering whether or not
3 beneficiary cost sharing was considered. There were effort
4 sin these to improve processes of care for beneficiaries,
5 but was beneficiary cost sharing given high cost sharing
6 for these drugs part of the thinking around the bundled
7 payment in any of them?

8 MS. RAY: I think beneficiary cost sharing --

9 DR. NAYLOR: [Speaking off microphone.]

10 MS. RAY: Not that we are aware of, no. The only
11 way that I think beneficiary cost sharing was at least
12 affected is in the case of United MD Anderson approach,
13 which gives them one bill for the entire year of services,
14 so it does simplify in that respect.

15 DR. CROSSON: Nancy, I have two questions. The
16 first one, from the case studies that you looked at and
17 maybe conversations you have had, do you get any sense
18 about the degree of latitude or lack of latitude in the
19 choice of drugs based upon whether or not providers or in
20 the case studies were trying to adhere to national
21 protocols?

22 MS. RAY: From the literature -- and we included

1 a small discussion of it -- the use of clinical pathways,
2 at least among commercial payers, has well diffused.

3 Within the case studies themselves -- I know, for
4 example, the Medicare case studies is requiring practices
5 to report on the guideline that is being used?

6 MS. SMALLEY: Yeah. In most of the case studies,
7 there was some element of considering clinical guidelines
8 or adhering to some kind of pathway or something like that.
9 I'm not sure if that gets at your question.

10 MR. HACKBARTH: Maybe I misunderstood, but I
11 thought, I interpreted the discussion, description of Peter
12 Bach's approach as saying that it was guideline-based, and
13 so the bundle, the amount of the bundle is based on if you
14 adhere to the guideline, whereas the Medicare approach, I
15 think is based on average cost experience with oncology
16 patients, and it's not specific to a guideline. Did I
17 interpret that correctly?

18 MS. SMALLEY: Right. It's not specific to a
19 pathway, but there is the quality monitoring for CMMI's
20 model. There is a component of that where --

21 MR. HACKBARTH: Yeah. But the calculation of the
22 bundle and whether you're saving money or not is based on

1 an average cost experience --

2 MS. SMALLEY: It's not based on a specific --
3 right.

4 MR. HACKBARTH: -- which is the way Medicare
5 historically has determined prospective rates.

6 MS. SMALLEY: That's correct.

7 MR. HACKBARTH: But an alternative model -- and I
8 think Peter Bach's is based on your cost would be X if you
9 followed this guideline, which is the right way to provide
10 oncology case.

11 Is this what you're getting at, Jay?

12 DR. CROSSON: Well, there is a policy question
13 buried in here that I'm loathe to bring up in this Round 1.

14 MR. HACKBARTH: Well, we will applaud for your
15 self-discipline and move on to Craig then.

16 DR. CROSSON: Wait. I have the same question.

17 [Laughter.]

18 DR. CROSSON: The second one, in the material we
19 read, there was a discussion of the oncology medical home,
20 the so-called Come Home Project. Are there -- and you
21 didn't bring that up in the discussion here. Is there
22 something to be learned there, or what do you think?

1 MS. RAY: I think there is something to be
2 learned there. We are awaiting the formal evaluation of
3 the demonstration. My understanding is that it is ending
4 this year. It was a three-year demo.

5 When we talked to the folks at CMS, they said
6 they applied some of what they learned from that demo into
7 the latest demonstration, the oncology care model.

8 My understanding from reading about the Come Home
9 medical home is that they believed that there was savings
10 due to declines in the inpatient admissions and ED visits,
11 and that they were able to -- because they stayed open
12 later, patients came to the office instead of going to the
13 ED or the hospital outpatient. And plus, they set up a
14 phone triage system to help patients deal with symptoms or
15 what have you. So I think there are important lessons that
16 will be gained from that demo.

17 DR. SAMITT: Thanks, Nancy. Two quick questions
18 for you. On this slide, I know the inclination is to look
19 more at controllable costs or outpatient costs, but I do
20 have a question about the inpatient. Is it possible to
21 tease apart oncology-related avoidable admissions within
22 this bucket versus those that are not?

1 MS. RAY: You know, I think that's something that
2 we can look into doing for the fall.

3 DR. SAMITT: Because as we think about what's in
4 the bundle or what's not --

5 MS. RAY: Right.

6 DR. SAMITT: -- you would think that could be
7 included in the bundle, given that it may be under
8 oncologist influence.

9 MS. RAY: Yeah.

10 DR. SAMITT: My second --

11 DR. MILLER: There is some complexity.

12 MS. RAY: Clearly, there is some complexity. I
13 mean, that would not be an easy thing to do. We could
14 begin to look at that this summer.

15 MR. HACKBARTH: So, Craig, for the non-physicians
16 in the group, would it be an example of an identifiable,
17 avoidable oncology-related admission?

18 DR. SAMITT: So, for example, it would be -- most
19 oncology is outpatient. So if you think about a clinical
20 protocol that avoids a nadir of disease-fighting status,
21 the oncologist should be able to control that nadir through
22 other types of drug regimens. So whether you give GSF

1 that would stimulate the growth of infection-fighting
2 cells, that would be under an outpatient influence, and if
3 the protocol wasn't sufficient to avoid that, a patient may
4 need to be hospitalized with a low blood count, or other
5 transfusion or other things that actually could be done to
6 control the side effects of chemotherapy, that would be an
7 outpatient-controlled effort, and an admission should be
8 avoidable in certain instances.

9 DR. MILLER: And I just want to say, again, I
10 think that was a very good example on how much information
11 from claims data that we'll be able to go through and say
12 avoidable or not. That's why I wanted to just put a flag
13 out on the play and say we can definitely look at this.
14 How deep we'd be able to get into something like that is
15 what is making me a little nervous.

16 DR. SAMITT: It may be worth looking at. I'm not
17 sure how hard it actually would be to tease apart avoidable
18 versus not avoidable.

19 DR. MILLER: We can get some outside consultation
20 on this, though.

21 DR. SAMITT: And at the end of the day, it may be
22 so small, it may not be worth it to think about including

1 in the bundle, but it may be, at least to quantify, the
2 distinction may be useful.

3 And then on Slide 7, in terms of the trigger
4 event, when you talk about cancer diagnosis, could that be
5 the diagnosis that is made by any clinician, so it could be
6 that PCP's cancer diagnosis, or would you require it to be
7 the oncologist's cancer diagnosis?

8 DR. MILLER: What would you like?

9 [Laughter.]

10 DR. MILLER: I think both Nancy and I are looking
11 at each other and unclear how from a policy perspective you
12 would want to do this, and that would be a question. And
13 then from the claims analysis, we could probably try and
14 tease out where these things are coming from and then put
15 it back in front of you and then exactly people like you
16 could say that makes sense or it doesn't make sense.

17 MR. HACKBARTH: Clarifying questions? Herb.

18 MR. KUHN: Yeah. Just one quick question, and it
19 really has to do with the examples that you've shared of
20 the various demonstrations, both private sector and CMS
21 thus far.

22 In the evaluation of those, were they able to

1 differentiate the power of the incentives to drive down
2 cost versus the fact that those in the demonstration were
3 being observed, and therefore, their behaviors changed
4 because of observational activity going on there? Do we
5 know the difference between -- were the incentives powerful
6 enough versus just the observation, or were the evaluation
7 contractors able to do that?

8 MS. RAY: Help out, Katie.

9 Of the case studies that we included, there's
10 only been one write-up evaluation, and that's the United
11 where they continue paying fee-for-service, which is drop
12 the drug payment to ASP plus zero.

13 Do you want to add?

14 MS. SMALLEY: Yeah. I guess the only thing I
15 would add is that that evaluation, it was still kind of
16 unclear, kind of the internal mechanics of what was driving
17 costs, so I don't know --

18 MS. RAY: Right. Because recall with that
19 approach, they found that total cost went down, but drug
20 costs went up, and that was a little bit contrary to what
21 they thought what would have happened. And they conclude
22 in the paper it's not clear why it happened.

1 DR. COOMBS: So, in the paper on page 16, you
2 give the case study for Blue Cross/Blue Shield, and with
3 prostate cancer and radical prostatectomies. What I was
4 interested in, this in conjunction with the pie chart on
5 Slide 5, it's been said that a lot of the cost -- well, the
6 revenue sharing between the Part B drugs and the
7 professional fees are a balance between what's expected --
8 let's see. How can I say this? It's that the professional
9 fees may be somewhat lower in comparison to other
10 specialties in a similar area, and it's more compensated by
11 the Part B.

12 So when you bundle it together, when you bundle
13 the drugs and the professional fees together, is there a
14 way that the bundling breaks out that it's more equitable
15 in terms of professional fees for physicians? Because, you
16 know, it may be that ASP plus six and you add the
17 professional fees balances out in the end with other
18 services. I'm not sure that the breakdown is not
19 comparable to other services that use the more expensive
20 drugs.

21 DR. MILLER: So maybe one more passthrough. So
22 here's at least a couple of things that I'm hearing here.

1 An oncologist gets revenue from a drug and also gets a
2 professional fee.

3 DR. COOMBS: Right.

4 DR. MILLER: And so part of your question seemed
5 to be around that. And then it seemed to also be, when you
6 bring in the other parts of the bundle, does that have --
7 and this is where I started to lose --

8 DR. COOMBS: Does the bundle address a more
9 equitable kind of professional fee that does not tie in the
10 payment for the drug Part B? In other words, it's --

11 DR. MILLER: Here's the question that I have, now
12 that you said it. You're using the word "equitable." What
13 do you mean when you say that?

14 DR. COOMBS: Well, I shouldn't say equitable, but
15 is it similar to other specialties and their professional
16 fees? I'm not sure what the professional fee looks like
17 for oncology, for administration here versus what
18 rheumatologists do, immunologists do with IVIG, what does
19 it look like compared to those same specialties that give
20 the high-cost drugs.

21 MR. HACKBARTH: Yeah. It's been a point of
22 discussion in the past when oncology payments have been

1 discussed. Oncologists say, "Well, if we could make more
2 money through the administration or the patient
3 coordination, then we wouldn't be so dependent on income
4 from the drugs," and so that's the tradeoff that you're
5 talking about.

6 DR. COOMBS: Right.

7 MR. HACKBARTH: I don't know --

8 DR. COOMBS: Specifically with a bundle with the
9 prostate cancer, it's more surgically based than it is
10 administering agent. So it would be a different kind of
11 bundle that you might create with a cancer that you're
12 going to be more aggressive with surgery versus less
13 aggressive.

14 MR. HACKBARTH: Yeah.

15 DR. COOMBS: It's going to look very different in
16 terms of the different services on the pie chart.

17 MR. HACKBARTH: So to the extent that we use
18 bundling in the potential additional income that
19 oncologists could gain by their share of savings from low
20 cost under the bundle, that would move them still a further
21 step away from how most physicians gain their income. Most
22 physicians, they provide a service, submit a code, and they

1 get paid for that. Oncologists' income would be based on
2 their fees for administration plus some profit out of the
3 drugs plus some profit by reducing hospital administration.
4 If I'm understanding you correctly, that would make them
5 even less like surgeons than they are today.

6 DR. COOMBS: Right. But if you were to subtract
7 all of those and just go with what does it look like for
8 just the professional fee alone --

9 DR. MILLER: Well, I mean, if you want to -- here
10 is one way to reset this is if you want to think of this as
11 a Round 1 kind of transaction, what we can definitely do is
12 for specialties that you named and anyone else that you're
13 interested in, kind of go through and show you the
14 professional fee across the different specialties, and
15 maybe that helps you get your head around the equity issue
16 that you're looking at. So from a mechanical and a data
17 point of view, we can come back with that kind of
18 information.

19 I think the complex question that you'll
20 immediately rejoin is if you want to make what you think is
21 equitable, it's going to be different across different
22 specialties, and part of their practice expenses and their

1 professional fees are all different for all the reasons
2 that I won't bore you with and that you know well too. And
3 then you will have the overlay of the bundle, and then you
4 guys will have to come to a judgment of whether that's
5 equitable and fair, but we can certainly put the basic
6 numbers in front of you.

7 DR. COOMBS: And then the last thing is, looking
8 at the CMMI and the various bundles, I wanted to ask this
9 question. How much did they include shared decision-making
10 in end-of-life care as a component of the quality indices?

11 MS. RAY: One of the requirements for
12 participating in that demonstration will be providing
13 patient navigation services, which I do believe includes
14 some sort of shared decision-making.

15 Katie is going to track to see whether it's an
16 explicit -- I'm not sure if it's an explicit quality
17 measure, however. We can check, and we will get back to
18 you on that, but they are required to provide patient
19 navigation services.

20 MR. HACKBARTH: Okay. Continuing Round 1.

21 DR. REDBERG: Thanks very much. This was a
22 really interesting chapter.

1 My clarifying questions were just the \$11.7
2 billion is for all oncology drugs, correct, not just --

3 MS. RAY: The \$11.7 billion is all Part B drugs,
4 oncology and non-oncology. That's 2013, furnished in a
5 physician's office and paid based on ASP. So oncology
6 drugs represents about \$6 billion of that, roughly.

7 DR. REDBERG: And that's for all oncology drugs?

8 MS. RAY: Yes.

9 DR. REDBERG: Do you have any data on what
10 percentage of all spending is allocated to breast, colon,
11 and lung cancer, which you had looked at in more detail?

12 MS. RAY: Of that, using 11.7 as the denominator,
13 no, I don't. That, I don't --

14 DR. REDBERG: I'm just wondering what -- those
15 are obviously the most common cancers, but I don't know if
16 that drug spending is --

17 MS. RAY: Right. I could get back to you on that
18 with something. Yeah. I don't have that here.

19 I mean, my understanding is that it's probably
20 heavier in chemo than some other types of cancer, like
21 prostate, for example. At least that's my understanding,
22 but let me get back to you on that.

1 MR. ARMSTRONG: This hopefully is not a Round 2
2 question, but I was trying to just clarify: What is the
3 problem that we're trying to solve? Is it this weird
4 incentive that comes from ASP plus 6 percent and concerns
5 that we're spending too much as a result of that? Is it
6 just a very expensive course of care and, you know, highly
7 risky and we want to feel like -- or create a payment
8 policy that gives more control over that? We talk a lot
9 about, particularly in these pilots or these case studies,
10 the benefit that comes from better coordination of the
11 different types of care, and, you know, kind of a view of
12 outcomes.

13 And so when we get to the payment policies, it
14 seems like we're going to need to be pretty clear about
15 which of those problems are really most important for us to
16 solve, and I just wonder if we had a point of view as we
17 came into this.

18 MR. HACKBARTH: Can the answer be all of the
19 above?

20 MR. ARMSTRONG: It could be [off microphone].

21 DR. MILLER: I'll give you my view and why this
22 is in front of you. So go back several months -- and I

1 can't remember the specifics, but we had conversations
2 about least costly alternative and the notion of trying to
3 set, you know, in a sense a reference point type of policy.
4 That was very much about drugs in Part B. We also had
5 discussions about going back into ASP and asking about
6 whether the categories in ASP were set up in such a way
7 that you drove as much competition and reaching the average
8 sales price.

9 There were reactions -- and, you know, I'm
10 characterizing your comments, and so I'm trying to do my
11 best here -- of like, well, you know, this is complicated
12 because each of those instances kind of involve the
13 government making a decision. Isn't there a way to try and
14 get this decision much more in the hands of the clinician
15 and a decision point between the clinician and the patient?
16 And there was a specific mention -- I'm looking down at
17 that end of the table to see if I get a nod -- of like
18 could we think about bundling? I don't want to call
19 anybody out or anything, but could we look at bundling?
20 And so we went back and said, well, half of Part B is
21 oncology. There's some motion out in the private sector
22 where people are trying to bundle. We'll come back with

1 that.

2 This is going to be a constant dilemma for you
3 guys. I'm going to just take the motion to get way -- or
4 the opportunity to get way out of Round 1. There is this
5 tension where, you know, the Commissioners want to be in
6 kind of large -- I would characterize many of the
7 Commissioners wanting to be in large population-based types
8 of solutions, yet we live in a world that is still very
9 spread out between fee-for-service and ACOs and MA, and
10 we're going to have this constant tension of what do you
11 want to do on the fee-for-service side and how do you -- if
12 you want to encourage people into the other world, what do
13 you do? And I feel like these conversations often come
14 back to that kind of principal point. I'm done.

15 MR. HACKBARTH: And I think that was really well
16 done, Mark, and that last point is, I think, important and
17 there is this constant tension. I just want to really
18 pound on your first point. I think, if I understand these
19 different models, it's sort of exemplified in the models.
20 The Bach approach, if I understand it correctly, says let's
21 define what the right care is and have a payment system
22 based on it as opposed to the traditional Medicare

1 prospective payment model and saying let's not prescribe
2 what the right care is, let's look at the average cost and
3 set a prospective payment based on that.

4 Having watched Medicare policy from a lot of
5 vantage points for a lot of years, you know, my personal
6 belief is it's very difficult for CMS to do the Bach
7 approach and prescribe a pattern of care. And that to me
8 is part of the appeal of this bundling. Let's decentralize
9 the clinical decision about what's appropriate care but
10 create a system where there's an incentive to economize
11 where possible while also producing high quality. It's a
12 decentralization. I just think that's, generally speaking,
13 a much more effective way for Medicare to achieve these
14 goals than trying to use the coverage process or a
15 guideline specification process.

16 MR. ARMSTRONG: And I just was thinking that,
17 well, if the real issue is we pay these providers to
18 administer these drugs at ASP plus 6 and that creates
19 faulty incentives and it's kind of unique, well, let's just
20 change that.

21 MR. HACKBARTH: Yeah.

22 MR. ARMSTRONG: And that's part of the reason why

1 I was asking --

2 MR. HACKBARTH: Kathy was, I think, the person
3 that Mark was alluding to.

4 MS. BUTO: Actually, I think the episode bundling
5 was actually Jay's idea, but I think it is an important
6 avenue to explore. When we were talking about LCA, we're
7 really talking about drugs that are in a category where
8 you've got multiple drugs that could compete potentially
9 against an effectiveness guideline and a price could be set
10 that way.

11 There's a lot of frustration around -- and we
12 tend to kind of conflate these -- the new high-cost drugs.
13 And so the question is: How do you go at an area of
14 therapy where you sort of have a unique drug or maybe one
15 or two drugs in a category? And it's very tough to go
16 after innovative drugs unless you can do it in the context
17 of let the practice figure out whether they need that drug
18 or something that may already be available that may not
19 produce the same benefits. And the bundle, at least in my
20 view, is one way that you can provide that flexibility.

21 So I think it solves in a way a different
22 problem, but it's the one that keeps coming up. Whenever

1 we talk about LCA, it's funny that the issue of the high-
2 cost hep C drugs comes up, and yet I'm not sure that they
3 lend themselves to LCA as well as they might lend
4 themselves to something more like the Bach approach that's
5 an evidence-based bundle, maybe a more limited bundle.

6 So I think it's worthy of our thinking about it.
7 For one thing, it moves away from the government having to
8 make very politicized decisions in this area. And it also
9 tries to push more the notion of evidence-based practice.
10 So I think that was the rationale behind the exploration.

11 I have to say, looking at these options and
12 particularly the CMS model, you know, I'm a little baffled,
13 but we can get to that in Round 2 because I'm not sure --

14 MR. HACKBARTH: I do think we need to be
15 realistic that this isn't a panacea. So when, you know, a
16 new drug comes out that has a very high price tag that
17 would sort of swamp the bundle that's been created, you
18 know, there will be controversy about, well, the bundle
19 price is too low because it doesn't take into account this
20 innovative new drug. So it doesn't make all problems go
21 away by any stretch.

22 MS. UCCELLO: So I want to build off Mary's

1 question about the cost sharing. It's something I hadn't
2 thought of, so I thank her for bringing this up. I want to
3 make sure I understand this correctly.

4 So in MD Anderson, there's one bundled payment,
5 and the cost sharing is based on that one cost, right? So,
6 in effect, that means that some people are going to be
7 paying more than they would have otherwise, and some less,
8 if it were -- right? So I think as we move forward on this
9 kind of thing -- and I would imagine that the broader the
10 bundle, the bigger the variation could be compared to what
11 they would have paid before.

12 MS. SMALLEY: Right. In the MD Anderson example
13 also, they picked a very narrow, specific type of cancer.
14 And so I think that, you know, the variation was less
15 because MD Anderson has kind of been working on, you know,
16 kind of streamlining that for a long time, and that's part
17 of why they were able to do that prospective payment that
18 way.

19 MS. RAY: And to be clear, they have eight
20 bundles based on the treatment approaches, so that's
21 another way that they are reducing the variation, I would
22 imagine.

1 MS. UCCELLO: Right, but I think -- and I won't
2 say this in Round 2, but I think as we move forward on
3 this, it's important to kind of understand a little more
4 about how beneficiary cost sharing will be affected and how
5 the different designs may affect that differently.

6 DR. MILLER: The only thing to keep in mind in
7 that is, depending on how you construct the bundle, if you
8 keep a fee-for-service process running underneath, you
9 know, sort of a shared savings, I'm not sure it's
10 immediately true that the beneficiary gets it. And so that
11 might be a design thing that you guys want to talk about in
12 Round 2.

13 DR. HOADLEY: Yeah, I had some similar thoughts
14 about cost sharing, which we can get back to in Round 2,
15 but my specific question relative to that was on the CMMI
16 demonstration, since that's an example that isn't bundled
17 at the level of the drugs, right? So the cost sharing
18 would still be done the way it is, and the shared savings
19 would be separate. With the \$160 monthly fee, would there
20 be cost sharing attached to that?

21 MS. RAY: I don't think so.

22 DR. HOADLEY: Okay. And my other questions are

1 sort of tags on earlier questions. On Slide 6, you know,
2 you said you can go back and look at sort of numbers, if
3 you started the trigger event earlier at the diagnosis. Do
4 you have a sense at this point of how much earlier the
5 diagnosis tends to be than the first oncology?

6 MS. RAY: You know, I don't want to misspeak.
7 Let me -- we can get back to you on that.

8 DR. HOADLEY: That's fair enough.

9 MS. RAY: Okay.

10 DR. HOADLEY: And on 5, I think Glenn asked
11 about, you know, whether the pattern would be different for
12 other kinds of cancer than the three you looked at. Is it
13 different among these three? Have you looked at that?
14 Would you get a similar pie chart for each of the three?

15 MS. RAY: I'd have to get back to you about
16 whether it's a similar pie chart. Actually, it's down
17 here. But what I can tell you is that the average cost per
18 beneficiary for the 180 days is lowest for the breast
19 cancer patients and is higher for the colon and lung cancer
20 patients.

21 The other item to keep in mind is this does not
22 include Part D.

1 DR. HOADLEY: Right.

2 MS. RAY: So that is something else that --

3 DR. HOADLEY: Breast cancer in particular would
4 have Part D drugs.

5 MS. RAY: Part D drugs. And when I did look into
6 Part D drugs, those patients -- the breast cancer patients
7 did use more antineoplastics in terms of dollars, Part D
8 dollars. But, again, I only looked at it after the first
9 Part B drugs, so I don't know what was going on before the
10 first Part B drug.

11 DR. HOADLEY: So it seems like it would be useful
12 -- I mean, it's a lot of different cuts on the data, I
13 realize.

14 MS. RAY: Right.

15 DR. HOADLEY: And you may not be able to give us
16 every particular split we want, but it would be useful to
17 be able to think about some of those other splits, and we
18 may get more specific as we get into this. I'll leave my
19 other things for Round 2.

20 MR. HACKBARTH: So just to follow up on that
21 point about some types of cancer involving significant use
22 of Part D drugs, you know, I think that would be an

1 important consideration in design. For sure you wouldn't
2 want to create an incentive where because only Part B drugs
3 are included in the bundle, there's a much heavier use of
4 Part D drugs, some of which are going to be very expensive
5 for patients because of specialty tiers and whatnot.

6 MR. THOMAS: Just two questions. First, did you
7 look at the types of quality measures that were looked at
8 in the various pilots? And were any of the quality
9 measures around the coordination of care, kind of going
10 back to Scott's point? Was there an improvement in
11 coordination of care or patients' perception of
12 coordination of care in any of the pilots?

13 MS. RAY: The United pilot is the only one that
14 we have an evaluation for, and that one does not discuss
15 that. They discussed that there was no change in survival
16 and that patient admissions went down. There's lots of
17 measures in the new CMMI oncology care model, which I
18 expect after the five years we would hope to learn
19 something about that.

20 MR. THOMAS: And then I know in the United it
21 indicated that surgical intervention was part of the United
22 bundle with MD Anderson. Are any of the others including

1 surgical intervention?

2 MS. RAY: The Blue Cross/Blue Shield of Florida
3 one is based on the surgery for prostate cancer.

4 MR. THOMAS: And then CMMI, that's really kind of
5 post-surgical intervention and really kind of focused on
6 the medical oncology and radiation oncology --

7 MS. RAY: Right. For the CMMI, the trigger point
8 is the chemotherapy administration. If the patient is
9 managed only on, let's say, surgery and radiation oncology
10 --

11 MR. THOMAS: Then --

12 MS. RAY: That's right.

13 MR. THOMAS: Okay. Thank you.

14 DR. CHRISTIANSON: Yeah, also on the CMMI, the
15 way you wrote that up, it seemed like it's kind of more in
16 the formative stages than -- yeah. So obviously one of the
17 things that stands out is the 30-plus quality measures and
18 seven domains, and the statement in your writeup that said
19 that payment would be adjusted based on that. Do we know
20 anything more about that? How much of the payment is at
21 risk for adjustment based on those measures, and how might
22 that work?

1 MS. SMALLEY: So the payment is from the shared
2 savings component, is the payment that would be adjusted
3 based on the quality metrics. So when you're comparing the
4 actual expenditures to the benchmark target price, there's
5 that 4 percent discount rate. And then if the actually
6 expenditures fall below that, the practices are eligible
7 for up to 100 percent of that difference, and that's based
8 on the quality measures. So if they perform well in all of
9 the quality measures, they could theoretically get all of
10 the shared savings. And if they perform well in some and
11 not others, that percentage would go down.

12 DR. CHRISTIANSON: So did I understand that 4
13 percent then is really the potential gain, or --

14 MS. RAY: The 4 percent, so every -- CMS will
15 calculate a benchmark for every practice. From that
16 benchmark they will subtract 4 percent. I guess that's
17 supposed to be the government share. And so the difference
18 between the practice's actual spending and the target, that
19 would be the potential shared savings for the practice.
20 And if the practice met 100 percent on its quality metrics,
21 that practice would get 100 percent of the savings, between
22 the target, which is the benchmark minus 4 percent on the

1 one-sided.

2 MR. HACKBARTH: And so it's the minimum savings
3 ratio, to use the --

4 MS. RAY: Yes.

5 MR. HACKBARTH: -- ACO language, 4 percent if the
6 minimum savings.

7 DR. CHRISTIANSON: All right. Thanks.

8 MR. HACKBARTH: Okay. We're ready for Round 2.
9 Could you just help me think about the relative merits of
10 narrow versus broad bundles? All other things being equal,
11 you know, I would be inclined to go broader as opposed to
12 narrower, of course, with appropriate boundaries on maximum
13 risk and the like. Just talk about what the arguments are,
14 pros and cons, on bundle size.

15 MS. RAY: Well, starting with the broad approach,
16 a broader approach would give clinicians and practices more
17 opportunity to affect other services: inpatient
18 admissions, ED visits, hospital outpatient department
19 visits. On the other hand, it could be more complex to put
20 into effect a broader bundle if it affects multiple
21 provider types.

22 On the other hand, the narrow approach, like the

1 Bach approach, just the oncology drugs and the
2 administration, I mean, that's -- there's no opportunity
3 for savings anywhere else.

4 MR. HACKBARTH: The United experience, which was
5 surprising that the oncology drug spending went up and
6 hospitalization and other services went down, really sort
7 of caused me to think, well, a broader bundle really may
8 make sense. You know, if there is a great new drug that
9 comes in that can potentially reduce other types of
10 utilization, you want clinicians to have both that
11 incentive and that opportunity to shift the allocation of
12 resources in oncology care. So I'd be interested to hear
13 what other people think about that as we go through.

14 DR. REDBERG: Just to follow on that, I think
15 there is an advantage to a broader bundle, because like a
16 lot of things -- you know, there's a lot of different ways
17 to treat the same cancer, prostate being one example,
18 chemotherapy, radiation, or surgery. And there are a lot
19 of studies indicating the results aren't very different,
20 you know, for a lot of different cancers with different
21 courses of treatment and what you get is sort of depending
22 on who you see, you know, in your first encounter. And so

1 you wouldn't want to create perverse incentives to get care
2 that was not necessarily the best outcome base, and that
3 seems to me an advantage of the broader bundle.

4 MR. HACKBARTH: Others on this particular point?

5 DR. CROSSON: Yeah, I agree with that. I think,
6 you know, experientially, as we heard from the United
7 study, it was not just cost of hospitalization but total
8 costs actually went down when drug spending went up. And I
9 think what I heard Nancy say was that it's likely that the
10 Come Home medical home project is going to show similar
11 results. So for all the reasons that Nancy said, which is
12 it gives the physician or other caregiver or team of
13 caregivers --

14 DR. NAYLOR: He told me I could poke him.

15 [Laughter.]

16 DR. CROSSON: -- a broader opportunity to make
17 tradeoffs and the like, which -- it also, you know, as I
18 think Mark mentioned earlier, it's one of these
19 opportunities that we have to kind of introduce into the
20 more diverse marketplace of care the notion of care
21 coordination, of working together in teams and accepting
22 risk for the total cost of care.

1 There's one other point that I think is important
2 to take into consideration, and it has to do with the fact
3 that if we were to choose narrower bundles, we might very
4 well find, you know, as it looks like as is already the
5 case, that the latitude that exists in the choice of
6 pharmaceutical agents is narrower than we might expect.
7 And I think one of the reasons for that is a lot -- I think
8 folks know this, but a lot of the oncology care that's
9 delivered in the country is actually delivered on protocols
10 that are established at NIH and other places, oncology
11 groups that exist around the country. And there are some
12 areas of latitude, but there's not complete latitude. And
13 I think we would potentially have a risk -- or at least,
14 you know, looking like we were doing something which could
15 disincite physicians from signing up for research protocols
16 if, in fact, there was a strong financial incentive to have
17 more latitude in drug selection than was indicated if one
18 signed up for a cooperative protocol.

19 So I just think -- I guess I'm thinking we need
20 to be thoughtful about that, and maybe as we talk to more
21 people in the oncology field, get a sense of how much
22 latitude actually exists in the choice of administered

1 drugs, at least.

2 DR. NERENZ: I just wanted to speak directly in
3 support of Jay's point, and I was going to make the same
4 point, basically, that so much of oncology care is protocol
5 driven that I think as we think about the design of
6 bundles, we want to be clear about are we fundamentally
7 thinking about choices among all sorts of varied drug
8 treatments, and Jay's point would suggest, well, maybe not.

9 But on the other hand, we may be thinking about
10 situations in which there are opportunities for care
11 coordination, side effect prevention, unplanned admission,
12 and my sense of the intent of this CMMI demo is that, more
13 so than the choice of drug. I guess I'm -- another way of
14 phrasing Jay's point.

15 DR. CROSSON: It's broad.

16 DR. NERENZ: Yeah. Broad, good.

17 MR. HACKBARTH: On this same point? Mary, Bill,
18 is it on this point? Go ahead. Mary then Bill, and then I
19 have --

20 DR. NAYLOR: I also really support a broad
21 approach. I think Slide 4 or 5 tells really extraordinary
22 stories. We have 60,000, I think, in this study, and

1 12,000 die within 180 days. So if you were to try to
2 uncover what was going on in inpatient, you might be
3 watching a lot of people at end of life, bearing high
4 costs, et cetera. Only 4 percent, or about \$1,600 of the
5 \$41,000, is being spent on home care and hospice.

6 So if that goal is reducing total Medicare
7 spending at the same time that we're ensuring some higher
8 quality of life, I think we have to have a very broad
9 opportunity here to really adjust care as patients' needs
10 are changing.

11 DR. HALL: Listening to the discussion so far, I
12 think what we're talking about is what do you mean by this
13 term we use over and over again, "oncology services." What
14 is this bundle looking like? I think Scott raised some
15 issues, and I think Warner as well. Are these just
16 discrete episodes of administration of a drug, or is there
17 a broader way to look at this?

18 And I think here's another opportunity for us to
19 sort of think large. My crystal ball is no better than
20 yours, but it's probable that in the future of Medicare
21 that any of us in the room here who reach that age have at
22 least a third or a 50 percent chance of either having had

1 or will have cancer. Increasingly, cancer is a chronic
2 disease, much in the same way as heart disease is.

3 So I think the model is saying oncology services
4 are someone makes the diagnosis, we give them a drug, and
5 let's make sure that we're using protocols, that we have
6 some cost effectiveness in this drug.

7 And then when that ends, we put them on hospice.
8 That's a model that's been used traditionally, but I don't
9 think that's the model of the future, so what does that
10 really mean, I guess. Well, to me, it means that there are
11 a lot of issues about oncology services that have to do
12 with, I guess what Mary was referring to and others in the
13 room, of what we might say quality of life. There are some
14 credible stories that sort of pass among physician groups,
15 largely oncologists.

16 A good example would be that parents of children
17 with cancer will say they don't have to ask the doctor when
18 their child is getting worse, and what's the clue? The
19 health care personnel don't talk to them anymore, or
20 stories about a woman who writes a great deal who had a
21 patient in psychotherapy. She was a physician, and this
22 woman said that she had decided with her oncologist to take

1 a holiday from specific drug treatment. She said, "I'm not
2 sure this is how I want to live the rest of my life," and
3 when she asked when the next appointment would be, the
4 oncologist told her, "Well, there's no reason for you to
5 see me again because we're not delivering some kind of a
6 drug or something." So she decided to undergo chemotherapy
7 just so that she could have the reassurance of being with a
8 physician that was knowledgeable and that had developed a
9 relationship with her.

10 So I think CMMI demonstration may give us some
11 clues as to what we really mean by oncology services, so I
12 really would think we should look very carefully into a
13 broader approach. It's going to affect a lot of us, if it
14 hasn't already.

15 MR. KUHN: I'm also kind of in the camp of the
16 broader bundle, and I think that's worth looking at for a
17 couple of reasons. One is a little bit of what Bill was
18 talking about, and I'm trying to think about more the
19 patient experience in this effort.

20 So one is, if it's a narrow bundle, does it
21 create some arbitrary decision-making that might be made
22 out there, and if it's a broader bundle, does it give the

1 physician more latitude to design the treatment plan and
2 the activities that are related to that?

3 Then also, I think about -- and maybe the
4 clinicians here can help me think this through -- is does a
5 broader bundle also help deal better with symptom
6 management that folks who are going through chemotherapy
7 are dealing with, whether it's the issues of pain, fatigue,
8 and nausea, and the administration of antiemetics to deal
9 with some of those and those issues out there. And I just
10 think a broader bundle maybe gives them more latitude to
11 manage some of that symptom management, which is so
12 critical for those that are going through chemotherapy.

13 DR. COOMBS: Thank you very much.

14 Jay brings up a very good point, and I thank you
15 for that because I was thinking along those lines. Breast
16 cancer treatment at various stages is pretty much
17 predictable throughout the country.

18 One of the things I thought about is the broad
19 bundle is -- I think I favor that in some scenarios.
20 Narrow bundles might be more advantageous when you have
21 something like prostate cancer. The patient goes in, gets
22 their prostate done, and that's it. And they're fine.

1 They go back to work, and they do their thing. Whereas, as
2 you've mentioned some of the other interventions after
3 chemotherapy is delivered, during chemotherapy, actually
4 require a lot of supportive treatment, whether it's
5 supportive treatment because of symptomatology and even
6 pain management, and so I think when you have someone who
7 has a considerable amount of pain, nausea, and vomiting,
8 those kind of things can be handled with a broad system, a
9 broad approach to bundling. So I think I would favor that.

10 One of the things, since the mic is on, I was
11 thinking along the lines of how do you look at quality and
12 efficiency and mortality in such a fluctuating group of
13 diagnoses -- colon cancer, lung cancer, and breast cancer,
14 all thrown into one bundle. Someplace like MD Anderson has
15 the capacity to do some really innovative things in terms
16 of looking at data, looking at cost, and becoming efficient
17 and saying, "In our hands, the national data says this in
18 terms of survival at the given states, and our data
19 indicates this as well." And a smaller entity or a low-
20 volume provider might not have that same capacity.

21 So I think the benchmarks for quality and
22 efficiency, looking at mortality, with the smaller

1 providers, it's going to be very different than in MD
2 Anderson, and it's almost like it's a high volume -- and
3 we've always had this discussion about providers -- high
4 volume, are they better performers because of the mere fact
5 that they are high volume and they see a lot more and they
6 do a lot more. Naturally, we cannot provide a high-volume
7 provider like an MD Anderson in every single ZIP code in
8 the country, but I think we have to take into consideration
9 that Medicare beneficiaries are not all in the MD Anderson
10 region.

11 MR. ARMSTRONG: Just briefly, I mean, you know
12 I'm a big bundle kind of a guy. In fact, I think go
13 bigger, go home as far as bundles are concerned.

14 [Laughter.]

15 MR. ARMSTRONG: In fact, I think for the record,
16 we ought to say bundles -- the best bundle for dealing with
17 our issues here is one that prevents cancer to begin with,
18 right? Okay, so I said that.

19 Now, having said that, I'm actually not sure I
20 agree with what we've been saying. First, what are we
21 trying to solve? Is it we're spending too much on drugs
22 because the payment at ASP plus six creates the wrong

1 incentives? There's a solution to that that has nothing to
2 with bundles, it seems to me.

3 Second, I'd like to understand. Walmart is
4 buying bundles for orthopedic surgeries. This is happening
5 around bundles that actually are remarkably predictable,
6 and there's very little variation in the outcomes. It
7 seems oncology care is kind of the opposite of that, and so
8 I would just before we leap to the conclusion ask, Is this
9 really the best place first? Is a bundle the best solution
10 to the problem we're trying to deal with? And second, is
11 this really -- if we're going to use bundles, is this the
12 best population of patients for us to apply those bundles
13 to?

14 To be honest, there's a lot about protocols and
15 so forth in oncology I have no knowledge about, and so I
16 could be wrong about that. But I just think it was worth
17 challenging our assumptions about that as we launch into
18 this evaluation.

19 DR. MILLER: You also made a comment yesterday
20 when we were talking about Part D and we were going through
21 all the risk stuff, and you made a similar comment, right?

22 [Laughter.]

1 DR. MILLER: My batting average today, I want to
2 apologize to Kathy. I think she must have been sitting
3 next to Jay that day.

4 I thought you said yesterday -- and maybe I
5 should take this offline because what I thought you were
6 saying yesterday was we're spending all this time on risk
7 and trying to think about the risk structure of D, but is
8 there -- I almost asked yesterday. You said is there
9 almost like a bigger question we should be asking about how
10 we think about how we pay for drugs here. I almost took
11 your comment that way, and I wonder if you're saying that
12 in so many words again here today.

13 Maybe you and I ought to talk a little bit
14 because I feel like there is a consistency in your comments
15 that are trying to push in a different direction. I'd like
16 to make sure I follow that.

17 MR. HACKBARTH: Let me just give my own personal,
18 very specific answer to your question. I don't see this as
19 a way of fixing problems that may exist with the ASP
20 payment system. This is a different conversation, and
21 that's in part why my instinct -- not a conclusion, but an
22 instinct -- is a broader bundle is better. It isn't just

1 about how much we pay for drugs. It's also about which
2 drugs are appropriate and which other services are
3 appropriate in high-quality oncology care. So I don't
4 think that we are taking on something big and complicated
5 to solve a narrow problem like, "Oh, we don't like the ASP
6 system." I think the objectives here are much broader than
7 that.

8 MR. ARMSTRONG: Yeah. And, Mark, we should take
9 that offline. If it was brilliant, then I'll take credit
10 for it, but I don't really remember what it was.

11 [Laughter.]

12 DR. REDBERG: Otherwise, it was Kathy.

13 MR. ARMSTRONG: I do think in oncology, to the
14 degree I know about this, there are very expensive and not
15 so expensive surgical versus drug versus radiation
16 alternatives, and to me, that's much more around engaging
17 in an evidence-driven evaluation of the alternatives, and
18 to the degree we create a payment policy that inspires that
19 -- and that really makes sense to me -- I'm not sure that's
20 a bundle, necessarily.

21 But if that's really what we're trying to solve,
22 then I'm all for it. I actually thought we got into this

1 through our concern about the specific Part B drug
2 spending.

3 MR. HACKBARTH: This has been helpful, Scott.

4 As you probably noticed, we're over time, and I
5 want to get through everybody who's had their hands up and
6 been waiting patiently, and then I also want to allow a
7 very brief opportunity to sort of open up -- have people
8 identify other big issues that they would like Nancy and
9 Katelyn to explore in the next round. So my targeting for
10 finishing is at ten o'clock. If you would help me get
11 there, I would appreciate it.

12 Jack.

13 DR. HOADLEY: I'll try to be brief.

14 I mean, in some ways, I think the counter-issue
15 that we might have been trying to solve isn't so much the
16 ASP issue, but the least costly alternative issue, which
17 you can almost think of as kind of a mini bundle, and it's
18 a mini bundle in the sense that it's among drugs that are
19 very similar, so it's not really the way we normally think
20 of bundles. It's saying if there's a couple drugs -- it's
21 almost like generic and non-generic level of similarity or
22 one step above that.

1 On the one hand, I'm a little like Scott. On the
2 one hand, I find it very appealing to think about this, the
3 broader, because -- I mean, Craig talked about some of the
4 things that you might do to keep somebody out of the
5 hospital that had more to do with the ancillary services,
6 the ancillary drugs, dealing with symptoms and side effects
7 and keeping you healthy. Given the chemotherapy and the
8 idea that those would be in the bundle makes a lot of sense
9 because they should be part of the overall package, even to
10 the point of thinking about what keeps people in and out of
11 hospitals and all that.

12 The problem is I have trouble thinking about --
13 so if we're at this level of a large bundle and we're
14 setting some kind of an average price on it, what are we
15 now averaging across? Are we averaging across such a huge
16 array that you really actually create the other kinds of
17 incentives? If I think about how sort of the DRG world
18 thinks, you start to then subdivide. So we've got the
19 bundle for treating breast cancer, okay, but now how many
20 comorbid conditions, and what stage cancer? Maybe that's
21 the right way to go; maybe not.

22 Some of this has to do with choices. Do we want

1 the choice of treatment when things might be very diverse
2 in cost to be overdriven by -- I mean, it becomes just as
3 cost driven if the incentives are we have one average, and
4 so if you pick the expensive one, you're really going to
5 lose a lot of money. Pick the cheap one; you're really
6 going to make a lot of money. That's as much of a
7 financial thing as saying, "Okay. We've got it exactly
8 lined up with the cost of each service that has their own
9 profit margins and so forth on it."

10 Then eventually, I want to see us linking this
11 back to cost sharing, which would be the issue I'd put up
12 in sort of last thing, and if the cost share is now
13 attached to the bundle now, the patient has their own set
14 of odd incentives. They are going to pay the same amount,
15 regardless of treatment. That could be good, but they
16 don't have the same options. If they want to choose a very
17 conservative treatment, they are still paying part of the
18 cost of other people's less conservative treatment.

19 MR. HACKBARTH: Those are really important
20 points, Jack. So if you go broad, then that means either
21 you have to have really good risk adjustment, so that
22 you're not really being unfair or have real confidence that

1 the people receiving the bundles have large numbers, and
2 there's going to be lots of averaging ongoing, which is
3 probably not true in this case.

4 Then you try to counteract problems with
5 potential risk selection and people being unfairly burdened
6 by narrowing and doing clinically homogeneous subgroups,
7 and you've got to find an appropriate balance. Breadth has
8 strengths, but it also brings with it potential problems
9 and need for risk adjustment and all that stuff. These are
10 not simple choices.

11 DR. HOADLEY: And risk adjustment would mean
12 something very different inside this world.

13 MR. HACKBARTH: Exactly.

14 DR. HOADLEY: We're not talking about age --

15 MR. HACKBARTH: Right.

16 DR. HOADLEY: -- and people with certain comorbid
17 conditions and things. We'd be talking about risk
18 adjustment within sort of a cancer context.

19 MR. HACKBARTH: Exactly. Really good points.

20 Warner, you had your hand up?

21 Let me just see the hands of people who want to
22 get in here. Okay. so I have Warner, Kathy, Dave, Craig,

1 and Rita.

2 Who wants to open up a completely new issue?

3 DR. REDBERG: Let him speak first.

4 MR. HACKBARTH: Okay.

5 DR. HOADLEY: I could say that I've raised the
6 cost sharing kind of link and not say it again.

7 MR. HACKBARTH: Okay.

8 Warner.

9 MR. THOMAS: I would just say one. I think the
10 concept is a good one. Two comments I would make.

11 One, I think having a broader bundle in certain
12 instances where you look at a surgical intervention where
13 there could be, going back to the point made earlier, that
14 that could or could not be an option, I think could make
15 some sense, although I think there's some concerns there.

16 I do think going down the road, if we have a
17 bundle around chemo and radiation and the treatment
18 protocols here, I think would be very helpful because I
19 think there are incentives there that are not necessarily
20 aligned. So I would say that that would be a positive
21 direction to go. I would actually say in certain
22 diagnoses, a broader bundle could make some sense, but I

1 would say in almost all diagnoses, going the direction of a
2 chemoradiation, that treatment regimen could be very
3 helpful.

4 MS. BUTO: I was going to say that I think a
5 combination of what Scott was talking about, a little bit
6 about the broad bundle, is something that could be further
7 pursued. In other words, the model would actually start
8 with kind of the United One approach, which is the
9 assessment team, and then the bundles could be broad but
10 then focused on whether it's going to be radiation
11 oncology.

12 And by the way, I think there already was a
13 radiation oncology bundle, a weekly management fee, that
14 when I was there we created to allow more flexibility for
15 the practice. So there have been tiny efforts to try to
16 bundle some of this to make it more rational for the
17 provider groups.

18 So you could then create a broader bundle that
19 would include aftercare, hospitalization, et cetera, plus,
20 say, radiation oncology or chemotherapy.

21 Two points I wanted to make are I really hope
22 that in thinking about the bundling of an oncology drug

1 approach that Part D would be included. I mean, I just
2 think your point, Glenn, that what isn't in, you're going
3 to create some kind of a distortion that you can't even
4 anticipate yet.

5 And the other thing I would just mention -- and
6 this might be a follow-up -- is that I think it's important
7 for us to think about, a little bit, the criteria that an
8 agency like CMS would use in trying to assess what
9 opportunities to go after.

10 If you could look at those areas of treatment, it
11 could also be surgery. It could be hip replacement,
12 whatever, but oncology is clearly one of them where the
13 agency ought to be developing different approaches,
14 criteria, and then some notion of the ability of an agency
15 to actually implement this thing.

16 I think some of this gets so complicated. I
17 looked at the CMMI demonstration, and I thought 5 years,
18 all these different quality measures, one-sided risk. At
19 the end of the day, I think some of us could imagine what
20 the result is going to be. It looks like it's going to be
21 more cost with the per, the monthly fee, and one-sided
22 risk.

1 So I just feel like if you go at it from the
2 point of view of where do we think the opportunities are to
3 do a better job of providing incentives, and then what are
4 the approaches that will actually improve the overall
5 outcome. And this approach, focusing just on oncology
6 drugs, may not be the right one, but I just thought a
7 combination of Scott's approach and then a broader bundle
8 around that assessment was a better way to think about it.

9 DR. NERENZ: Okay. Two very quick things. If
10 this is going to come back around to us, the latter part of
11 the chapter on pathways, I'd appreciate it if you could
12 clarify more for us what the difference there is, if any,
13 between pathway, protocol, and guideline. I couldn't tell
14 in reading it exactly what that was, and since we've said
15 that cancer care is characterized by being protocol-driven,
16 I'd be really interested in knowing is there an additional
17 concept under the word "pathway"? So future.

18 And the other thing is that although -- on the
19 CMMI demo, although I think it's very appropriate to have
20 it on the list here of bundling demos, I don't think that
21 is its essence. To me, its essence is more practice
22 transformation and care coordination. So if I was going to

1 say what kind of a demo is it, I'd say it's more of a p kc
2 transformation and care coordination demo than it is a
3 bundling demo. It's got features of both, but what's
4 dominant I --

5 DR. SAMITT: I recognize why we jumped in
6 immediately to the size of the bundle as the first topic,
7 although I actually wonder whether that question is the
8 last question to answer, because as I was trying to go
9 through it, very similar to Scott, I tend to be a big
10 bundle guy. But as I thought about that in this particular
11 instance, I have some concerns.

12 So, for example, how would we address the
13 stinting issue? I'd be a little worried that the risk of
14 stinting increases as the bundles get bigger. If you're
15 dealing with a discrete episode and you say I'm going to
16 look at the costs of drugs, when you prescribe drugs in a
17 particular cancer diagnosis, stinting is less likely. But
18 if someone's diagnosed with cancer and now there's this big
19 bundle that you could spend or not spend, I would be
20 worried.

21 Likewise, the other factor in here that's not
22 considered is who's accountable for the bundle. So with

1 colon cancer, is it the PCP that's accountable? Because
2 they could direct the patient in a variety of different
3 directions. Is the colorectal surgeon accountable? Is it
4 the oncologist that's accountable? And so yet again, I
5 think you'd have to figure out who would be accountable for
6 the bundle, and the bigger the bundle, the more vague it
7 gets.

8 So I would argue when we come back to this, we
9 should think about some of the other detailed elements
10 perhaps first, and it may guide us to the right decision
11 about how to think of the size of the bundle.

12 DR. REDBERG: First, just to respond to the last
13 part of Craig's and then give you my big picture thing. So
14 I could say I'm a big bundling kind of gal.

15 [Laughter.]

16 DR. REDBERG: And I understand, of course, the
17 stinting issue, but I think we should also recognize how
18 much harm there is in the current system with the incentive
19 to overtreat, because we have a lot of harm -- a lot --
20 from overtreatment, and people say, you know, there could
21 be -- but right now I think if you want to talk -- you
22 know, we want to get to the right place, we're kind of over

1 here in terms of incentives for the opposite of stinting,
2 you know, for overtreating people where they're really
3 suffering at the end of life and not getting good care, as
4 Mary alluded to.

5 And so I think, you know, getting back to our
6 goals, our goal is always to focus on the Medicare
7 beneficiary and how can we deliver the best care. And to
8 me the best care is, you know, the best treatment and then
9 still compassionate care, and that's I think where we
10 really have a lot of room for improvement in oncology care,
11 because we know that a lot of people get very toxic and
12 disfiguring and unpleasant treatments at the end of life
13 without any benefit. And there are a lot of different
14 reasons for that.

15 So, you know, to me we do best when we stick to
16 the evidence of treatment that improves outcomes because
17 then -- and that's why I think an outcome focus in whatever
18 bundle or approach we take is really important.

19 And I wanted to point out a few trends in
20 oncology in particular. One is that the FDA has been
21 moving towards approving oncology drugs in particular on
22 the basis of markers and surrogate outcomes, progression-

1 free survival, and even biomarkers. The problem is, as we
2 saw, for example, with Avastin, that you can approve
3 something on the basis of progression-free survival and say
4 we're going to wait for the studies, which then take longer
5 to look if there's a benefit on survival, even when there
6 is not a benefit on survival, and so now you're giving a
7 very toxic and very expensive drug with no improvement in
8 survival. Practice patterns are established and don't
9 change, and that is just one example. And that is
10 happening more and more where drugs, very expensive and
11 very toxic drugs, are being approved on surrogate markers
12 without evidence of benefit on survival.

13 Then I'm not an expert on oncology guidelines,
14 but like a lot of other guidelines, I know that they're not
15 always based on evidence. They're also based on expert
16 opinion, which may not -- and I've heard criticism of the
17 NCCN because a lot of the guideline panels there have a lot
18 of people with conflicts of interest, and that -- because
19 anything -- and that was particularly pointed out to me
20 because I think anything listed at NCCN Medicare has to pay
21 for, but it's not always a very strong evidence base, and
22 there are other reasons that -- and so I think, you know,

1 if we're looking at how we want to spend the Medicare money
2 on treatments that improve patient care, I think we need to
3 look really closely at the evidence that we're looking at,
4 and then, again, you know, if we were going to focus on
5 outcomes, I think that's a better way to do it.

6 And then just lastly -- and I think Mary alluded
7 to this -- we know that a lot of people are getting care at
8 the end of life that is really futile and toxic in oncology
9 and that people would do better with sooner referrals to
10 palliative care and hospice treatment. And I think that
11 it's important to recognize that in the bundles. You know,
12 that example that Bill mentioned I hear about a lot where
13 patients at end of life feel like their doctors don't talk
14 to them anymore when they don't have treatments for lots of
15 different reasons. I think we become very focused in
16 medicine on giving, you know, medical treatment or surgical
17 treatment and feel like we've failed if we can't offer --
18 and I think, you know, we really need to start focusing on
19 the fact that we have jobs as physicians even if we don't
20 have drugs that we can give patients, and that it's not a
21 failure of medicine or a physician to say, you know, "I'm
22 very sorry, but you are at the end of life, but I am still

1 here for you. I am still your doctor, and I will still
2 continue to see you and care for you," because I think it
3 is very hurtful and harmful. And I would hope that, you
4 know, we'll keep that in mind as well when we -- because I
5 think it's certainly not the only reason, but right now the
6 system tremendously rewards doing, you know, expensive
7 treatments that often don't help patients at the end of
8 life instead of focusing on patient goals, which is really
9 a more compassionate death often at home, not in the
10 hospital.

11 DR. CHRISTIANSON: Just a real -- I think this is
12 consistent with what Dave said and certainly with what Rita
13 said. The bundling discussion tends to, it seems to me,
14 start with the notion that can we construct a bundle that
15 will save Medicare money without having a detrimental
16 effect on quality. And that's certainly consistent with
17 the value-based purchasing notion of getting more for the
18 Medicare dollar.

19 So my question for you two, to think about, not
20 to answer now, is: If instead we viewed value-based
21 purchasing as using the same amount of money to get better
22 outcomes -- and I think this is consistent with what Rita's

1 saying -- in terms of quality of life and in terms of
2 clinical quality, would our discussion be different? Would
3 we be thinking about bundling and what the issues are
4 different if we -- if the goal of bundling was framed as
5 improving quality of life, improving quality of care for
6 Medicare beneficiaries for the same amount of money, which,
7 again, is value-based purchasing. We're getting more for
8 the dollar. So that's just a sort of general question for
9 you to think about, I think.

10 MR. HACKBARTH: Okay. Thank you, Nancy and
11 Katelyn. I'm sure we'll hear much more of this topic in
12 the future.

13 So our last session is on synchronizing Medicare
14 policy across payment models.

15 Julie, are you leading? Whenever you're ready.

16 DR. LEE: Good morning. This morning, we
17 continue our discussion on synchronizing Medicare policy
18 across payment models.

19 In your mailing materials, you have a draft
20 chapter for the June report containing our analyses from
21 January and March and new materials on beneficiary
22 decisionmaking and coding adjustment. We'll try to pull

1 all the parts together in today's presentation.

2 We'll begin with a review of previous
3 presentations and go over key design issues raised during
4 past discussions. There are additional issues for you to
5 consider, including those related to policy design,
6 beneficiary decisionmaking, and coding adjustment.

7 In January, we showed that no one model is
8 uniformly less costly to the program in all markets. MA
9 and ACOs tend to have lower program spending than fee-for-
10 service in high service use areas; whereas, fee-for-service
11 tends to have lower spending than MA in low service use
12 areas.

13 For example, when we looked at the relative
14 program spending for MA, ACOs, and fee-for-service in
15 markets where all three models exists, we saw that MA and
16 ACOs had lower program spending compared with fee-for-
17 service in markets that are in the highest quartile in
18 service use.

19 In March, we shifted our focus to the beneficiary
20 perspective and looked at three illustrative examples for
21 calculating beneficiary premiums.

22 For simplicity, we went through the examples for

1 two market areas, Portland and Miami, which are at the
2 tails of the distribution in terms of average fee-for-
3 service spending. We added Columbus, Ohio, as a market
4 area whose fee-for-service spending is roughly in the
5 middle of the distribution.

6 This table summarizes the three illustrative
7 examples from last month. Just to review, the three
8 examples were defined by two policy levers: one, how the
9 base premium was set, whether nationally or locally; and,
10 two, which Medicare option that base premium paid for,
11 whether fee-for-service Medicare everywhere or "lower of"
12 fee-for-service or MA in each market. In other words,
13 either fee-for-service Medicare or reference MA plan,
14 whichever was lower cost.

15 As you can see in the table, beneficiary premiums
16 can vary across different options for Medicare coverage and
17 also across the market areas. For instance, if you look at
18 the second example, where a nationally set base premium
19 pays for the lower of fee-for-service or MA, the base
20 premium of \$101 buys fee-for-service in Portland; whereas,
21 it buys the MA in Columbus and Miami. If beneficiaries
22 choose other options, then they might have to pay more.

1 In other words, beneficiaries pay more for MA in
2 Portland, but they pay more for fee-for-service in Columbus
3 and Miami.

4 Throughout our examples, there were two numbers
5 that had a direct effect on beneficiaries' premiums: the
6 average fee-for-service spending and the median MA plan
7 bid.

8 Especially under the second and third examples,
9 where the base premium paid for the lower of fee-for-
10 service or MA, the difference between these two numbers was
11 added to the base premium if the beneficiary chose a
12 higher-cost option.

13 This slide shows the distribution of the
14 difference between fee-for-service spending and the median
15 MA bid. To the left of 0, the median MA bid is higher than
16 average fee-for-service, and to the right of 0, fee-for-
17 service is higher than the median bid. For example, about
18 2 percent of beneficiaries are in market areas where the
19 median MA bid is higher than fee-for-service spending by
20 \$100 or more. And about 28 percent of beneficiaries are in
21 markets where fee-for-service spending is higher than the
22 median MA bid by \$100 or more.

1 By definition, this distribution is going to look
2 very different with a different reference bid. We picked
3 the median MA bid for illustration in our examples. But
4 there's a distribution of MA bids to choose from in many
5 market areas.

6 Moreover, our analysis used plan bids from the
7 current MA program, which is different from the three
8 examples we looked at. Under different rules, MA plans are
9 likely to bid differently and make different decisions
10 regarding whether to enter or exit a particular market.
11 Consequently, some markets might not have MA plans.

12 Let's briefly review where we began our
13 discussion. No one payment model is uniformly less costly
14 to the Medicare program in all markets. So we want to
15 create financial incentives for beneficiaries to choose
16 efficient models.

17 In this policy context, our illustrative examples
18 of calculating beneficiary premiums highlight two key
19 design questions.

20 The first question is: How is the base premium
21 set? Nationally or locally? This question is about the
22 variation in spending across market areas.

1 Under the second example, the premium does not
2 vary across areas; whereas, under the third example, the
3 premium varies with local fee-for-service spending.

4 Another way to think about this question is:

5 Is it fair for beneficiaries in high-spending
6 areas to pay higher premiums for the same basic benefit?
7 Or is it fair for beneficiaries in low-spending areas to
8 cross-subsidize beneficiaries in high-spending areas?
9 These questions reflect the exchange between Glenn and Kate
10 about equity at last month's meeting.

11 The second design question is: Which Medicare
12 option does the base premium pay for? Fee-for-service
13 Medicare or the lower of fee-for-service or MA? This
14 question is about the variation in spending that exists
15 across different Medicare options within an area.

16 Put another way, is it fair for beneficiaries to
17 pay the same premium regardless of whether they choose a
18 higher-cost option or a lower-cost option? Is it fair for
19 taxpayers to shoulder higher program spending when
20 beneficiaries choose a higher-cost option?

21 Depending on how you answer these two questions,
22 there might be potential savings in program spending, and

1 if so, how to share potential savings between the program
2 and the beneficiary.

3 In addition, there are other design issues we
4 haven't addressed. We briefly mention just a few.

5 First, what kind of a transition or phase-in
6 would a new policy require, such as specifying a number of
7 years for the phase-in or a cap on the dollar change in
8 premiums?

9 Second, would it apply to all beneficiaries or
10 only those who are newly eligible? In particular, how
11 would low-income beneficiaries be affected?

12 Lastly, would it apply to all markets or those
13 meeting a certain threshold of conditions, such as a
14 minimum level of MA enrollment rate?

15 Our discussions so far have focused on using
16 premiums to create financial incentives for beneficiaries
17 to choose efficient models for Medicare coverage.

18 If they have to pay higher premiums for fee-for-
19 service in areas like Miami, they would have to trade off
20 the perceived benefits of fee-for-service with MA that is
21 lower cost, and vice versa in places like Portland.

22 But to design incentives that can change people's

1 behavior, we need to consider how beneficiaries actually
2 make decisions and respond to incentives.

3 Here are some key points to keep in mind about
4 how beneficiaries make decisions?

5 First, beneficiaries make a basic tradeoff
6 between being able to choose any doctor or keep their
7 current doctors versus cost. The findings from our
8 interviews and focus groups suggest that those who can
9 afford Medigap premiums would choose traditional fee-for-
10 service plus Medigap, while those who might be more worried
11 about costs and more willing to accept a limited network of
12 providers would choose MA.

13 And beneficiaries make these tradeoffs with the
14 information they have. Although they have more information
15 available to them than ever before, they may not
16 necessarily have a better understanding of the Medicare
17 program. In fact, the increased volume of information may
18 contribute to the confusion because they might not always
19 open or read mail sent from CMS. Health insurance
20 counselors say that this is true regardless of the
21 education level and income of the individual.

22 So in order to simplify information and

1 decisionmaking, beneficiaries look for sources that are
2 easy and convenient. In particular, many of them rely on
3 other "human" sources, such as family, friends, brokers,
4 agents for MA plans.

5 But simply providing information about Medicare
6 would not guarantee that they are going to make the best
7 choices for themselves. There are several reasons why
8 beneficiaries can get overwhelmed by choice.

9 First, our ability to understand and use health
10 insurance -- Medicare included -- may be limited simply
11 because health insurance is a complex product. It requires
12 people to consider multiple dimensions simultaneously, it's
13 filled with unfamiliar terminology, and it requires a high
14 level of numeracy to make informed judgments. Moreover,
15 people have different preferences and needs for health
16 care, which can be also uncertain and unpredictable.

17 Second, the psychology literature suggests that
18 too few or too many choices are not desirable. In fact,
19 people may prefer fewer choices to reduce the likelihood of
20 making a poor choice or the sense of regret about their
21 choice.

22 When it's difficult to choose among options,

1 people may focus on variables that are simply easier to
2 measure, like premium cost, and ignore other salient
3 factors, or rely on recommendations from others, or just
4 simply stick with the same insurance coverage year after
5 year, even when better options are available. Such
6 strategies or shortcuts, however, may lead to eliminating
7 options they may actually prefer more.

8 Finally, the nature of how choices are presented,
9 described, and framed can influence people's
10 decisionmaking. Because we are prone to systematic biases,
11 our decisions are quite sensitive to the context in which
12 we make them, whether it's the order in which choices are
13 arrayed or the words used to describe and frame them.
14 Therefore, designing processes around people's choice could
15 take these biases into account and minimize them, if
16 possible.

17 Now Carlos will discuss issues related to coding
18 adjustment.

19 MR. ZARABOZO: Our discussion of synchronization
20 involves comparisons of the cost of one payment model
21 versus another in different market areas. In making the
22 comparisons between MA and fee-for-service and in showing

1 numerical examples, we use costs for an average
2 beneficiary, or what is referred to as a beneficiary with a
3 risk score of 1.0. Part of what determines a person's risk
4 score is the diagnoses that they have. A risk score for a
5 very sick beneficiary would be much higher than the risk
6 score for healthier person.

7 If we are to make valid comparisons of costs
8 between MA and fee-for-service, then the coding of
9 diagnoses affecting expenditures needs to be consistent
10 between the two sectors to make sure that a 1.0 average is
11 determined the same way in each sector, fee-for-service and
12 MA.

13 Similarly, in comparing quality between MA and
14 fee-for-service, we want to make sure that in each sector
15 coding of diagnoses is consistent and comparable between
16 the two sectors. Coding adjustments may be necessary to
17 ensure consistency and accuracy.

18 Currently, consistent coding is important in
19 Medicare Advantage because of the way plans are paid.
20 Payments vary depending on a beneficiary's health status
21 and demographic factors. Each Medicare beneficiary is
22 assigned a risk score based on diagnoses and demographics.

1 The risk score tells you the relative cost in fee-for-
2 service Medicare of providing care to a given beneficiary
3 compared to the average beneficiary. The diagnoses, and
4 the relative costs of serving a person with a given
5 disease, are determined from the claims data of fee-for-
6 service Medicare and the Medicare program expenditures
7 represented by those claims.

8 The risk scores of MA beneficiaries are based on
9 the diagnosis information submitted by MA plans. What
10 happens in MA is that plans code more completely or more
11 intensively than is the practice in fee-for-service
12 Medicare, so there is a mismatch between the risk score
13 that a person has as an MA enrollee and the risk score the
14 same person would have in fee-for-service Medicare.
15 Because under the current risk adjustment system the
16 appropriate payment, if you will, should be based on the
17 risk score the person would have had in fee-for-service,
18 there is a coding adjustment to the MA risk scores to make
19 the coding consistent between MA and fee-for-service.

20 In the same way that there is currently a coding
21 adjustment for MA, in order to have accurate bids that
22 represent what the bid is for a person of average health

1 (or a 1.0 risk score), a coding adjustment would be
2 necessary to compare a 1.0 bid from an MA plan to a 1.0
3 level of expenditures in fee-for-service Medicare. The
4 same would be true of comparisons to ACO per capita costs
5 if it was found that ACOs coded more intensively.

6 Coding intensity also affects the evaluation of
7 quality. Some quality measures are risk-adjusted based on
8 diagnoses. For example, sicker beneficiaries are more
9 likely to have hospital readmissions, and this likelihood
10 of readmission is taken into account in determining whether
11 a hospital or plan performs well on readmission measures.
12 For quality measures that are not risk-adjusted, more
13 intensive coding may increase the universe of beneficiaries
14 included for a particular measure, with a possible mismatch
15 between one sector and another that affects the apparent
16 performance on quality measures.

17 Today in MA the coding adjustment for payment
18 purposes is an across-the-board uniform coding adjustment
19 across all plans. As we pointed out in the material you
20 received, a question to consider is whether there should be
21 varying coding adjustments by geographic area or by plan.

22 DR. LEE: Here's the key design questions from

1 several slides ago. The first is the question of national
2 versus local base premium. This question follows the
3 conversation Glenn and Kate had last month about whether
4 Medicare beneficiaries should pay the same base premium or
5 not.

6 The next question is: Which Medicare options
7 should the base premium pay for? And if there are
8 potential savings in program spending, how to share them
9 between the program and the beneficiary.

10 And, lastly, we're interested in your ideas and
11 guidance on possible next steps on this topic.

12 MR. HACKBARTH: Thank you. This has been really
13 good, a terrific analysis and very thought-provoking.

14 Just a question about terminology. We use the
15 term "fee-for-service" to describe traditional Medicare,
16 and I wonder whether that is, in fact, the right term to
17 use. Increasingly, Medicare, traditional Medicare, is not
18 fee-for-service. We're talking about bundling and all
19 sorts of things that actually are moves away from fee-for-
20 service yet would still be encompassed in this alternative.

21 You know, I wonder what the right label is. I
22 don't know. "Traditional Medicare"? "The government-

1 managed insurance plan"? I don't know. But it seems to me
2 that fee-for-service may not be really the correct
3 descriptor.

4 In fact, for me, the most important
5 characteristic of traditional Medicare for this purpose is
6 that it is the free choice of provider plan. You pay a
7 single premium, national premium, and you are guaranteed,
8 you have an entitlement to a free choice of provider,
9 regardless of how much that provider costs compared to
10 other alternatives. And so I don't have an answer for this
11 question, but I do think referring to it as "fee-for-
12 service" is increasingly inept, and maybe it would be good
13 to find another term. "Traditional Medicare" has been the
14 best that I can come up with, but you can tell why I'm not
15 in the advertising business.

16 [Laughter.]

17 MR. HACKBARTH: So Round 1 clarifying questions.

18 DR. SAMITT: So my questions are mostly about the
19 coding section, the clarification. So in the materials,
20 the chapter that you had sent around, you talk about the
21 5.16 adjustment versus the need for a further reduction by
22 3 percent. Can you elaborate on sort of how you did that

1 analysis and, you know, if coding is essentially used to
2 really help us to distinguish between the complexities of
3 two different populations, what alternative methodology are
4 we using to determine whether 5 percent versus 2 percent is
5 the right adjustment?

6 MR. ZARABOZO: And I'm going to invite Scott to
7 answer that question.

8 [Pause.]

9 DR. HARRISON: So we had taken samples of
10 beneficiaries who had been in MA for different periods of
11 time and been in fee-for-service for the same amount of
12 time, looked at their baselines, and saw that the coding --
13 the risk scores grew faster when you were in Medicare
14 Advantage. And so we weighted then by how long everybody
15 had been in MA, and the MA population probably is about --
16 has coding about 8 percent higher than what the people
17 would have had if they had stayed in fee-for-service.

18 DR. SAMITT: So, in essence, comparing the
19 trajectory of a patient who -- a like patient who would
20 have stayed in fee-for-service versus the patient who
21 switched --

22 DR. HARRISON: Right.

1 MR. HACKBARTH: -- from fee-for-service to
2 Medicare Advantage and the delta between essentially the
3 curves, the trends.

4 DR. HARRISON: Correct.

5 DR. SAMITT: Okay. Thank you.

6 The second question I have is on Slide 4, the
7 all-market comparison, 105 percent to 100 percent. Does
8 that 105 percent take into account all payments, including
9 additional payments for risk adjustment? Risk adjustment
10 is already factored into that distinction?

11 DR. HARRISON: Yes.

12 DR. SAMITT: Okay. Thank you.

13 MR. HACKBARTH: Clarifying questions?

14 DR. COOMBS: Has there been any attempt to look
15 at proxies for risks that are not necessarily correlated
16 with coding? You know, you present in the presentation
17 about more intensely coded -- coding in the MA plans as
18 compared to the fee-for-service. Has there been any other
19 kind of proxies of, for instance, the percentage of
20 dialysis patients under MA plans versus non-MA plans? I
21 mean, I don't know if that's something that can be done.

22 MR. ZARABOZO: Well, I don't know whether -- what

1 the percentage of dialysis patients in each would tell you
2 about the respective coding.

3 DR. COOMBS: Yeah, just in terms of the level --
4 if you were to take a very sick population -- and it
5 doesn't have to be dialysis patients; it could be anything
6 -- to see what the difference might be reflected in actual
7 sick patients being cared for in MA plans. I mean, if you
8 have a tool, an instrument that doesn't level the playing
9 fields in terms of one being more intensely coded, which is
10 directly tied into risk adjustment, which is directly tied
11 into quality, and directly tied into reimbursements on one
12 side, and the fee-for-service is lacking on coding, I mean,
13 maybe more robust EHRs, EMR on one side versus the other.
14 But if you have a differential and your ability to assess
15 one over the other, it begs the question that the
16 reimbursements or whatever, the quality bonuses are going
17 to be different.

18 MR. ZARABOZO: Well, one thing, for example, that
19 -- it's an article that we cited by Kronick and Welch was
20 looking at the one diagnosis in particular, they said there
21 appears to be higher coding in the MA plans is major
22 depression. And so the HCC categories, there are only two

1 mental health categories: major depression and
2 schizophrenia. So they looked at the relative prevalence
3 between MA and fee-for-service, and you have a higher
4 prevalence of major depression, which kind of indicates it
5 might be more coding, because there's nothing below major
6 depression that feeds into the HCC risk assessment that can
7 be used for coding purposes.

8 So there are differences in that -- I mean,
9 that's one way to judge are there differences in the
10 coding.

11 MS. UCCELLO: So I have a few questions.

12 On Table 8 in the mailing materials, you show a
13 huge difference in the risk score in plans in Miami versus
14 Portland, and so I was wondering if you could just expand
15 on -- if there's anything other than the obvious one on
16 here.

17 MR. ZARABOZO: One thing, I mean the fee-for-
18 service risk score, too, is very different between Miami --

19 MS. UCCELLO: Okay, that's --

20 MR. ZARABOZO: Yeah, yeah, that's -- yeah.

21 MS. UCCELLO: Okay. How much MA bid variation is
22 there within an area? You talked about using the median.

1 Is there a lot? Is there a little?

2 DR. LEE: Actually, there's a lot. So if you are
3 looking at minimum to maximum in each area, that is very
4 wide range. Now that they -- distribution is quite lumpy.
5 You know, you can have -- the difference between the lowest
6 and second lowest could be quite big. So that I think
7 varies from area to area.

8 MS. UCCELLO: And it might come into play when we
9 think about how we define this lower of kind of thing. I
10 haven't worked it all out in my head yet, but -- and,
11 finally, on Slide 9, you talk about the additional design
12 issue of whether this is done in all market areas or only
13 those that have above a certain threshold. I assume there
14 you're talking about MA enrollment above a certain
15 threshold? So are there -- this would matter most, I
16 imagine, in places where the MA would be the lower. Are
17 there any -- and those would presumably be in the high-cost
18 fee-for-service areas. Are there high-cost fee-for-service
19 areas that don't have robust MA enrollment? How big of a
20 deal is this?

21 MR. ZARABOZO: Okay. We had previously mentioned
22 Cook. I haven't checked lately in Cook County, but Cook

1 County was an example of, you know, high expenditures and
2 not very much MA penetration there. But I haven't, again,
3 looked lately at what the --

4 MS. UCCELLO: Okay. So this is a real issue as
5 opposed to just theoretical.

6 MR. THOMAS: I think this was in a previous
7 report, but did we -- for the markets that have all three
8 types of options, what percentage of those markets is fee-
9 for-service the cheaper option?

10 MR. ZARABOZO: Fee-for-service, traditional
11 Medicare --

12 MR. THOMAS: Traditional Medicare.

13 MR. ZARABOZO: Without ACO --

14 MR. THOMAS: Correct.

15 MR. ZARABOZO: -- probably -- I don't have the
16 number right here, but almost a third. In many cases it's
17 almost a third, but I want to say that the differential
18 isn't a lot. So, you know, if you look at like the
19 ACO/fee-for-service differential, sometimes one's a little
20 higher, sometimes one's a little lower, and part of that
21 could just be the random variation that we see. And I
22 think the better figure is the one where we look at the

1 average differences that show on average in those high-
2 spending markets you can save about 2 percent with MA or
3 ACOs, and in the high-spending areas generally the
4 government is spending more on -- at least on MA. Excuse
5 me. The low-spending areas the government is spending
6 more.

7 MR. HACKBARTH: Continuing Round 1.

8 MR. GRADISON: Looking at page 9 in the meeting
9 brief, necessarily you've -- well, maybe not necessarily,
10 but you compared 2015 data because it's available with 2013
11 data for ACOs, which is the most recently available data.
12 It would seem to me that you might be better off to use
13 2013 for all of them rather than -- because you're using it
14 for analytical purposes anyway, and you recognize in the
15 document, the last sentence on page 9, that this could
16 change as more recent data -- that is, that data for 2015
17 rather than 2013 -- becomes available for ACOs. It's sort
18 of a presentation thing, but it kind of jarred me to think
19 we're comparing two different years and trying to draw
20 observations out of that data. So that's just a comment.

21 DR. CROSSON: Yeah, so, Carlos, when you're
22 talking about the coding thing, I heard you say something

1 about wanting to watch in the future ACO coding. I wasn't
2 sure I understood that because virtually or perhaps all ACO
3 models currently in existence and even planned, with the
4 possible exception of one of the Vanguard models maybe,
5 it's basically just fee-for-service payment. So why would
6 ACO coding -- why would you think ACO coding would be
7 different from fee-for-service coding?

8 DR. MILLER: Probably two things driving -- I'm
9 sorry. I think it's probably two things driving that
10 comment, and we had this very direct conversation in
11 getting the presentation together.

12 One is that if you -- and we took you through in
13 the Executive Session a bit of CMS' next generation and
14 ACO, and there's some looking down the road to using, you
15 know, regional benchmarks, moving off of historical, and at
16 a very simple level. The reason that they started off with
17 historical benchmarks is you don't have to risk-adjust them
18 because that's your population, now you have to beat your
19 history.

20 To the extent that they start to move off of
21 that, then you have to think about, well, do you have to
22 risk-adjust this baseline if you're going to hold them to

1 something that's more market or regional oriented. That's
2 the first thought.

3 And the second thought, it's the same thought,
4 but we're talking about synchronization here and thinking
5 about a baseline or a benchmark that cuts across ACOs, MA,
6 potentially fee-for-service, depending on how you think
7 about the beneficiary. And there, again, it would probably
8 mean we have to introduce a risk adjustment type of process
9 to that, which then might mean that the ACOs have the same
10 incentive as an MA.

11 Did I get that about right?

12 MR. ZARABOZO: Yes, and in some of the ACO
13 models, like the NextGen that David talked about, they are
14 going to have risk adjustment based on HCCs, so you'll get
15 a bigger benchmark up to a certain degree if you have
16 higher risk scores, meaning those ACO doctors have an
17 incentive to code.

18 DR. CROSSON: So it is related to the projection
19 of what the Vanguard -- at least that's what they were
20 calling it -- or newer ACO models might look like. That's
21 the substance of it.

22 DR. MILLER: That's the near term, and the

1 longer-term [off microphone] would be what you as a
2 Commission decide about what you want to do on
3 synchronization. It would decidedly be an issue there, and
4 I think that's why--

5 MR. ZARABOZO: The other point is the quality
6 point, which is if you're going to be measuring quality and
7 comparing fee-for-service and ACOs and MA, you know, for
8 bonus purposes or whatever, you would like to have
9 consistent coding.

10 MR. HACKBARTH: Okay. Any other clarifying
11 questions?

12 [No response.]

13 MR. HACKBARTH: Okay. Let's move to Round 2,
14 and, Mark, would you frame this issue? Put up the slide
15 that has the various options for how to set the basis of
16 comparison, you know, the one that Kate referred to.

17 DR. MILLER: Okay. So the last time we talked
18 about this, Kate very methodically went through a number of
19 the issues and sort of talked out with all of you about how
20 she was trying to understand. And what you'll remember --
21 and she was sitting over around where Alice is sitting --
22 is she came down and she and Glenn had an exchange, and we

1 thought that this might be a good place to bring you back
2 to. And it kind of comes down to two issues, and let's see
3 if I can do this in a way that's clear, as clear as Cori
4 was yesterday, for example.

5 One is imagine the average fee-for-service per
6 beneficiary in the country is \$9,000 or \$10,000 per person,
7 okay? And you know that that varies across the country.
8 You know it's almost two times that in Miami, and you know
9 it's 20, 30 percent less than that in Portland.

10 One very strict way to ask the question is:
11 Should the beneficiary premium in that instance be the same
12 in all of those markets? Miami has much more fee-for-
13 service spending; Portland has somewhat less than average.
14 Why does the beneficiary pay the same premium? And you
15 could define "equity" two different ways, and this is the
16 exchange that Glenn and Kate were having, which is, well,
17 it's higher in Miami so the beneficiary should pay a higher
18 premium; or the reverse, which is, no, the beneficiary
19 should pay the same premium because they don't have any
20 control over what happens in Miami. And that's a very
21 intense, philosophical issue that has to be thought
22 through.

1 Now, I told the story from just a straight fee-
2 for-service point of view because I think it's simpler, but
3 when you get into this where are we going to set the
4 premium and how are we going to set the premium, it comes
5 back into play. Do you adjust the premium for underlying
6 differences in the cost of the market?

7 The second question is also very significant,
8 which is, What does that premium buy? So let's just say
9 you settled out -- and I hate to speak for her not being
10 here, but I think Kate was of the mind you pay the same
11 premium throughout the country, but that -- and that's one
12 way you could resolve it, and Kate and Glenn were talking.

13 But the second question is: What does it buy?
14 So, currently, that premium buys you twice as much fee-for-
15 service in Miami and, you know, 20 percent less fee-for-
16 service in Portland. And one of these options says you can
17 still get -- and that's the top option. At a national
18 premium you can get fee-for-service in any market. And
19 notice in the top tranche there, there's a flat premium,
20 101, and then notice the third row of that premium, the
21 federal contribution is quite different. So, in Miami,
22 it's a thousand bucks, and in Portland it's 500.

1 The other way you could do it -- and I would draw
2 your attention to the second tranche, third row. You could
3 say the federal contribution will not go all the way up to
4 fee-for-service; it will only go up to the lower of. And
5 notice in Miami you're no longer paying \$1,000 in federal
6 contribution; you're paying \$600. And then the
7 beneficiary's premium is a function of what choice they
8 make.

9 And so one more time -- I'm afraid I've made this
10 more complicated. One more time. Should the premium vary
11 by geographic variation and cost for the -- or expenditure
12 for the beneficiary?

13 Second question: What does that premium buy in
14 your market, the lower of fee-for-service or managed care?
15 And very different consequences for the government's
16 contribution, and then what the beneficiary pays out-of-
17 pocket depending on what choice they make.

18 And I guess the very last sentence I'll say --
19 well, I'm done.

20 DR. NERENZ: Just a technical question on that
21 point. When we talk about premium in this discussion, our
22 base premium, we're really talking about Part B premium,

1 right? Because there is no Part A premium. Is that a fair
2 statement? And then if we are, the variation across region
3 is not all Part B variation. In fact, it's a lot of post-
4 acute whatnot.

5 So I'm just trying to think through with you,
6 Mark, that, you know, we talk about what it buys you.
7 Well, we're sort of loading a bunch of other variation on
8 to and up/down in a Part B premium, so you're buying
9 something other than Part B with the higher Part B premium.
10 My question -- does that even matter? Is that even
11 important?

12 DR. MILLER: I'll step out first on this, but I
13 would like some close support here. And I don't feel like
14 I'm getting the real engaged looks from you that I want to
15 get. I'm getting a lot of looking off like this.

16 [Laughter.]

17 DR. MILLER: Okay. What I would say is for the
18 purposes of this exercise, I wouldn't spend a lot of time
19 thinking about that. What I would say is it's really a
20 question of to purchase the Medicare benefit, where would
21 you set -- how would you set the premium and what would
22 that premium buy? For purposes of this conversation,

1 that's what I would say.

2 To make my point about geographic variation,
3 yeah, it really is about the Part B premium, because that's
4 what's going on right now. But I think I ought to ask you
5 for the purposes of this discussion to step back from that
6 a little bit and say, you know, what premium would the
7 beneficiary pay to get their Medicare. You know, these
8 kinds of ideas involve lots of, if you want to put it this
9 way, back-room discussions of then what do you do about,
10 you know, the purchase and the choice of Medicare, and does
11 it remain an A-B split type of situation?

12 For the exercise, I would say try and get above
13 that. But that's my take.

14 DR. SAMITT: So I'm trying to get my head around
15 it, and I looked at this through two different dimensions.
16 One is if I'm a beneficiary in any of these markets, if I
17 want to purchase the lowest-cost alternative, it will be
18 identical in each of these scenarios. So if I'm in Miami-
19 Dade, then I'm always, if I want to pay less, going to pick
20 the MA option in any of these three scenarios. And the
21 same would be true of Columbus and Portland.

22 So I guess the question is: How material would

1 these options be and having beneficiaries make a choice if
2 a choice is around price?

3 MR. HACKBARTH: And so I think that's a really
4 important issue, and you'll recall -- it's really
5 unfortunate that Kate isn't here today because she's so
6 good on these issues. But, you know, there is, as I
7 understand it from Kate, some literature on behavioral
8 economics that people respond differently to different
9 types of incentives. The incentives can be the same in
10 dollar terms, but people respond much differently to a loss
11 than they do to a potential gain. They may respond
12 differently to cash as opposed to added benefits. And so I
13 think all of those are issues in terms of how you might
14 structure the choice.

15 DR. MILLER: And can I just do one thing? I'm
16 going to go to the board, which is going to frustrate her,
17 but I'm going to do this anyway, because I think this is
18 really important, and I want people to get [off
19 microphone].

20 DR. SAMITT: So kind of this notion of a withhold
21 versus a bonus, and the psychological impact of whether it
22 would be a positive or negative impact.

1 MR. HACKBARTH: And Bill Gradison has often made
2 this point. The difference between cash versus added
3 benefits may evoke a different beneficiary response as
4 well. So if it was still that, you know, you had Scenario
5 1 but plans were writing checks to beneficiaries who
6 enrolled in MA in Miami as opposed to the beneficiaries
7 getting gym memberships and, you know, vision care -- I
8 think GAO has done some analysis suggesting that some of
9 the added benefits are not heavily used, and presumably
10 they're not highly -- therefore, are not highly valued by
11 beneficiaries. But in the calculations, you know, they
12 count for, oh, this is your reward for joining an MA plan
13 in Miami.

14 DR. SAMITT: So my second issue, which may be a
15 less important dimension, is if I'm a Medicare beneficiary
16 and health care costs are so important to me that I am
17 willing to move cities to find the best environment, the
18 next way to look at this -- and it may be more of sort of
19 an equality issue in terms of beneficiaries in City A
20 versus City B -- is that in the first scenario, relative to
21 the various metropolitan areas, I'm going to pay the most
22 for my health care in Portland. In the second scenario, it

1 doesn't really matter. It's equal regardless of what
2 market I'm in. And the third scenario, I'm going to pay
3 the most if I'm in Miami-Dade.

4 So I couldn't help but think of some of the GPSI
5 discussions we've had and sort of the cost-of-living
6 differences, and does that factor into -- from a Medicare
7 beneficiary and a cost-sharing standpoint, if you're going
8 to live in sort of higher-cost or higher economically
9 driven markets, should you costs be higher in those markets
10 for health care? So that would be the second dimension
11 that I looked at when I saw this grid.

12 DR. MILLER: The only thing I would say about
13 that -- and I want a nod here or a nod, a shake -- is they
14 should think of these numbers are certainly risk adjusted,
15 like a one-point over risk for the purposes of this
16 exercise. Should they be thinking of these as wage-
17 adjusted numbers? Because these are not -- is that -- no.
18 Okay. So then --

19 MR. HACKBARTH: Okay. I have Warner and Jack,
20 and we'll come back up this way. Warner.

21 MR. THOMAS: I don't know if this is more of a
22 question or remark just around how we should look at this -

1 - or to the team here, but the thing about this, it looks
2 like in 70 -- roughly 70 percent of the markets, the ACO or
3 Medicare Advantage model is more cost effective. Is that
4 correct? And in the 30 percent, that the models are
5 relatively close? Is that accurate?

6 DR. STENSLAND: That's in the ballpark. I think
7 the ACO and the fee-for-service are maybe the lower cost
8 models, you're saying, in maybe two-thirds, and they are
9 just a little bit lower cost in those. And I think the MA
10 is a little more spread out in that it's maybe generally
11 close, a fair amount more expensive in some markets like
12 Portland, and then there's just a couple markets where it
13 really saves you a lot of money, like in Miami.

14 MR. THOMAS: I guess the question I ask myself is
15 that, with the right incentives, could the ACO and MA model
16 be a more cost-effective model in all markets? We keep
17 talking around the issues of bundles and incentives and all
18 that sort of thing, and I know we talk a lot about ACOs.
19 This is kind of looking at all-in, and the question I ask
20 myself, What would have to happen in those markets where
21 it's not the more cost effective to get it there? And then
22 what sort of incentives should be put in place to try to

1 steer or try to incent beneficiaries into those models?

2 MR. HACKBARTH: Warner, I think that there are a
3 couple, at least a couple variables here. There are some
4 markets where there are relatively few providers, rural
5 areas and the like, where I think it's difficult for
6 Medicare Advantage plans to operate without subsidies for
7 Medicare because they have very little leverage with
8 providers. They can't really play one provider off against
9 another. So there are sort of market structure issues for
10 at least some segment of the country.

11 The other thing that is happening in places like
12 Portland is the utilization rates are very low, and to the
13 extent that Medicare Advantage succeeds by changing
14 patterns of care, it's just a lot tougher to be beat the
15 benchmark in Portland or in Seattle than it is in a high-
16 utilization area like Miami.

17 So I'm not sure that it's necessarily true that
18 in a place like Portland, where MA plans prosper and we
19 have high MA enrollment in Portland, that it's because
20 there have been subsidies. We pay more in Portland for
21 Medicare beneficiaries to go into private plans than we do
22 in traditional Medicare. Traditional Medicare is very

1 efficient in Portland because the utilization, the base
2 utilization rate is very low, and it's always going to --
3 on a level playing field, it's always going to be tough for
4 MA to succeed. Right now, it succeeds through subsidies,
5 to be real blunt.

6 MR. THOMAS: Right.

7 So I would totally agree with that. The question
8 I would ask is in that situation where you have a low
9 utilizing fee-for-service market, would the right kind of
10 ACO structure incentive -- I'll just take Seattle. So in
11 Seattle, if you have low utilization, my guess is in
12 Scott's model, with what he has from an integrated model,
13 they're going to be able to, I believe, probably outperform
14 a traditional unorganized fee-for-service model, if not
15 every time, many times, especially with the right
16 incentives and over time with the right coordination and
17 what not.

18 I kind of come back to -- I understand you are
19 always going to have a rural market where maybe the model
20 just doesn't work or it's a very fragmented system, but I'm
21 also of the belief -- and I think we ought to be
22 challenging ourselves to think about end markets like

1 Portland that have low utilization, which is great, there's
2 probably still opportunity, if you have the right model in
3 place with the providers to do even better than they're
4 doing today in a relatively unorganized, traditional fee-
5 for-service model.

6 DR. HOADLEY: So I've got two kinds of comments.
7 One is trying to think about picking up from what Mark's
8 response to Dave's question of sort of framing this the
9 right way. So I completely agree that we don't want to
10 complicate this framing with the fact that the premium is
11 on the Part B side. I think that makes sense to try to
12 jump a step above that, but it may also make sense that we
13 should be framing this without the complication of the
14 negative number up here or the fact that there's this
15 benefits versus cash kind of complication, that in a sense,
16 we ought to be thinking if this was all just done in pure
17 dollar premium tradeoffs, so that even if it meant
18 artificially shifting the numbers, so we don't see a
19 negative number, or we just think of a negative number in
20 some way that ignores the fact that it may come in benefits
21 versus cash, that we might also want to not have the
22 complexities of the wage differences.

1 Some of these, I'm not quite sure what you would
2 do empirically or how we would do it, but the fact that
3 there are cost-of-living differences partly embedded in
4 this is a complexity that kind of distracts from the core
5 question I think we're trying to answer, and even this
6 issue of the sort of underlying fact that the MA numbers
7 are based on bids which have built in it these subsidies,
8 because of where we stand, even at a point in time in a
9 transition to full ACA changes and some of that kind of
10 stuff. So should we be trying to pull those subsidies out
11 so we're actually looking at the core question?

12 That's just some thoughts on -- I mean, I think
13 the point is we really want to frame this as if these
14 distractions were in the way, what's the right mix of
15 incentives?

16 MR. HACKBARTH: So it's not clear to me how
17 Medicare's subsidies that happen through the Medicare
18 Advantage payment system affect the bidding process, which
19 is our best estimate of plan cost.

20 One of the most striking parts of this analysis
21 to me was how little variation there is in the MA low bid,
22 geographically. You see the fee-for-service cost. You

1 have a two-fold-plus variation, and the MA bids between
2 Miami and Portland, pretty doggone close.

3 DR. HOADLEY: So is it the case that in the way
4 we've done these numbers that we really are looking at bids
5 before we take into account benchmarks?

6 DR. LEE: They are bids. So it's supposed to be
7 plan's estimate of the cost of providing A and B benefit.

8 DR. HOADLEY: Right.

9 DR. LEE: However, their bidding strategy --

10 DR. HOADLEY: Strategy.

11 DR. LEE: -- seems to be against the MA
12 benchmarks, and so that's why the correlation is very
13 strong to MA benchmarks.

14 DR. HOADLEY: So I misspoke a little --

15 MR. HACKBARTH: I'm sorry, Jack.

16 So just to elaborate on that, what correlation,
17 Julie, are you referring to?

18 DR. LEE: So the correlation between bids and MA
19 benchmarks is much stronger than correlation between bids
20 and fee-for-service spending. If you want to look at fee-
21 for-service spending as a kind of environment, you know,
22 the cost of A/B benefit, that correlation is actually quite

1 small.

2 DR. HOADLEY: In theory, people are bidding truly
3 based on their cost, but in reality, the bid acknowledges
4 that there is a benchmark going on in the market, and
5 naturally, you're going to bid somewhat differently.
6 Either it's your incentive to change your cost, which is
7 one way to think of it, or it's an actual bidding behavior
8 that means your bids are not exactly your cost.

9 MR. HACKBARTH: Yeah. Okay.

10 DR. MILLER: I would say -- well, go ahead.

11 DR. HOADLEY: Well, if you want to comment on
12 that, I was going to go on and say so my view of this is if
13 -- sort of putting all those distractions aside, I still
14 have difficulty with the notion that beneficiaries who
15 choose a fee-for-service or traditional Medicare, because I
16 do like the notion that we should be changing the
17 terminology -- beneficiaries that choose traditional
18 Medicare are paying for something that's differing
19 geographically that is not changing what their purchasing
20 is as a package of services. It may change the average
21 cost. So some cases, it's the physician practices or the
22 hospital costs are simply higher in their markets, whether

1 for wage reasons or for competition market reasons, or that
2 others in their region are getting -- demanding and getting
3 or being given more services than I would necessarily get
4 if I'm the consumer in that market.

5 So I go back to that notion that I'm not real
6 comfortable with the idea that I have to go in and pay for
7 a higher price just because of where I live. It might mean
8 I want to move to another area, and of course, that's not
9 really a practical choice in most cases. So that's kind of
10 where I come back is trying to think about what's the right
11 kind of equity, and I see it on the Part D side where you
12 don't have -- it seems like there's even less logic for the
13 geographic -- but it's there, and so we do in fact have the
14 result that we're putting in sort of scenario two and three
15 in Part D where people are paying a higher price for the
16 same bundle of drugs for the same set of prescriptions, not
17 because the drugs cost more, but because something about
18 behavior about prescribing or something in their state, in
19 their market, just based on where they live.

20 MR. HACKBARTH: Isn't that what happens to the
21 rest of America?

22 DR. HOADLEY: Maybe, but do we have to -- if that

1 is not a good result --

2 MR. HACKBARTH: Cori.

3 MS. UCCELLO: This isn't going to be coherent, so
4 I'm going to need a translator.

5 MR. HACKBARTH: You have points from yesterday.

6 MS. UCCELLO: Okay. I can carry them over.

7 [Laughter.]

8 MS. UCCELLO: So this kind of builds off the last
9 things that Jack was saying, but I seem to recall a thread
10 from last month's conversation that when we were thinking
11 about paying differently for the different areas because
12 they have higher or lower cost, one of the things to think
13 about is would charging those higher costs lead -- put
14 pressure on provider behavior, and I seem to recall that
15 the thought around that was maybe not, but I think we need
16 to bring that back in.

17 It's reasonable to really seriously consider
18 charging those different costs by area if we think that
19 those will lead to, at least in the high-cost areas, lower
20 utilization or lower prices.

21 DR. MILLER: That was very good, Cori. Really
22 coming along.

1 When that thread occurred in the meeting last
2 time, what I thought Glenn said --

3 MR. HACKBARTH: Go ahead.

4 DR. MILLER: All right, but you can jump in here
5 and do your thing.

6 I think what Glenn was saying at that point --
7 because I kind of remember this thread too -- is, again,
8 look at your second tranche, look at Miami. You have that
9 \$509 payment that the beneficiary might have to pay to be
10 in fee-for-service. The beneficiary says, "I'm not going
11 to do this. I'm going to go to a managed care plan." The
12 physician in Miami sees their patient shifting from fee-
13 for-service to a managed care plan and says, "Wait a
14 minute. What's going on here? What do I need to do?" And
15 I think this is the point that you're driving at. If
16 providers start to see their business shift, does it put
17 back pressure on the fee-for-service crowd to change their
18 style?

19 And I think you said something.

20 MR. HACKBARTH: Yeah. And this is the mechanism
21 behind the spillover theory, that in fact there has been
22 some empirical research suggesting that there are

1 spillovers from MA enrollment into fee-for-service
2 expenditure levels, and Kate mentioned that at the last
3 meeting.

4 Scott.

5 MR. ARMSTRONG: I just would start by saying this
6 focus that we've had on synchronizing payment between MA
7 and fee-for-service and ACO, I think is a really important
8 agenda, and I also, for the record, agree MA should cost
9 less than fee-for-service. So we should be moving in that
10 direction.

11 But what's been really interesting to me is this
12 highlight now that this analysis has given to this
13 incredible variation in the cost of the program by virtue
14 simply of different geographic markets, not demographics,
15 not anything else.

16 And while I am really sympathetic to the impact
17 on the beneficiary and higher out-of-pocket cost in
18 different markets, I like the idea that there would be a
19 real different out-of-pocket cost between MA and fee-for-
20 service in different markets.

21 I guess I would take it -- and so I'm okay with
22 that. I would take it one step further and just say to me,

1 it's the third line, the federal contribution on that top
2 category that is the big issue that jumps out for me.

3 And I know it's a little off topic, but I just
4 wonder. We spend so much time confronting the different
5 payment between hospital outpatient and physician office
6 practice for like services, and we have a really clear
7 policy position on that. We spent a lot of time looking at
8 the least costly -- paying at the least costly alternative
9 for drugs or for other alternatives. Why don't we work up
10 some indignation over how dramatically different we're
11 paying in different markets for basically the same service
12 as a program? To me, that's not for today, but that's an
13 issue that I think, if we did some quick math, offers
14 spectacular impact on future expense trends for the
15 Medicare program if we were to take it on.

16 So it's a little off topic, but, boy, this
17 analysis to me offers a real bright light on an issue that
18 I think will be very worthy for us to take on in the year.

19 MR. HACKBARTH: To me, options 2 and 3 and the
20 fact that you have much less variation in MA bids than you
21 have in fee-for-service cost suggests that if you want to
22 move towards less geographic variation, this is one

1 mechanism that may help do that.

2 MR. ARMSTRONG: Yeah. I guess the point I was
3 making was that -- so the whole lever is moving, then, the
4 issue into choices the beneficiary has, and they look like
5 pretty good choices to me. But I would just ask, Is there
6 more that we can do?

7 I mean, we really -- most of our attention is on
8 payment policy to providers, and these are scenarios that
9 don't differentiate our payment policy to providers. I
10 mean, I don't know what that looks like, but why are we not
11 expending a discount off of what we normally would pay for
12 people who practice in Dade County, as an example?

13 MR. HACKBARTH: When we move away from
14 traditional fee-for-service towards various sorts of
15 bundled payment systems, I would hope that over time, that
16 would lead to some compression of geographic differences
17 because I think that part of what's going on here is that
18 in some parts of the country, there is a much stronger
19 culture of taking advantage of the financial incentives in
20 fee-for-service than in other parts of the country.

21 If you change those fee-for-service incentives,
22 you may also see some compression, so that may be a benefit

1 of moving towards bundles.

2 Okay. I have Kathy and Jay and then Craig again,
3 Warner. Anybody else want to get in here? We've got 20
4 minutes or so left.

5 MS. BUTO: Okay. I will try to be brief.

6 DR. SAMITT: A question about Scott's --

7 MR. HACKBARTH: Sure. Sure.

8 DR. SAMITT: I just have a clarifying question
9 about the math, now that I hear Scott speak, because my
10 understanding is this federal contribution amount or this
11 over-\$1,000 amount in Miami-Dade is inclusive of a risk
12 adjustment payment, that when you back out, the complexity
13 of illness in Miami-Dade versus Portland, that number drops
14 to the 700-some-odd range. And yet this methodology,
15 including the discount in the MA premium looks like it goes
16 against -- I'm not articulating this well. I feel like
17 Cori now. It looks like it goes against the fee-for-
18 service amount as opposed to the backed-out bidding amount
19 for the MA plan. So that's the piece that's confusing to
20 me, that aren't these federal contribution differences,
21 especially in the beginning -- doesn't that represent the
22 fact that there's different risk adjustment levels in these

1 various markets, or no?

2 DR. LEE: All the numbers are for risk score 1.0.

3 DR. SAMITT: All of the numbers?

4 DR. LEE: Yes.

5 DR. SAMITT: In the third column, for example, in
6 the third tranche?

7 DR. LEE: Uh-huh.

8 DR. SAMITT: Great. Thank you very much.

9 MS. BUTO: Well, I'll try to be brief. I was
10 kind of going in the same direction as Scott. I think what
11 we haven't really settled on and we need to come back to at
12 some point is what our goal is here. Is our goal to
13 guarantee fee-for-service at the same rate premium to every
14 beneficiary in the country, or is our goal to try to look
15 at the federal contribution and say what's inequitable, to
16 use someone else's term -- how should the government be
17 paying for these services around the country?

18 That's why I think Example 1 cries out for making
19 that choice because that's the one where, clearly, the
20 choice is driven by -- it's going to cost the beneficiary
21 the same everywhere in the country, and I would like to see
22 us really give serious consideration to that assumption

1 because I think that's going to continue to drive -- if you
2 look at the Miami column again and the over-\$1,000 federal
3 contribution, the government is continuing to subsidize a
4 certain level. Even if it's a great saving to go to the
5 managed care planning, you're getting a lot more service,
6 is potentially affordable with that kind of a federal
7 contribution.

8 To me, it's inherently inequitable because it
9 drives a much richer package, even if it tries to be more
10 efficient, between fee-for-service and Medicare Advantage.
11 So I think we have to get to that point of saying what
12 drives -- what's our first principle here in terms of what
13 we'd like to see the premium drive, if you will.

14 MR. HACKBARTH: Let's see. Who else do I have?
15 Jay, I think I have you.

16 DR. CROSSON: Yeah. I have been struggling with
17 this since we first discussed it almost a year ago. I
18 think for the same reason that Kathy just said -- which
19 definition of equity are we pursuing, and which one do we
20 think is the most important?

21 One of the problems I think that I have -- and
22 I've seen it now several times as we look at this -- is,

1 quite honestly, thinking about Miami-Dade, because Miami-
2 Dade is not just at one end of the Gaussian distribution.
3 It's clearly an outlier, and so it drives numbers that
4 we're staring at there like the federal contribution is
5 over \$1,000 compared to about half.

6 I almost would wonder, as we think about this, as
7 we get more towards practical choices, that we kind of put
8 that out of our mind because maybe that has to be dealt
9 differently with some sort of capping or something like
10 that.

11 But when we start thinking about things like
12 which mix of choices of equity we're going to make and we
13 start looking at numbers and we start thinking about
14 feasibility and acceptability to beneficiaries and actually
15 getting there, that we deal with numbers -- and maybe part
16 of this is adjusting these for regional input costs,
17 because that's another sense -- that's another issue of
18 equity. If I happen to live in Miami or New York or San
19 Francisco because that's where my job is, is it my
20 responsibility then to pay more for Medicare when I've put
21 in the same amount of money as everyone else over my
22 career, or should I be paying at a national kind of level?

1 If we were to back out -- and I know Jack talked
2 about it as a complexity, but if we were in the future, if
3 we sort of back out that piece and just say we are going to
4 adjust for regional input cost, not regional utilization or
5 any of this stuff that's being driven by inappropriate
6 care, but just the input cost, and we take out the outlier
7 and we look more at, say, from the 25th percentile to the
8 75th percentile and we start looking at numbers and we get
9 a sense of the tradeoffs and the political, even
10 feasibility of that, maybe we'll have an easier time
11 thinking about the tradeoffs.

12 DR. MILLER: I think that was all very well put.

13 I think the notion of adjusting for the input
14 prices makes a lot of sense in terms of equity. You will
15 still see a lot of geographic variation, and I know you
16 know that because a lot of it is utilization. As David
17 said, a lot of it is post-acute care, but I think at a
18 technical level, you're probably right.

19 Then the other thing I would just get you to
20 return your attention to, because I know you don't have
21 anything else to do, is the portion of the paper where in
22 response to your comments the last time, we tried to show

1 you the distribution, and it's absolutely true that Miami
2 is a huge outlier, and a lot more of these decisions are --
3 there's a lot within the \$100 range, but there are a fair
4 proportion that are beyond the \$100 range. We as staff and
5 you as Commissioners -- take a look at that table because
6 it does start to move in that direction, and we'll try and
7 think about how to come back and display it in a way that
8 gives you a better sense of that.

9 MR. THOMAS: I'm kind of off this topic in a
10 little different direction, but something I would like to
11 see around synchronization was brought up at the end of the
12 chapter, and I think it could be accelerated, quite
13 frankly, is the synchronization around quality metrics
14 because, frankly, it's a major issue. It's very different
15 amongst the different paying mechanisms.

16 I know there's a lot of complexities about what
17 we're talking about here and a lot to be considered, but I
18 think on the quality side, something that could be
19 accelerated and simplified much quicker.

20 MR. HACKBARTH: I feel like I'm missing one other
21 person at least. Somebody else have a comment?

22 [No response.]

1 MR. HACKBARTH: Okay. Let me just then make one
2 final observation. I think this analytic approach is
3 really helpful in provoking thought about what the issues
4 are, and this has been a good discussion.

5 Still another way to look at this from my
6 perspective is in terms of fairness, and I've talked to
7 Jack and Cori about this at some length. I know this is
8 complicated, and there aren't clear right answers to it.
9 But as the father of two 20-somethings and as I'm about to
10 go into Medicare myself pretty soon, I've been thinking a
11 lot about how fair this system is to younger people.
12 Increasingly, we have a system for non-Medicare
13 beneficiaries in America where free choice of provider is
14 not the norm; in fact, it's almost nonexistent. Even among
15 large employers with the most general health plans, the
16 base plan is a preferred provider organization. It has a
17 network, and you pay more to go out of network.

18 Increasingly, health benefits, even in large
19 employers, high-deductible plans are increasingly common.
20 Increasingly, employers are moving towards defining
21 contribution arrangements where basically the employer
22 says, "We're going to pay this amount," often keyed to a

1 low-cost option, and if you want a richer option, you pay
2 more.

3 These same principles are embodied in the
4 Affordable Care Act. We tie the contributions to a
5 relatively low-cost plans, and if you want the gold plan,
6 you pay additional money out of pocket.

7 So those are the principles that increasingly
8 guide health care for everybody else in America, including
9 struggling young families that have lots of health care
10 bills of their own, and they may not have very generous
11 health care coverage, and they have college expenses. And
12 it's really going to be people like me who have an
13 entitlement, pay my \$100-some a month, and so long as I've
14 been in Part A-covered employment, I get free choice of
15 provider. I get to stay in that, even if there are
16 dramatically lower cost options in my community, and my
17 kids pay for it, and that's not what they've got. So to
18 me, there's a whole ethical dimension here about is this
19 system fundamentally a fair one, or should we think about
20 redefining the entitlement for Medicare beneficiaries? The
21 entitlement is into a health care system like the rest of
22 the country has, and I feel particularly strongly about

1 this because I think the likelihood that my children are
2 going to have Medicare in the same terms that it's offered
3 to me, given the demographics, it's very low. So they are
4 going to pay high taxes to subsidize people like me, and
5 then when it's their turn, the rules are going to be very
6 different.

7 I worry about Medicare beneficiaries. I've
8 devoted much of my career to the Medicare program because I
9 care about it, and I care about social insurance, but I
10 really worry that the system is antiquated, and it doesn't
11 work for the rest of the country. It's not really fair to
12 the rest of the country.

13 Having said that, I know in my conversations with
14 Jack and Cori about this, there are lots of really
15 complicated issues about how you make a transition, and I
16 don't pretend to have the answers to those. But I do think
17 this discussion is in part analytic, and this is really
18 good work, but it's also in part about values and I think
19 what's fair to the rest of the country.

20 So, on that note, over and out. I am done.

21 [Laughter.]

22 MR. HACKBARTH: Thank you for the work on this

1 folks, and we will have our public comment period.

2 [Pause.]

3 MR. HACKBARTH: Nobody. We are adjourned. Thank
4 you all.

5 [Applause.]

6 [Whereupon, at 11:56 a.m., the meeting was
7 adjourned.]

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