# MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

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

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[10:15 a.m.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

coordinated approach across episodes of care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

providers from large losses.

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

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

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

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

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

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

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

These results are expected and reflect the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you very much, Carol.

We'll take clarifying questions.

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

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

DR. CROSSON: Jack.

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

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

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

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

DR. HOADLEY: Right.

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

DR. HOADLEY: Right.

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

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

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

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

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

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

DR. CARTER: Yeah.

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

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

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

[Laughter.]

DR. CROSSON: On this? Yes, Cori.

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

DR. CROSSON: Thank you. Alice?

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

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

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

DR. COOMBS: Right.

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

DR. COOMBS: Okay.

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

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

DR. CARTER: Yes.

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

DR. CARTER: Right.

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

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

DR. CROSSON: David.

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

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

DR. CARTER: Yeah.

DR. NERENZ: How does that work?

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

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

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

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

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

DR. CROSSON: Other clarifying questions?

[No response.]

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

So, Mary, would you like to lead off?

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

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

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

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

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

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

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

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

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

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

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

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

There is tremendous concern about fragmentation.

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

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

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

So those are my recommendations.

DR. CROSSON: Thank you, Mary.

DR. NAYLOR: Oh. And I totally support.

[Laughter.]

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

[Laughter.]

DR. CROSSON: Bill.

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

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

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

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

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

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

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

DR. CROSSON: Warner.

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

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

DR. CROSSON: Herb.

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

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

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

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

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

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

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

It's for the patients who have kind of multiply

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

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

DR. CARTER: Right.

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

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

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

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

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

MR. KUHN: Thank you.

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

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

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

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

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

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

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

DR. MILLER: [Off microphone.] Right.

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

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

MR. KUHN: Yeah. Yeah.

[Laughter.]

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

churning under the water looks right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

But, really, the last thing is right, site

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

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

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

dealing with, is that possible or not?

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

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

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

DR. CROSSON: Yeah, the demo idea --

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

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

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

[Laughter.]

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

give you a really straight answer to that.

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

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

DR. CROSSON: Rita, on this issue?

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

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

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

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

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

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

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

Warner, I have you next.

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: David.

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

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

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

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

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

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

[Laughter.]

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

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

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

DR. CARTER: I don't know.

[Laughter.]

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

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

requirements obviously have an incentive for longer stays.

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you.

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

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

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

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

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

MS. THOMPSON: I know.

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

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

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

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

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

[No response.]

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

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

DR. COOMBS: Telehealth.

DR. MILLER: Telehealth.

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

[Laughter.]

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

[Pause.]

DR. CROSSON: So there is an agenda.

[Pause.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

visit per month.

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

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

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

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

CMMI permits the use of telehealth services,

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

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

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

MS. PHILLIPS: Thank you Zach.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

particular, cost savings.

I will now pass things off to Ariel.

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

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

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

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

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

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

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

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

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

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

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

Next, we'll discuss Medicare Advantage.

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

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

Another implication is that the MA benefit would

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

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

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

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

services in their bid amounts?

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

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

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

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

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

DR. CROSSON: Thanks very much.

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

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

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

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

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

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

MR. GAUMER: That is my understanding, yes.

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

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

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

DR. CROSSON: Okay. All right.

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

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

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

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

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

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

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

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

DR. MILLER: Right, and so --

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

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

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

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

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

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

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

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

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

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

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

MS. PHILLIPS: Usually. In addition.

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

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

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

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

DR. NAYLOR: Thank you.

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

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

So, you know, question one is: How much

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

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

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

MR. ZARABOZO: No [off microphone].

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

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

DR. MILLER: Oh, no.

DR. CROSSON: Don't bring it up?

[Laughter.]

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

DR. MILLER: Right.

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

[Laughter.]

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

DR. JOHNSON: Yes.

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

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

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

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

MR. ARMSTRONG: My question was asked.

DR. CROSSON: Asked and answered.

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

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

Did you get any sense from the privacy insurers

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

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

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

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

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

guys?

DR. HOADLEY: Yeah.

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

DR. HOADLEY: Yeah.

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

DR. CROSSON: Cori.

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

[Laughter.]

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

MS. UCCELLO: Get ready, Carlos.

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

[Laughter.]

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

DR. MILLER: Oh no --

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

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

that question, and --

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

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

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

DR. MILLER: [Off microphone.]

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

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

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

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

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

DR. REDBERG: Right.

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

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

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

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

determination.

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

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

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

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

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

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

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

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

MR. THOMAS: Okay.

DR. CROSSON: You can go first.

Jon has a question.

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

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

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

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

that.

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

DR. CROSSON: Round one question. Question.

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

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

effectiveness, but --

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

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

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you, Alice.

Herb.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you, Herb.

Warner.

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

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

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

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

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

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

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

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

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

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

that participate, that would be great. Thank you.

DR. CROSSON: Bill Gradison.

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

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

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

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

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

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

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

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

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

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

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

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

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

Kathy.

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

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

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

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

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

contribution.

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

[Laughter.]

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

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

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

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

DR. CROSSON: I agree completely. Jack.

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

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

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

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

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

DR. CROSSON: Last word, Mary.

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

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

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

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

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

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

have.

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

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

Please introduce yourself and what organization you represent.

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

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

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

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

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

DR. CROSSON: Thank you very much.

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

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

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

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

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

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

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

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

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

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

Thank you.

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

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

AFTERNOON SESSION

[1:32 p.m.]

DR. CROSSON: Okay. I guess we'll be ready to start the afternoon session.

This afternoon represents the new phase, I think, in the Commission, taking up again the issue we have discussed before of the drug costs in the Medicare program, drug costs, quality, and access, as well. But, we have, as you know, if you have been following the work of the Commission, we have been concerned, as have others, about rising drug costs and we have endeavored and we will endeavor over the next year or so to take a comprehensive look from the perspective of Medicare and particularly from the perspective of the tradition of MedPAC's support for the Congress and what recommendations we might be making to help improve access and quality, but particularly the cost of pharmaceutical services.

So, we're going to have three presentations this afternoon touching on potential approaches that we will take. We will see some recommendations, as well, based on prior discussions. And we're going to start off with Rachel and Shinobu taking us through Part D.

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

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

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

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

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

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

The second feature is the 80 percent reinsurance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

drugs, five percent can be a real financial burden.

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

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

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

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

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

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

also more effectively manage benefit spending and negotiate lower prices.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part D has more restrictions on plan formularies

than what insurers and PBMs use in many commercial plans.

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

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

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

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

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

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

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

processes.

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

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

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

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

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

In terms of the implications of Draft

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

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

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

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

DR. CROSSON: Thank you very much, Rachel and

Shinobu. Excellent work and presentation as usual.

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

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

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

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

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

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

MS. SUZUKI: [Nodding yes.]

MS. UCCELLO: Thank you.

DR. CROSSON: Clarifying questions.

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

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

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

DR. REDBERG: Sure.

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

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

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

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

DR. REDBERG: Yes.

DR. SCHMIDT: Okay.

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

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

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

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

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

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

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

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

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

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

DR. HOADLEY: Thank you.

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

right? I mean entirely or partially?

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

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

MS. SUZUKI: Yes.

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

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

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

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

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

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

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

DR. SCHMIDT: Okay.

MS. BUTO: Right. Thank you.

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

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

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

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

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

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

MR. THOMAS: I got it. Okay.

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

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

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

DR. CROSSON: Other clarifying questions?

[No response.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. MILLER: First of all --

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

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

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

We had some sense of how many people were kind of

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

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

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

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

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

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

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

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

DR. CROSSON: Kate, on this?

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

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

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

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

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

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

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

DR. SCHMIDT: Yeah.

DR. BAICKER: Yeah.

DR. HOADLEY: Cap.

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

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

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

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

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

DR. BAICKER: Right.

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

DR. HOADLEY: Right.

DR. BAICKER: Right. So anybody who --

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

DR. BAICKER: It's everybody --

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

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

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

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

DR. HOADLEY: Right.

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

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

DR. BAICKER: Right, right.

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

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

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

DR. BAICKER: And we can --

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

DR. HOADLEY: It will get bigger.

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

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

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

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

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

DR. BAICKER: Right. So --

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

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

DR. HOADLEY: You need a behavioral effect.

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

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

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

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

DR. HOADLEY: A small amount.

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

DR. HOADLEY: Right.

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

DR. CROSSON: Okay. We will endeavor --

[Laughter.]

DR. CROSSON: You got a result?

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

Jack, have you finished your comments on Recommendation 1?

DR. HOADLEY: Yes.

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

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

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

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

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

DR. CROSSON: All right.

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

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

Okay. Kathy.

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

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

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

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

DR. CROSSON: Craig.

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

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

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

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

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

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

DR. MILLER: And the other thing I would add

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

[Laughter.]

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

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

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

program, as Jack mentioned.

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

MS. UCCELLO: Yeah.

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

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

MS. UCCELLO: -- is still a burden.

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

MS. UCCELLO: I'm not done.

[Laughter.]

DR. CROSSON: Why did I think that?

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

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

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

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

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

DR. CROSSON: Okay. Thank you.

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

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

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

So I am comfortable with this recommendation, but

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

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

[No response.]

[Comments off microphone.]

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

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

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

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

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

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

MS. BUTO: Sure.

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

MS. BUTO: We might want to mention that

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. MILLER: That's true.

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

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

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

DR. REDBERG: Those nights and weekends.

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

[Laughter.]

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

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

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

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

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

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

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

mind.

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

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

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

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

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

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

DR. CROSSON: Okay, on Recommendation 3.

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

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

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

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

MS. BUTO: Thanks.

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

incentive to use, say, a biosimilar?

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

DR. MILLER: I thought the thinking here for [off microphone] allowing two tiers, one of the specialty drugs could find its way down to something less. That was the thinking.

DR. HOADLEY: At the very least, that should be more explicit.

DR. MILLER: Absolutely. And, you know, that's always true, and we'll always take that and make the text more clear.

The other thing, I can't tell from your exchange, I think our general posture has been, you know, the plans in the market tries to innovate, you know, from year to year as new drugs and new indications come on, and over time they have pushed this process of kind of differentiating. Now you have a tier between, you know, preferred generics and non-preferred generics because, you know, some of the prices are even rising there. And I couldn't tell from your comment and then your exchange, are

we saying we would then go back to plans and say, okay, now here is how you have to do your tiering? Whereas, I think we've generally taken a posture of unless we see a tiering that's really abusive, we tend to let the plans kind of figure out how they want to structure some of this stuff.

DR. HOADLEY: Certainly, the status quo has been a lot of flexibility, and what CMS has done in several stages over the years is tried to put some discipline on it, so they've got now ranges of allowable copays or coinsurance in certain tiers. They've got more labeling requirements. This year's call letter says, "Well, because we've seen this phenomenon where there's a lot more generics on the so-called brand tiers, that plans could switch and just call it a non-preferred tier without designating a non-preferred brand."

But what I keep hearing on the beneficiary community side is this is just getting more and more confusing. So, when beneficiaries are trying to figure out how to pick a plan and then how to use their plan once they pick it, you know, they can obviously go to the plan finder and just say, "Forget what all the tiers are called, and just tell me what it's going to cost me." But there was a

time when we thought about the tiers were sending signals to people, that we really do prefer you to use certain drugs over others. But the complexity has gotten to the point where it's like overwhelming to most people, and I think that's part of what I'm saying, is we're continuing to just split it up.

I get the notion of having a less expensive tier. I think that's a good thing, but I'm just wondering whether there's a different way to get at it and whether all the amount of sort of planning, experimentation is sometimes at the expense of beneficiary comprehension of what's going on.

DR. CROSSON: Mary.

DR. NAYLOR: So I support the recommendation, except for the last bullet. Really stimulated by this last conversation. I think that -- and especially, I think in the body of the work, you talked about the management plans that commercial plans are using, and that these would need to be carefully monitored by CMS to make sure we weren't restricting access.

But if you -- the list of options of 15-day fills, refills, and specialty pharmacy designations and this tiering, I mean, if all of those tools were applied,

it could dramatically restrict access, I think, to Medicare beneficiaries.

So I would be very concerned to just say permit plans to use certain tools without real understanding of the implications it would have on access for this population.

DR. CROSSON: So, Mary, I think one of the reasons it was worded this way was not just for simplicity and lack of complexity, but also to provide CMS with some latitude in terms of which among these tools they decided to use.

We could -- I'm trying to understand whether you're suggesting that we actually, in the next version, list those that we think should be included or what.

DR. NAYLOR: I'm just trying to make sure that we don't impose -- well, I mean, I would want to make sure maybe in the write-up that the suggesting -- enabling the Secretary to permit plans to use tools to manage specialty drugs does not result in severely restricting access to people that need it.

DR. CROSSON: So this is a point that could be made in the text; is that right?

DR. NAYLOR: It is. And it is made in the text. There is a comment that that could happen and that CMS will need to carefully monitor it. So I'm just trying to figure out what's the right language, I guess, that would enable management tools, but that would not -- you know, that are really paying attention to this population.

I mean, I'm thinking of the 75-year-old who will have to go to a pharmacy for specialty drugs, who would have to go every 15 days. So I'm just thinking of the combination of what might be made available and use that could restrict access. So I guess I am looking for more assurance that, on the one hand, it provides plans with the flexibility that they need, on the other hand, does not severely create access issues for the beneficiary. So that's -- maybe it's a language.

DR. CROSSON: In the way the recommendation is worded or the comprehensiveness with which the point is made in the text?

DR. NAYLOR: I don't know, to tell you the truth. Maybe it's the comprehensiveness with which it's in the text, but, you know, a real caution around how application of multiple tools simultaneously could really create access

issues for the population, so something like that.

DR. CROSSON: Okay, thanks. Kathy. Kathy and Scott.

MS. BUTO: Yeah. Just a quick comment on Mary's comment. I share her concern and think that maybe one way to deal with this is to have the Secretary -- because it isn't just this recommendation. We've got two others, one of which is actually going to probably increase the plan's risk on the reinsurance end, which I think is going to put more pressure on the plan, you know, from the get-go. So we could see, with a recommendation like this, the use of multiple tools that will make access difficult.

I think another way to deal with it is to have our recommendation also sort of suggest that the Secretary needs to do an impact assessment really of all of the recommendations and the impact they might have collectively on beneficiary access and to develop ways of monitoring that access over time, something like that, because we can't just take them individually. All three of them are going to have an impact on beneficiaries.

DR. MILLER: The only other thing I would suggest -- and I haven't cleared this with the Chairman -- is we

may also be able to get at least a few words into the reg itself that imply the intent of what we're trying to pull off here. You've sort of made two tiers, maybe not so bad if it does this, whatever other things. If our concern is some balance between flexibility and access, maybe there's at least a few words where that pointer is in there, and then we can go into the text and say this is the kinds of things we're talking about. And then it's at least visible enough to all view as you vote that it has been taken into account, and then the text can try and go after the issue.

DR. CROSSON: Including Kathy's idea in the text.

DR. MILLER: And I don't have any objection to what Kathy said, so that could get in there as well.

DR. CROSSON: Yeah, okay. Scott.

MR. ARMSTRONG: So, on the one hand, I want to agree, Mary, with your concern that these policies shouldn't limit people who need help from getting the care they should be getting, but I really disagree that if -- particularly, Kathy, it reminds us we're looking at all three of these recommendations, and if we're going to shift a whole lot of responsibility to the health plans for a lot of really good reasons, then we need to allow the health

plans to apply tools to pharmacy drugs that they've been applying for decades to all sorts of other kinds of care with, you know, responsibility for assuring access and clinical quality and all the other things that we hold them accountable to.

And I would just say that split fills as an example has saved my system tens of millions of dollars and our patients tremendous improvement in quality of care because we're engaged short order after very expensive prescriptions and finding out was it really the right drug or not.

Specialty pharmacies give our beneficiaries the opportunity to engage clinical pharmacists who have specialty knowledge around their prescription in a much higher quality kind of course of care, and so I think we need to be careful about this. But these are exactly the kinds of interventions and tools that, in a broad sense, we've been advancing through payment policy for the five, six years that I've been part of MedPAC. I wouldn't be too cautious about applying this to our medical drug cost as we're starting to move into that neighborhood.

DR. CROSSON: Okay. Well, Rachel and Shinobu

will work this all out.

Oh, sorry. Jack, one more.

DR. HOADLEY: Just to follow on, I mean, this is the challenge, then, sort of this mix of comments. Because we're just seeing the recommendations, we're not able to look at it in the context of the text that will be written, and so, obviously, part of the test will be how we put this together.

But, I mean, I think I take Scott's comments -- or I think these are the techniques that could really work. They've got to be done, and I trust Scott's plans to do this really well. I'm not sure I trust every plan to do this well, to make sure that they've got specialty pharmacies contracted that are convenient to where beneficiaries live, to make sure that they are handling a split fill in a way that somebody who is frail and can't always get out can get it delivered to them instead of having to go down and pick it up.

I mean, I think coming up with some of the -- and maybe this, again, writing this into the text when we raise these kinds of issues, on the one hand, a split fill does these good things. On the other hand, if it's done in a

way that makes it hard for people to get those drugs, they need to be -- consideration about delivery or other kinds of things. And then we can put that all together.

I also would wonder which of these things the Secretary already has the authority for. I mean, certainly, the specialty tiers, the Secretary created them in the first place. They're not in law. The Secretary could do that today, so we may -- it's something, I know, Kathy sometimes brings up is which are these things does the Secretary already have the authority to do and which of these things -- and maybe the specialty pharmacy is an example of something the Secretary could not do today, but maybe she could. And so that just probably is a useful thing to mention as well.

DR. CROSSON: Okay. Very good discussion. Thank you, everyone. I think we have exhausted our time for this topic. Thank you, Rachel and Shinobu. Very good work, as usual.

And now we're going to move from Part D to Part B.

[Pause.]

DR. CROSSON: Okay. So, now we're going to have

a discussion about Part B. We're going to have, based on prior discussions we've had at the Commission, we're going to have one recommendation as it applies to dispensing and supplying fees. But, the majority of the discussion, I think, is going to be to take us through some potential avenues that we could explore, some of which we've referred to before, some of which may be a little new, and in the process of discussing the presentation, or we're going to try to focus in or prioritize those areas that we think have the most potential benefit as well as feasibility.

So, we have Kim Neuman, and it looks like Kim has got a shotgun there. Joan Sokolovsky has joined us again.

DR. SOKOLOVSKY: Silent partner.

[Laughter.]

DR. CROSSON: Silent partner. I thought maybe the shotgun was under the table.

Kim, go ahead.

MS. NEUMAN: So, as Jay said, today, we're going to continue our discussion of Part B drug payment policy issues that we began last spring and that we discussed most recently at the November meeting.

Today, we'll focus on three types of issues.

We'll first talk about the six percent add-on to the average sales price and a policy option to restructure it, a topic we've discussed previously.

Then we'll discuss some broader policies beyond the add-on payment that could have the potential to increase price competition among Part B drugs or put downward pressure on ASP. These are ideas we could develop further over the next cycle if there's interest.

Lastly, we'll revisit the issue of the Part B dispensing and supplying fees and we'll have a draft recommendation from the Chairman for your consideration.

One last thing to note. As far as going forward, the idea is that the topics we discuss today would be included in a June report chapter with the potential for these issues to be developed further in the future, depending on your guidance.

You've seen this slide with background on the ASP payment system before. I'll just highlight a couple of quick points. As you know, Medicare pays for most Part B at a prospective rate equal to 106 percent of the average sales price. ASP is the drug's price from the perspective of the manufacturer. ASP is defined as the price realized

by the manufacturer for sales to all types of purchasers, with some exceptions, net of rebates, discounts, and price concessions. The price an individual provider pays for a drug may differ from ASP for a variety of reasons, such as price variation across purchasers.

As we've discussed previously, concern has been expressed that the six percent add-on to ASP gives providers a financial incentive to prescribe higher-priced drugs. However, few studies have looked at whether the six percent add-on is influencing prescribing behavior.

In November, we modeled two budget neutral options to restructure the six percent add-on. We took a hybrid approach where we reduced the percentage add-on and added a flat fee. Commissioners had several reactions to this. Some Commissioners expressed concern about whether providers would be able to purchase drugs within the Medicare payment amount. Some Commissioners felt the policy changes were modest and suggested we consider models that generate savings. And several Commissioners urged further work to consider broader approaches.

So, with that feedback, we've done additional work on all of these points. First, to get a sense of how

the prices providers pay for Part B drugs compare to Medicare's payment rate, we obtained proprietary invoice price data from IMS Health Incorporated. These data break out prices for the clinic channel of purchasers, which includes physician offices, hospital outpatient departments, and non-hospital surgery centers and dialysis facilities. We analyzed data for 34 Part B drugs that accounted for about two-thirds of Part B spending in 2014.

Because our contract with IMS Health does not allow us to report actual prices, we focused on the ratio of the invoice price to the average sales price and summarized our results across the 34 drugs.

This chart shows the trend in the median 75th percentile invoice price as a percent of ASP between first quarter 2012 and second quarter 2015. So, here's how to interpret this measure. If the median 75th percentile invoice price is 103 percent of ASP, that would mean that for half of the 34 drugs, at least 75 percent of the volume was sold to clinics at an invoice price at or below 103 percent of ASP.

Now, looking at the trend line, what we can see is that this measure of invoice prices as a percent of ASP

declined in second quarter 2013, the same quarter the sequester went into effect. As you know, Medicare's payment rate is ASP plus six, but the sequester reduces it to effectively ASP plus 4.3 percent. So, this chart suggests that some manufacturers may have responded to the sequester by changing their pricing patterns in a way that mitigated the effect of the sequester on some providers.

Next, we look more closely at the distribution of invoice prices as a percent of ASP across the 34 drugs for one quarter. Here, we have data for first quarter 2015. Looking at the first two lines in the chart, we can see that for about two-thirds of the 34 drugs, at least 75 percent of the volume was at an invoice price less than 102 percent of ASP.

In summary, these data suggest that for a substantial portion of the volume for many of the drugs in our analysis, there is still headroom between providers' acquisition costs and the Medicare payment rates, even with the sequester.

Now, turning back to our work modeling alternatives to the six percent add-on to ASP, we've modeled a new policy option that generates savings. The

option is 103.5 percent of ASP plus a flat fee of $5 per drug administered per day. Overall, this approach is estimated to save about 1.3 percent, or about $270 million annually, and that's based on 2014 data, assuming no shifts in utilization. These savings would be split 80/20 between the program and beneficiaries.

The policy has the effect of increasing the add-on payments for drugs with an ASP per administration of less than $200 and decreasing the add-ons for higher-priced drugs. The policy option would reduce, but not eliminate, the difference in add-on payments between higher-priced and lower-priced drugs. Specifically, it reduces the difference in add-ons between two such products by about 40 percent.

Jon, you had asked for a real world example of how this would change the add-on payments for two products that were therapeutic alternatives and we've added a table showing that in the paper.

Next, we have the revenue effect of the policy option on different types of providers. Hospitals and physicians that tend to prescribe higher-priced drugs, like oncologists, ophthalmologists, and rheumatologists, would

see reductions in their Part B drug revenues in the range of 1.5 percent to 2.1 percent, and you can see that in the middle column on the chart. As a share of these providers' total Medicare revenues, the effect is smaller, particularly for hospitals, and that's the far right column. Also note that payments would increase modestly for primary care physicians, who tend to use more inexpensive drugs, and would be virtually unchanged for suppliers.

In addition to concerns about the six percent add-on, there are also concerns about the overall prices Medicare Part B pays for drugs. The largest component of Medicare's payment for Part B drugs is the ASP. The six percent add-on is a relatively small share of the total payment. If the Commission wishes to influence Part B drug payments to a larger degree than possible through the add-on payments, we could consider Medicare payment policies that create more incentives for price competition among drugs or that put downward pressure on ASP.

Today, we'll explore three options. First, an ASP inflation cap. Second, consolidated billing codes for Part B drugs. And, third, restructuring the competitive

acquisition program for Part B drugs.

The growth in ASP plus six payment rates for individual drugs is driven by manufacturer pricing decisions. In theory, there's no limit on how much Medicare's ASP plus six payment rate for an individual drug can increase over time.

In your paper, we included a table showing ASP growth from 2005 to 2016 for the 20 highest expenditure drugs. This shows that the median ASP growth across the 20 highest expenditure drugs was slower than inflation from 2005 to 2010, but has exceeded inflation since 2010. For example, in the last year, ten out of the 20 highest expenditure drugs have had an increase in their ASP of at least five percent.

A policy option that could be considered would be to place a cap on how much Medicare's ASP plus six payments for an individual drug can grow over time. This could potentially be operationalized through a manufacturer rebate to Medicare when the ASP for its drug increases faster than a specified inflation benchmark. One possible model for this type of policy is the inflation portion of the Medicaid rebate. Other approaches are possible, as

well.

If Medicare had an ASP inflation cap, it would protect against the potential for a dramatic increase in the Medicare payment rate for a product and it would also potentially generate savings for drugs with ASP growth exceeding the inflation benchmark.

Next, we consider incentives for price competition under the ASP payment system. Single-source drugs and biologics receive their own billing codes and are paid based on their own ASP. Having drugs with similar health effects in separate billing codes does not promote price competition. There are examples of high-expenditure competitor drugs with relatively stable or increasing ASPs, which demonstrates that price competition among non-generic drugs is limited under the ASP payment system.

Also related to this is coding policy for biosimilars and reference products. CMS finalized a policy to group all biosimilars associated with the same reference product in one billing code. But even though all biosimilars will be in one billing code, the reference biologic will remain in a separate code and paid its own ASP plus six rate per the statute.

In other work, the Commission has held that Medicare should pay similar rates for similar care. Given that principle, a policy option that could be considered is to give the Secretary the authority to put drugs with similar health effects in the same billing code. With two or more similar products in the same billing code and paid at a rate that's based on the average ASP for the products, drug manufacturers would have more of an incentive to lower their price below their competitors to make their products more attractive and garner market share. This would promote price competition and generate savings for beneficiaries and taxpayers.

Another approach that could be considered to spur price competition for Part B drugs is a competitive acquisition program. Medicare's initial experience with this type of model for Part B drugs was not successful, but we can explore whether there are ways to restructure it.

So, first, this slide has some background on how the original program worked. The MMA required Medicare to implement a competitive acquisition program called CAP for Part B drugs furnished by physicians. It operated from July 2006 to December 2008. The idea was to take

physicians out of the business of buying and billing for drugs and eliminate any financial incentives associated with furnishing drugs. With this program, the physician could choose to enroll or could choose to remain in the regular buy and bill fee-for-service system.

Those physicians that participated obtained drugs for fee-for-service beneficiaries from a vendor. The physician would submit a prescription to the vendor for an individual patient before the patient's office visit. The patient would ship the drug to the physician. The physician would then administer the drug and bill Medicare for the drug administration service only. Medicare would pay the vendor for the drug and the vendor would collect the beneficiary cost sharing for the drug. Competitive bidding was used to select the vendor and to set the prices Medicare paid the vendor. Although Medicare offered vendor contracts to more than one organization, only one company, Bioscript, chose to participate.

The original CAP program faced several challenges. Physician enrollment was low; about 1,000 practices participated each year. The vendor had little leverage to negotiate discounts. For single-source drugs

and biologics, the vendor was required to offer each product and, therefore, had little leverage to negotiate. Medicare paid the vendor more than ASP plus six for the drugs. There were several reasons for this, including a flawed process for updating the bids. The vendor, Bioscript, declined to sign a contract to continue serving as the CAP vendor for 2009 and the program has been suspended since that time.

While the original CAP program faced a number of challenges, we could consider options to restructure it to encourage physician enrollment and give the vendor more negotiating leverage. Your paper walks through some different approaches that could be considered for doing this. For discussion purposes, here's an example of a possible approach.

First, several steps could be taken to encourage physician enrollment. Physicians could be offered the opportunity to share in any savings from the CAP program. At the same time, the ASP add-on percentage could be reduced or eliminated in the traditional buy and bill system, making it less attractive. And to reduce administrative burden on physicians as well as the vendor,

the program could be changed to a stock replacement model instead of physicians having to pre-order drugs for each individual patient.

Second, the vendor could be permitted to operate a formulary and, like physicians, could share in any savings generated by the program.

Finally, to the extent that the program led to lower prices, the savings could be shared with beneficiaries through lower cost sharing.

To make this more concrete, let's talk through an example of applying this approach to a specialty. We'll use ophthalmology as our example. I want to note, though, that using ophthalmology as an example does not mean the CAP program would necessarily be limited to only a few drugs. A restructured CAP program could also be applied broadly across specialties, like, for example, the original CAP program applied to about 180 drug billing codes.

We've picked ophthalmology because there's a sizeable amount of drug spending, but a limited number of drugs, and spending is concentrated among just a few competitor drugs. So, there may be opportunities to garner price competition and get savings. So, here is how this

might work.

As noted previously, ophthalmologists would be encouraged to enroll in the CAP program in several ways. The ASP add-on in the traditional buy and bill system would be reduced or eliminated. At the same time, physicians who chose to enroll in the CAP program would have opportunities to share in any savings generated by the program. Organizations that wanted to become CAP vendors would submit bids to Medicare on the price at which they could offer each drug. Organizations that could offer the lowest prices would be selected as vendors. Vendors' leverage to negotiate discounts would come from their ability to construct a formulary and from physicians having shared savings opportunities. Both ophthalmologists and the vendor would be eligible for shared savings, in other words, extra payments, if the program saved money. Beneficiaries would also share in savings by paying 20 percent of a lower price.

So, last, we have the issue of the dispensing and supplying fees. You will recall we discussed this in November and there was general agreement on the issue. In 2014, Medicare and beneficiaries spent about $155 million

on the Part B dispensing and supplying fees. The dispensing fee is $33 per 30-day supply, or $66 per 90-day supply of inhalation drugs. The supplying fee is $24 for the first prescription in a 30-day period and $16 for each additional prescription in that period for three categories of Part B-covered pharmacy furnished drugs. These dispensing and supplying fee rates were established in 2006 based on limited data. OIG has reported that Medicare Part B and Medicaid paid dispensing fees of less than $5 per script for these categories of drugs in 2011.

In light of this, the Chairman's draft recommendation reads, the Secretary should reduce the Medicare Part B dispensing and supplying fees to rates similar to other payers.

The implications of this draft recommendation is that it would reduce Medicare program spending and beneficiary cost sharing, and we would expect no adverse impact on beneficiary access or providers' willingness or ability to serve beneficiaries.

So, that concludes the presentation. We'd be happy to answer any questions and look forward to your discussion.

DR. CROSSON: Thank you, Kim. A very nice job.

Let's do clarifying questions, and we'll take the whole report. Alice, Herb, Kathy.

DR. COOMBS: Thank, Kim. The graph on page 6, you talk about the sequester having an effect. What would the graph look like without the sequester? I was trying -- I had a hard time understanding. You said that the industry responded to the sequester. If they didn't respond, what would the graph look like?

MS. NEUMAN: So this graph, just to clarify, is the invoice price, the 75th percentile invoice price, divided by 100 percent of the ASP. So, if nothing changed, you might expect a flat graph, but we see this marked change at the same time that the sequester occurred.

DR. COOMBS: And just help me to understand the reasoning behind the -- I'm looking at the drop, thinking that it was appropriate, but it's not?

MS. NEUMAN: It's not -- there's no judgment about appropriate or inappropriate. The idea is that when the sequester happened, Medicare's payment rate to providers effectively went down from 106 percent of ASP to 104 percent of ASP. So, under that situation, you might

think that the spread that a provider gets between what Medicare pays them and what they pay for the drugs would shrink, but what appears to have happened in this chart is that at the same time that the Medicare payment rate went down, the provider's price, as a percent of that payment rate, also went down. And so it seems to have mitigated the shrinkage of the spread for the providers.

DR. MILLER: Maybe another way to say this, in this case, there's always a bit of a tension of Medicare saying is it 106 or 103 or whatever the case may be, and what's the manufacturer going to do? Because a lot of initial reaction from the physician community would be "You can't do this because they won't change their prices, and then I'll get sunk." And so it's very hard to judge, and it's also very hard to judge drug by drug. And we're not asserting this happens in all instance, but there was a little moment of a -- I don't call it a natural experiment. Kate will get all over me. But, you know, where we could kind of look at the data.

As someone who has done real ones, I just didn't want to get cross-wise with you.

[Laughter.]

MR. KUHN: So two questions, Kim. First, on the dispensing and supplying fees, so whether it's the inhalation drugs or the anti-emetics, presses those, are they traditionally mail order, or are these actual visitations to a pharmacy to get these drugs?

MS. NEUMAN: So the inhalation drugs may be supplied by the same company --

MR. KUHN: The DME.

MS. NEUMAN: -- that supplies the DME, and so it may go directly to the patient's home.

With the pharmacy-prescribed drugs, it could go either way.

MR. KUHN: Okay. And just on the question on the inhalation drugs, so a person gets their nebulizer and gets their drugs. That may come in the mail. It may be delivered by the DME supplier, but they already have a billing code that gives them the instructions on instructing the beneficiary how to use the product. This is just an additional payment for just supplying this drug? Am I understanding that correctly?

MS. NEUMAN: So the dispensing fee covers getting the drug to the beneficiary, so what you sort of commonly

think about the services of a pharmacy dispense a drug to a beneficiary.

There is this issue of training the beneficiary in how to use the nebulizer. CMS, in their final rule on the fees, said that the training of the beneficiary is part of the DME, responsibility of the DME supplier, not the part of the drug supplier.

MR. KUHN: Right. Thank you.

And the second question had to do with the competitive acquisition program. So you laid out a series of issues of maybe how to restructure it. RTI was the evaluation contractor. As part of their evaluation, I assume they interviewed BioScript, who was the vendor at the time. Do the recommendations or the information you have in the report and then up on these slide decks comport with what RTI found from the vendor in terms of reforms that would be necessary to make this program work in the future?

DR. CROSSON: Can I help? Because I actually read the report, and I didn't see any recommendations at all.

MR. KUHN: Okay. Thank you.

DR. CROSSON: If I'm wrong, go ahead. Sorry.

DR. SOKOLOVSKY: No, you're not wrong, but at the time, we also met with BioScript, and the things that they told us, the things that were the biggest problem for them, was the way in which ASP was updated or not updated, and also this -- well, that was their biggest problem, that they were making a lot of money on some drugs, but there were some drugs that particular specialties were going to BioScript for because the price had gone up a lot, and it was not being updated. So they were losing money on that particular -- those particular drugs, and that was a big problem for them. The update process didn't reflect ASP changes.

DR. MILLER: And that was in part because there was an indexing in this, too, right? The way this works, it wasn't like an interactive thing where the vendor was extracting prices. There was sort of a negotiated price, and then that got indexed, which was also another kind of odd feature.

DR. CROSSON: Kathy.

MS. BUTO: So my question is around Slide 12, the ASP inflation cap. My understanding, Kim, is that,

although we lay out the issue as possibly being operationalized through the rebate, in the paper, page 26, we talk about it could also be operationalized through a payment rate limit sort of a la what we do with other payment systems where we apply some sort of a Medicare increase that could limit what the increase is. So it could be done either way, as I understand it.

And the difference is that if you do it through a rebate, the provider, in a sense, gets ASP plus 6, and then the program later will get a rebate if that -- the price increase is above inflation, right?

The other difference is, as I understand it, the beneficiary would pay more under this option than under the Medicare puts a limit on the increase in the payment rate option because, if Medicare puts a limit on the payment rate, the beneficiary will pay 20 percent of that limited payment rate, where under a rebate, the beneficiary is paying the copay based on the inflated, if you will, rate, as I understand it. Is that right?

MS. NEUMAN: So, if you limited the Medicare payment rates to providers, then the beneficiary's cost sharing at the point of care would be lower than it would

be through a rebate.

On the flip side, if you go for a rebate, then the money comes back to the program, which then will filter back to the beneficiary through the Part B premium. It will get spread across more beneficiaries, smaller amount of effect on a larger number of beneficiaries, or with limiting the payment rates, it will be a bigger effect on a smaller group.

DR. CROSSON: Okay. Clarifying questions? Warner.

MR. THOMAS: On page 7, I just want to make sure I understand the chart. So if the pricing is limited to ASP plus 106 percent, then how on the 34 drugs are they charging above the 106? They're charging the provider above 106, and then the provider is just being reimbursed the 106? Is that how it works?

MS. NEUMAN: So this says that 12 percent of the drugs had an invoice price that was greater than 106 percent of APS --

MR. THOMAS: Right.

MS. NEUMAN: -- among our 34. There's a couple of things that could explain that. One thing is that these

prices do not reflect off-invoice rebates. So some of the prices in our analysis may be overstated for that reason, so that could be one thing. It may not be 106 when you took that into account.

The second thing is that there is variation in prices across purchasers, and so some of this could be, you know, the certain segment of the purchasing group is not getting as good a price as others. It could be both or a combination.

MR. THOMAS: So the ASP --

DR. BAICKER: It's the "A" in the ASP. It's an average, but any individual person --

DR. MILLER: So what you said is correct, but there's also another explanation of what might be going on. Somebody could be buying a drug above 106 percent, or it could be that what we're -- the acquisition cost we're measuring here could not reflect fully some of the rebating or discounts that somebody is getting.

MR. THOMAS: How confident are we in the ASP calculation?

DR. MILLER: As confident as the manufacturer's numbers that they submit. I mean, these are supposed to be

market transactions. I mean, they're supposed to --

MR. THOMAS: But we're really not sure.

DR. MILLER: Is there any auditing that's done of this?

MS. BUTO: I'll just speak for my former company. That's one of the most rigorous audits that went on because you're subject to all kinds of federal penalties, criminal penalties, et cetera, if you misreport the data, so yes.

And it was, on just a side note, very difficult because until ASP came in and the requirement for reporting came in, different parts of the company had different definitions of what these different rebates, free goods, et cetera, et cetera, were. So they had to go through a whole level-setting exercise, so that the definitions that could be audited were the same. So, yeah, I'd say at least for that company, it was a rigorous process.

MR. THOMAS: Do we know what the range of pricing is on the 34 drugs? We're kind of comparing to the average price, but do we know the range of pricing? Is it from 50 percent to 100 percent? Is it tight? Do we have any idea?

MS. NEUMAN: So you can kind of get a sense of that. In the paper, there's Table 4 that shows you the

50th percentile and the 90th percentile as well, and so you can kind of get a sense from that that -- how tight it is depends on how you define that, but it's a pretty narrow range. If you look at the median across the 34 drugs at the 50th percentile, you're at 99.7 percent of ASP. The median at the 75th percentile is 101.6, and the median at the 90th is 100.4, so yeah.

DR. REDBERG: Related to that, when you gave us that date, you said you can't report the actual prices. Why can't we report the actual prices?

MS. NEUMAN: We purchased this data. It's proprietary, and part of our contract, we agreed not to report the prices.

DR. MILLER: Kim will go to jail.

[Laughter.]

DR. CROSSON: Clarifying questions? Alice.

DR. COOMBS: I just had another question. It would be helpful if you could march out an example of what it would look like for the average sale price and then what kind of impact a prompt pay has versus a rebate and the end result, what's the end-result number of the actual cost, because I'm just kind of interested in all of the variables

that affect the end point.

So prompt payment may be something that they don't consider. Is it considered a piece of this average sale price in the end in terms of the end point?

MS. NEUMAN: The regulations on calculating the APS say that they have to subtract out prompt-pay discounts that the manufacturer gives to the wholesaler, but we don't have a window on how much that is because the manufacturer is reporting a single number for each NDC. So we have no idea, the components or anything like that.

DR. COOMBS: Okay. So the prompt pay is pre, and the rebate comes after, obviously, but you don't have any kind of cumulative effect?

MS. NEUMAN: No. We just have the final ASP number that the manufacturer reports.

DR. CROSSON: Okay. So here's what I think. I have a sense, mostly from our previous discussion of the dispensing and supplying fees, that we're not going to have a lot of discussion there. Maybe I might be wrong, but I don't think so. So we will separate these issues and spend, hopefully, the bulk of our time talking about the four, you know, Part B options that we have here.

I have to say that I don't know that we need to winnow these down because I think, in many cases, we're just getting into them for the first time.

I also know from having talked to Kim and John and I and Mark and thought through these that there's nothing perfect here. These vary a lot in terms of potential impact, feasibility, complexity, and the like. And what I hope we can do in the discussion is pull out some of those issue and kind of illuminate us collectively about that and then see where we want to go.

So, Jack, you are working very hard today. You are on the hook again.

DR. HOADLEY: So, first of all, I think this was a really great analysis, and I think the new information you brought to us really helps inform this discussion a lot, so I really appreciate that. Thanks.

I think the -- I was one of the people that had encouraged us to look at an option that was actually saving money to the program as opposed to the budget-neutral options, and I think what I saw here sort of convinced me that that makes sense as a good direction. I mean, I could even imagine going more aggressively. I think the biggest

deterrent in going more aggressively is sort of where the sequester fits in, and we've always said that we try to make policy pretending the sequester doesn't exist. If you think about the sequester coming off, 103.5 plus $5, then you're getting a lot closer to the actual ASP. If we don't think of it in those terms, then there's no reason we couldn't sort of bring it down by kind of like the sequester is already doing. So there is that sort of conundrum of how to think about the sequester. But that aside, I mean, I think this gets us in the kind of territory to try to create some savings.

I also like the inflation cap option. I'm glad Kathy raised the cost-sharing implications, and I think that's an important -- and I guess I would prefer, among the two approaches, to -- I mean, I think you're right. The cost sharing would go to the beneficiaries, indirectly to everybody or directly, but these are the people that are facing the cost sharing for this drug, Medigap coverage aside. So I would probably prefer to see it done in a way that would protect those beneficiaries who are using those drugs. I think that's a relatively minor issue in the scheme of things when you assume that not a lot of people

are going without their Medigap protection.

I also like the consolidated billing codes approach. I think one of the things that we're really going to face in the future is how to make sure that we achieve the savings that is promised by the availability of biosimilars, and this wouldn't obviously have to be just in the biosimilar versus original manufacturer situations, but certainly, in those situations, forcing the competition even more strictly than under the current statutory rules would help. So I do like that option as well.

The restructuring the cap program, I guess I'm just more of a skeptic on whether it will get anywhere. Having paid a fair amount of attention back on the original one and watching the total lack of enthusiasm from the provider community and then ultimately from the vendor, I think the kind of rethinking of it makes a lot of sense.

I'm just sitting here thinking I'm not sure that even with the redesign of it that we necessarily get a big response to it, so I wonder how much of that is worth it. On the other hand, since we're mostly in the business right now of sort of laying out some potential options to put on the table, I think it's a perfectly good option to have out

there, and maybe if we wanted to get more serious about it down the road, getting some sense of response from both the provider community and the potential vendor community on whether this -- some of the issues about inventory stocking or some of the issues that got in the way the last time, and you've got ideas here on the table to try to do that better. But whether that works from the point of view of the providers involved, I think is an open question.

So I think we're really putting some good ideas on the table. In some ways, it would be nice to be moving forward with a recommendation. There's a lot of talk from a lot of different sources about trying to make some adjustments on the 106 percent, and this might be a good window to weigh into that. If we feel like there's just too much, it's too much of a moving target in terms of where we are and where our discussion is, then I can appreciate that.

And then, last, I have no problems with the dispensing and supplying. I think that's a good recommendation as well.

DR. CROSSON: Okay. Discussions. Kate, Warner, Bill.

DR. BAICKER: So I think we've come in a really productive direction in thinking about modifying the ASP, and I'm a little of two minds about whether it should be a revenue-neutral package or a revenue-saving/generating package in that -- the point is nicely illustrated with the revenue-neutral one, but I'm not clear which one is better, but I like the direction a lot.

The reason I like that one and thinking about the consolidated billing codes is that they both encourage focusing on the highest-value care for the patient, what the patient really needs, not using care that's of questionable value when better-value care is available. They both move in that direction on a chassis of ideally competitively based prices.

I'm much less comfortable with the inflation cap idea, which really sounds a lot like just straight price controls and maybe undermines the competition towards higher-value care that we're trying to embed in a lot of the other things that we're doing. So I'm not so enthusiastic about that one.

The restructured CAP program, I hadn't known much about it until I read the chapter, and it really sounded

kind of cool on paper and really didn't work at all. And so I share Jack's skepticism about that, which doesn't mean that it isn't worth thinking about why it didn't work and whether it would work better in a system that had a restructured ASP, as you highlight in the chapter. But I'm not sure how much energy to sink into trying the same not so successful tactic again.

So that's my feeling about those four.

DR. CROSSON: I'm going to jump in here a little bit on the restructured CAP. You know, in the context of what I said in the beginning, this is one of the approaches that is complicated, may have feasibility issues, but down the line could be extremely impactful, because it's essentially restructuring the market that is created between the physicians and the drug manufacturers.

It may have escaped notice, but one of the design features that Kim presented here was essentially reintroducing the CAP program as an option, but at the same time reducing the ASP much more dramatically than we're talking about. And that, you know, by itself produces a rather significant net savings of somewhere -- if we had a model that was similar to the original cap that included

180 or 70 percent of the prescription cost, if I remember that correctly, that would represent a savings of somewhere around $800 million a year to start with, as well as whatever incentives then were created for the physicians who chose this in consultation with the patients to manage the cost of drugs, much in the way that they're managed in integrated delivery systems who are in a prepaid environment.

So that's the promise. Of course, getting there, you know, is another question, I mean both from a design perspective and politically as well.

DR. BAICKER: And getting the physician out of the business of, you know, potentially making money based on the different choices of drugs sounds like a great idea, but the "C" in the CAP, I didn't quite understand how that was playing out with just the one vendor. So it all makes much more sense to me if there are multiple vendors, and without some guarantee of competition there, I'm not sure how well it would work.

DR. CROSSON: And, again, it's sort of -- I mean, this is a modeling exercise because there's about six or eight moving parts here, and depending on which one you

pull, you could get something that's viable or something that's not viable at all. And I think we'll have an opportunity to spend more time on that.

But I think your observation is one that I have as well, which goes something like this: The add-on to ASP, at least the way I think about it, is essentially kind of like sort of a reinsurance payment. I mean, it's basically providing money to make up for the fact that not every provider can negotiate the average sales price. So at least half of that money -- if I'm wrong, Kate, you're the economist. At least half of that money is going to providers who have been able to negotiate the average sales price or better. And so the question is: Of what utility is that money? And, you know, I think a model that gets the physicians essentially out of being a drug vendor with the attendant costs to the Medicare program, but in addition provides real incentives for the physicians through selection of drugs, through utilization management, through the volume of drugs prescribed, all the mechanisms that I think some of us are familiar with, has some promise.

It also requires -- and one of the

characteristics that Kim brought to the table was the ability to use a formulary of some sort. And as we said earlier today, there's a whole range of formularies that one could design.

So, anyway, I just wanted to add to what you said.

DR. BAICKER: Okay. Now we both want to respond to what you said, you know, like debate rule style.

DR. CROSSON: Right, right.

DR. BAICKER: You mentioned economist, so I get to say something.

[Laughter.]

DR. CROSSON: I also mentioned physicians.

DR. BAICKER: You guys jump right in. How about you just talk right over me?

[Laughter.]

DR. BAICKER: So we had been concerned in previous discussions that that insurance policy was really important if there were a lot of people who weren't being able to purchase under that, and the extra information that you brought to the table in terms of the distribution of prices that are currently paid, and that sequester graph,

which I find pretty telling, suggests that it's not so necessary to fulfill that function and really is just a bonus payment for prescribing a drug.

DR. HOADLEY: And I think, you know, again, the concept of this feels like it should have worked, but it felt that way ten years ago. And I think the question is the ability to make the practical sides of it work as well. I think a lot of the physicians would love to be out of the business, a lot of physicians have gotten out of the business in exchange for moving to the OPD side already. So we've got that trend going on in the background.

One of the things, I think -- and Joan may remember this better than I -- when we looked at those things a long time ago, was the sort of different response from the oncologists whose need for these drugs was a lot more likely to be determined on the day of providing the drug versus, say, the rheumatologist who's given the RA drug who knows, you know, weeks in advance exactly what drug and what dosage is going to be provided. And, again, this reconceived thing does come up with an inventory system that should handle that better, but one of the questions is, again, will it work?

We've also got a discussion coming up on the oncology side of maybe rethinking oncology in yet other ways, and that would leave this maybe to handle the rheumatologist and some of the other specialists who use more predictable drugs.

So, yeah, I mean, there's a lot of potential promise.

DR. CROSSON: Okay. So the moderator inserted himself. Sorry about that.

MR. THOMAS: So I would just say that I think the analysis has been great. I think placing the cap on the ASP going forward makes a lot of sense. I think if you were to place this same rigor and analysis on this part of the industry that we have on the rest of the industry where we look at access, where we look at profitability, where we look at availability to invest, I think we would find that we probably would keep flat or even decrease payments based upon the performance of this part of the industry. So I think the cap on the inflator makes a lot of sense.

I would challenge us to look at the proposed reductions, 1.3 percent. I would actually challenge us to potentially look at being more aggressive there. You know,

if you think about the percentage change, it's relatively small in the scheme of the industry. And, once again, I think it's an opportunity to think about whether ASP should be the average or whether it should be the cap. So I think that would be another concept to think about going forward.

The consolidation of billing codes I think makes a lot of sense. I think it certainly would create a situation where, you know, if we have similar drugs, they kind of go in similar categories. I think that absolutely makes a lot of sense to consolidate those billing codes.

On the competitive acquisition, I would agree, it seems like that has been a challenge. I think we ought to actually look at the first couple recommendations, see if we can make significant progress there, and once again then, you know, continue to watch the change as we move forward.

MS. BUTO: The first recommendation, which is the ASP+ add-on plus flat fee, I would -- and we didn't get into this, but there's some drugs that are very low cost where, when you do that, they get a big increase. It struck me that we could look at the lower of that or ASP plus 6 percent if they're a drug that's such a low cost

that would actually boost payments for that drug without any rationale, really.

On the inflation cap issue, I share some of Kate's concern about price controls, which is why if we did something like that, I would much prefer looking at limiting the payment rate Medicare pays. I think that's totally within our purview. And it also has the additional, to my mind, benefit of reducing the beneficiary out-of-pocket, not just bringing rebates back to the government. So that's the way I would prefer it.

I'm not a fan of consolidated codes. I think this is really very similar to least costly alternative, which I have issues with, and I just boil them down to say that I think, oddly enough, this is even potentially more difficult for the beneficiary than LCA because under LCA I think we imagined that if they needed a higher-cost drug, they could at least appeal it. But if you're setting the rate on an average, I don't see any basis for appeal there. I mean, I think the beneficiary just pays out-of-pocket a higher co-pay for the more expensive drug. So I'm concerned about it driving prescribing when we don't know a whole lot about it.

Secondly -- so I'm worried about that, but, on the other hand, I don't think it actually applies to very many drugs where you've got multiples that would gain the Medicare program a lot from applying the policy.

And, lastly, I think it's going to reduce research in the category, so if it's a category that's in this consolidated code bucket, I don't think there's going to be much more invested in research in that category based on what I've seen, just the way research investment is made.

On the restructured CAP, I actually think that this should work. There ought to be a way to make it work because the issue of having the physician be the buyer and then the recipient of payments having to do with drugs I think has just really got to be sort of dealt with. And if we could think about what works in the private sector, whether it's specialty pharmacy or other things that provide the right tools, I think we ought to think more broadly about this. And maybe it's a longer-term option.

I also think it is more consistent with our interest in ACOs and managed and coordinated care than continuing to have physicians be the buyers and billers for

drugs. So to have an entity that specializes in this makes sense to me.

And then, lastly, I don't have an issue with the dispensing and supplying fees. I think that's fine.

MR. GRADISON: With regard to the ASP, I'm comfortable with Kathy's suggestion. It's certainly worth considering.

With regard to the inflation cap, there's some problems here. First of all, a new product comes out. If you know that you're going to be limited with that new product to an inflation cap, there is a powerful incentive to have a very high launch price. Now, you say, well, we're going to -- we want to deal with that. Then you -- that's how you get back into the price-fixing thing -- or price control thing.

Another situation that could easily happen in this field, FDA comes in, they say you've got to stop production, there's some issues here. You've got to completely change your manufacturing process. The company salutes and moves ahead to do it, but in the process incurs a lot of costs, or at least they do calculations which suggest they're going to incur a lot of costs, and then

they have to decide whether they really want to stay in that market with that particular product because -- or in that situation you have to have some kind of an exceptions process. It gets very complicated, and I'm not sure it would work very well.

With regard to the CAP program, the previous attempt with the voluntary process probably poisoned the well in the sense it may discourage people from participating the next time around. But aside from that, I think it's almost too exquisite a design. It's something that works beautifully in principle, but I'm not sure it works in practice. And to be more specific about it, if I were a provider, I'm not so sure I'd want to be a part of this. It would change a lot about the way I keep my inventory and the way I do my billing and the way I even deal with my patients, co-pay arrangements are changing. But more than that, from the provider's point of view, they would be moving from something that's reasonably fixed and determinable to something that's contingent on a savings. That's something we may want to encourage but in -- and that could well work with a mandatory program. But with a voluntary program, it might not -- you might not really

learn very much. The people who might choose to participate might not reflect the larger universe with a mandatory program.

With regard finally to dispensing fees, I'd like to know a little bit more -- and maybe I should have asked this earlier, but how much money are we talking about there in aggregate for individual providers? Because the reason I ask that, if it's not a whole lot, fine, and that's a judgment call to be sure. But if it's a substantial amount, it might create an incentive for the providers to look somewhere else to make up for that, and that somewhere else could be higher-priced drugs, if it's 3.5 percent, it's still more, 3.5 percent of a higher number than if it were a lower number. I don't know what the behavioral effects might be outside of the payment for the dispensing fees.

My recollection, which I admit is not as clear as I'd like in commenting upon this, from some earlier work I had done which had to do with Medicaid was that some of the states had driven the -- now, this is not the same kind of -- I guess it is the same kind of dispensing fee. They had driven the dispensing fees down to a point where it was

having some behavioral effects, significant behavioral effects. As I recall, it had to do with choices of generics -- and you're nodding. You know a lot more about this than I ever will, Jack. But I think there's some experience here that we can learn from in the Medicaid program, particularly in certain states.

Thank you.

DR. HOADLEY: Just a quick follow-up. I think the issues with the dispensing fees in Medicaid, Bill, were more with sort of standard drugs as opposed to the sort of supplier -- that's where I'm not sure if they're necessarily comparable, but your right about your recollection.

DR. CROSSON: Okay. Thank you.

DR. NERENZ: Just a thought about the first bullet, which seems relatively straightforward, and I know we've talked about it a lot. But I was very struck by Table 6 in the materials, and I appreciate it's not on the slide so it's a little tough for others to follow. But I'm just trying to understand, and my question fundamentally gets to we don't talk a lot about the influence of the co-pays as a restraining force. And I'm just curious, using

this example, why that would be so.

Basically what you've got here are two different drugs, both of which are somewhat expensive, but one clearly more expensive than the other, that at least according to the background are equally effective as part of a cancer care regimen -- no health benefit, no survival benefit, nothing, but different price.

Now, the illustration says that become of the different price, if a physician prescribes the more expensive one, he or she will get $540 more through the plus-6-percent mechanism, and a lot of this is -- we're concerned about that that's driving the choice of the more expensive drug. Okay. And then if we change the policy, that $540 difference drops to $315, and we think, okay, well, that will make it better than. And it might.

But what seems to be, I will call it, the elephant in the room, there's a $9,000 difference in the actual drug cost in the regimen, and presumably beneficiaries are seeing at least some of that in the form of a co-pay unless it's all covered by Medigap or something.

So here then is the question: Why is the co-pay

tied to that $9,000 difference, not restraining what the physician's doing for $500? Why isn't that working now?

MS. NEUMAN: So one argument that people make that the 6 percent add-on does not influence prescribing behavior is the point that you're making, that providers will take into account cost sharing, and the fact that the cost sharing is higher for the more expensive drug would result in them picking the cheaper drug. And I think as we've talked about here, there's a lot of uncertainty about what in the end happens and what's driving these choices. And so I don't think that there is a clear body of knowledge about sort of which forces are dictating what's happening.

DR. NERENZ: It may just be a minor semantic thing, just to test it, the way you just phrased it, the clinician tries to take into account the patient ability to pay a co-pay. But I'm also curious why the patient is not more active in this. Why don't we see dynamics where the clinician says, "I think we want to use this drug, but actually it's going to cost you $20,000 more, and it has no benefit." Why doesn't the patient say, "No, we're not going to do that"? Why does that not happen?

DR. MILLER: Remember some of what's going on in -- this example is -- is this an oncology example?

DR. NERENZ: Yes [off microphone].

DR. MILLER: I mean, you know, I think there's sort of the dynamic of what's going on at that particular moment for the patient, and, you know, having been through it, I get some of that.

I also think way back in the day, Joan -- it's good you're here. Way back in the day, the provider might sort their patients to whether they do it in the office or whether they send the patients who can't afford it to a hospital. So I think -- and then Jay has made this point elsewhere, that to the extent that there are pathways, you know, a physician may be following those and saying this is the right combination here.

And so there's been this whole conversation about the 106. There's a lot of assertions and some early-on evidence that suggested it might drive more expensive prescribing. But then there's also these conversations. Is that true of all drugs? Is oncology different? What's the evidence these days? And it's very hard to do an antecedent because you don't have a natural experiment,

which Kate ought to get on. You know, those types of things. Exactly what is driving these prescribing patterns?

DR. CROSSON: Alice, did you want to make a comment on this?

DR. COOMBS: Yes. I think, David, you kind of -- you stole this thought from me, because as long as you have that three or two or the one -- anything above that 100 percent, a long as you have that, you have this gradient that's created. And so for a physician to make those choices, I think, there's not much difference in my mind with adding the $5 versus a differential of $315. I think you're always going to have the higher-priced drug that leads people to maybe make that decision without consideration of the co-pay for the patient.

Is there data that says that one drug is better than the other? And sometimes there might be. There might be some kind of preferential treatment by a physician. But I think the problem is really the way it's put together. As long as you've got 103, you can have 102, you can have 102.5. No matter what you do, when you add this little measly $5 on the end and you think that's going to make a

difference with a decision, that table actually points to the crux of the matter, because you have created a gradient, and the gradient is fairly significant.

The real question -- Mark, you kind of alluded to it -- is that physicians might make decisions based on them having to keep this drug on the shelf. I mean, it was mentioned in the paper about the vendor not being able to supply the drug in an expeditious fashion. The patient comes into the office. You might want to do something. And all of a sudden the physician's stuck there inconveniencing the patient because a vendor failed to meet his requirement of getting something to the doc. That is really burdensome for a beneficiary. Okay? How about showing up for chemotherapy and you don't have chemotherapy?

And then there was the other proposal of how do we correct the CAP system, and that was the replacement on the shelf so that if you use it, you get it replaced by -- you get a replacement by the vendor. That's problematic too because some of the shelf life is very short, so I think that's an issue as well.

It is fraught with a lot of different problems.

I'm not sure we're really getting to the crux of the matter in terms of deciding -- I talked at Jack earlier about desegregating, some sort of way put the vendor over here, if we're going to do a vendor, put the vendor over here, and put the dispensing or acquisition all in one category for the provider. I don't know if that's possible, but it has to be something where the provider sees that it's important for them to make the right decision and the most appropriate decision for the patient, as well as shared decisionmaking. And inculcated in this is the fact that there must be shared decisionmaking, some sort of shared decisionmaking. But to be honest with you, there's not an incentive here for you to talk about, well, do you want to take this drug versus that drug? There's not an incentive to say that I want this patient to really understand the differential between the two drugs. And I think that's problematic.

So, I mean, when I look at this, the restructuring of the cap program, something has to be done where the provider is actually incentivized to do due diligence with your decision-making. And all of the rest, I think, is kind of window-dressing until you get to the

real crux of the matter.

DR. CROSSON: Thank you. Rita.

DR. REDBERG: Thanks. I wanted to talk a little bit. You know, we have been concentrating on the 6 percent of ASP, but I think we should talk a little bit about ASP because that's 100 percent, and I'd like to have mechanisms for downward pressure on average sales price. I find it disturbing that these prices are secret because you can't have a market and competition when prices are secret.

We know that we have very high prices, and so certainly, we can look at the 6 percent, but the program is paying a lot of money on 100 percent of the average sales price.

DR. MILLER: Let me give one clarification. What we couldn't disaggregate and tell you was the acquisition cost, which is different than the average sales price that Medicare constructs and pays out of a series of acquisitions cost, because we had purchased the data proprietary.

I mean, the ASP is known.

MS. NEUMAN: Right. It's --

DR. MILLER: Right. And you may want to shift

your comments and say, well, I'm talking about acquisition stuff, in which case, you know, then back on track, but the ASP is known.

DR. REDBERG: Well, the ASP has to be known or you can't pay the 6 percent.

DR. MILLER: Exactly.

DR. REDBERG: But how about how do you calculate the ASP? Do we know the range that goes into the ASP?

MS. NEUMAN: So CMS has instructions about how to calculate and what kind of things count as a discount and what don't and how to handle various things. So there is guidelines, but the raw ingredients of what they use to calculate the ASP, no. That's proprietary to the drug manufacturers, and we don't see that.

DR. REDBERG: But what I mean is for any particular drug. If you know the average sales price -- but do you know what the range is that got to that average?

MS. NEUMAN: No.

DR. MILLER: To that end, that information is not easily obtainable and is proprietary.

DR. REDBERG: Okay. So that is my point that it's hard to have a market when you don't know the average

sales price. You don't know the prices that everyone is paying. People are in a difficult position for negotiating -- or plans are in a --

DR. MILLER: So I think where you're headed -- and you're talking about a transparency argument and whether the transaction data is more transparent, I think is where you're headed. At least on the staff level, we just kind of got hung up on ASP in your opening comment. Right.

DR. REDBERG: So, for example, with the inflation cap, I understand the idea, but I think -- and I think maybe Bill said this too. It's the launch price I'm worried about. That's the really high -- then you're talking about inflation, and we can -- there are certainly concerns about it.

I do support the consolidated billing codes. I think that's our principle of similar prices for similar care. The instance, the idea that there's a different reference code for the original than for the biosimilars, I don't think is a good idea. That's not the idea of having biosimilars. It's to drive down prices and their similar therapeutic effects.

I think that was it. Thanks.

DR. CROSSON: Kate, one second. On this point? Yeah, go ahead.

DR. BAICKER: I just wanted to note that in -- there's a counter-argument to the very persuasive transparency points that you're making. In lots of private markets, the negotiations are proprietary. We don't know what health plans pay hospitals. We don't know what hospitals pay doctors. And there's an argument to be made that in a world where everybody knows those, that actually drives prices up because then nobody gives a discount, because if I give you a discount then and you know that I gave you a discount, then you demand the same discount. And so this is -- it does -- I think that you're making a very good argument about transparency and one that could very well result in lower prices, but it's less clear than it might seem ahead of time, and it's much more common in private markets than one might think. Hospitals and doctors and health plans hold that information very close too.

DR. REDBERG: It's very hard to know, without looking at the data, who is getting a discount and who

isn't, and you're really talking about private health care markets because it's not very common not to know prices in any other kind of markets.

DR. MILLER: And there is pressure even in those markets to start to make that transparent. If you really want to get geeked out, you should come to our lunch sessions. This is what we have raging arguments about when people get put in headlocks and all that kind of thing --

[Laughter.]

DR. MILLER: -- about whether transparency or price discrimination, which I think is to your point, Kate, results in the lowest price, so we should continue this.

DR. CROSSON: This is all documented on film.

[Laughter.]

DR. CROSSON: You know, in April, we'll have a little show or film festival.

MS. BUTO: I promise I'll keep it short. Oh, I'm sorry.

DR. CROSSON: Hang on. Alice, you were on the list. Did you finish your point?

DR. COOMBS: Yeah.

DR. CROSSON: Okay. All right. So, then Kathy

and then Warner.

MS. BUTO: And the short is that at least when the Medicare drug benefit was enacted, the initial proposal was to make PBM discounts transparent, and I believe -- and I don't know if they would stand by this today -- that CBO estimated the cost of the benefit would go way up because of the very thing that Kate was talking about.

What happened, based on Medicaid best price, was rebates flattened out, and prices across the board in total ended up costing more than savings. So I don't know if they'd stand by that analysis today, but it ended up coming out of the legislation for that very reason.

DR. CROSSON: Warner.

MR. THOMAS: I just wanted to comment on the launch price. I guess what I get a little confused with is that, in the delivery side, we're constantly coming up with new procedures or new things that we're doing, and somehow we figure out how a price gets set of what's going to be paid for that procedure, whether it's a new type of surgery, whether it's a new approach, and so -- but yet we don't use that when we look at launch prices of new drugs. So I just kind of raise it as something to be thought about

as we think about pricing of drugs and especially new drugs and their launch prices because it sounds like we're worried about where that initial launch price is going to be set, but yet in other areas when we set Medicare fees, we come up with a price and we set it.

DR. CROSSON: Okay. This has been very helpful. I think Kim and some of the rest of the staff will -- don't go yet. We haven't -- we've got to do the recommendation.

So we have a recommendation. Can we show Slide 20? I've heard some discussion about this already. I haven't heard any objections or queries about it, but I want to give everybody an opportunity now. We're not voting on it until next month. Comments? Questions about the recommendation on page 20?

[No response.]

DR. CROSSON: Seeing none, thank you very much, Kim and Joan, and we will move on to the final presentation of the day, oncology bundling.

MS. RAY: Good afternoon. This is the second of two sessions on Part B drugs. We are going to look at four approaches that attempt to improve the value of drug spending and the delivery of health care services. In

contrast to the approaches that you discussed at Kim's sessions, these four approaches that we are going to discuss would generally take longer to implement. Also, we are going to focus on anti-cancer drugs.

We focus on anti-cancer drugs, chemotherapy, and their supportive drugs administered in a physician's office of hospital outpatient department because Medicare spending is substantial, about $11 billion in 2014. Last spring, I presented findings from our analysis that showed in 180 days following the administration of an anti-cancer drug for newly diagnosed cancer patients, anti-cancer drugs and their associated administration services accounted for more than half of total spending. In our June 2015 report, we began to explore approaches for bundling oncology services.

So, today's presentation is based on your interest in looking at different models. Last spring, when we were discussing the idea of oncology bundling, Commissioners also were interested in learning about other approaches, so we have brought back some new ideas that are used by payers and providers. The first two approaches are relatively narrow and they focus on the drug price and drug selection, risk sharing agreements and clinical pathways.

The last two approaches are broader, attempting to affect the use of drugs and other services, CMS's oncology medical home, and episodes of care. There are more approaches and ideas in your briefing paper and I'm happy to take questions about these other ideas at the end of the presentation.

So, let's move to the first approach, risk sharing agreements. From the payer's perspective, these agreements are intended to improve the value of drug spending by linking the price of a drug to its effectiveness. It reduces uncertainty for the payer in paying for drugs, particularly new and costly drugs whose effectiveness in clinical practice might be unclear.

In your briefing paper, we summarize an arrangement in the United Kingdom between the National Health Service and the product developer for bortezomib, Velcade. That is an anti-cancer product, anti-cancer drug, that's used to treat multiple myeloma administered in the clinician's office or hospital. Under this agreement, established in 2007, the product developer refunds the full cost of the product or provides replacement product to the payer for patients who, after four cycles of treatment,

have less than a partial response. The response is based on a biomarker for disease progression.

There are examples of risk sharing agreements for oral drugs in the United States and these include anti-cholesterol drugs, a drug that treats diabetes, and a drug that treats osteoporosis.

So, this slide raises some issues in implementing these agreements in Medicare. These agreements are not always easy to implement, but there is increasing interest by commercial payers and PBMs to put them into effect. There are high transaction costs to develop and adjudicate the agreement on the part of both the payer and the product developer.

Agreements are very data intensive to administer and track. Measurement is a key issue to finding a clinically relevant outcome that occurs in a reasonable time period. Longer-term outcomes that occur years out might be more challenging. The more successful arrangements have been ones with easily measured and reliable outcomes.

Another issue is having the infrastructure to easily track outcomes, for example, using administrative

data versus chart review.

Defining the financial agreement, for example, whether a discount or refund is provided or replacement product, is another key issue.

Medicare would need statutory authority to implement these agreements for Part B drugs and would also need to create the necessary infrastructure to implement such approaches.

Moving to clinical pathways, our second approach, they attempt to reduce prescribing variability, maintain or improve quality of care, and reduce costs of care. Pathways are evidence-based treatment protocols used by payers and providers that identify specific treatment options based on efficacy, toxicity, and then cost. Pathways are more specific than guidelines, but are often based on guidelines. Some providers have developed their own pathways while others use pathways developed by third-party vendors.

There is some limited evidence showing that pathways reduce treatment variation and decrease costs. On the other hand, some have raised concerns that some pathways are too rigid, do not include non-drug components

of care, and may discourage appropriate off-label use.

So, here are some issues to consider if Medicare were to implement pathways. A key issue for Medicare would be how to develop and update clinical pathways. One option would be for Medicare to invest the resources for pathway development, which could be costly and challenging. Alternatively, the Secretary could evaluate existing pathways for use. However, some existing pathways are proprietary. Another issue is that some practices are already using multiple pathways from different programs. Some providers have linked financial incentives to the use of pathways and have adjusted payment based on pathway adherence.

Medicare would need statutory authority to implement pathways under Part B or could test such an approach under CMMI's authority. The practices participating in CMMI's oncology care model, which is expected to begin this spring, will be required to report if the care they furnish is consistent with a pathway or a national guideline.

So, now, let's discuss a broader approach. The first is CMS's oncology medical home. Its goal is to

improve health outcomes through improvements in access and coordination of care, reduce admissions and ED visits, and reduce total cost of care. The oncology medical home builds on the concept of patient-centered care under which a designated provider is responsible for complying with requirements for integrated care, evidence-based medicine, performance measurement, and enhanced access.

CMS provided a grant to test the community oncology medical home, COME HOME model. Seven practices participated, treated Medicare, Medicaid, and commercially insured patients with seven cancer types. Enhanced capabilities on the part of the practices included the use of triage pathways and extended access. The three-year grant ended in 2015 and we are waiting for the final evaluation of the program's effect on quality of care and total costs.

So, here are some issues that Medicare would need to decide on to implement the oncology medical home. Defining the trigger event, diagnosis or treatment, and the patient population is certainly one. Determining practice requirements, such as enhanced access, patient education, and shared decision making. How to pay providers is

another issue, including the idea of risk sharing in the longer term. With additional evidence on the effect of the COME HOME model on quality and spending, CMS under CMMI authority could test this approach nationally.

So, moving to the last approach for today's session is an episode of care approach implemented by United Healthcare. The goal of United Healthcare's pilot was to reduce potential financial incentives to prescribe one drug versus another. We discussed this approach during our April 2015 meeting and in our June 2015 report. The pilot paid participating practices ASP plus zero percent. It removed the add-on and converted the add-on into an episode fee. There was an opportunity for shared savings in this pilot that was linked to improving the survival rate or decreasing total costs.

According to the peer reviewed publication under the three-year pilot, total spending was reduced by 34 percent. However, drug spending increased. While it is not clear what drove the increase in drug spending, the larger scope of the episode means if a more costly drug or longer chemotherapy regimen is appropriate, oncologists have the opportunity to do so without necessarily

jeopardizing overall savings.

So, here are some of the issues to consider if Medicare were to implement oncology episodes or bundles. This list comes from our June 25 report. I'm going to highlight two of the design features, but we'll be happy to take questions that you might have about other design aspects.

The first element is the services included in the bundle. Bundles or episodes that include more services require providers to be accountable for a wide range, thereby creating greater incentives for care coordination than narrowly defined bundles.

Another key element is the type of payment. One option is to pay providers prospectively, while another option is to maintain fee-for-service payments and adjust net payments retrospectively.

CMMI could test an episode of care approach, which it is doing. The oncology care model is described in your briefing paper and it is a six-month episode that is triggered by chemotherapy administration.

So, to summarize, the narrow approaches that I've discussed attempt to improve the value of drug spending

while the broader approaches attempt to improve health care delivery. Providers would have somewhat greater flexibility under the broader approaches, and the broader approaches give more opportunity for providers to decide on the value of services.

We are seeking guidance from you about which direction, which approach you would like us to further pursue.

That concludes my presentation and I'm happy to take questions.

DR. CHRISTIANSON: Okay. Thank you, Nancy.

I think we'll do just a general set of questions for Nancy on this and just -- so, don't worry about whether your question is clarification or something else. And, Jack, were you going to take the lead on this? David, you were going to. Okay. Go ahead.

DR. NERENZ: Nancy, this is good work.

Let me just start -- well, a couple of very quick observations, but I think I'll try to focus on the first point that you have up here and we'll see where we go.

The very first minor point is that I think as you appropriately labeled it in your own introduction, most of

the content here is about chemotherapy and about drug costs as opposed to oncology more generally. The title of the thing says "oncology," but I think we just observed that we're not talking about surgery here in any significant amount. We're not talking about radiation therapy. So, just -- you said that, and I agree with it, but that's just so we understand, because there are areas of discussion we could get into that I presume we are not going to get into, or at least you have not led us into.

MS. RAY: No, not yet, but --

[Laughter.]

MS. RAY: But -- oh, I'm getting myself in trouble, but certainly, some of the concepts that we've presented here could certainly be applied to other aspects of oncology care, and there are examples of surgery-based episodes and radiation oncology is another area that could be looked at.

DR. NERENZ: All right. Well, then I presumed all we needed to do was clarify that the scope of this discussion was chemotherapy and we just hadn't said so. Now, if that's not it, well, then --

DR. MILLER: That's the way. Yes.

DR. NERENZ: Okay. Well, then -- all right. Then, that still takes me to where I was going to go next anyway.

[Laughter.]

DR. NERENZ: Just to reinforce the point that you have up there, in the examples we've been given, I think there are some very distinct differences that you've captured by the phrase "narrower and broader." I was thinking of them perhaps in some slightly different terms. Some of the projects are very specifically and very directly about drug costs and drug use. The pathway things, for example, are quite tightly focused about that.

The oncology care model is not. It's about the specific thing being done that's novel is this per patient per month care coordination payment, and its effects are presumably in areas like unplanned and unwanted ED visits, readmissions, what not. Although there certainly can be attention to drug costs in the context of that program or that model, I would have to say its essence is not drug costs.

So, again, I just want to emphasize for those following along here that the examples we have here really

are different, as the point is made here, in their focus, their scope, and the range of their potential effects, and the bundling projects, of which the oncology care model is an example, is really about more than drug use, drug costs, okay. So, I wanted to go with that.

Then the only other thing I wanted to get into a little bit, and this probably ties back into the discussion we had in the previous session about Part B in general, in that chapter, as I brought up in the question, there's this very nicely crafted example about two drug alternatives that are in that example identical in their clinical effects but different in their costs. And, I think as we -- and we talked about that.

Now, in this discussion, I think the scenario shifts just a little bit, but in an interesting way. It's very unusual, I think, in oncology to have two things that are precisely identical in terms of their clinical effects, but it's fairly common to have things that are close. And, it seems to me, but I'd be interested in other discussion, particularly among the clinicians here, how the choices and how the eventual costs of care really get crafted.

What I'm thinking is that as research goes on and

as clinical trials are done, in any one cancer domain, we get new things coming that are a little bit better than what we had before, and these new things that are a little bit better than what we had are often way more expensive than what we had. And the issue of price and drug use comes down to this question of how much are we in the Medicare program willing to pay, and through the copays beneficiaries, how much are we willing to pay for a little bit of benefit, and that -- whether that's driven by this plus six percent, I think, now sort of fades a little more in the background.

I think this is a little more about how do we as patients, how do we as a society think about this tough question of how do you pay for more benefit, and I'm thinking the framing of it is frequently significant, that if you look at a published clinical trial or you look at a summary of some aggregates, you may say that a particular drug might increase average life expectancy, say, by four weeks. And, so, now as a policy thing you say, okay, what's four weeks worth.

But, I don't know that that's exactly how it's captured in the mind of the patient or even in the

clinician, because in oncology specifically, it is literally a life and death thing. Often, you're talking about the probability of cure, which is measured in a different way, and maybe these two different drugs have marginally different probabilities of cure. But, the decision when it finally comes down to it may not be about one month additional. You know, that's a statistical average. It may be about what are the chances that I will survive or not survive this horrible disease.

And, so, I think as we think about these options and how they play out, we have to carefully think, how does this decision of this drug or that drug, this regimen, that regimen, how is it framed in the patient's mind and how is it framed together in the clinician's mind and in the patient's mind, and eventually, how do we come up with something where sort of clinically and ethically we do the right things for patients but we don't waste money.

So, I'm not sure quite where that takes us, but this is deep, deep water because of the specific nature of this disease.

DR. CHRISTIANSON: So, not wasting money is a good thing, right.

DR. NERENZ: [Off microphone.] I think we can settle that --

DR. CHRISTIANSON: Yeah.

DR. NERENZ: -- but it's all the rest of it --

DR. CHRISTIANSON: Okay. So, just before we go into individual comments, just sort of remember that the notion here is to provide the staff with some general guidance about if we really feel that one of these directions versus another is the right way to go, not sort of, gee, I didn't like this part of the United Healthcare model, right. So, do we want broader stuff? Do we want narrower stuff? What do we think the most promise is? So, who's --

DR. MILLER: Can I say one thing?

DR. CHRISTIANSON: Yes.

DR. MILLER: Obviously, I agree with that, and in the larger context of what's gone on today, at least as we move from B to oncology, the way your guys' conversation went last time was -- or several times ago, I can't remember, but there is the stuff of, like, oh, is there something we can do about the price of Part B drugs. Then there were sets of comments about, well, maybe there are

differences in these drugs and can we construct different ways to think about utilization of the drugs, because you're right, a lot of this now isn't about the price, and, so, it's really about how you control and make decisions about which drugs you use, and then broader scopes of services.

And, so, there's B, as we did in the last session, then we're taking half of the book of business in B, $10 billion, and asking a different question, which is do you want to think about utilization strategies as it relates to those.

DR. CHRISTIANSON: It looks like a lot of people want to talk, and so just to keep it easy, let's just start with Alice and go around the room.

DR. COOMBS: Thank you, Nancy.

So, in the chapter, on 23, it talks about the overall spending in the UnitedHealthcare model was decreased from 98 to 64, something like that, not including drugs, right? And then the drug spending went from --

MS. BUTO: Including drugs.

DR. COOMBS: Including drugs?

DR. MILLER: Yeah. Drugs went up, but --

DR. COOMBS: Drugs went up, but does that 98 to 64 include --

MS. RAY: Right. Total spending, the net went down --

DR. COOMBS: Right.

MS. RAY: -- even though the drug component went up.

DR. COOMBS: Okay. So that's actually a very good thing, with the ASP of 100 percent. Okay.

DR. HOADLEY: I'm not sure I got much to add on the core question of sort of the different approaches. I mean, one of the things that this brings me back to is the drug launch prices. I mean, a lot of this is driven by -- I mean, the way we're trying to -- because that these drugs are launched a thigh prices, which is not really the conversation we're having right now, but I think David put all this out very clearly that this is a bigger set of issues because most of the decision-making is not around price.

I mean, I guess I just generally would encourage us to continue to look at this range of options. I think things like CMS demos will be -- should be informative, and

I don't have in my head right now how quickly we started to get more of those kinds of results, but trying to figure out what we can learn from the different things that have been tried, which is what you sort of laid out to this point, and continuing to see what's happening seems like a very helpful exercise.

DR. CROSSON: Herb.

MR. KUHN: Nancy, two quick questions. One is, if you look at the medical home, the oncology medical home CMS is working on how, how do local coverage determinations impact how that might work in different parts of the country? So say there's an LCS that makes a change in terms of the use of a particular drug, does that impact how CMS would configure these things differently around the country, or is it going to be the same around the country? Will they override LCDs? How might that work?

MS. RAY: So you're talking about LCDs specific to the anti-cancer drugs?

MR. KUHN: Yes.

MS. RAY: You know, I'll have to get back to you on that. That's a good question.

To my recollection, I would want to look at the

RFA for the oncology care model to see if that's dealt with or not addressed.

MR. KUHN: Okay, thank you.

And then the second thing, in the paper, there was a discussion a little bit of this initiative that Express Scripts has launched into that is looking at differential pricing on impacts on different tumors. Any indication how effective that has been in terms of controlling prices or managing the process so far?

MS. RAY: Can you just say a little bit more about --

MR. KUHN: Yeah. So I --

MS. RAY: Oh. what page are you on?

MR. KUHN: There's an Express Scripts program that was mentioned in the paper, and I'm just curious when did it start. What have they learned from it? Have they published any information on it so far?

MS. RAY: So these arrangements are proprietary. It's often very difficult to get specific information about them.

The one that we focus more on was the anti-cancer drug arrangement in the UK, because that is infused in a

doctor's office or a hospital outpatient department. The paper did provide other examples of what commercial payers and PBMs are interested in doing, but I don't have specifics yet on how these agreements have materialized.

MR. KUHN: Thank you.

DR. SCHMIDT: You're referring to the indication-specific pricing, the Peter mock idea?

MR. KUHN: I don't know if he did that. It might similar to what Peter had done, but it was specifically cited on page 17 on this Express Scripts initiative, but if it's similar to what Peter had recommended, I'd be interested in hearing about it.

DR. SCHMIDT: That is brand-new, so I don't think that there is much to report yet.

MR. KUHN: Thanks.

DR. CROSSON: Cori.

MS. UCCELLO: So this presentation was framed in terms of narrow approaches and broader approaches. Do these necessarily have to be mutually exclusive? I mean, I could envision a risk-sharing arrangement within an episode of care. I think that might be really interesting to think about.

MS. RAY: Right. And clinical pathways, where are being used -- were used in the episode of care, can be used in the episode of care, as well as the oncology medical home.

DR. CROSSON: Warner.

MR. THOMAS: I think the approach that United used should be further studied and considered to be expanded. I mean, certainly, there's a lot of hospitalization and rehospitalization that goes on with oncology patients that probably could be managed -- have improved management in an oncology medical home-type model. So I think thinking about how you wrap all the services together -- the hospital component, in- and outpatient; the actual treatment, radiation, infusion -- I think there is probably a lot of improvement that could be done there with multidisciplinary teams to impact cost. So I think trying to build upon this model is a really attractive approach.

DR. CROSSON: Rita.

DR. REDBERG: Nancy, I have a question and then some comments. Do we know what costs went down in the United model, if drugs went up?

MS. RAY: So, in the publication, they mentioned,

first of all, that it wasn't set up to statistically analyze that, but they did see a drop in admissions and radiology.

DR. REDBERG: Thanks.

So, in further discussion, in general, I think broader approaches to improve health care delivery are good, but I wanted to start with sort of first looking at whether the drugs or the treatment was indicated in the first place because the example on the Executive Summary page 1 of that proton beam therapy is more costly than IMRT. Well, IMRT has never been studied in a randomized controlled trial for prostate cancer. So, I mean, to compare something very expensive to something a little expensive, that never worked anyway. We don't really know if you would have been better off with nothing, which is certainly preferable for the beneficiary and much cheaper for the program.

You know, we're talking about all this treatment for prostate cancer when we don't -- the task force recommendation, the part of Health and Human Services, says we shouldn't even have been screening for prostate cancer because men would be better off if we left them alone, and

they wouldn't have all this chemotherapy and surgery and radiation therapy.

And so I think when we're talking about treatments, we first have to look at should we be doing anything and is it appropriate, and that's the first step I think in the pathway, is to look at the value, because we're doing some cancer treatments that people would definitely be better off without.

And then you had mentioned about looking at if you got a month of life, would that be better, but that really brings up another problem with oncology drugs, is that most of them are now being approved on surrogate markers, and they're not getting approved on "Would you live?" They're getting approved on "Do your biomarkers get better? Does your imaging get better? Does your progression-free survival get better?" None of that correlates to "Do you live longer?" So now we're getting very expensive drugs on the market, and we don't know if they're helping patients to live longer, even when they are indicated.

And then the last thing I wanted to comment on was on page 15. It says, for example, that if the drug is

used for an off-label indication, but that's another area, I think, of concern, is that Medicare is obligated to pay for off-label indications if they're listed in the NCCN. But the evidence behind that compendium is often not there, and so, again, maybe we're paying for very expensive drugs that people would be better off without. And I'd like to relook at that as well.

DR. HALL: I guess I have a little bit of dissidence here. You mentioned at the very beginning that -- in the very first paragraph, the expense involved with covering drugs and just looking at that in the abstract. Does the data include comprehensive cancer centers, or is this just looking at all chemotherapeutic agents given in a doctor's office that falls into fee-for-service payment?

MS. RAY: The analysis that we included in the June 2015 report looked at all providers, all sites of care.

DR. HALL: Okay.

MS. RAY: Including comprehensive cancer centers.

DR. HALL: Okay. I think we may be lumping things that are somewhat unrelated or true and unrelated, and just very simply, if it turns out that a lot of private

oncologists in their office are prescribing drugs kind of independent of a more comprehensive approach, that definitely needs to be looked at. And any alternative to that might be very fruitful.

But I don't think that's really the direction we should be going in. I think that if we're going to improve cancer care, it's probably going to be in an interdisciplinary mode, and so chemotherapy is certainly an important and expensive part of that. But it's taken out of context with what else is going forward. I don't really have a solution, how we dissect that out, but I think if we spend a lot of time just individually looking at fee-for-service payments, what we're going to conclude is a better way of prescribing medication is an interdisciplinary cancer center where you have a lot of different resources for the total care of the patient.

DR. CROSSON: This way. Mary.

DR. NAYLOR: So I think it was Cori who said I think we should be looking at these both, not an "and." The cancer in a Medicare population is often one of multiple health problems, and so thinking about the critical role of care management and what the oncology

medical home was attempting to do was to really link with not just all of the people involved in cancer, but the primary care providers and others to deliver comprehensive care. And I think the evidence is pretty compelling here that comprehensive care is very important. GI cancer is one in five of the admissions, your wonderful report says are avoidable, hospitalizations are avoidable, and for symptoms, for treatment, adverse events, for not having access to care, those kinds of issues, and it seems to me all of that, UnitedHealthcare pointed to the value of a comprehensive approach.

At the same token, I think the issues around clinical pathways and risk-sharing agreements make a great deal of sense in terms of thinking about the drug component of this. So my recommendation is that these are both approaches. The comprehensive approach should be both narrow and broad in scope.

DR. CROSSON: Craig.

DR. SAMITT: So I would echo that as well. I would see these as nested opportunities where you want to have both a narrower incentive as well as a broader one. If you were to have me pick, I would actually be more in

favor of the oncology medical home because for the reasons that we've talked about, Rita has talked about in terms of the episodes themselves, some of these episodes may not actually be necessary, or we may not be doing good for the beneficiary in thinking of it as an episode level. But if we think of it from an oncology medical home perspective, thinking all of the various options, episodes or not, that that would be the way that I would want to think about cancer care.

But within the medical home, we would want to assure that should episodes occur that there is protocol that is being followed, and that's why in addition to medical home, the one I would pick would be pathways. Are we adhering to pathways and guidelines when episodes are required within the context of a broader population health view of cancer care in the medical home?

DR. CROSSON: Nancy, correct me if I am wrong, but I think this summer, we are going to get more information about the medical homes, the COME HOME project, rather, and how well that's performed. Is that right?

MS. RAY: We are awaiting the final evaluation of it, yes. Yes. Hopefully, this summer.

DR. CROSSON: Kathy.

MS. BUTO: I just wanted to make the point that on the Velcade project that I actually think that's a really good example of something else, which is this issue that both Rita and Warner have brought up about high launch prices. So there is a category, and I would add coverage with evidence development is another. What do you do about a new potentially breakthrough drug that comes along? And this was that case, and that's the reason the company got into a negotiation with NICE to essentially guarantee the outcome, which is very unusual.

So more than a cancer example, I think it actually falls into a bucket of potential "What do you do about new, potentially very promising drugs?" and that we could look at that set of tools as a whole category.

And, as part of that, I was saying to Mark earlier that it's helpful -- looking for Rachel and Kim and others, but it's probably helpful for us to get the background on what happens when a new drug doesn't have ASP because there haven't been enough sales in the commercial sector, how does Medicare set the rate, so that we start with an understanding of how that's done initially and I've

forgotten, and then look at various tools that we might want to encourage that would do a better job of paying for the right care for these new drugs.

DR. CROSSON: Okay. Other questions, comments on the report?

[No response.]

DR. CROSSON: Nancy, thank you so much. We shall return to this topic.

[Pause.]

DR. CROSSON: Now we have the opportunity for the public comment period. For those of you who want to make a comment, please come to the microphone so we can see who you are.

A comment for particularly newcomers, this is not the only or the best way to provide input, to MedPAC staff particularly. You can do that online or in person.

We'd ask you to state your name and your affiliation and limit your comments to two minutes. And when this red light comes back on, the two minutes will have expired.

I see Sharon at the microphone. Go ahead.

MS. McILRATH: So for those who don't know, I'm

Sharon McIlrath with the AMA. I wanted to raise the question of the difference between what happens when you reduce ASP in the hospital outpatient setting versus what happens when you reduce it in the physician setting. I don't know if the data that you looked at would look at the prices that the physicians are buying it at versus what the hospitals are buying it at or what a small practice can buy it at versus what a large practice could buy it at.

A fear in the physician community is that you will drive the little guys -- and there is already, as you can see in your June report from last year, a much higher increase, four times as big an increase in the -- sorry, my throat's all -- in the hospital outpatient department as in the physician setting. So a fear is that you're going to drive it all into the hospital where the facility fee and the 340B discount make it much easier for somebody to subsidize the lower price that they're getting on the drug now.

So it would be interesting, I think, to look at some simulations of what happens if it all moves into the hospital and various percentages of difference that would occur that way.

DR. CROSSON: Thank you.

Seeing no one else at the microphone, we are adjourned until 8:30 tomorrow morning. Thank you.

[Whereupon, at 5:00 p.m., the meeting was adjourned, to reconvene at 8:30 a.m. on Friday, March 4, 2016.]

# MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

Friday, March 4, 2016
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
KATHY BUTO, MPA
ALICE COOMBS, MD
WILLIS D. GRADISON, JR., MBA, DCS
WILLIAM J. HALL, MD, MACP
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AGENDA PAGE

P R O C E E D I N G S

[8:30 a.m.]

DR. CROSSON: Good morning. We are going to spend the morning on a topic that we have been working on in different versions over the last two years or so. We've had a number of different names -- synchronization, some other names I won't mention. But it fundamentally is predicated on the notion that we have had in front of us that, at least from the perspective of the Medicare program and the beneficiaries, Medicare fee-for-service, Medicare Advantage, and fee-for-service incorporating different payment mechanisms ought to be on something like a level playing field. I think we're discussing it from the perspective of competitive pricing, but that's the underlying notion that we've been working on. And so we're going to take that on again, take a little bit of a different look at it, with the expectation that we can advance this process along.

So we have plenty of time for the discussion. It is a complex issue. So we're going to have a presentation by Eric Rollins, Carlos Zarabozo, and Scott Harrison. Eric, I'm not sure, but is this your maiden voyage in front

of the Commission?

MR. ROLLINS: Second.

DR. CROSSON: Second time, okay. Then it's okay that we don't have any champagne for you.

[Laughter.]

DR. CROSSON: But you can start out.

MR. ROLLINS: After, we can talk.

DR. MILLER: Because there's sort of two topics here, the way we were thinking we would do this is Eric will do his, we'll get clarifying questions. Then we'll do the second topic, and then we'll do the whole shebang. And so that's the game plan, just break it up in pieces so you can kind of absorb it.

[Pause.]

DR. MILLER: And if I wasn't clear, Eric will stop, clarifying questions on Eric; then we'll do the other things; you'll get clarifying questions there. And then you just do the whole deal. So there will be a little break in which you'll be asking questions.

DR. CROSSON: Okay, Eric.

MR. ROLLINS: Good morning. Today Carlos, Scott, and I are going to discuss ways that Medicare could use

competitive pricing to determine beneficiary premiums in the fee-for-service and Medicare Advantage programs. Our discussion today builds on the analyses that we presented to the Commission last spring on synchronizing various aspects of Medicare policy across the fee-for-service, MA, and ACO sectors.

I'd like to start by giving you a quick overview of the presentation. As Mark noted, we're going to cover a fair amount of material in this presentation, and as a result we've decided to break it into two parts. I'll start by reviewing our analytic framework for comparing fee-for-service and MA costs in different areas of the country and present updated figures for the three illustrative examples that we used last year to explore how Medicare could change the way it determines beneficiary premiums. I will also discuss some options for mitigating the potential increases in premiums that could occur under some of these examples, and then we'll have a round of clarifying questions on Part 1.

After that, we'll move on to Part 2, where Carlos and Scott will discuss how competitive pricing could be used just within the MA program to achieve savings. There

will then be a round of clarifying questions on Part 2 followed by the normal Round 2 of policy discussion, which will cover this entire presentation.

Moving now to Slide 3, the Commission has made numerous recommendations over the years that would strengthen the incentives for both fee-for-service providers and MA plans to provide good-quality care in an efficient manner. The incentives that Medicare beneficiaries face can play an important role in reinforcing those efforts. In particular, policymakers could create financial incentives that encourage beneficiaries to use more efficient delivery models. If those efforts help lower Medicare spending, the savings could be shared between taxpayers and beneficiaries and could thus benefit both groups.

The next slide summarizes the framework we used to compare fee-for-service and MA costs in different parts of the country. First, we began by grouping counties together to approximate the insurance markets served by private plans. Using a combination of core-based statistical areas and health service areas, we created a total of about 1,200 market areas in the 50 states and the

District of Columbia. Our market areas are thus often bigger than the service areas that MA now uses, which are usually based on individual counties.

Second, we calculated average fee-for-service spending for 2016 in each market area and did so in a way that made fee-for-service spending comparable to the spending included in MA plan bids. This effectively allowed us to approximate a fee-for-service "bid" in each market area.

Third, we recalculated MA bids for 2016 to reflect the use of our market areas instead of the existing MA service areas.

Finally, we assumed that the quality of care is the same in both the fee-for-service and MA sectors.

Moving on now to Slide 5, here's an overview of the three market areas -- Portland, Oregon; Columbus, Ohio; and Miami, Florida -- that we used for last year's analyses and will return to in this presentation. All three areas have a large number of Medicare beneficiaries, many MA plans available, and high MA enrollment rates.

For 2016, the national monthly average for fee-for-service spending is $784 per beneficiary. With that as

a yardstick, you can see from the figures highlighted in yellow that fee-for-service spending is well below average in Portland, slightly below average in Columbus, and well above average in Miami. Finally, the median and average MA plan bids are higher than average fee-for-service spending in Portland, but lower in both Columbus and Miami.

In our analysis, we looked at three different ways for calculating premiums that would encourage beneficiaries to use the more efficient delivery model. Under the first illustrative example, there is a base premium that equals a fixed percentage of national average fee-for-service spending and buys fee-for-service Medicare in every market. This approach is similar to how Medicare currently calculates the Part B premium.

Under the second example, the base premium is also calculated using the national average for fee-for-service spending. However, in this example, the base premium buys either fee-for-service Medicare or the reference MA plan -- whichever costs less in a given market. In other words, if fee-for-service is lower than MA, then the base premium buys fee-for-service Medicare. And if fee-for-service is higher than MA, then the base

premium buys the reference MA plan. Therefore, what people can buy at the base premium will vary across markets depending on how fee-for-service compares with the reference MA plan.

Under the third example, the base premium is calculated in a different way. Here it's a fixed percentage of either local average fee-for-service spending or the cost of the reference MA plan -- whichever is lower in that market. As in the second example, the base premium buys either fee-for-service Medicare or the reference MA plan -- again, whichever costs less in that market.

In all three examples, the base premium pays for a specific delivery model. If beneficiaries enroll in something else, their premiums are increased or decreased by the full difference in cost.

Slide 7 lays out two key considerations to keep in mind when you're comparing these illustrative examples. First, the examples differ significantly in their impact on existing premiums. Under Example 1, most Medicare beneficiaries do not see their premiums go up: the fee-for-service premium is the same, and many MA enrollees see lower premiums because their plans are less expensive than

fee-for-service. However, MA enrollees in plans that are more expensive than fee-for-service do face higher premiums.

In contrast, under Examples 2 and 3, a majority of beneficiaries face higher premiums because the base premium now buys the lower of fee-for-service or the reference MA plan in each area. In areas where MA is less expensive, this means that fee-for-service premiums increase, and MA enrollees in plans with bids that are higher than the reference plan pay more as well. And in areas where fee-for-service is less expensive, most MA enrollees pay higher premiums. So you can think of Example 1 as an approach that relies more on carrots and Examples 2 and 3 as approaches that rely more on sticks.

Second, the examples also differ on how much beneficiaries versus the government are responsible for paying for the regional variation in Medicare spending. In Example 1, there's a uniform base premium in every market, which means that the federal contribution is responsible for picking up any additional costs due to regional variation across markets. In Examples 2 and 3, the base premium buys the lower of fee-for-service or the reference

MA plan in each area, with the beneficiaries who use a higher-cost delivery model paying the difference. As a result, the federal contribution would be more uniform across markets, and beneficiaries would bear more of the responsibility of paying for geographic variation. Finally, the use of locally set base premiums in Example 3 would reduce premiums for many beneficiaries compared to Example 2.

On the next two slides, I'll show how Examples 1 and 2 would work in the Portland, Columbus, and Miami markets. We're setting Example 3 aside to keep the presentation manageable and because its impact is broadly similar to Example 2. For illustration only, we used the MA plan with the median bid as the reference plan, but how you define the reference plan is a policy choice. For instance, it could be the lowest bid, the average bid, or something else. We also assumed that the base premium equals 13.5 percent of the Medicare Part A and Part B benefit cost. This percentage approximates the share of fee-for-service spending for Part A and Part B benefits that will be covered by the Part B premium in 2016.

Slide 8 has our first example. Each market has

two columns: one shows the cost of fee-for-service, and the other shows the cost of the median MA plan. In each column, the beneficiary premium is shown at the top in green, and the remainder, which is the federal contribution, is shown below that in gray.

In this first example, a nationally set base premium buys fee-for-service Medicare in every market. The base premium equals $106, which is 13.5 percent of the national average fee-for-service spending of $784. If beneficiaries enroll in an MA plan instead, their premium is increased or decreased by the difference between local average fee-for-service spending and the plan bid.

In Portland, which is shown on the left, the median MA plan costs $60 more than fee-for-service ($712 versus $652), and as a result, the premium for the MA plan will be $60 higher than the base premium, for a total premium of $166. By contrast, in both Columbus (which is shown in the middle) and Miami (which is shown on the right), the median MA plan is less expensive than fee-for-service, and premiums for the MA plan would be reduced accordingly. In Miami, the cost of the median MA plan is so much lower than fee-for-service ($744 versus $1,102)

that the difference would completely eliminate the beneficiary's premium and still leave another $252. Here we show the beneficiary receiving the remainder as a cash rebate -- that's the gray segment with white lines -- but it could also take the form of extra benefits.

Note also that within each market the federal contribution is the same regardless of whether the beneficiary enrolls in fee-for-service or MA. However, the amount of the federal contribution would vary across markets, from a low of $546 in Portland to a high of $996 in Miami. In Miami's case, the total federal contribution includes the cash rebate.

Slide 9 has our second example. There is still a nationally set base premium of $106, but it now buys either fee-for-service or MA, depending on which costs less in a given market. In Portland, fee-for-service is less expensive, so the base premium of $106 buys fee-for-service, just as it did in the first example. However, the situation is now different in Columbus and Miami. In those markets, the median MA bid is lower than local average fee-for-service spending, so the base premium of $106 now buys MA instead of fee-for-service.

Beneficiaries who enroll in the more expensive option would pay a higher premium that reflects the full additional cost. For example, average fee-for-service spending in Columbus is $40 higher than the bid for the median MA plan ($744 versus $704), so beneficiaries who enroll in fee-for-service instead of the MA plan pay a premium that is $40 higher. The difference between the fee-for-service and MA premiums is particularly stark in Miami, where the cost of fee-for-service is more than $350 higher than the median MA plan.

As in the first example, the government contribution is the same for beneficiaries in a given market area, regardless of whether they enroll in fee-for-service or MA. However, since the base premium would now buy the lower-cost option in each area, the government contribution in many areas, such as Columbus and Miami, would be lower than in the first example.

Moving now to Slide 10, the illustrative examples that I have just discussed would give beneficiaries an incentive to enroll in the lower-cost delivery model. That incentive would be provided through beneficiary premiums that vary based on the relative costs of fee-for-service

and MA in each market. As a result, the extent to which those two benchmarks differ is a key factor in determining how much premiums might increase or decrease.

This slide shows the distribution of the difference between fee-for-service spending and the median MA bid for 2016. The values on the horizontal axis show local average fee-for-service spending minus the median MA bid in each market. As you can see, there are areas where MA is more expensive and areas where fee-for-service is more expensive.

The two biggest columns in the slide indicate that about 45 percent of beneficiaries live in areas where local average fee-for-service spending and the median MA plan bid are within $50 of each other. Under our illustrative examples, the change in beneficiary premiums for these areas would be relatively small.

On the other hand, about a third of beneficiaries live in areas where local average fee-for-service spending and the median MA plan bid differ by $100 or more. Most of these beneficiaries live in areas where fee-for-service is much more expensive than MA -- that's the right-hand tail of the distribution -- but there are also some

beneficiaries who live in areas where MA is much more expensive than fee-for-service -- that's the left-hand tail of the distribution. Tables 6 and 7 in the paper list the biggest markets where MA and fee-for-service premiums would see significant increases, using our third illustrative example.

When we presented on this topic last spring, many of you expressed concern over the magnitude of the potential increases in premiums that could result in certain parts of the country and asked us to examine ways of mitigating the potential impact on beneficiaries. We'll turn to that now.

On Slide 11, there are many ways that policymakers could mitigate the impact of higher premiums on beneficiaries, and this slide just sketches out some broad options. As we go through these, keep in mind that the examples we've discussed are meant to give beneficiaries a financial incentive to use a more efficient delivery model for their Medicare benefits, and that mitigating the impact of higher premiums reduces the effectiveness of that incentive.

First, the higher premiums under the new system

could be phased in over time, which would give beneficiaries and plans time to adjust. During the transition period, premiums could be a weighted average of the amount calculated under the old system and the amount calculated under the new system, with the weight for the new system rising over time. Second, policymakers could limit how much premiums increase from year to year, using either a dollar or percentage limit. Under this approach, the transition to the new system would take longer in areas where the difference between fee-for-service and the median MA bid is larger.

Policymakers could also tie efforts to mitigate premium increases to other program goals. For example, prior Commission analyses have found that supplemental coverage such as employer-sponsored or Medigap plans increase Medicare program spending. Policymakers could discourage the use of supplemental coverage by providing more protection from premium increases to beneficiaries without supplemental coverage.

Finally, policymakers will also need to consider the potential impact of higher premiums on state Medicaid programs and low-income Medicare beneficiaries. Medicaid

currently pays the Part B premium for about 15 percent of all Medicare beneficiaries through the Medicare Savings Programs. Under our illustrative examples, higher premiums could lead to a significant increase in Medicaid spending in some states. Policymakers could mitigate this impact by exempting Medicaid from paying the higher premiums or by limiting the amount of assistance that Medicaid is required to provide. On the other hand, policymakers could also expand the eligibility rules for the Medicare Savings Programs if they believe that beneficiaries who currently do not qualify would need assistance with the higher premiums.

This next slide demonstrates how different approaches could be used to mitigate premium increases. The figures here are based on the second example that we discussed earlier in the presentation, where a nationally set base premium pays for either fee-for-service or the median MA plan, whichever costs less. This time we use Chicago as an example because it is one of the largest markets where the cost of fee-for-service exceeds the median MA plan by $100 or more. Here we roughly project premiums for 2016 through 2021, using growth rates from the

latest Medicare trustees report, and assume that the transition to the new system starts in 2017.

The green line at the bottom of the graph, marked D, shows fee-for-service premiums under current law. The yellow line at the top, marked A, shows how premiums would increase if Medicare switched immediately in 2017 to the new system for calculating premiums. The two lines in between, marked B and C, illustrate two options for mitigating the increase in premiums. Under Option B, the higher premiums are phased in over a five-year period and take full effect in 2021. Under Option C, fee-for-service premiums could not increase by more than $20 annually during the transition to the new system. Given the size of the difference between local average fee-for-service spending and the median MA bid, the transition to the new system would still be under way in 2021 and would likely take more than a decade to fully implement.

Again, these options are for illustration only, but they demonstrate how policymakers could substantially mitigate the impact of higher premiums under a premium support-type model.

Moving to Slide 13, we've now reached the end of

the first part of this presentation, and it's worth noting some caveats to keep in mind about our analysis.

First, we have assumed here that quality does not vary across the beneficiaries' choices, which is unrealistic.

Second, for simplicity, we only compared fee-for-service and the MA plan with the median bid in each market. But as we noted in the paper, there are numerous other MA plans available in many market areas, and the premiums for those plans could be higher or lower than what we've shown here for the median plan.

Third, our analysis is static; we haven't tried to model how beneficiaries and plans might change their behavior if the rules for calculating beneficiary premiums change. Our analysis used plan bids from the current MA program, which is different from the three examples that we looked at today. Under different rules, MA plans are likely to bid differently and make different decisions about whether to enter or exit a particular market. One potential consequence is that some markets where fee-for-service is more efficient might no longer have MA plans. We also haven't tried to quantify how beneficiaries would

respond to changes in their premiums. Our examples show that changes in the method for calculating premiums can have a major effect on their finances, but we didn't address how individual beneficiaries would weigh premiums against other factors such as provider access and their perception of quality in deciding which delivery model to use. In markets where MA is more efficient, one potential consequence of the examples we've presented is that the share of beneficiaries enrolled in fee-for-service could be quite small.

Finally, we'd like to reiterate that our examples are for illustration and don't represent a definitive or comprehensive set of design choices. There are many other ways to calculate beneficiary premiums.

That concludes the first part of our presentation. I will now be happy to take any clarifying questions.

DR. CHRISTIANSON: Okay. Who wants to start with a clarifying question? Jack.

DR. HOADLEY: So thank you for all the new analysis. It's really very helpful, and I think that overall, the presentation of this, which is obviously very

complicated, you've done a good job of making it clear.

I asked in advance some version of this, but I wanted to get some of this on the record, which is how you're treating the extra benefits that most, if not all, MA plans today would have and include in what beneficiaries purchase. So can you talk about how that plays out in these models and how you've done it so far?

MR. ROLLINS: Sure. So, as you know, right now the provision of extra benefits is common under the MA program, and under the approaches we've outlined here, that would really no longer be the case. MA plans on the one hand and fee-for-service on the other are primarily going to be competing based on the overall price of providing benefits, which would be reflected in the premiums, and so that would be the main way that the two systems would interact.

DR. HOADLEY: So would you anticipate that extra benefits, the kinds of things that are offered today, whether it be some of the more marginal benefits, like hearing or vision coverage or things like providing the maximum out-of-pocket, cap on out-of-pocket expenses, would those come as an additional premium?

Again, on the Part D side, those are unsubsidized by federal dollars. I mean, obviously, we could look at any of those as policy choices, I assume, but have you thought at all about sort of how to build that in?

MR. ROLLINS: I think I would agree with you that its' very much a policy choice. It's not part of the examples we presented here, but it's certainly something that you could add. And it will be an element of something that Carlos and Scott are going to talk about in their half of the presentation.

DR. HOADLEY: And I would just add that one of the extra benefits in effect that many MA plans are doing in their bid is assigning some of their rebate dollars over to subsidize the Part D premium. So I would presume in a simple version of this, sort of following along the lines you do, the Part D premiums for the MA plans, instead of being subsidized and in some cases down to a zero premium, would revert back to having the sort of normal, full Part D premium.

MR. ROLLINS: Under the examples we've outlined here, yes.

DR. HOADLEY: Okay, thank you.

DR. MILLER: In a sense, it's sort of when you think about going to models like this, you are sort of shifting off of -- I think this is the case. You're kind of shifting off the current circumstance where plans bid based on extra benefits -- or compete -- I'm sorry -- on extra benefits to one that's more clearly a premium signal, and then he said, "Could you build that in?" And I was surprised by nobody breaking a sweat out there.

It would be, at least in a behavioral way, hard to do that. All we could do is sort of take a block and say I'm going to assume, you know, 5 percent of extra benefits or something like that. Is that what we're thinking here? Because I couldn't immediately envision how we would at least behaviorally -- because he was saying certain benefits go away, some benefits stay, that type of thing.

MR. ROLLINS: I guess my thought was that to the extent that there are elements that MA plans now offer that fee-for-service does not, that you would want to include, such as the cap on out-of-pocket spending, you could think more broadly about is that something you would want to have in both fee-for-service and MA as sort of the standard

benefit package.

DR. HOADLEY: I mean, I'll come back to some of this on the other round, but I think part of it is just thinking about when we're thinking about the changes in out-of-pocket cost that beneficiaries face, I just want to make sure we don't forget that that's already built in what people -- people don't think about the fact that they're getting extra benefits in the sort of standard MA kind of thing. And I just think we need to make sure we're thinking that through.

DR. CHRISTIANSON: I've got Bill, Craig, and Scott. Bill?

MR. GRADISON: Thank you. I think this is a related question. Looking nationally at these numbers, do you have any rough estimate of the difference -- do you have any rough estimates of how price versus volume varies within fee-for-service; that is to say, if we look at the high and the low fee-for-service geographic areas, how much of that could be explained by either price versus volume?

And the second question, somewhat closer, I guess, to what Jack was asking about, is whether, again, on a national basis, you can give us a rough idea of how much

on average these extra benefits in dollars and cents are worth for the average MA plan as against the standard fee-for-service Part A plus Part B.

MR. ROLLINS: I'll answer the questions in reverse, and Scott and Carlos should correct me. My impression is that right now under the MA program, the extra benefits or the rebates that the plans receive are between $60 and $70 per month, per beneficiary.

In terms of your first question, how much of the regional variation that we see in Medicare spending is due to price versus utilization, I don't have a good number off the top of my head.

DR. MILLER: We did do that a couple years back. I don't remember the numbers off the top of my head. Do you, actually, Dan?

Why don't you come up here.

DR. ZABINSKI: Oh, thank you. How about if I -- Kate. Thanks, Herb.

DR. MILLER: Sorry, Kate. You lost your seat.

[Laughter.]

DR. ZABINSKI: My recollection -- and this is -- I mean, I always caveat things. If I did it more than two

weeks ago, you know, take it with a grain of salt.

DR. MILLER: We know that.

[Laughter.]

DR. ZABINSKI: Yeah, yeah. Okay.

But my recollection is if you take out price and health status, you get like 45 percent of the variation reduced.

DR. MILLER: And I can't remember how much health -- we can get this.

DR. ZABINSKI: Health did a little more than price is my recollection. Yeah. Right?

Thanks, Herb.

MR. KUHN: You bet.

DR. MILLER: And, Bill, we can get you the actual number.

MR. GRADISON: Well, I'll wait until the next round. I have a follow-up related to that.

DR. CHRISTIANSON: Craig.

DR. SAMITT: So I'm trying to understand the key drivers between the various alternatives, the examples, and I just wanted to clarify. So it seems in Examples 1, 2, and 3, the relative value to beneficiaries between fee-for-

service and MA in each market is the same. So the driver to select one over the other should remain the same because at least the relative value is equal.

And let me finish my thought. But the remaining difference between 1, 2, and 3 would either be the difference in federal contribution versus beneficiary contribution or the difference between beneficiary and beneficiary from various geographic markets.

So I just wanted to make sure that those were the distinctions between the various examples.

MR. ROLLINS: For the three examples we discuss in the paper and the two I sort of outlined here, yes. We were comparing the average cost of fee-for-service on the one hand and the bid for the median MA plan on the other. So, in dollar terms, the differential between the two is the same in all the examples.

Where you see the premiums differ is because sort of what that reference plan is buying and what it's tied to, whether it's fee-for-service or whether it's the lower cost option in each market.

DR. SAMITT: So that the incentive should still

exist in every example for the beneficiary to choose the lower cost option.

MR. ROLLINS: Yes.

DR. BAICKER: Just there's one other difference that you didn't mention that seems important is there's a difference across them in how much you're flattening across areas versus not. I think your point about the delta always being there is important, but depending on how you do the benchmark, there can be more or less flattening of the difference in contribution between the high-cost areas and the low-cost areas.

DR. SAMITT: Yeah. I referenced it as geographic difference.

DR. BAICKER: Yeah.

DR. SAMITT: But, yeah, thank you.

MR. ARMSTRONG: So this is an amazingly complicated topic, and I have to just say the slides you just walked through, I think I get it better than ever, and so congratulations on that. But now my questions may convince you I was wrong.

[Laughter.]

MR. ARMSTRONG: Is it true -- first of all, when

we started this, part of what we were trying to do is reconcile and create a comparative choice per the goals that we laid out between -- within markets between MA and fee-for-service options, and so we're clearly doing that. But I read this -- and correct me if I'm wrong, but it looks like potentially some of the biggest implications are actually reconciling the variation in fee-for-service cost from region to region. Is that a fair statement?

MR. ROLLINS: That would certainly be a major element of moving to this type of model, as we noted in the presentation, who is paying the cost or who bears the responsibility for the variation that you do see in spending across markets.

MR. ARMSTRONG: It actually seems that you're accomplishing different policy goals if you pick Example 1 versus Example 2, shifting between a reconciliation between the different types of plans within a market versus accomplishing that and trying to reconcile the regional variation that you see across the country. So, anyway, I think that's brilliant. So you affirmed I am kind of getting that.

Second, you made the point that even in the

examples -- particularly, I am thinking about Example 2 -- you are using a median MA plan, but there's huge variation in some of those markets. So the real impact could be quite different when you drill into the actual experience. I got that, correct?

MR. ROLLINS: That's right.

MR. ARMSTRONG: And then, finally, building on Bill's questions, particularly if this has as much to do with how you reconcile variation region to region, the question I think becomes quite relevant: Well, why is there so much variation? And is it possible that implementing some of this will really change practice patterns in Miami, as an example, and change what the impact for beneficiaries will actually be in terms of the choices they face once you start putting this into place?

MR. ROLLINS: In terms of the actual effect, obviously that would be something that --

MR. ARMSTRONG: You don't want to predict?

MR. ROLLINS: No. I predict that I would be wrong.

[Laughter.]

MR. ROLLINS: But, you know, the broader goal

here is to give beneficiaries an incentive to use a more efficient delivery system, and so exactly how that would play out in a specific market, it's difficult to know in advance.

MR. ARMSTRONG: Okay.

DR. MILLER: I want you guys to hold that question in your mind because the last time I went through this, Kate also went after this point, which is when you make these decisions, how much are you asking the beneficiary to bear the geographic variation in the market versus the program? And that is decidedly one -- as you've picked up on, one of the things that's going on here, and she was on that point last time, and now you're on it. And so, when we get back to discussion, you guys should express opinions on that.

MR. ARMSTRONG: She's always been ahead of me.

DR. MILLER: She's been a head of me too, so --

[Laughter.]

DR. CROSSON: I have Warner, and then I have Jon, Kathy, and Rita.

MR. THOMAS: So one question I had is the MA premiums continue to be normalized to fee-for-service

rates. Is that in your model and in your projections here going forward, kind of the continued reductions and in MA premiums?

MR. ROLLINS: I'm not sure I understand exactly what you mean by --

MR. THOMAS: So, as part of the setting of MA premiums going forward, there is a continued modification to get them closer to fee-for-service rates.

MR. ROLLINS: For paying for benchmarks?

DR. MILLER: Well, I would answer that differently. I would have said now you're not modulating. You're letting whatever the competitive price between fee-for-service or MA set the benchmark in a market. So, whereas now it's sort of the benchmark in MA -- and I may be misunderstanding the question too. But right now, the benchmark is what's -- in the county or whatever we're talking about, what's fee-for-service in the MA benchmark, is either 95 or all the way up to 115 percent of that. Now the benchmark would be which is the lower bid. So, in a sense, some markets, fee-for-service will drive that, like we said Portland. Other markets, MA will drive that, if I understand your question.

MR. THOMAS: So I guess the question I would have is, have we looked at a comparison of what the difference would be with this new model here versus what the existing MA model would be going forward? Is there a comparator there? Once again, maybe I'm kind of going down where Scott was a couple years ago and just trying to understand this. I'm not sure I necessarily understand it.

So, basically, you're saying that the MA premium would be pegged off of the fee-for-service or the median MA bid that comes through that year.

DR. MILLER: Yeah. There's a couple of different -- I should probably let this go back over to Eric.

I mean, what I was trying to say is right now you have an administrative benchmark, and it is fee-for-service. That's expressed in law, and the plan's bid is judged relative to that.

In this circumstance -- and it varies a bit by example, but in the lower -- the two lower-of examples, the benchmark would be set by whichever of those two is lower, MA or fee-for-service. So it's no longer, in a sense, tied to fee-for-service, but I want to be clear. In some markets, fee-for-service could be the price-setting option.

MR. THOMAS: Okay, yeah.

DR. MILLER: And then to your other question, what we've done here, Eric, is we've said out in this hypothetical examples, the beneficiary's premium would compare across fee-for-service. What we haven't done is necessarily said in any given market, how much it's different from the average current MA premium. Is that right?

MR. ROLLINS: Correct. We just looked at the median plan. We didn't get into sort of -- as Scott noted, there's a range of MA plan costs. We haven't sort of probed into that in terms of how much the variation -- how much variation you'd see in premiums within just the MA sector.

DR. MILLER: And I would just align myself with Eric's earlier comment. The other thing beyond your point of, like, look at there's a lot of variation in here, that's still even saying static, looking at current bids. You put this in place, the whole dynamic would change. We could look at some stuff, but it would be -- so it would be very heavily caveated because once you put something like this in play, as you're intending, it changes the dynamics

significantly if someone were to do this.

DR. SAMITT: So now I am like Scott. I am more confused --

DR. MILLER: I'm sorry about that.

DR. SAMITT: -- because I presumed there are two things going on here. One is what is the benchmark and then bid process, and then what is the premium-setting methodology? And so I presumed in these models that the benchmark would still be set comparable to average fee-for-service, and then the bids would follow. But that would presumptively stay the same as it is historically. But, in terms of how to determine the premium that would be charged, it would be done differently than it is historically in these models.

So I presumed the benchmarking and bidding process, short of the second part of the presentation today, would be somewhat comparable.

MR. ROLLINS: I think somewhat comparable. I mean, I think for this process, if you went down this road, when the MA plans submit their bids, they would know what the estimate for fee-for-service spending is going to be for their area, and so the various plans would each submit

their bids. There would then have to be sort of a reckoning, once you had all the fee-for-service information on the one hand and all the MA plan bid on the information to figure out what is the -- you know, which is cheaper, MA or fee-for-service, which plan, if it's MA, is cheaper as sort of your benchmark. And then and only then would you be able to say here are what the premiums are going to be for the coming year for fee-for-service on the one hand and all the various MA plan options that are available on the other.

DR. CHRISTIANSON: [Speaking off microphone.]

DR. CROSSON: On this point, Jack?

DR. HOADLEY: Yeah. I mean, one of the ways I think helps me think about it is MA would work a lot more like Part D. So, when Part D plans are bidding, they don't know what the benchmark is going to be because it's a product of the collective of their bid. So the best example of that is like the LIS benchmark, whether you're going to be a zero-premium plan. You know if you bid low, you've got a better chance of any up there, but you don't know how your competitors are going to bid. So you don't really know where you're going to end up, and MA would

become like that with this extra variable of fee-for-service, which is like one piece of advance knowledge. But you don't know in advance whether the average or the median or whatever we pick as the benchmark ends up below fee-for-service or above fee-for-service until the bids come in.

DR. SAMITT: So what you're saying, that we would uncouple the MA bidding process from average fee-for-service as it's done today?

DR. HOADLEY: But not completely uncouple it.

DR. SAMITT: Well, you would have the information, but average fee-for-service wouldn't peg to a benchmark. You would have the knowledge of average fee-for-service, but the bidding process would be uncoupled from --

DR. HOADLEY: But, if it turns out that fee-for-service average is the lowest, then that becomes the benchmark. So it's like they're like one of the bidders, except their bid is known in advance.

MR. ROLLINS: I would agree with that.

DR. CROSSON: I'm sorry. Warner, you were not done.

MR. THOMAS: Right. Sorry to cause all that

confusion.

[Laughter.]

MR. THOMAS: Now I'll go back to my original question. No, I'm just kidding.

So, on the MA bidding -- so right now, for MA plans that have additional benefits because they feel like there's room in the premium to add additional benefits, in this new model, essentially does that go away because you are essentially bidding on just what the traditional fee-for-service benefit structure is?

MR. ROLLINS: In the examples I have outlined here, yes. There are obviously other scenarios you could consider. But for what's outlined here, yes. It's just the standard A/B benefit package, and they're competing essentially on the price of providing that coverage.

MR. THOMAS: And they could add other benefits if they felt they could fit it into the model, or they would just bid just solely on what those A/B benefits are?

MR. ROLLINS: Well, again, as we saw in one of the examples with Miami where there's a big spread between fee-for-service in Miami, you could see a scenario where some MA plans are so much cheaper than the benchmark that

they do have -- in the case I showed, it was a negative premium, a cash rebate. But as I said, you could have a scenario where that is provided as extra benefits instead.

But unlike the current MA system where the benchmark is known in advance and so the plans, when they submit their bid, know sort of what they're going to have to work with in terms of rebate dollars and what kind of extra benefits they can provide, under this system plans wouldn't know until later in the process sort of whether or not they were going to have that -- be in that position.

MR. ZARABOZO: Of course, to the extent that the difference is cash, you as a beneficiary, if you get a cash rebate, can use that cash to purchase the extra benefits that you otherwise would have gotten through the plan.

MR. THOMAS: Sure.

MR. ZARABOZO: And as we move into the next section, the various designs that we're going to talk about include extra benefits, to get to Jack's question. So the Bipartisan Policy Center, they have a standardized benefit package that is the Medicare benefit package plus a set of extra benefits defined as reduced cost sharing and out-of-pocket cap. But it's standardized across the plans, and

then in the President's budget proposal, there are extra benefits valued at 5 percent, as we'll talk about, 5 percent of the average bid in a given area. So there would be extra benefits. And in the case of the Bipartisan Policy Center, they also say, in addition, plans can offer as optional supplemental packages, other extra benefits that beneficiaries would pay for. And, of course, they would have the cash to pay the premium related to the extra benefits.

DR. MILLER: And on that point, Warner, there are markets around the U.S. where there's such a strong culture of managed care and a perception on the part of the beneficiary that they're getting a better benefit that right now there are supplemental premiums in some markets where beneficiaries as a regular matter of course pay them.

MR. THOMAS: Two quick questions, the first being on the fee-for-service cost structure that's mapped out here. Does that include the administrative costs of the program in the kind of per member per year cost structure?

MR. ROLLINS: Yes.

MR. THOMAS: Okay. And then my last question is: As we look at differentials across geographic areas, do we

look at the percentage of Medicare eligibles that are duals versus traditional Medicare recipients? Do we look at any sort of breakdown of the population? Or do we just kind of look at a Medicare recipient as just being the same across the country?

MR. ROLLINS: For these purposes, we're sort of just looking at Medicare beneficiaries in aggregate. Again, these are all figures sort of adjusted for health status for a beneficiary of sort of average health.

MR. THOMAS: Great. Thank you.

DR. CROSSON: Jack, you were not--

DR. HOADLEY: No, thanks.

DR. CHRISTIANSON: I guess what I want to say is partly something that Mark just brought up, which is on your Slide 13, the second bullet point where you talk about this being a static analysis, I think is really, really important to underscore because this whole story about how you set prices using this methodology really depends a lot on dynamics and responses and so forth. So some of this stuff we're seeing is quite limited, and I thought if you go back to Slide 12, maybe you could help highlight that point for us, because that looks like it's dynamic because

it's over time. But I think it would be helpful if you could be very clear about the static assumptions that underlie that graph, because I think the graph is -- could be misleading to people if they don't understand what those assumptions are.

MR. ROLLINS: Certainly. It's static in the sense of it's a projection of sort of what the premiums would be for each sector, fee-for-service versus MA. I think the dynamic part is what would beneficiaries choose to enroll in in response to these.

DR. CHRISTIANSON: You are essentially assuming the premiums stay the same as that first year, right, as you project -- as you roll that projection out?

MR. ROLLINS: You mean under Line A? That's the one for the premium under the new system.

DR. CHRISTIANSON: Yeah, as you do these comparisons, are you looking -- you're looking at how to mitigate that difference that you saw in the first year and what that would look like over time? Or am I not getting that right?

MR. ROLLINS: No; that's correct. The extent to which it differs is going to potentially vary from year to

year, obviously, and the plan bids vary from year to year.

DR. CHRISTIANSON: Yeah, because each plan, there will be new bids every years.

MR. ROLLINS: Yes, that's right.

DR. CHRISTIANSON: Yeah, so the static part of it is kind of an assumption that there aren't new bids every year and that you're playing with the initial set of differences, right?

MR. ROLLINS: In that sense, yes.

DR. CHRISTIANSON: Yeah. So it looks dynamic. It's not dynamic. It's really -- we know that the bids will change year to year, and that graph is just representing a very extreme set of assumptions about bidding behavior.

MR. ROLLINS: Yes.

DR. CHRISTIANSON: Okay.

MS. BUTO: I hope I'm not throwing us back to, you know, do we really understand this, but I want to -- I know we haven't talked about Example 3, but I just want to go back to it for a second to figure out whether Example 3 is an example where it actually doesn't address or wouldn't have a noticeable or a major impact on regional variation.

In other words, because it's a locally based premium situation, it would tend to be less disruptive to the local area but would leave in place or might actually, you know, never address the issue of regional variation in spending. So I just want -- that's Question 1.

And then Question 2 is: Do we think that Example 2 will generate the most program savings over time? Or don't we have a sense of that?

MR. ROLLINS: In terms of the first part of your question, which is sort of how does Example 3 versus Example 2 compare in terms of dealing with regional variation, the effect of them would be fairly similar at a high level because in both cases the base premium is going to be paid to the lower of fee-for-service or MA in a given market. And so relative to Example 1, where there's sort of a uniform premium that everyone pays in every market, in this case you're only going to link it to the less expensive option in each area. And so in the two slides that I showed here where between Example 1 and Example 2 you had a reduction in the federal contribution in Portland and Miami, and you saw that the government contribution was much more uniform in Example 2, the scenario in Example 3

would look fairly similar to what you saw in Example 2.

MS. BUTO: I was assuming that having a nationally based premium would actually drive more change from region to region, but you're saying you don't think that's going to happen.

MR. ROLLINS: I think the incentives would be strong under both Examples 2 and 3 because they're being tied to the lower-cost option in each area.

MS. BUTO: Okay.

MR. ROLLINS: And then the second part of your question was, as I recall, which option essentially saves more for the government. In that sense, comparing just Example 2 versus Example 3, Example 2 would save a little bit more for the government than under Example 3. You'll see -- and this is in the examples in the paper. Under Example 3, in a lot of cases the base premium would be a little bit lower than that sort of $106 that I was talking about, because in a lot of markets you've either got fee-for-service is cheaper than national average or there's an MA plan in the area which is cheaper than the national average, and that would sort of determine the base premium. And since in a lot of markets the base premium would be a

little bit lower than what we have now, you know, by corollary the federal contribution would be a little bit higher.

MS. BUTO: And 2 versus 1 in terms of which would save more money for --

MR. ROLLINS: Example 2 would save much more.

MS. BUTO: Okay.

DR. CROSSON: Jack, back on this?

DR. HOADLEY: Yeah. Would I be right in saying, when we look at Slide 5, the median or average MA bid is fairly constant -- you made this point -- across these otherwise disparate markets in terms of fee-for-service spending. And it seems to me that's why Examples 2 and 3 kind of end up with relatively the same effects. If it was -- if the universe were such that Portland MA bids were significantly lower or Miami MA bids were significantly higher, then Examples 2 versus 3 could have rather different effects. Is that right?

MR. ROLLINS: I think that's right, yes.

DR. MILLER: And to the extent it is, it also means that where you peg the MA big may matter. You know, if the average is very different than the median, if you go

to the 75th percentile or you go to the 35th percentile, depending what those distributions look like in a market, your comment would extrapolate even further.

DR. HOADLEY: As well as Jon's comment about sort of the dynamic effects. If this bidding pattern is in some way a result of the current rules and new rules might lead to much different bidding patterns, then it would matter a lot more as well.

DR. MILLER: And on that point, Carlos and Scott, based on some work you guys -- and I think Jeff was involved in this as well, just to make sure that all of the suspects are rounded up on this. You were making the argument in that work that the benchmark was a high determinant of the bid.

MR. ZARABOZO: That's right.

DR. MILLER: Yes, so I think you can say that the current bids are a product of the current rules pretty strongly, and that's why, you know, Jon's point -- and we've tried to point these caveats of what you're seeing here in a static market you shouldn't attach yourselves to. These are illustrative examples based on what we know. If you change, I mean, you're changing the dynamics

considerably.

DR. REDBERG: I just want to be sure I understand. With regard to the premiums, and you were talking about mitigating the effect of higher premium, but wouldn't another way -- the beneficiary could just choose the lower-price option, right?

MR. ROLLINS: That's right.

DR. REDBERG: So we wouldn't --

MR. ROLLINS: In some ways you could argue --

DR. REDBERG: I mean, it does seem to then get away from the whole point of this, is to try to make it more efficient if we offer these other choices.

MR. ROLLINS: Yes.

DR. REDBERG: The differences are striking in some of the areas. I mean, certainly it would be nice to have more data on quality, but my strong suspicion is we're looking at increased volume of questionable quality. That's all.

DR. CROSSON: Okay. Seeing no more clarifying questions on the first part of the presentation, let's move on to Carlos and Scott. I believe we're on Slide 15.

MR. ZARABOZO: The illustrative examples of

competitive bidding that Eric has presented show the financial obligation of a Medicare beneficiary choosing among MA plans and traditional fee-for-service as an option. The Medicare program achieves savings by limiting what the government pays on behalf of each beneficiary. There are also clear incentives and price signals to show the options that are least costly to the beneficiary.

Another possible means of reducing program costs is to use competitive bidding in the Medicare Advantage sector only. A proposal of this nature was put forth by the Bipartisan Policy Center and is also an element of the President's recent budget proposal; and a number of years ago Medicare designed demonstration projects of health plan competitive pricing that had similar design features.

The current Medicare Advantage program is referred to as a competitive bidding program. What would be different in the MA-only competitive bidding proposal is that there would not be a predetermined, administratively set benchmark for plan bidding. Instead, the benchmark would be determined based on plan bids. For example, it could be set at the weighted average of the bids. In addition, in each of the proposals or examples of this

approach that I mentioned, plans would not be basing their bids on the current standard Medicare Part A and Part B package. Instead they would bid on a standardized enhanced package, or a package with a fixed value of additional benefits for all plans, that includes extra benefits beyond what Medicare covers. Having an enhanced package recognizes that MA plans are currently providing extra benefits, and those extra benefits are what makes MA attractive to beneficiaries. The President's proposal, for example, specifies that the benefit package for bidding purposes will have a value that is 5 percent greater than the average bid for the standard Part A and Part B benefit package in the area.

Regarding the potential for program savings, both of the recent proposals of this nature include mechanisms whereby this alternative approach to MA bidding would apply only in areas in which there would be program savings when compared to current law Medicare Advantage expenditures.

Now I will discuss what would happen in an MA-only competitive bidding scenario. When plan bids determine the benchmark -- for example, by using a weighted average premium -- some plans will be above the benchmark

and other plans will be below the benchmark. This contrasts with the current situation, where the norm is to bid below the administratively set benchmark. What will happen under the options where benchmarks are determined based on bids is that beneficiaries will receive a cash rebate, or premium refund as we are calling it here, when they choose a plan with a bid below the benchmark. Bids at the benchmark will have no added premium; and to enroll in a plan with a bid above the benchmark, a beneficiary would have to pay an additional premium (as is true today).

However, as I mentioned, in the various designs that have been proposed, all plans will include extra benefits beyond the basic Medicare Part A and Part B benefit package. In the bid-based system, when beneficiaries are choosing among plans and between a plan and fee-for-service, beneficiaries will take into account the value they place on the extra benefits that all MA plans will offer and the associated premium cost or premium refund available through each plan. The differences will vary from market to market and from plan to plan.

From the beneficiary point of view, here is how an MA-only bidding approach differs from the current

system. One difference is in the premium structure. Most beneficiaries are now in plans that charge no premium for the Medicare Part A and B benefit package, and a small share of beneficiaries are in plans that reduce or eliminate the Part B premium that beneficiaries would otherwise have to pay. So, currently, as shown on the left portion of this slide, the primary basis of competition among MA plans is through the offering of extra benefits, but what those benefits are and what their value might be vary from one plan to another in a given market. Because of this variation in benefits, in can be difficult to compare one MA plan to another in a given market under the current system. However, when compared to fee-for-service, MA plans are offering extra benefits beyond the Medicare benefit.

The bid-based benchmarking option is different, as shown on the right-hand side. The primary basis of competition in MA would be based on the premiums that plans charged or their level of cash rebates. In a given market, some plans will have cash rebates, and some will require the beneficiary to pay a premium to enroll. With regard to benefits, in the bid-based benchmarking, all MA plans in a

given market are essentially equivalent to each other in that every plan would be offering the same level of extra benefits -- either a specified package of benefits, such as coverage of cost sharing, or a benefit package with a fixed actuarial value, such as 5 percent above the value of the standard Medicare package. This benefit standardization simplifies a beneficiary's ability to compare one MA plan to another because the main distinction among MA plans will be the premium differences from one plan to another. So beneficiaries can easily compare one plan to another just based on dollar differences in cash rebates or premiums.

As for the comparison with fee-for-service, in the bid-based benchmarking, there are two factors: the extra benefits and any associated cost. The system is designed to have all plans offering the same level of extra benefits. In plans that are at or below the benchmark, beneficiaries receive those extra benefits without paying an additional premium, so the benefit package is clearly more generous than fee-for-service Medicare. If there is a plan premium, to compare such a plan with fee-for-service, the beneficiary would have to weigh the premium cost of MA enrollment against the value of the extra benefits not

available in fee-for-service Medicare.

Scott will now walk you through an illustrative example of how the bid-based benchmark system would work.

DR. HARRISON: Thank you.

Carlos mentioned that the bid-based benchmarks would be used only in markets where the new system would lower Medicare spending compared with current law. On this slide, we revisit our three markets. The first two lines show the market averages for the current MA benchmarks and bids. The third line shows the current MA payments that result, excluding adjustments for quality ratings that would be dealt with separately under the bid-based benchmarks.

For illustration purposes, we are assuming that the bid-based benchmarks and, thus, payments would be set at the weighted average bid for a benefit package valued at 5 percent above the value of Medicare fee-for-service Part A and Part B benefits. In other words, the payment under bid-based benchmarks will be the average of the current bids plus 5 percent.

So we can compare the two rows highlighted in yellow to determine whether these markets would use bid-

based benchmarks. You can see that the plans in Portland are currently paid an average of $736 per member per month and would be paid $759 under the bid-based benchmarks. So moving to the new benchmarks would actually cost Medicare an additional 3 percent in Portland. Medicare would pay plans an additional 2 percent in Columbus, but would pay 13 percent less in Miami.

Thus, we assume that for now the bid-based benchmarks would not be used in Portland and Columbus, and the rest of the analysis slides do not show them.

Bid-based benchmarks would be used in Miami under our assumptions, so we illustrate what we might expect in that market through the bids of three hypothetical plans. Recall from the previous slide that the average bid in Miami was $743 per member per month for the Medicare benefit. For the bid-based benchmarks plans submit for a package equal to 105 percent of the Medicare benefit, 105 percent of $743 is $780, so here we assume that the weighted average bid for the bid-based benchmark package is $780 per month.

The top row shows the bids of three hypothetical plans, and for symmetry, Plan B is bidding the average, the

$780 I just mentioned. Plan A bids five percent below the average, and Plan C bids five percent above the average. Under the bid-based benchmark system, Medicare pays all plans the weighted average bid, shown by all the $780s in the second row. For that bid, plans provide Medicare fee-for-service benefits plus the extra benefits valued at five percent, or in this case that would be $39 per month.

Under the bid-based benchmarks, the reward for a plan to bid low is the ability to charge the enrollees lower premiums or simply to give cash back to the enrollees. Plan A would refund about $39 per month to beneficiaries who enrolled in the plan. Plan B would have no premium, as its bid is equivalent to the weighted average bid that determines benchmark. And Plan C would have to charge a premium of $39 per month.

On the bottom line, we have added the two sources of extra value that beneficiaries might consider when deciding whether to choose fee-for-service or Medicare Advantage. Plan A could be seen as providing $78 of value in addition to the value of the fee-for-service benefit. That takes the form of $39 in extra benefits funded by the five percent rebate and $39 in cash for a beneficiary that

would receive -- that the beneficiary would receive for enrolling in a plan that bid $39 below the benchmark. For Plan C, the $39 in additional premiums offsets the $39 in extra benefits, so the value of that plan looks like the value of the fee-for-service package.

Now, let's compare the bid-based benchmark system in current law through the eyes of the beneficiary. The first three lines here are the same as the last three on the previous slide, and they show the extra value these plans would provide under bid-based benchmarks. The last row shows the current law rebates that these plans would have received in Medicare payments to provide extra benefits.

Focusing on the last two lines, we see that under current law, beneficiaries who enroll in these three plans in Miami would get extra benefits with a much higher actuarial value under current law than under bid-based benchmarks. We do see that under bid-based benchmarks, beneficiaries would have clearer incentives to enroll in lower-bidding plans, as the differences between the plan benefits is in easy to see premium differences, although perceived differences in networks and quality could still

play an important role in plan choice.

However, there could be a concern, because the plans do not look as attractive relative to fee-for-service as they do under current law. For example, Plan C members pay no additional premium under current law and receive extra benefits funded by $133 in rebates. Under bid-based benchmarks, however, Plan C enrollees would pay an additional premium of $39 and receive extra benefits valued at $39. So, there is some risk that while beneficiaries have stronger incentives to join lower bidding plans, they may have weaker incentives to join any MA plan rather than staying in fee-for-service Medicare.

This slide shifts the focus to Medicare program savings. If we compare the Medicare payments to the three plans, we see that the uniform payments of $780 per member per month under bid-based benchmarks are well below the payments under the current MA system, which range from $876 to $914 for these illustrative plans. While Medicare saves $96 to $134 for each member that remains in these plans, remember that each member that feels that the new plan benefits may not be so great a value and so returns to fee-for-service, those numbers would cost Medicare $1,100 per

member per month in Miami. That $1,100 cost is about $200 more than these members are costing Medicare under current law. So, any budget savings from moving to bid-based benchmarks in Miami is dependent on beneficiary perceptions of plan value and their subsequent movement between fee-for-service and MA.

Let me highlight some broad conclusions from our session. Currently, competition, both among MA plans and between MA plans and fee-for-service, focused less on price and more on benefits, which may be more difficult for beneficiaries to evaluate. Because of the nature of the competition and the lack of financial neutrality in many markets, the beneficiary does not always have an incentive to choose the most efficient option. Thus, the current system is not truly competitive. Competitive pricing systems, like those we have discussed today, have such incentives, though they may not always be well targeted.

Given the magnitude of the possible increases in premiums if fee-for-service is part of the competitive pricing system, policy makers may want to consider options for mitigating the impact on some beneficiaries, both in MA and in fee-for-service. The potential impacts on low-

income beneficiaries and state Medicaid programs would also be important considerations.

And, now we look forward to all of your questions and comments. Please let us know if you have requests for additional information to be included in the chapter for this June's report or any additional research you would like us to do for the next report cycle.

DR. CROSSON: Thank you, Scott and Carlos.

We are open for clarifying questions on the second half of the presentation. I have Rita, Kate, Jack, and Bill -- I'm sorry, and Jon. Rita.

DR. REDBERG: I'm just wondering if we have any idea how beneficiaries find out about what MA plan benefits and costs are. It doesn't seem that easy to get that information out.

DR. HARRISON: Now?

DR. REDBERG: Yes.

DR. HARRISON: They get lots of mailing, plans. There's a Medicare Plan Finder, which some people find useful and others may find more confusing. That's currently what goes on.

DR. REDBERG: And --

DR. HARRISON: Now, there are also state CHIPs, which can help out beneficiaries searching for plans.

DR. CHRISTIANSON: And senior centers and advisors in senior centers are an important source of information for beneficiaries.

DR. REDBERG: To use Cori's example, I'm pretty sure my mother has no clue on any of what her Medicare Advantage options are, and I was just thinking, is that unusual.

My other quick question, do you think beneficiaries in high-cost fee-for-service areas are aware that they're in high-cost fee-for-service areas? I mean, it seemed to me like one advantage, or sort of, would be to increase awareness of the cost, but I'm not sure they're aware currently that they're in a high-cost fee-for-service area.

DR. HARRISON: I don't know that they are aware, but they certainly know that the benefits -- people in Miami know the benefits in MA are much better than the benefits in fee-for-service because of that difference.

MR. ZARABOZO: And they may also know the cost of a Medigap plan, which varies from area to area, very high

in the Miami area. So, it's an indicator of --

DR. REDBERG: Interesting.

DR. CROSSON: Kate.

DR. BAICKER: So, I thought it was really helpful to frame the competition as being on a standardized set of benefits to understand how that would play out. The advantage of that is that beneficiaries can figure out what's going on. The disadvantage is you maybe lose some of the heterogeneity and innovation in benefit packages. So, my question is whether you have any data or information on how much variation there is now, and I don't even know what units you would describe that in, in what MA plans currently offer. What's the spread on the actuarial value of those extra benefits, or how variable are they? How much potential customization would we be losing?

DR. HARRISON: Well, certainly, just the size of the rebates in a market varies terrifically, so the benefit packages should vary a good bit. I mean, there are -- you know, the plans maybe tend to pay down the Part D premium first. They tend to lower cost sharing, but not necessarily in the same way. But, it can -- the benefits can vary quite a bit and the beneficiaries may not always

be able to appreciate that.

DR. CROSSON: Jack.

DR. HOADLEY: Yeah. I would reinforce Kate's question. I mean, I think you asked about additional information. I think -- I know it's not easy information to put together, and some years ago, I tried to look at sort of benefit variations and offerings, and we used to -- you know, years ago, we used to just count up how many had vision benefits, hearing, and that never seemed to really capture it, and the cost sharing differentials are so varied in the way they're structured, they're very hard to quantify. You know, the rebate dollar is one thing, but I'm not sure that really captures what beneficiaries see. So, I think to any extent we can get information on that would be really helpful.

My specific question was on Slide 21, and when you talked about the Medicare savings, I think what you were doing is comparing the cost of the average beneficiary, the average fee-for-service is your metric to sort of talk about the savings. The reality is that the actual switchers could be other than sort of average cost beneficiaries. Am I reading the way you calculated it

right, and how much difference -- I mean, we know over the years sort of the risk selection and so forth into the different sides of programs.

DR. HARRISON: Yeah. This is just the average, average beneficiary.

DR. HOADLEY: So, it might be interesting to sort of think about, at least conceptually if not necessarily quantitatively, sort of how that estimate of savings might vary if we know at least, say, the risk difference today between the average MA enrollee and the average fee-for-service enrollee and could play with that a little bit.

DR. CROSSON: Bill Hall, David and Bill and Scott.

DR. HALL: At sort of the front line of this whole thing, in many American communities, I don't think I agree that consumers will always go -- I think we're talking about -- for the low-price option when they start comparing systems. I have a community that has relatively low Medicare expenses nationally, probably in the lower quartile for sure, and maybe even lower. We have high penetrants of MA, largely two competing systems. And during the week or the period that -- where people are

allowed to enroll or change plans, the airwaves are full of options and presentations by the MA plans.

I think the average 90-year-old consumer doesn't read those things, doesn't hear them, and doesn't want to even know about that, and their decisions are made usually by their caregivers, their children, usually.

But, the emerging population, my sense is, of Medicare, present new Medicare recipients and future, is that they are incredibly knowledgeable and don't always compete on price. The old adages, do you want your brain tumor removed by the lowest bidder, that kind of thing, or something like that, something very -- well, I'll stop.

So, the conclusion slide is -- and here is my question. What if we assumed that people do not just compete on price, but they do compete on benefits and that probably MA is going to win that argument in the vast majority of cases. Does this change any of these dynamics at all in terms of what we're doing with this analysis? And how do we actually put the potential value of benefits into the equation? That's where I am on that.

DR. HARRISON: So, this analysis actually assumes that people don't move. The bids are the same and the

enrollment is the same. This is what happens if people don't move. If people moved, I think you would see some movement toward lower-priced plans. And then the other issue is, then, what happens if you were looking for a dynamic system, what happens in year two --

DR. HALL: Right.

DR. HARRISON: -- plans that bid high may not come back, that kind of thing. So, it could be a lot more complicated than this. This was trying to take the easiest example.

DR. MILLER: I also would say, and again, in terms of your clarifying question, you know, there's somewhat different answers for the two different ideas that we put in front of you today, which I realize is very complicated, but, you know, in the first example, one of the things that came out of the comments over here is the system definitely has a propensity to move towards more of a premium-driven decision set as opposed to an extra benefit-driven set, and then you've got questions like, well, how do you value that? What if you wanted to inject that back in? There's a certain complexity to that.

Here, then the second example, which takes fee-

for-service out of the equation, which is the big shift, but then says, I'm going to quantify and define that extra benefit package and builds it in and asks the plan to bid on that, and at least conceptually to your question is that's kind of what you could think about, is whether you compete on pure premium, and you take the Carlos point that the extra cash allows the beneficiary to purchase extra benefits if they want to do that, or you somehow try and build it into the package and ask the plan to bid on that. That creates certain complexity in comparisons, but it's conceptually the direction you could go in.

DR. CROSSON: Jon.

DR. CHRISTIANSON: On the conclusion slide, the last bullet point where you talk about policy makers may wish to mitigate the effects, could you talk a little bit more -- I mean, there's a connection, I think, between mitigating the effects and also how aggressively the plans might bid in terms of submitting low bid prices, at least in my mind. Most of the things I can think about in terms of mitigating effects actually result in sort of less immediate revenue for plans that bid low, or am I getting that wrong?

MR. ROLLINS: I think, broadly speaking, I think that's a fair characterization, that to the extent you're blunting this sort of incentive, this price signal you're sending, you know, the plans -- there's less reward.

DR. CHRISTIANSON: So, the more that we're concerned about protecting the beneficiaries from the financial consequences of the system are softening it over time, the less the potential savings might be for the Medicare program?

MR. ROLLINS: To the extent that there are positive consequences of moving to a system like this, it would take longer to realize them.

DR. CROSSON: David.

DR. NERENZ: I may ask this to Bill as well as to you guys. In a low-cost fee-for-service area, like Rochester and Portland, are the plans offering supplemental benefits, because you don't have a rebate full of dollars to fund that. Just as a yes/no, are there extra benefits?

DR. HARRISON: There are some plans with extra benefits in Portland. They would be generally lower level of extra benefits than offered in other markets, but there often are. And then people with Portland are okay with

paying premiums, and so they may also get some premium-funded extra benefits.

MR. ZARABOZO: And, of course, these areas are currently 115 percent of fee-for-service areas plus bonus payments of five or ten percent in these areas, so --

DR. NERENZ: I'm just trying to understand --

MR. ZARABOZO: In other words, the plans can afford currently to offer extra benefits in those areas.

DR. NERENZ: Okay, good. That was what I was looking for. Thank you.

DR. MILLER: [Off microphone.] But that's because the system that they're currently operating under don't look like this. Their benchmark is set above fee-for-service.

DR. NERENZ: Right, and that's exactly what I wanted to clarify. I know this has been in front of us, but as we get into the next round, I'm more interested in what's happening to the dynamics in that end of the distribution. I just wanted to clarify this point. Okay.

DR. CROSSON: Bill Gradison.

MR. GRADISON: In general, I like the idea of standardizing the benefit package, or at least having a

package with an ascertainable cost, five percent additional, whatever it is. The idea of having just one standardized package bothers me. Maybe I'm too wedded to the concepts that we wrote into laws years ago to try to standardize the Medigap market, which have different prices, but they're originally the A through J, and with some modifications since that time.

And, I just wondered whether you've taken a look or could maybe take a look at what would happen if there were additional -- yes, standardized, but several standardized packages and the common denominator would be, let's say, that they're five percent cost actuarially equivalent and spell it out, because there might be in some markets beneficiaries who would prefer one standardized package versus another standardized package.

DR. HARRISON: So, I think that the system thinks about one standardized bid for the basic package, or in this other system of the one higher level. But, we would expect that plans would then be able to offer extra benefits for cash. So, if you wanted to standardize what those other offerings could be, that seems like a possibility, also.

DR. CROSSON: Scott.

MR. ARMSTRONG: So, I just -- I'm thinking about the two parts to this presentation and how they relate to each other, and I assume, and I'm trying to figure out, can you do the first part and do the second part or not? I'm thinking you can't. But, you could do this sort of standardization and new bidding process for the MA plans without having done the first part of this presentation. Did I get that right? I'm trying to just understand how these two pieces work together or don't.

DR. MILLER: What I would say is yeah. I think he's got it right that we -- and maybe there is some imagination that I am lacking, but I think we put these in front of you to say, typically, when people talk about premium support, it's mostly the first half of the presentation, and fee-for-service in the mix. You have to think about the distributional impacts and all that.

Then the second half of the presentation is there's this new animal that kind of showed up on the scene if, well, what if you did it? And like a lot of these things, these ideas have history, and so new-ish animal on the --

[Laughter.]

DR. MILLER: Yeah. Sorry, Jack. We've seen this before.

On the scene. But it has gotten some attention more recently in two, couple of places, and you would be saying, "No, the competition applies to MA only," and very much the standardization of the benefit in order to "Why would a person pick MA if MA didn't offer them something extra?" comes into play. And since you've held fee-for-service neutral, it's like, okay, you could do competition here, but you need to add something for the beneficiary to say, "Oh, I want that," in addition to whatever price signal you drive out of the competition.

So that's the long way of saying I think you have this organized in your head right.

MR. ARMSTRONG: Yeah. No, actually, that was helpful to me, and I think I got that.

We've talked a lot about we're building this modeling to sort of distinguish between the impact of price on choices versus the impact of extra benefits on choices, and I just think it's worth saying. I'm not sure we've been explicit about it, but there are a lot of other

variables, too, that influence these choices, and so we just need to attend to that. I mean, your provider is a really good example of that and the different networks people have. I don't know where or how that comes into play, and I'm fine with this approach, but it is -- there are other variables there.

And then the final thought -- and I haven't really given this very much thought, but particularly in this section, it sounds -- this sounds familiar to me, the way we're building this, given the work we've just been doing in the last few years to build individual and family state exchanges and the standardization of the benefits and creating a competition. And I just wonder if we thought at all about -- so what worked and what didn't work in that, and is that in any way relevant to what we're trying to do here with the kind of MA bidding structure, standard benefits and so forth that you guys are talking about?

DR. CROSSON: Scott, thank you. Okay. So Warner, Jon, and then Kathy.

MR. THOMAS: I guess one of the things I wonder as I look at this is if we're making this more complicated than it needs to be, and it seems to me that we have

markets where MA is significantly cheaper than fee-for-service, and why wouldn't we start with those markets and try to get more people in the MA plans, just with the way MA works today? I mean, it might be part of the benefic structures, why they are either more cost effective or why people are choosing them, and if you go to just a standard benefit package, even with the dollars, I mean, maybe we don't know if that would change why people move or not move. I mean, we just don't know.

It just seems like instead of retooling the whole MA program, are there ways that we could start in areas that we know are challenges, very high-cost areas, and get more folks to move into a more cost-effective model with some type of either financial incentive or how we want to structure it?

And then in areas that -- I don't know. It just seems to me like we're really making this very complicated. We could do that, and then that would drive those costs and those areas, hopefully, lower to what are more of the national benchmarks, and then we could continue to evolve from there. But it just seems like the proposals that are on the table are going to take so much time to implement,

that by the time we get there, you know, who knows kind of where the overall cost structure would be in general? So I would just put that out as one thing to consider and think about.

DR. CROSSON: Jon.

DR. CHRISTIANSON: So, on your Slide 15, you kind of drop in there that there's some experience that CMS has had with an earlier demonstration program, and not everybody may be conversant with that. Maybe you could talk about that very briefly and what lessons do you think -- what insights from that, Kathy's -- what insights could be drawn from that, that have informed your thinking about what you're doing now?

MR. ZARABOZO: Yes. In 1996, Kathy --

[Laughter.]

MR. ZARABOZO: -- the then-HCFA designed a demonstration project which was going to start in Baltimore where there would be plan bidding. They would be bidding on a package above the Medicare benefit package, but the bids, it would be a similar thing, that you would have a bid. You would have the weighted average bid or a median bed would determinate what plans would charge, and the

program would not state in advance what the benchmark would be.

So the Baltimore concept ran into political opposition, and it didn't happen there because the plan said, "Well, we'd like to know the benchmark in advance. We'd like to be able to offer extra benefits," and then that didn't go forward.

Then they moved to Denver, and in Denver, they also tried a similar thing. The requirement for demonstration was they had to be budget-neutral, but the plans already, the cost -- the fee-for-service costs were very high, and it was expected plans would come in below that and still be able to offer extra benefits. So there was a standard extra benefit package.

In Denver, they went as far as getting the bids from the plans until there was a temporary restraining order which ended -- essentially ended the demonstration.

The bids were revealed in an article in Health Affairs, and they were shown to be well below the Medicare fee-for-service levels, including the extra benefits. And then the Barbara came a long and required that there be a demonstration of this concept, and it also said there would

be a national -- there will be a standard benefit package, but in each area, there will be a committee that will determine what kind of benefits are we talking about in this area. And that was going to be in Kansas City and Phoenix, and those didn't happen either.

So, yes, there was an experience with this, but it did not come to full fruition where we could judge what might really have happened.

DR. CHRISTIANSON: And I think one of the conclusions was that the plans did not see this particular pricing approach as advantageous to them.

MR. ZARABOZO: Yes, yes. And so, when they moved to Denver, the, again, issue was "We want to know the benchmark in advance, and we want fee-for-service to be included now." That was not raised in Baltimore.

DR. CROSSON: I just --

DR. HOADLEY: Wasn't there also an ACA provision for a demonstration as well?

MR. ZARABOZO: Yes. There was going to be a demonstration through various -- in various parts of the country, and what happened there was that different -- different bills were introduced that said this is not going

to happen in my area, this is not going to happen in my area. So, if you look at this list of this is not going to happen, it pretty much covered the country, and that was repealed recently, that particular provision. Yeah.

DR. CHRISTIANSON: So, back to my question, was there anything that you learned from this that could inform your design of such a program going forward in terms of just -- you know, not the politics of it, but just the way this should be designed?

MR. ZARABOZO: Well, the bids coming in, very much lower in Denver, is indicative of -- because they're not bidding against a known benchmark. They are bidding against each other, essentially, so --

DR. CROSSON: I just want to add a point here, sort of a cautionary note, because we had a little bit of a similar discussion yesterday as we were talking about maybe reinvigorating the CAP program. I mean, I think there's a tendency -- I share it sometimes as well -- to look at something that's happened in the past and that's either had an execution failure or a political failure or both and say, well, let's not do that again. And I think we have to recognize, particularly in this case, that this is 20 years

later.

Now, a lot of the forces that you've described are probably still in place, but on the other hand, we're 20 years further along in terms of the cost of the Medicare program, on the Treasury, and on beneficiaries, and so I think, going along with what Jon said, I would look at these things that have failed in the past as most entrepreneurial businesses do, not as an indication to not proceed, but as a learning opportunity in order to improve ideas.

MS. BUTO: I was just going to add, first of all, when we did get bids in from Kansas City, but we were not allowed to open them, I think the real lesson we took at the time was that the plans initially opposed any demonstration. Then they agreed to work with Congress on language to enable a demonstration that would have public input and so on and so forth. In the end, the lesson I took away from the two, Phoenix and Kansas City, being stopped was that the argument they kept coming back to was including fee-for-service.

I think that's still a relevant lesson because the areas that were chosen were areas with high fee-for-

service spending, where there was likelihood of program savings, but they made the case I think pretty strongly that those savings should be gotten from fee-for-service as well, not just -- what did we call it back then? -- Medicare plus Choice.

DR. CROSSON: Maybe at the time, you might have employed Johnny Carson as Carnac because I think I remember he was able to read the information without opening the envelope.

MS. BUTO: The answer, yeah, before he had the question.

DR. CROSSON: On that note --

[Laughter.]

DR. CROSSON: Wow! This is a complicated issue. I am going to call on you in a second, Craig. Do you remember you volunteers?

DR. SAMITT: I did.

DR. CROSSON: Okay.

MS. BUTO: I have one more question.

DR. CROSSON: Kathy, I thought we got you. Go ahead.

MS. BUTO: I just wanted to go back to something

that -- I want to make sure I got this. I thought that -- and it's sort of related to the last comment -- that in discussing the MA-only approach, what I was hearing is we would go to areas where there was high per-beneficiary spending, high fee-for-service spending. Not necessarily? Okay.

DR. HARRISON: You'd end up going to places where the bids were well below the benchmark.

MS. BUTO: Oh, where the bids are well --

DR. HARRISON: Current bids are well below the benchmark.

DR. MILLER: But, Scott --

DR. HARRISON: That would then give you room to have an extra benefit.

DR. MILLER: But wouldn't that tend to be the areas with high fee-for-service?

DR. HARRISON: Miami, yes.

MS. BUTO: I thought that was --

DR. HARRISON: But, like, Albuquerque would be another areas which is a low-spending area. Yeah, it just depends.

DR. MILLER: I take it back.

MS. BUTO: Okay. Because what I was -- one of the lessons I thought I took away from the discussion was that there is a hazard when fee-for-service is not included that the benefits are not going to be -- especially in a competitive environment like that, the extra benefits with the lower premiums are just not going to be attractive enough at 5 percent to stop people from kind of escaping back into fee-for-service. So that that to me is a cautionary note about going down that route, even though it sounds appealing.

And then my question to you was whether the 5 percent -- I thought I heard you say to Bill Gradison that it would have to be a standard 5 percent extra benefit package, or could it be an actuarially, you know, variable, if you will, extra benefit package?

DR. HARRISON: There are different opinions on that, and we've tried to stay neutral on that.

MS. BUTO: Okay. No, I was just thinking back to Kate's point that this issue of having some ability to vary the benefit, the extra benefits might have some value, even though it undermines the simplicity part of it.

DR. HARRISON: Right. We think even if it was a

standard actuarial value and you let there be some variation, at least the beneficiaries would sort of see -- they'd be more likely to see the plans as more equal in benefits.

DR. CROSSON: Okay. I am going to call on Craig in a second to start us off, but I am struck not just from the reading, but from the discussion in the presentations that we've got, as a number of people have said -- we've got a lot of moving parts here, not just within what's been presented in the two presentations or even within the presentations, but also, as Jon and others have pointed out, the fact that we're looking at a static set. We're looking at a set of static models, when in fact we would -- in order to make the right judgments here, we have to at least take into consideration the dynamic impact of whichever set of choices we choose.

So I want to -- I'm don't want to steal Craig's thunder because I know he's got important points to make, but I wanted to suggest that in our discussion, in order to help the staff, we talk about -- or those who wish to talk about the relative -- our perspective of the relative importance of a set of values that have been expressed here

and in these models. And I may not have them exactly right, so feel free to correct me.

But one of those -- and these are not discrete. They interact, unfortunately, but one of them is to increase program savings. That's one goal I've heard in the presentations and in the discussion.

Another one -- and, of course, it's related -- is to create incentives for beneficiaries to choose more efficient care. So those are related, but they're somewhat discrete in terms of what models we might choose.

A third one, which we've talked about in the past, is sort of along the lines of our general site-neutral policy, would be equalize the cost to the Medicare program across the various offerings within a market, so that Medicare is essentially held harmless, depending upon the beneficiary's choice.

Another one that has come up as well is a goal to try to equalize costs, both to beneficiaries and to the program, across geographic areas.

And the last one -- and, again, I'm sorry these are not discrete -- is to change the competition for beneficiaries from benefits to price.

Now, I may not have captured everything, but I think it might be helpful -- and, Mark, jump in if you want, but I think it might be helpful to guide the next phase of this work for the staff to hear from people in terms of which one of these values or potential achievements you would see as the most important because that then helps drive to the right model or set of models or approach.

So, with that, having hopefully not stolen any of Craig's thunder, take it --

DR. SAMITT: Thanks, Jay. I think it was helpful for you to frame the principles, and I just want to thank the team for making what is very complex pretty understandable in this session. I think I do get it better than I have before.

So there are -- my feelings are somewhat mixed, even about the principles that you've described. What I like about all that I've heard today, both Part 1 and Part 2, is it does hit on several of these key principles, an incentive and encouragement for beneficiaries to select higher value alternatives -- and I'll come back to that -- as well as a savings to the program. And so I do think

that it hits on several principles.

But something that you said pushed my button, and it actually is in Slide 22 as well. Should our principle be that the beneficiaries incented to choose the most efficient option, or is it that the beneficiary should choose the highest-value option? Because there's very little that I've heard -- and it even says in the paper -- that quality is assumed as equal. And I don't think we should presume that quality is assumed as equal, and so I'd strike the most efficient option language and describe it as the most high-value option because I assume what we want is beneficiaries to choose alternatives that have better access, better quality, better service at a lower cost. And I'm afraid that all that we've been talking about simply boils it down to price alone.

And I could envision alternatives through this model, especially in markets that may have a higher MA cost than a fee-for-service cost, that beneficiaries will pick lower quality alternatives because all we're doing is really offering a comparative price. And so we need to find a way to integrate the other key variables, and I think Scott alluded to this as well. There are other

variables than price. It's pure transparency about network -- is your doctor in the network? -- about access standards, about quality and service.

So I like the idea. We're moving in the right direction. I just think we have to factor in several other things than what we're describing here, which seems to be boiling down to cost alone.

DR. CROSSON: Okay. Comments? Let's go to Jon, Alice. We're going to move down this way and then come back this way.

DR. CHRISTIANSON: Okay. Just a quick comment here. I think several people have noted how complex this is, so I'm going to make it more complex now. I think actually Scott and Carlos and Eric have done a good job of simplifying it.

Some of the things they haven't talked about which are big design issues in Medicaid bidding programs are eliminating plans that are high bidders. We haven't talked about that at all. But that, the data shows us, tends to drive bids down. If you know, the consequence of not submitting a low bid is you don't get to enroll anybody. That's a bigger incentive. So that's one issue

that you haven't talked about that I think you might want to at least raise. When you talk about your design, you have to explicitly say we haven't built this into the design.

The reason I think it's important to do that, again, is because several Medicaid programs have done that, so it's not like it's out there and can't be done. It has been done politically. Of course, you have a real budget constraint at the state level, so they're really willing to push on this.

Length of contract, you know, we're assuming bidding every year. Bidding doesn't have to occur every year. It doesn't occur in the private sector every year. It doesn't occur in some Medicaid programs every year. So that kind of goes together with not letting everybody be a winner because if you have a program in which you are going to say some plans are not going to have access to Medicare beneficiaries and they won't have access for three years, that's another package of incentives that's pretty strong.

Now, the negative of that, we all know, is that if you have that kind of a program, it's going to disadvantage smaller regional plans or plans that just

really concentrate on Medicare beneficiaries because they may not be around to bid again after the three-year contract. And we've seen that in some Medicaid programs. So it will be advantageous to large national plans that are bidding in different service areas all across the country. They win some, they lose some, but they're going to be there the next time.

So there are these different kinds of consequences to research design choices that you have implicitly made in terms of modeling, but the Medicaid programs are made differently. So I think one of the things I would encourage you to do is look at some of those Medicaid program bidding systems that are out there now and say, okay, here's some examples of things that have been tried in the real world, and they are feasible. They may not be what we want to do, but I think they at least should be out there.

DR. COOMBS: Thank you very much. I've learned a lot this morning. And, Jay, thanks for those guidelines.

One of the things I thought about in reading the paper is: What do we do for this large group that we don't have a good idea about the dual eligibles and the LIS? And

the graph that you have on page 10, Slide 10, which is also in the reading material, one of the questions I wanted -- I looked at the graph and I thought about it, and I said, What would be the distribution of dual eligibles in the side to the right? And does that impact some of what we see here? And is the population equally represented on both sides of the graph for both LIS and the dual eligibles?

I know this is a hard thing to get our arms around, but the question would be: Would any of the models disproportionately affect one group versus another?

DR. CROSSON: Who wants to take that on? Who wants to run for the hills?

MR. ROLLINS: We could look to see sort of the distribution of the dual eligibles specifically, how that compares to sort of this slide that you're referring to, which is sort of the overall Medicare population, to give you a sense of sort of whether it looks about the same or to the extent that it differs.

DR. COOMBS: Thank you. And then the other question is benefits versus rebates with surplus. One of the things that I thought about was how often does the

surplus extrapolate into outcome, and that's the whole notion of what is a quality benchmark that can be assessed based on surplus. In other words, underbidding is associated with equal quality, so the question would be, you know, we're making an assumption when an MA plan does very well that the surplus trickles down to an outcome event. And so that I don't think is necessarily a valid assumption always. It's the same assumption as saying when corporations do well, they affect the unemployment rate. And that isn't always true.

So, you know, as I thought about the whole notion of, well, should there be a defined benefit package, that would be one avenue. But how well does that defined benefit package actually result in -- I mean, a lot of plans might have smoking cessation, weight reduction, gym memberships. You know, I have a health plan that has a gym membership. I have it taken out of my deduction, but I imagine that some people are the same way.

So how much does that actually extrapolate into outcome? And I know that some plans might have innovative things where they do, especially with the smoking cessation and things like that, weight management, where they can say

these are the kind of data we have.

Now, that's not something that you can do on a large scale, but certainly some of the places that you have in the graphs, like Chicago, I think Hawaii, you pointed out some areas that are the highest bidders in one area, and I don't know if that's something that you could look at, but to see if there's any kind of outcome-driven programs that correlate with the surpluses in terms of what they do in terms of monitoring those folks, those benefits that seem to be -- beneficiary benefits that should result in some changed behaviors as well.

DR. CROSSON: Thank you.

DR. HOADLEY: So, again, as I said before, I think you guys have done a great job of expanding what you've had out on the table before and sort of helping to clarify, and I agree with several people that the material even in this presentation has helped to clarify things in significant ways beyond what was written. It's hard for us.

I guess some of what I'm trying to think about -- and you've heard some of my earlier questions on sort of how extra benefits play into this; I think it goes, Jay, to

one of your questions about changing the competition from benefits to price -- is just really trying to think through what we're doing here. And I guess I'm struck, for example, by the second, the MA-only thing, and using this 105 percent benchmark. If you sort of took that back into the first illustration, on the one hand, that feels like it reflects more like what MA plans do today, because most MA plans are probably doing something -- I don't know. Again, we don't necessarily have the quantitative measure, but something like a 5 percent enhancement with the maximum out-of-pocket cost limit and some of the cost-sharing changes, and maybe you go well beyond that certainly in many markets.

But, on the other hand, I don't know that we'd want to see a competition with traditional Medicare where we built in a benefit advantage. So we're saying this is price competition, except that the MA plans get to play with a bigger benefit package, and you're sort of saying a traditional Medicare, you can't have a level playing field when you're bidding.

So, you know, should we be pairing this if we're doing something more dramatic like the first set of

examples with an enhanced traditional Medicare benefit package, so really change the A/B to include that maximum out-of-pocket limit, maybe clean up some of the cost sharing. Obviously, we've talked about those benefit design changes in other cycles. But maybe if we really want to move this to a competition on price, we should make a better benefit package and let both players compete over that. So that's one point to throw out there.

DR. MILLER: Can I say one thing before you move to another one [off microphone]? Because I was trying to think about this, and some of that was driven by Scott's comment and maybe some comments down there that I can't pinpoint.

I almost wondered whether, if you tried to drive it back -- you know, the 5 percent concept back into the true premium support concept, whether you ask for two bids from a plan, because my mind immediately went less to build up fee-for-service and more to you give me two bids, one for fee-for-service and one for 5 percent, but then my thinking kind of ran off the end of the pier. It's like now I have two bids, what do I do?

DR. HOADLEY: Well, you can go into the Part D

kind of model where, you know, again, I don't know how much of it you'd replicate, but in Part D you say to every plan you have to offer a basic plan, so on the P2P side.

DR. MILLER: Right [off microphone] enhanced one.

DR. HOADLEY: And then you can offer an enhanced one if you want, and, you know, in the marketplace, we said yes, and your enhanced plans have to be at certain levels. So we have the gold, platinum, and silver, and all that. So we've helped a little bit with the standardization. So, again, maybe there are concepts, and I don't know the right mix or even whether I like all the outcomes. But I think, as we want to work it through, I think we could look at the Part D, sort of basic enhance, think about whether traditional Medicare ought to have a chance to have an enhanced -- that might get at some of the Medigap -- now I'm making this three times more big and complicated in doing this -- or whether drawing from the marketplace sort of several levels but not sort of infinite variations, and maybe it's at levels of actuarial value, not necessarily levels of absolutely standardization to address some of what other people said, although complexity from a beneficiary choice point of view, you know, there are pros

and cons from all that.

DR. MILLER: Sorry I interrupted [off microphone].

DR. HOADLEY: So the other kind of thought I have is trying to think about the core focus on what we're doing under -- again, now I'm talking about the broader, the first part of the presentation, and with Examples 2 and 3. And it was sort of a revelation to me in thinking about the fact that the difference between -- because up until now, I keep thinking, well, 2 and 3 are really kind of the same, but that is a product of sort of current bidding patterns that have MA being pretty flat across the country. So I don't want to try to get into that complexity.

But with those two examples, the question is: Are we essentially asking the majority of beneficiaries to pay for the health system's either inability or unwillingness to figure out why we have geographic variation and fix it? And is that -- I mean, this was one of the questions that we started to highlight in earlier in the day. And why should we be asking beneficiaries to pay for this or beneficiaries being on the hook somehow to behave in a way that will cause that behavior to change?

And the simple result, without a lot of complicated dynamic changes that we might, in fact, anticipate, in a market like a Miami or a Dallas or a Houston or some of those high-cost markets, you could easily imagine a scenario where almost everybody slides into MA because the cost of staying in fee-for-service is so great.

Now, people's stickiness and other kinds of things will keep that from happening. Our mitigation strategies would slow down that process, but if we just sort of, you know, jump to the conclusion. Well, now we've had other conversations about the impact, say, on hospital prices of having traditional Medicare in the market, and as traditional Medicare has -- its pricing of hospital services, for example, helped to set the basis for lower savings, and without that factor in those markets, do we lose that?

So I think trying to think through do we really want to be in a situation where we essentially move the entire market to Medicare Advantage -- and I worry about that for a number of reasons. One is that sort of, you know, absence of the public sector price impact that we've

talked about. The other is whether, you know, again going back to sort of the quality of the MA plans, in some markets we have really good, robust integrated systems. In other markets we have what seem to be pretty much just plans that organize or reduce network but don't do a whole lot more in managed care.

Now, again, what's the dynamic effect of all that in a bidding process? I think that gets really complicated and more than my little brain can try to figure out today. But I think that's the concern I have of sort of thinking about putting all the burden on the beneficiary to sort of pay the price of what we've otherwise been unable to do in terms of trying to address costs in high-cost areas and would it actually not help things if everybody just said, okay, fine, we'll shift to MA, and now we've lost one of the levers that may have helped to damp down costs.

DR. MILLER: You know, to a point that Kathy made that some of the plans when those demonstrations were going on, you know, it's not fair if fee-for-service isn't in it, which is an equity issue and probably an argument. The other argument we've made in previous iterations of this conversation is you keep fee-for-service in there as part

of the bidding process precisely to keep some of that anchor.

Now, if a market completely evaporated, you know, maybe there's issues there. But the whole idea of keeping fee-for-service in the bidding process is to provide an anchor to -- you know, we don't immediately absorb the private sector prices, which are much higher than Medicare.

The other thing to keep in mind -- and I'm about to say something that I'm not 100 percent sure of, so I need some -- I mean, the way we've structured these models in terms of between 2 and 3 and the geographic variation, the beneficiary carries some of greater of the geographic variation between the two. But there are other ways to actually make that occur even much more heavily -- right? -- if you keep the federal contribution constant. And so there's even a design choice underneath it where you'd be really saying to the beneficiary you're carrying the weight of the geographic variation. Between 2 and 3, you carry some of it. But the heavy lift on it is still, I think -- unless I'm missing something -- carried by the federal government. Is that right? Or did I totally --

MR. ROLLINS: I think for 2 and 3 you've shifted

a lot of the responsibility to the beneficiary.

DR. HOADLEY: Especially 2, right [off microphone].

MR. ROLLINS: Arguably, for both of them.

DR. HOADLEY: If plans bid -- I mean, if the variations we see in -- I mean, the problem is we don't really understand the variations in fee-for-service very well, and why is it that we're seeing this large gradient in fee-for-service and much closer to flat on MA. Is it some combination of selection? Is it because there's a lot of fraud in Miami? You know, is it something that, again, all beneficiaries are part of? Or is it really just because, you know, there's -- is it rates of providers? You know, we don't understand that very well. But if there was much more of a tilt, then it seems like Model 3 was designed to shield the beneficiary from more of that. We just don't get to see it very well given the way the numbers play out. I think.

DR. HARRISON: 3 would basically charge the beneficiary 13.5 percent of the variation between areas. There is no variation in 2. They're all going to pay the same base premium.

DR. HOADLEY: Right [off microphone].

DR. MILLER: So in 3 you are building into [off microphone] the beneficiary's premium, 13 percent of it, that geographic variation. And so you are asking them to carry it, but --

DR. HOADLEY: I said it backwards [off microphone].

DR. MILLER: Exactly. Yeah, right, you could actually -- we didn't discuss this here and didn't construct it here. You could design models where they even carry a heavier portion of that.

DR. HOADLEY: Do we have any markets that are more extreme variations in their average bid than the three examples that we've mostly been working with?

MR. ROLLINS: Variation between the --

DR. HOADLEY: Where the median MA bid is more deviant from national fee-for-service.

MR. ROLLINS: Miami would be high on the list --

DR. HOADLEY: But it's not very different in terms of on that chart.

MR. ROLLINS: I mean, there are a lot of -- you see a similar differential, if you look at Table 7, for a

lot of other major areas, like Los Angeles.

DR. HOADLEY: But the -- right. I mean, I'm talking about the fact that the median MA bid on Slide 5 is almost constant between Portland, Columbus, and Miami. It's $712 to -- $704 to $744. And I'm thinking that maybe it's in some of the examples in the longer paper. But where the MA is more off the line and sort of how things play out there, is what I'm trying to think about. This is more detailed than we probably have time for right now.

DR. CROSSON: Kathy, do you have a point on Jack's point?

MS. BUTO: I do, actually. I wanted to go back to his point about enhancing fee-for-service. And I guess I want to go back to your list, Jay, and partly Craig's comment about value. One of the things that wasn't on your list was the issue of continuing to have incentives for beneficiaries to move into more managed environments, more managed scenarios, whether it's ACOs or MA plans. So that's not in there.

If we then go to -- one of the proposals or suggestions Jack was putting out there is enhancing fee-for-service seems to me -- although it would make the

bidding process more of a level playing field, I don't know why we'd want to enhance fee-for-service. I'm just trying to understand that in light of our other principle, which we haven't put out here, that we'd really like to encourage people to move into high-value managed care settings.

So I just want to ask that question as we think about this in some of these permutations that we not forget that we don't necessarily want to make fee-for-service more attractive.

DR. NERENZ: So, Kathy, could you just qualify what you mean by "enhance" in this question?

MS. BUTO: Enhancing fee-for-service?

DR. NERENZ: What does "enhance" [off microphone]?

MS. BUTO: I don't know. I was picking up on a point Jack was making about if we're going to have the added benefits in MA --

DR. HOADLEY: What I meant was things like the maximum out-of-pocket limit that doesn't exist or some of the kind of wacky cost sharings for longer hospital stays and some of those -- the things that Medigap deals with.

DR. CROSSON: Yeah. And just to be clear in

terms of a list that I gave you, I was using the language that we were using here today at the Commission, move towards more efficient care. I don't know that, in my own mind, at least, that's terribly different from what you're saying.

And to Craig's point, I certainly would not argue with the fact that underlying that -- and the word "efficiency" doesn't carry it, I understand that -- but the notion of at least equal quality, if not a preference towards higher quality, would also be there.

Kate.

DR. BAICKER: So, I, too, wanted to echo Craig's point that, clearly, quality matters and we need to think about how you layer on improvements in quality and rewards for improving quality onto all of this. I'm going to abstract from it and I'll just call everything value, but to focus on some of the premium points we're trying to put a finer point on, but we have to keep Craig's point in mind about how then the quality metrics layer on top of that.

To boil it -- I've tried to just boil it down in my thinking to a couple of the key questions because there are so many practicalities in variance, and the point that

seems most important to me is that beneficiaries face the full import of how much higher or lower value the plans they're choosing are and that they reap the benefits if they're enrolled in a much more efficient high-value plan. And, so, again, back to Craig's initial point that the delta between what they pay if they're in fee-for-service versus what they pay if they're in an MA plan, each of the three options in the first part maintains that incentive for enrollees to choose the lower cost, higher value plan, and I think that that's a great move in the right direction.

And then we're left with the question of should fee-for-service be in that mix, as in the first set of options, or should it just be among MA plans, as in the second set. And Jack's point about, well, fee-for-service would be competing on an unlevel playing field if there was a five percent, highlights the point that there is no fee-for-service plan. There's nobody bidding. It's this collection of individual people that has no collective bid.

So, then, the question is what is the beneficiary entitled to under the Medicare benefit? Is every beneficiary entitled to the lowest cost provider of care

that we deem of sufficient quality and providing at least this much, this generous a benefit, regardless of how that's provided, or is every beneficiary entitled at the existing premium structure to fee-for-service?

If you say, every beneficiary is entitled to fee-for-service, then you go with the -- at this price -- then you go to the second option and you let the plans compete amongst themselves with the beneficiary really getting the full advantage of choosing a lower value -- a lower cost, higher value plan.

Or, you say, you know what? Beneficiaries are entitled to this package of care delivered at this quality, and if MA is doing that more efficiently than fee-for-service, then that's the Medicare contribution, and if the beneficiary wants to stay in fee-for-service, the beneficiary has to pay that delta, even if it's going to be huge in someplace like Miami.

In choosing that, you're thinking, who's bearing the cost of the system delivering really high cost care? Do we want to say that beneficiaries in a high cost place are just not able to get the fee-for-service benefit at the same price as their fellow citizens in an area where the

system is working better, but it's through no fault of their own that they're living in the high cost area? And that goes back to Scott's question about who bears the cost of the geographic variation.

If I thought we would be in a world where immediately everybody would move over into MA and fee-for-service would just disappear, that would present a lot of logistical problems. So many of our other programs are built on the fee-for-service chassis. We rely on fee-for-service prices to mitigate private prices. If the world transformed that way instantaneously, there would be some problems, although we spend a lot of time thinking about how we could drive people into better managed plans. So, we can't do too much hand wringing if it were to happen overnight.

But, I don't think that that's a real possibility. I don't think that our risk is people switching over just too fast. And, so, I'm willing to live with that risk while moving towards a really equal footing kind of competition as laid out in the first set of options.

One of the problems with the first set of

options, you note that beneficiaries have a pretty hard time knowing, and you picked up on this, as well, what the benefits really are, and it's apples to oranges, and one of the advantages of the second set was that it would standardize that a little bit. But, I suspect, although I don't have any data, that part of the reason we're in that world is that beneficiaries are not able to reap the full benefit of the lower cost plan.

So, in today's world, plans add in benefits to get up to that level per force. If we were in a world where, rather than throwing on some benefits that the beneficiary was not even able to perceive, the plans just gave them cash, I suspect that they would spend less of their resources on plans that had benefits that the beneficiaries didn't perceive. So, maybe you solve that problem a little bit or mitigate it by being in a world where the full pass-through of the savings goes to the beneficiary.

So, I think that that leaves me favoring the first set of options over the second with a moderated glide path. You don't want to have beneficiaries suddenly face the full costs of living in a high cost area and have to

switch plans. So, you want to transition that in a rational, reasonable, smooth way. Have fee-for-service in the mix in the competition and then let plans offer flexible benefits that beneficiaries actually value, and it would be the plans' problem to make sure that they presented that in a way that beneficiaries could perceive well.

So, that's where I am.

DR. MILLER: [Off microphone.] Can I get you to say one more sentence? If I followed your cascade --

DR. BAICKER: My rant?

[Laughter.]

DR. MILLER: No, no, no. No. I thought you were really clear, and I think you're being fairly precise about looking at all this and saying, if it were me, this is where I'd go, and I think this is helpful.

I also -- do I infer correctly that if you're on the first option side of things and you're concerned about the beneficiaries carrying the weight, you'd gravitate more to -- and I'm sure I'm going to get it backwards -- but, I think, two over three, where the bene carries more of the geographic variation in three, if I have that right.

DR. BAICKER: I -- yeah --

DR. MILLER: Because you did express a concern of how much the bene has to carry --

DR. BAICKER: So, I think in the long run, you probably do want to be a force towards flattening. So, in the long run, there should be some more national -- I don't want to use the word benchmark, because -- contribution definition. But, I would get there gradually.

DR. MILLER: Yeah.

DR. BAICKER: It's not the individual beneficiary's fault for living in a high cost area, but the way we're paying is making it a high cost area. And, so, you have to balance those two things by saying, in the long run, we shouldn't be enabling this excess cost. In the short run, we can't put the whole burden on the beneficiary. So, that's what I would be trying to weigh.

DR. MILLER: Mostly, you'd go after that through a transition and some mitigation of how --

DR. BAICKER: And then there's always going to be -- you do always want to build in -- some places just are more expensive overall. Rents are higher in New York than they are in rural areas. So, I don't think that it would

be literally equal, but I think that you would squeeze out the excess that's not attributable to broad cost-of-living and cost of doing business differences.

DR. MILLER: And unless I'm really missing something, I mean, we're talking about bidding that adjusts for health status and prices and that we're really down to talking to why are there ten MRIs here and only one here, right?

DR. CROSSON: Thank you, Kate.

So, we're moving down this way. Cori, you look pained --

MS. UCCELLO: I feel like I just should say something, but I don't --

[Laughter.]

MS. UCCELLO: I'm going to sign on with Kate's comments.

I think -- you know, we talk about, or I've talked about in my day job how important it is when people are choosing plans not to focus solely on the premium. And, so, we're, in a sense -- when we're moving in these directions, which I am supportive of broadly, we're focusing more on the premiums. And, so, just within these

kinds of structures, we just have to make sure that benes signing up understand that premiums aren't the only cost that they're going to be incurring, and in standardizing plans versus allowing variations in plans by the actuarial value, you know, at the end of the day, those still aren't going to tell any individual person what their spending is going to be. So, they're useful just in terms of general generosity to an average set of people, but for one particular person, two plans that have the exact same AV can impose severely different out-of-pocket costs to them.

So, I don't know where that fits into this, but just kind of something to keep in mind as we're thinking about these standardizations or not kinds of issues.

DR. MILLER: I'm sorry to keep interjecting, but what I was thinking about, because this started with Craig, and as we're going around the table in a couple of these comments, it's almost like -- just for the moment, let's say that five stars is the correct measurement system, just to use that as someplace to draw a bead, where you'd almost say -- and I'm sure I'm going to get this wrong -- you say to the beneficiary, you know, if you move to MA, there is a premium impact. But to Jon's point about plan

participation, you could say no plan can participate unless they have at least some minimal quality standard, so you're sort of trying to drive the decision in that sense, and that connects something to what Jon said.

But, also you could say, and your premium impact -- and this connects to something that Eric was laying out -- if you could tie the premium impact to other policy goals -- he mentioned Medigap, but perhaps it's quality in the sense you say -- here's your full premium impact if you go to a three-star plan. Here's your premium impact if you go to, you know, a five-star plan. And you try and signal to the beneficiary, you get a premium reduction -- or, I mean, you have to pay -- you get more -- I did it backwards. I knew I would.

You get a greater reduction in your premium if you go to a five-star plan than if you go to a three-star plan, so try and send some signal that way and have some mitigation on a quality benchmark. That assumes you have a measure, and I've left out networks and all the other things and --

DR. SAMITT: But, the problem is you'd also need to harmonize the comparison between fee-for-service, so --

DR. MILLER: [Off microphone.] And, I've got to tell you, and we've said that many times in this room and we're not there.

MS. UCCELLO: And I think the network issue is not just some throw-away. Oh, yeah, and the networks are different. That's a big deal --

DR. MILLER: [Off microphone.] Yeah. I agree.

MS. UCCELLO: And, so, it's just hard.

One short comment that I was going to make, but I think has been corrected, but I'm going to make it anyway. The second -- the MA only stuff. As we're going through this, I'm thinking, why don't we just lower the benchmarks in these high-cost areas? Aren't we going to get to the same result without all this other stuff going on? But I think I heard the answer is, this is not just the high-cost areas where you would have savings under this MA only bidding system. Is that right?

DR. HARRISON: That's true.

DR. CHRISTIANSON: Warner, you're next.

MR. THOMAS: So, just a couple of comments. I guess the first, I agree with Craig's comment that I think we need to look at the highest value, not necessarily just

the lowest cost, and I think Cori brings up a great point, that we cannot -- we really can't evaluate that across the different models because we just don't have consistent quality measures. So, I think whatever we do, that needs to be kind of paramount, as well.

The other comment I would make is I think it's important for us to understand, especially in the high-cost areas, why do people choose traditional Medicare versus MA, I mean, because in many cases, they're turning away -- it's a better financial incentive to actually be in MA versus traditional Medicare because they don't have the out-of-pocket costs. They more than likely have more benefits. So, there's something here.

I think what our experience has been is that people continue to go into traditional Medicare, one, because they're not price sensitive, and two, because they travel or want to be, you know, want to make sure they kind of have a broader area that they feel like they can use the services in a much broader area. Now, with a national, that would be a lot easier to do than with some of the regional MA plans.

So, I just -- I come back to, I'm not sure just a

financial incentive will do this, or maybe there is some tipping point on a financial incentive there. But, I think it's -- I think there's something more significant than just the financial piece that's driving the decision making in these other markets. So, I just lay that out as just another piece for consideration.

DR. CHRISTIANSON: Rita, do you want to speak on this topic?

DR. REDBERG: My only comment, and it really is just on Warner's, is I thought we had seen data previously that a lot of fee-for-service beneficiaries kind of default into the fee-for-service as opposed to actually actively choose it because they've looked at -- they made those decisions that they wanted to travel. And, that's why I think, particularly with the Secretary and the move to get away from fee-for-service for Medicare in the next few years, I think focusing on value could improve the program as well as make it more efficient, because, I mean, clearly, we can see from the different fee-for-service costs around the country, there's a lot of inefficiencies going on and I suspect very low-value care. So, I think moves that would at the same time increase efficiency and

increase value and eliminate sort of the waste in the program, which I'm hoping that these alternatives would do, would be great.

DR. SAMITT: Can I weigh in on that, as well, which is one of the things you haven't talked about in the report, and I would imagine it would be a subsequent step, is this notion of defaulting to fee-for-service. And, so, how does that factor into this? If we believe that, by market, there are higher value alternatives, should the auto assignment or the default methodology change so that if not actively selected, that a beneficiary would actually be assigned to the highest value alternative as opposed to fee-for-service?

DR. CHRISTIANSON: Warner, did you want to weigh in on something Rita said?

MR. THOMAS: Yeah. I think this concept of -- I mean, we all know when it's reenrollment period time that the MA plans are very aggressive from a marketing perspective, so I think they're trying to get the message across.

You know, perhaps, once again, going back to what Craig is saying, maybe the default should be different in

these markets. I mean, maybe the default should be MA versus traditional Medicare.

DR. CROSSON: Bill.

DR. HALL: This has been very informative. I hadn't expected these two hours to be as informative as they've turned out to be.

[Laughter.]

DR. HALL: I just want to say a word about I think the common theme around the table is that we're very much concerned about paying for quality. If you just take the people sitting at this table, we know that there are differences in quality that are not only regional, but are within -- largely within large regions, but are there in every single American community. Doctors pick their own doctors knowing with a great deal of insider knowledge. Hospital administrators have that same kind of knowledge.

But, I think one of our goals on this committee is to deal with the vast majority of Medicare recipients who are disadvantaged. In other words, we're saying to them, in some senses, you're entitled to pick poor care if you want to. That's your God given right. I don't think any of us would agree with that, but it kind of comes out

that way.

So, I think as we go into these discussions, of course, we have to be price sensitive, but I think we need to speak much more about pushing people into systems of care that are probably going to give them a higher quality. The quality measures are getting better. They're not perfect, of course.

So, any time we get into these discussions, yes, price is important, but I think we also have to remember that quality is even more important in the final analysis, and if it's good enough for us in making decisions, it should be for us to help individuals to pick according to quality.

So, I get a little nervous when we say we're going to see which is the cheapest system. I don't think we have to do that any more. I think things are moving very rapidly in the quality spectrum.

DR. CROSSON: David.

DR. NERENZ: Most general comment, I think this is moving in the right general direction, and I think we're on the right track in looking at these various options about pegging payment at a certain level and then letting

beneficiaries be more responsible for choices around that.

Kate expressed eloquently much of what I was thinking. I can't improve on that, so I'll just say I second that. Nicely done.

Just a couple of fine points. Many of the things we're talking about strike me as sort of most easily and most naturally right in places like Miami where it's very high fee-for-service cost, and we're talking about options that would encourage people either to move to something else that has distinctively lower cost -- and I'm going to get to value in just a second -- and then if you want to stay fee-for-service, you pay the difference. And, as Kate pointed out, you can calibrate that. You can weigh it. Okay. Then that part, on that side, it seems pretty good.

I think there's a little, slightly different issues on the other side -- the Rochester, Portland, that side. As a first thing, I like the policy symmetry, and I'm actually comfortable with the idea that it just flips the other way, that basically what Medicare would pay for in some of these models would be now a fee-for-service choice, and you would pay more if you want to be an MA.

But where I think that hits just a little bit of

policy wall is that what could happen, then, is that MA plans in those areas could go away. I mean, if people don't find extra value and choose them, they could go. So now we're left with a situation where in perhaps many of the low-cost fee-for-service areas, there just are not MA plans. Now, that's the quandary.

Personally, I'm okay with that, but I know there's another policy direction that says, well, there should be MA everywhere. You see this pop up in the annual update renewal time for MA, and I just think there may be two conflicting policy goals in that particular area. And you just have to wrestle with this question: Do we accept as a simple policy goal that there should be MA everywhere? And I don't see it myself.

Then, to Craig's point -- I guess Cori as well -- on the issue of value, I accept the idea. The concept is fine. The question I think, then, that we'd have to pursue is where, at what level of analysis and what level of beneficiary choice, are there meaningful differences in quality from which you could determine value. Are there meaningful differences at the product level, fee-for-service versus MA? Maybe. I don't know that I see it

clearly.

Are there meaningful differences at the plan level within MA? Maybe. We got star ratings, but, again, are those meaningful? Are those important? And then you just keep doing down. How about hospital? How about doctor?

I don't know the exact answer, but I think part of our discussion of this and to incorporate value into the discussion is going to have to be informed by at least whatever we can know on that point. And if we think there are truly meaningful quality differences all the way up to this big product level, then I think that has to be factored into how we talk about this.

If the meaningful differences are way down deeper, more fine grain, then I think we worry less about policy incentives that push people either into MA or fee-for-service because the important quality and value decisions are yet to come. They're within those.

MR. GRADISON: I think I'm picking up from Dave's point, which in part relates to the degree of national uniformity versus local variation.

When Medicare and Medicaid were created, one of

those grand compromises was struck where basically the idea was Medicaid would have great variation across the country, state by state, and Medicare was going to be a uniform.

But I've been struck over the years how much pulling and hauling there has been on that. I would suggest in Medicaid, there is somewhat of a drift towards national standards in certain respects, and in Medicare, I'd say the drift is actually in the other direction. And we've talked about a lot of those variations today. For example, some of these variations around the country in Medicare are tangible and somewhat immeasurable; for example, traditional fee-for-service versus MA plans, MA plans versus other MA plans. Networks obviously vary. The price varies. The benefits vary, which is not, in a sense, strictly exactly what people might have been thinking about in 1965.

Quality is the wildcard here, and we know it varies, but how to measure it on an ongoing basis is one of the great challenges of our time. Now, that may sound pretty abstract in terms of what we're talking about, and I'll try to be more specific as quickly as I can.

After listening to this discussion and the

previous discussions on the same subject, I can understand better than ever why new beneficiaries -- we've talked about this -- tend not to decide to go into MA right away. There's more of a movement, I believe, in year two than in year one, and there is a message there. This thing is hard to size up, and so as we consider choices, additional choices, in a sense, I think that it's just worth reflecting upon, not that they shouldn't happen, but what this all looks like from a beneficiary's point of view.

I'm tempted to make a point. I probably ought to because I've only got one more year here. I may go down, at least so far, on record as having been on Medicare more years than anyone who has served here before, a record which may go unchallenged for perfectly good reasons.

[Laughter.]

MR. GRADISON: But with regard to new beneficiaries, there is one element that we haven't discussed here, and frankly, I don't remember discussing it in any other context, so I'd just like to throw it into the mix for the future. And that is trying to, maybe more pointedly, think about the transition. There are lots of different ways people have health insurance before they

ever reach Medicare eligibility. Medicare is different for most of them. Does it have to be? Let me be more specific. The ACA sets up bronze through platinum plans. Is there some way in which there can be some kind of interrelationship between those plans and the Medicare benefit package for those who might say, "I kind of like what I'm under. I like my bronze, or I like my platinum," recognizing there are price differentials? Interestingly, people seem to be accepting the fact -- those who passed the law certainly did, and a lot of beneficiaries seem to be accepting the fact that there's significant price differentials, and you get more choice if you pay more and so forth and so forth.

So I would like a little bit more focus on that aspect, with particularly asking the question how does this issue, very important issue we're talking about, relate to choices that might be made by people who will be getting their benefits under the ACA.

DR. CROSSON: Okay.

MS. THOMPSON: No one has been more educated today than me, so I want to say thank you to all of you.

And from a state with very, very low MA

penetration, this is a fascinating discussion to listen to because we will have many, many Medicare beneficiaries, and this is complex stuff.

But I just want to restate a point that was made earlier. My 83-year-old mother, who pays more than I would care to even admit for her supplemental insurance through a very dominant commercial company in the State of Iowa, being very hesitant about moving to an MA plan, as these plans start to become available, but the one criteria she looks at is will she be able to go to her physician. And she'll pay what it takes to be able to see her provider. So I can't emphasize that patient-physician relationship enough.

DR. CROSSON: Scott.

MR. ARMSTRONG: So I just wanted to weigh in and acknowledge. I think this topic is profoundly important for MedPAC. I'm glad we spent a couple of hours on it, and I think it deserves many, many more hours going forward. In fact, I think this debate will be one of the key policy debates for the Medicare program in the next couple of years. Well, of course, I encourage future generations of MedPAC commissioners to take it on, and hopefully,

actually, you'll solve it before I'm a beneficiary.

Example No. 2, I think describes a future that we should find a way to make implementable. I won't repeat Kate's points, but I really agree with her comments, and there are issues in this, of course. And I think the balance between the beneficiary's responsibility to deal with high costs in certain markets versus the program has to be one of those issues that we reconcile, but we've solved those kinds of issues in a variety of other ways, and at the very least, managing the transition process is a key part of that.

Also, just to these points about value and quality, the spectacularly high costs in Miami, to me, alone are an indication of poor quality, and so I think it's an issue we have to take on. And I have never seen a better path described for how MedPAC through payment policy could begin to address some of the issues around that spectacular regional variation.

The last point I would make -- and this is in part because of the people I hang out with. When we talk, what Jack was mentioning, we are looking for a more pure way of price or value basis to -- I don't think that was me

-- on a price or value basis to offer comparisons to our beneficiaries, not only is it difficult for beneficiaries to really judge -- and that's complicated, but there are a lot of variables that you have to consider. It is a complicated comparison, and one point that hasn't been made but just needs to be put on the table is that comparing fee-for-service to the MA plans, we haven't acknowledged that we require MA plans' compliance with very complicated and very expensive regulatory requirements and quality reporting and a lot of other things that also at some point has to be folded into. If we are really trying to compare apples to apples, somewhere that has to be acknowledged.

DR. CROSSON: Kathy, on this?

MS. BUTO: Yeah. I just wanted to associate myself with Example 2. I think I would also like to see that fleshed out, including how to account for or take into account value and so on.

I am increasingly -- I am having trouble with the second bucket of MA-only options and whether -- to me, the downsides are it doesn't include fee-for-service. It could actually drive people back to fee-for-service, and it might reduce the helpful variation of extra benefits. So I'm

just trying to figure out -- I know there might be the benefits are a simplicity for the beneficiary and potentially savings, but it seems to me, the more savings you are able to actually get from that option, the more likely it is people will go back to fee-for-service. So I'm just not sure that's a good tradeoff.

So, again, for that whole bucket of things, I'm wondering if we want to put a huge amount of more time into it.

DR. CROSSON: Jon.

DR. CHRISTIANSON: I'm probably just extending or piling on maybe on Scott's comments too. But I'm glad from the recent comments here that we don't seem discouraged by the complexity here. I think that's one possible outcome we could come away from this and say, well, we just -- you know, it's just all too complex.

I think we've made a lot of progress in terms of setting prices for MA plans over the last decade or so. I think it's a lot better now than it was, and I think one of the advantages of keeping on in this track is that we want a system by which the MA plans eventually reveal through their bids, the cost of providing services plus a

reasonable profit. And that has enormous value to us and to the Medicare program to know for a given level of quality, what it actually costs to provide that care. And the closer we can get to that, I think -- I mean, we really accomplish something. So even moving marginally in that direction is an important thing for us to do.

So I guess my general point is I really think we need to keep working on this, and yes, it's complex, and it's probably going to get more complex, the more we get into it, but if we can make even marginal changes that move us to this world where the bids reveal to Medicare what the costs are of providing high-quality care to the Medicare population, which we don't know based on the fee-for-service system, I think that's a real value.

DR. CROSSON: Thank you. I had Rita next and Jack.

DR. REDBERG: I just wanted to sort of follow on the point of quality because, when we talk about quality, as Scott said, when you look at the high cost, you think it can't be good care. But I think a better way to measure that perhaps is -- right now, none of the quality measures that we use look at overuse. As we know, fee-for-service

is a system that encourages high-volume care and high-volume care of questionable quality because you get paid the same for an inappropriate procedure or operation as you do for one that was needed to life saving. And so I think we need to have measures that penalize overuse or that rate overuse so that overuse gets into quality because otherwise we never get at that in a fee-for-service system, and we know that a lot of the variation we see in the high costs are due to inappropriate and wasteful procedures that are harmful for our beneficiaries. No one is benefitting from something that they didn't need. If they're going to get no benefit, they only have downside to it. But right now, as I said, none of the quality measures reflect that. So, when we look at quality, we really have to have overuse measures and measures that you're not doing inappropriate procedures as well as the ones where we're trying to encourage things that are beneficial for our patients.

DR. MILLER: Just for a commercial, Jim, I think for April, we have another low -- or I mean --

DR. MATHEWS: Yes, that's correct.

DR. MILLER: Yeah. So I think, Rita, you're going to get another shot at that in the April meeting.

DR. CROSSON: Jack.

DR. HOADLEY: So I continue, I think, to have more qualms about some of these directions than many of the folks around the table. But I think I just wanted to reemphasize a couple of points about, so if we go in this kind of direction -- I think Craig at the very beginning highlighted things like network transparency, and it goes to Sue's comment about so many of the beneficiaries. The first thing they care about is maintaining their physicians. If we are moving into something that is more aggressively going to encourage enrollment into Medicare Advantage, we've got to make sure -- something that is very hard to do now is where are my doctors, what plans cover, including my doctors, under what conditions. We get into tiered networks and all kinds of things, where is it going to be, extra high copays and all those kinds of things, and sort of revisiting issues about what is the definition of "network adequacy." And I know that's challenging because an integrated system like Scott's looks at a network in a very different way than a traditional commercial plan that is trying to offer sort of a network. And we've seen so much of a trend towards narrow networks, which, again, an

integrated system, it's the core of how it works, but in a non-integrated system can mean much more constricted choice to beneficiary, so that's one thing.

Thinking a lot more on -- and, Scott, you alluded to this -- sort of beneficiary support mechanisms, if people are going to have a lot more consequences to their choices, we will probably need to do things like beef up resources for things like the SHIPs that can help people, one on one, figure out how to do it, so they're not just trying to look at all those letters they get in the mail and the advertisements on TV to pick a plan, but somebody who can actually help them find a plan that meets their needs. And a lot of that, it feels like from the research needs to be one-on-one sort of counseling kind of resources, and we don't provide a lot of help in that dimension, plus building up some of the tools. So the plan finder right now cannot help you match your providers. So, again, that goes to sort of that point.

Three, if we get into some of the questions of what's the default choice for a beneficiary when they first turn 65, how do you make that interact with the network issues? We're going to assign you to a plan that has none

of your doctors, and then you'll only figure that out when you show up to try to get your appointment. We've seen a lot of those issues in Medicaid, where they do have that kind of default enrollment.

And what about sort of the quality dimension? We may evolve to a system where there are low-bid plans who could then become a default choice, which are really low bid because they're low quality, and this sort of goes back to one of Jon's earlier points. Should we be thinking about a system that rejects some plans? In some cases, it might be on high cost. In some cases, it might be on low quality. Now it takes -- you've got to get really bad before you get kicked out of the program. We do suspend plans, and we've had some fairly large plans suspended from being able to enroll new members because they've had significant quality issues or noncompliance issues. But I think thinking about the intersection between are we starting to do some kind of default choice into Medicare Advantage and then what should be the criteria for that, but that also brings in this question of what are the minimum standards to be in the program. I think Jon's idea had some appeal that maybe we should be thinking about a

system where some plans just don't make it into the program.

So that's a set of things that I think are really very important to think about. Again, I still have some fundamental issues about sort of the fairness to the beneficiary of some of these directions we're talking about, but if we do go there, we need to make sure the mitigation factors we obviously did talk about in terms of just stalling the process or making the process on a more gradual glide path and that's all appropriate, but a bunch of these other things, I think need to be thought about very clearly to make sure either during that transition or as well as once that transition is over that the beneficiary is fully empowered to not end up in a bad spot.

DR. CROSSON: Okay. This has been a good discussion, great work in terms of setting it up for us with the models. At the risk of my own neck, I'm going to try to summarize what I think was the main points that I heard here, which would help create direction.

Number one -- and I think we heard this starting with Craig and from multiple people -- please don't make these considerations here, the choices, purely based on

price or premium levels or the amount of savings for the Medicare program or even for the beneficiaries on a financial basis, but make sure that the considerations include quality or value or issues with respect to access, for example.

I thought I also heard something a little bit similar perhaps, and that is that there should be a bias towards promoting care coordination or care management. I heard that a number of times. I'm not sure that that's synonymous with Medicare Advantage. I think it may be synonymous with certain types of Medicare Advantage programs, and so I think, you know, one consideration here that might be derivative from that is, as we apply this, think about, whether it's through quality measurement and management and rewards to quality or some other mechanisms, modeling payment mechanisms that may, in fact, do just that, which is to promote the development of the movement of patients towards organizations which do manage and coordinate care.

I think there was not a unanimous but a majority perspective that favored the first part of the presentation, that is, moving towards a model which

incorporates fee-for-service as opposed to the second set of ideas that were brought forward.

I think that within the examples provided in the first set of presentations, the most commonly referred to model I heard during the discussion was Example 2. I think I also heard Kate mention that as well as the question of, as I started out earlier, what do we want to do about flattening the regional differentiation, not a lot of support for moving to Model 3, but a general sense that perhaps in some way over time, perhaps over an extended period of time, we grapple with that issue, but that to do it in a relatively short period of time would be quite disruptive and potentially penalize individuals just based on where they happen to live -- although in the long run, I mean, I think from the perspective of equity for the Medicare program itself, this has to be dealt with. Whether it's dealt with through pressure on the beneficiaries or dealt with through other mechanisms, I think we can perhaps spend some more time on.

I think also the point -- Jack raised this, but others did as well -- that the direction we go in needs to include beneficiary protections, not just financial

protections but protections in other areas, which may be made more acute by the change in the financial models that we end up with. And I agree with that.

And, finally, I think Bill Gradison's point that, you know, we are in a different world today after the Affordable Care Act, and that there may be a place for giving some consideration -- I'm not sure exactly how that would work, but some consideration to the fact that at least a large number of our citizens are going to be receiving their care through the exchanges, through the Affordable Care Act, will get used to a certain type of benefit design, and that potentially there may be some considerations there that we need to give to how we move forward with these models.

So that's about as focused and comprehensive at the same time as I can get. What have I left out?

[No response.]

DR. CROSSON: Okay. Thank you. Wonderful discussion.

Now it's time to move to the public comment session. I would ask any individuals of our audience who would like to make comments to come to the microphone so we

can see who you are and how many we have.

[No response.]

DR. CROSSON: Seeing none, we are adjourned until April. Thank you so much.

[Whereupon, at 11:18 a.m., the meeting was adjourned.]