

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, April 7, 2016
9:49 a.m.

COMMISSIONERS PRESENT:

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P R O C E E D I N G S

[9:49 a.m.]

1
2
3 DR. CROSSON: Okay. Can we take our seats,
4 please? I do have a request from our recorder here. Maybe
5 the microphones are not quite as vital this morning as they
6 normally are, so I ask the Commissioners as well as the
7 presenters, keep the microphone near you and try to direct
8 your voice into it so she doesn't miss some of the things
9 that are said here.

10 Okay. So Carol Carter is back with us, and we
11 are going to be going over again the response -- our
12 mandated report on a unified PPS for post-acute care. At
13 the end of this discussion we will ask for support of the
14 Commissioners to forward this report to Congress as we are
15 required to do.

16 So, Carol, you have the microphone.

17 DR. CARTER: Great. Good morning, everyone.

18 The IMPACT Act of 2014 requires the Commission to
19 prepare a report considering the design of a prospective
20 payment system spanning the four post-acute care settings:
21 home health agencies, skilled nursing facilities, inpatient
22 rehabilitation facilities, and long-term-care hospitals.

1 Aware that similar patients were treated across
2 the four post-acute care settings yet Medicare pays very
3 different rates depending on the setting, the Congress
4 requested the Commission to prepare two reports. The first
5 (due at the end of June) must evaluate and recommend
6 features of a unified payment system to span the four
7 settings and, to the extent feasible, estimate the impacts
8 of moving to such a system. After the Secretary issues her
9 own report, most likely in 2022, the Commission must
10 propose a prototype design in a second report, most likely
11 due in 2023.

12 Just as a reminder, mostly for the audience, the
13 report is the culmination of a lot of work that you have
14 discussed at many meetings. Since last September, we've
15 reviewed the various pieces of the report, and you provided
16 feedback on what was presented and what else you would like
17 to see in the report. In March, we discussed the draft of
18 the entire report and how the different pieces fit
19 together.

20 The draft report has the sections listed here on
21 the slide. Based on your comments last month, several
22 revisions were made to the draft. Of note, Mary, you

1 thought a summary table would be helpful for the takeaway
2 points of the report, and we added that to the
3 introduction.

4 Susan, you asked about what policies have been
5 waived by CMS' bundling initiatives and ACOs, and so we
6 added that information.

7 Alice and Mary, you both noted that outcome
8 measures could be tracked over a longer period of time,
9 more than 30 days and that hospital admissions would be a
10 good measure for looking at patients without a prior
11 hospital stay, and so we included both of those sets of
12 information in the chapter.

13 Herb, you asked for more discussion of the
14 finding regarding IRFs and their low-income shares, and so
15 we expanded that discussion.

16 I'll briefly summarize our findings on each
17 topic. Our findings should be seen as guideposts, not as a
18 prescription, for CMS in its own design. We've identified
19 features that should be included in the design, those that
20 appear to not be needed, and a third set that needs more
21 work before deciding whether or not to include the feature.

22 First, the overarching design features. Our work

1 confirms that it is possible to design an accurate payment
2 system spanning the four settings that uses a common unit
3 of service and a common risk adjustment method based on
4 patient characteristics to establish payments. The design
5 should adjust payments to home health agencies to reflect
6 this setting's considerably lower costs, and given the
7 differences in benefits across the settings, the design
8 should separately establish payments for nontherapy
9 ancillary services (such as drugs) and payments for routine
10 and therapy services. The design should include two
11 outlier policies: one for unusually high-cost stays and
12 one for unusually short stays.

13 We did not find strong evidence for adjusters for
14 IRF teaching facilities or for either a broad rural
15 adjuster or for providers located in frontier areas. It
16 appears that a robust risk adjustment, especially in
17 combination with outlier policies, can predict the costs of
18 these stays.

19 That said, there are areas for the Secretary to
20 explore further: first, whether low-volume, isolated
21 providers need protection. Also, more work on the risk
22 adjustment for the highest acuity stays would help ensure

1 these patients' access to post-acute care and protect the
2 providers treating them so they are not disadvantaged by
3 the payment system.

4 Recall that we examined how well the model worked
5 for over 20 different clinical groups, and we also looked
6 at four different definitions of medically complex
7 patients. The model worked well for most of these groups,
8 including three of the medically complex definitions that
9 captured the vast majority of these patients, and the model
10 predicted the cost of these stays as well. The Secretary
11 should also examine the need for adjusters for providers
12 treating high shares of low-income beneficiaries. We did
13 not have the data to do this analysis across the four
14 settings.

15 Turning to the impacts of a unified payment
16 system, our estimates should be considered as directional
17 and relative rather than as point estimates.

18 We found that a unified payment system would
19 result in more uniform profitability across different types
20 of stays, and this would decrease the incentive to
21 selectively admit certain types of patients over others.
22 Payments would shift between different types of stays,

1 generally increasing payments for medical stays and
2 lowering payments for stays that receive physical
3 rehabilitation services that are unrelated to patients'
4 conditions. For example, we estimate that payments would
5 increase for patients on ventilators and for most medically
6 complex patients.

7 In general payments would be lowered for
8 providers with high costs that are unrelated to their
9 patient mix. A high-cost outlier policy would help align
10 payments to a provider's cost and a transition policy will
11 give high-cost providers time to lower their costs in line
12 with the new PAC PPS payments.

13 In implementing the payment system, the Secretary
14 will need to consider the level of payments. We estimated
15 that in 2013, payments were 19 percent higher than the
16 costs of the stays.

17 Another issue is how long the transition will be
18 from the current setting-specific payments to the new PAC
19 PPS payments. A transition could also contemplate moving
20 ahead earlier with a PAC PPS that uses only administrative
21 data and refine the payment system when patient assessment
22 data become available.

1 Finally, the Secretary will need the authority to
2 recalibrate and rebase payments over time so they continue
3 to be aligned with the costs of stays.

4 Because a PAC PPS would eliminate payment
5 differences across settings, Medicare should move away from
6 setting-specific regulation; this would give providers the
7 flexibility to offer a range of services across the PAC
8 continuum. We know that overhauling Medicare's conditions
9 of participation is a complex undertaking, so we outline a
10 possible near-term and long-term strategy. In the near
11 term, when the PPS is implemented, the Secretary should
12 evaluate whether and which regulations could be waived.
13 The report mentions some possibilities to consider, such as
14 the 60 percent rule and the intensive therapy requirements
15 for IRFs and the 25-day length of stay for LTCHs. In the
16 longer term, CMS could consider developing a core set of
17 regulatory requirements that all PAC providers would meet
18 and additional requirements for any provider opting to
19 treat patients with highly specialized care needs, such as
20 ventilator care. Requirements would, thus, shift away from
21 being setting-specific to being condition-specific.

22 A PAC PPS retains some of the undesirable

1 features of fee-for-service, so the Secretary should
2 implement companion policies to protect both beneficiaries
3 and the program. We want the policies to encourage care
4 coordination and high quality care for beneficiaries, and
5 at the same time, we don't want the program to incur
6 unnecessary spending. Companion policies could include a
7 readmission policy to promote high quality of care and
8 encourage good care coordination. A resource use measure,
9 such as a PAC Medicare spending per beneficiary, would
10 counter the incentive to generate unnecessary service
11 volume, such as serial PAC stays. Both policies could be
12 organized as part of value-based purchasing that includes
13 both quality and resource use measures. Other quality
14 measures could include the rate of discharge to community,
15 changes in function, and measures of care coordination.

16 It will be important for CMS to monitor provider
17 responses to the new payment system, including indicators
18 of quality of care, selective admissions, unnecessary
19 volume, and the adequacy of Medicare's payments. Measures
20 of each, using existing data, are discussed in the chapter.

21 Given the shortcomings of fee-for-service,
22 Medicare needs to move towards episode-based payments as

1 soon as feasible. Providers should be at risk for quality
2 and spending over an episode of care, thereby reducing the
3 need for companion policies aimed at dampening undesirable
4 provider responses to fee-for-service. Thus, a PAC PPS
5 should not be considered the endpoint but, by beginning to
6 align PAC providers' payments, represents a good first step
7 towards broader payment reforms.

8 The Commission's work on a unified PAC PPS and
9 related policies will continue past this June's report. As
10 you know, we're required to develop a prototype design
11 after the Secretary has proposed her own design. We will
12 also look for opportunities to integrate our findings into
13 our annual update discussions, examining changes that would
14 align policies more closely to the broad PAC agenda. And
15 we will continue to develop and track outcome and resource
16 use measures across the PAC settings.

17 And with that, I would like to turn the
18 discussion back to Jay.

19 DR. CROSSON: Thank you, Carol, for the
20 presentation, and thank you again for what is a
21 considerable and excellent piece of work that you have
22 brought forward over these last months.

1 We will now have the floor open for questions of
2 Carol.

3 MR. GRADISON: Let me join with you in
4 complimenting the staff on the quality and depth of this
5 excellent report.

6 The Secretary is supposed to make recommendations
7 regarding the collection and analysis of common patient
8 assessment information and report in 2022. That is six
9 years off. Do you have an opinion as to whether it could
10 be done in less than six years? I appreciate that's the
11 statutory requirement, but just--

12 DR. CARTER: Well, as we have indicated in the
13 chapter, it looks to us like the payment system for most of
14 the patient groups we looked at does pretty well in
15 predicting accurately the costs of stays. So one could
16 proceed sooner using administratively available data that's
17 already available now, and then refine a payment system
18 over time to include the functional assessment data. That
19 would improve the accuracy of the predictions, particularly
20 for certain groups of patients. But I think especially as
21 you think about a provider's book of business across all of
22 its patients and the averaging that is always implicit in a

1 payment system, it looked to us like you could move more
2 quickly using existing data.

3 MR. GRADISON: Thank you.

4 DR. CROSSON: Other clarifying questions?

5 MS. BUTO: Carol, would you say that that's true
6 even if the Secretary were to proceed to refine the
7 existing PPS systems that there still could be -- in other
8 words, does your statement apply only if they were to go
9 somewhat more immediately to a PAC PPS rather than to
10 refine the existing individual PPSs?

11 DR. CARTER: The recommendations that we've made
12 about refining the payment systems are completely
13 consistent with what we've scoped out here. So doing one
14 actually would facilitate the other, and I see they're
15 moving providers in exactly the same direction, which is
16 basing payments on patient characteristics and moving away
17 from therapy-based payments. I think both need to be done.
18 The payment system changes we made back in 2008 for the
19 SNFs, so that one's out there. It could be done pretty
20 quickly.

21 So I do think even in the interim you could move
22 forward with the refinements to the individual PPS payment

1 systems.

2 DR. COOMBS: Thank you so much, Carol. This was
3 superb.

4 I notice on page 64 the -- we talked about this,
5 about the whole notion of cost sharing for the beneficiary.
6 We're not making really any kind of recommendations to the
7 Secretary as to, you know, looking into the future as to
8 what might be a reasonable adjustment or reconciliation
9 between SNFs, the LTCHs, the IRFs.

10 Do you have any kind of idea going forward if
11 that was a question to come back at us?

12 DR. CARTER: So the short answer is we really
13 haven't done that work. I think when we did the benefit
14 redesign work a couple of years ago, we talked about having
15 more uniform cost sharing across the different types of
16 services being used. The post-acute care is a ripe
17 candidate for that because the cost sharing is different
18 across the settings, but we have not done the work to sort
19 of construct what one might look like.

20 DR. CROSSON: I see no further hands for
21 clarifying questions. So now we're going to engage in a
22 discussion about the content of the body of the report that

1 we'll be sending to Congress. We will be, as I mentioned
2 before, asking for consent at the end of this discussion,
3 and, Mary, I would like you, if you would, to begin the
4 discussion.

5 DR. NAYLOR: So over the course of many, many
6 months, I think we have started each of these reactions,
7 Carol, to the work that you and your team has done, in
8 collaboration with Urban and partners, with how
9 extraordinary it is. But I have to tell you, when I read
10 this version, I was just blown away by the comprehensive
11 and extraordinarily clear description of the design
12 features, the path forward, the implications. And I really
13 think in so many ways this is not just a model for the ways
14 in which the staff and Commissioners optimally interact,
15 but it is clearly a model for how it is that the Commission
16 and its work can go forward in strengthening changing the
17 fee-for-service system. So I just want to start with and I
18 will end with congratulating you. It's just really
19 beautiful, beautiful work.

20 Of course, you give me one more chance to offer a
21 couple of ideas, and knowing me, let me fully do that, and
22 I'll be brief. But on page 54, when you talk about

1 defining the stay, it really helps to raise the challenges,
2 the conundrum, when you're talking about how to do this in
3 an effort to try to build a PAC continuum of services, you
4 know, when you talk about institutional PAC, et cetera. So
5 if anything, I would just say how just that dimension
6 reflects a real need to move as quickly as possible to
7 episode, because we're just not going to be able to move
8 Mr. Smith from hospital to skilled nursing for as short a
9 time as necessary to home health in one and consider that a
10 PAC continuum of services until we do that.

11 On page 55, alternatively, CMS could require
12 physicians to attest that the continued PAC, so, look, I
13 have two more days here, physicians and other health
14 professionals --

15 [Laughter.]

16 DR. CARTER: I'm channeling you. I'm sorry

17 DR. NAYLOR: No, no, no. But I get that. But
18 the science here is pretty robust that other health
19 professionals can really make great decisions about the
20 kinds of PAC services, et cetera.

21 On page 59 -- and I really appreciate a response
22 to Bill's earlier question how this positions much more --

1 much quicker movement toward this benefit. But I would
2 also say that equally push the Secretary to move functional
3 status data in as early -- much earlier than suggested in
4 order to be able to get it.

5 And, finally, on the measures, just to remind, I
6 think that the readmission measure -- thank you for all of
7 this and for all of the ways in which you incorporated, but
8 readmission measures here can equally include readmission
9 to PAC as something we should pay attention to.

10 All of that said, just really extraordinary
11 blueprint, outstanding work, just a joy to be a part of it.
12 So thank you and congratulations.

13 DR. CROSSON: Thank you, Mary.

14 Let me see hands for comments. Let's start going
15 down this way.

16 MR. ARMSTRONG: So, Jay, I would just briefly
17 echo Mary's comments and acknowledge that here we are --
18 Mary and I and a few of the rest of us -- 6 years on
19 MedPAC, and we have been talking about this issue for a
20 long time. I am very proud to be associated with this and
21 look forward to endorsing it.

22 In particular, moving payment policy from paying

1 post-acute services for how they've been structured over
2 time instead of for how beneficiaries need to be cared for,
3 and really underlying this, this is a way to reinforce
4 through payment policy the fact that the Medicare program
5 can do a better job than it's been doing, particularly in
6 the post-acute area, of actually reducing unnecessary
7 costs, saving the program money, but doing it through a
8 system that is reinforced -- that is focused more on the
9 beneficiaries' individual care needs. Wherever we get the
10 opportunity to make changes like that, we're doing our best
11 work, and I think this is a great example of that. Thank
12 you.

13 DR. CROSSON: Kathy.

14 MS. BUTO: Carol, thank you for this work. It is
15 really stunningly put forward. Given I think the size of
16 this job, I think it's really amazing, and I hope we can
17 look for ways to accelerate the adoption of a single
18 approach to PAC PPS and an episode-based one.

19 I have two somewhat minor comments. One is on
20 page 60 at the top where you talk about over time CMS
21 should consider specifying regulatory requirements by
22 patient type rather than by PAC setting, and I understand

1 what you're getting at, the core set of requirements. I'm
2 just thinking to things like licensing facilities and how
3 difficult that would be if the requirements were really by
4 type of patient, and I'm just not sure how those two work
5 together. So it's just a question.

6 I think elsewhere in the paper, you really talk
7 about core requirements that would apply, and it would
8 allow for different kinds of patients and even suggest that
9 we might want to look at policies that -- facilities that
10 want to specialize in certain kinds of patient acuity would
11 be asked to meet. So I just question how that would work.

12 And then the second one -- and I think I
13 understand why you didn't try to take this one because I
14 think it's difficult -- is the three-day prior
15 hospitalization stay in SNFs; if you go to a core
16 requirement, how that's going to work. I understand that
17 when we've talked about obviously counting observation
18 days, but how if you remove that requirement, then it
19 becomes just an open-ended benefit. So I don't know if you
20 thought about that or how we might deal with that in a core
21 set, once you get to the longer term.

22 DR. CARTER: So we have thought about it just a

1 little bit to note that one could. I don't want to scare
2 anybody. There are 10 to 15 percent of IRF and LTAC
3 patients that don't have a prior hospital stay, so one
4 could think about having that as a uniform requirement and
5 then think about the Commission has already recommended
6 counting some observation time towards the three-day
7 requirement but requiring at least one -- to be one
8 inpatient day. So you could make the requirement more
9 uniform across the settings.

10 The other I noticed in the BPC waiver, the three-
11 day stay is still required for nursing home residents, and
12 if that's the population you're most concerned about in
13 terms of generating additional revenue for a facility by
14 requalifying patients for a Part A stay, you might be able
15 to use that policy lever a little bit to at least dampen
16 that concern. So we haven't thought through all of that.

17 MR. KUHN: Carol, I am going to join in the
18 chorus of others. Just terrific work. This is the fifth
19 meeting we've taken this up. We have tortured you along
20 the way, and you have come back each and every time with
21 just great information, so thank you for that.

22 I think in the past, we've described this report

1 as a set of guideposts to help inform the Secretary as she
2 moves forward to think about this, but as I looked at this
3 last iteration, I think it's more than a set of guideposts.
4 It really is a more thoughtful roadmap to get us there, and
5 I think that's a tribute to you and the team's work of
6 putting this together.

7 What I like particularly about it is that, as
8 you've kind of enumerated here as you went through your
9 slide deck, it looks at all these key issues, whether it's
10 implementation, whether it's regulatory changes, whether
11 it's impacts, just a variety of different things that
12 captures that. But what I like mostly about this report,
13 above all else, it continues to focus where I think the
14 Commission's work has always been about, is on the patient,
15 and to make sure that we really focus on the access,
16 ultimately the quality and the value of these services as
17 we go forward.

18 I know when I was at CMS, I was part of the team
19 that I think implemented the last PPS system in kind of the
20 post-acute care settings out there, and I think even back
21 in '06, we were talking about when we were going to be able
22 to move to a unified payment system. And I think Bill

1 captured it right when we think about is it going to be now
2 in the 2020s, so that's 15 years after we talked about it.

3 My only observation -- I think I've made this
4 before -- I'll probably be on Medicare by the time we get
5 to this, and I look forward to benefitting from this
6 program in the future.

7 DR. NERENZ: Let me also say great, great,
8 fabulous work. Thank you.

9 My question is like Kathy's, about the folks who
10 may enter into the system without having had a prior
11 hospital stay. You mentioned that may be part of the
12 regulatory change. You talk about that on page 61. Then
13 you talk about perhaps an admission measure linked to that.

14 My question is a little more technical. Are
15 stays like that in the data set from which all this
16 modeling was done, and are there any known differences or
17 suspected differences about that particular class of stays
18 that would require some additional special attention, lower
19 cost, higher cost, different stay length? Do we need a
20 little asterisk for those if they are going to happen in
21 the future?

22 DR. CARTER: So we did look specifically at stays

1 with a prior hospitalization compared with stays that were
2 community admitted, and the model was equally predictive of
3 both classes of patients.

4 DR. CROSSON: Let's finish this side. Warner.

5 MR. THOMAS: Just real briefly, given the
6 magnitude of work here, I think it is very, very good. I
7 guess the question I have is, what do you see as the
8 downside of accelerating the potential change here, and do
9 you see any downside to potentially trying to accelerate
10 the change in these policies?

11 DR. CARTER: So we know the kinds of patients
12 that the model does not do as good a job predicting. So if
13 you were a facility that had a disproportionate share of
14 those patients or if you were small -- and all the payment
15 systems always deal with averaging, and when you are small,
16 that's harder. So that would be the downside, is for
17 smaller providers or providers that specialize in the
18 absolutely highest acuity.

19 And I want to emphasize here, the group that this
20 model didn't do well for represented 3/100ths of a percent
21 of states. So they're way at the tail, and not
22 surprisingly, we couldn't predict the costs of a tail very

1 well. But if you looked at severity of illness, Level 4,
2 chronically critically ill patients, or patients that had
3 conditions that involved five or more body systems, the
4 model did very well for all of those. And so I'm saying
5 the highest acuity patients are maybe a group we need to
6 focus on, but medically complex patients in general were
7 not a hiccup, and so I don't see that as a particular
8 problem.

9 Size for small providers. I mean, a payment
10 system was always averaging, and so that could be an issue.

11 MR. THOMAS: And then on page 61, really the same
12 thing David brought up, on the regulatory changes, I mean,
13 I think there's a comment in here about there's a concern
14 if some of these regulatory reliefs are put in place that
15 it could escalate the cost of post-acute care. But I think
16 there is also a concern that if there's not a regulatory
17 relief, then the change is really going to be difficult to
18 implement. So any thoughts on that?

19 DR. CARTER: Well, we do think that if you're --
20 as a short-term strategy, when you implement the PAC PPS, I
21 think CMS needs to think about what regulations need to be
22 waived, not after, but at the same time. And then as a

1 longer term strategy, we are proposing this idea that we
2 don't license by setting. We license by do you want to
3 treat ventilator patients; this is the requirements to do
4 that. If you want to treat patients with serious wounds,
5 this is the capabilities you need to have, so moving
6 towards patient-defined requirements as opposed to setting-
7 defined requirements.

8 But when this payment system is implemented,
9 given the conditions of participation are unlikely to be
10 changed quickly -- that is a complex undertaking; we
11 appreciate that -- I do think it's important to waive
12 certain requirements.

13 MR. THOMAS: Okay. Jay, I just wonder, given the
14 issue, the duration of this implementation, should we have
15 comments in the chapter just around the idea that people
16 could opt into it or organizations could opt into it if
17 they were larger and maybe have less likelihood of being
18 negatively impacted, or is there a way to recommend kind of
19 quicker adoption? So it's just a general comment. Thank
20 you.

21 DR. CROSSON: Herb, do you want to comment on
22 that?

1 MR. KUHN: Yeah. Just on that, if I recall
2 right, when the ESRD PPS system went into place, there were
3 options for them to opt in early, and because CMS got it
4 right, they almost had 90 percent opt-in the first year as
5 part of that. So it's not unprecedented, what he was
6 talking about.

7 DR. CARTER: Yeah. I think the SNF PPS was like
8 that also.

9 DR. CROSSON: Yeah. I mean, I think, just
10 generically, you probably need to have some parts of the
11 regulatory relief set of issues in place in order for that
12 to happen, but were that the case, sure.

13 DR. MILLER: I've been trying to think about it,
14 and I think we said some of this to each other, Carol.

15 DR. CARTER: Uh-oh.

16 DR. MILLER: This is always awkward.

17 And it goes right to where the comment started
18 over with Bill and Kathy and comments that they've made and
19 others have made of is there a way to move along on this,
20 and I wanted to make sure that Carol held the floor. And
21 in responding, she said either you could change the system
22 in a way that we have recommended, which is more patient-

1 oriented, silo-by-silo, or begin to think about this thing,
2 to try and respond to an array of questions there.

3 To me, one of the next generations of this work
4 is for us to think about if the "it" can be built -- and we
5 have done a prototype. The Secretary has to do her version
6 of it. What you could almost begin to do is blend payment
7 between each of the individual settings and this thing and
8 say -- start to move a transition and say part of your
9 patient will be based on your current silo-based thing and
10 part of your payment will be based on this, which will help
11 the transition also begin to change the underlying
12 incentives more towards the patient-oriented. And then
13 when you had something like that -- and I really think this
14 responsibility thing is a difficult set of issues to work
15 through, but if you could get through that, then I think
16 you might be able to say -- and if you want to move faster
17 and go instead of '20, 2020 to something that's faster,
18 then maybe you'd be in a position to do that. And that's
19 the way I've been trying to think about our next generation
20 of work on this.

21 And I can't remember how much of this I mentioned
22 to you, Carol.

1 DR. CARTER: We've talked about it, yeah.

2 DR. MILLER: Say it again?

3 DR. CARTER: We've talked about kind of different
4 versions of the transition in thinking about that.

5 MR. THOMAS: Just an add-on to that, Mark -- and
6 that's why my concern is -- I mean, I think all of this
7 work is great. It's just if the regulatory relief doesn't
8 occur appropriately, then really all the other great ideas
9 are going to be extremely difficult to implement. I just
10 wonder if we need to be more pointed about our thoughts on
11 that specific issue, so --

12 DR. CARTER: The chapter does say these need to
13 be happening at the same time, but I'll look for places to
14 emphasize that.

15 DR. CROSSON: Okay. Moving over to this -- I'm
16 sorry. We are going to work down. So I've got Jon, Kate,
17 Bill Hall, Jack, and I saw Alice's hand, so let's go down
18 this way. Jon?

19 DR. CHRISTIANSON: Carol, remind me of how this
20 payment work will interact or be integrated with the work
21 to move more patients, more beneficiaries into ACOs and
22 other organizations like that.

1 DR. CARTER: I'm not sure I understand your
2 question, but let me give it a shot. So the ACOs use fee-
3 for-service as what's kind of that platform, and so having
4 more accurate payments across the different settings would
5 be built into the ACO benchmarks, if you will. Is that --

6 DR. CHRISTIANSON: I was impressed with all of
7 the complexity of what you're trying to do, and then I
8 really thought probably episode-based payment would be
9 where we would want to end up. I don't know where the rest
10 of the Commissioners are on that, but you've noted it a few
11 times in the paper and in your slides.

12 I guess this is a question for the Commissioners.
13 Do you think we should be more aggressive in terms of
14 advocating for that than we are now, or, Carol, do you
15 think that we're not there yet in terms of the data and
16 analysis?

17 DR. CARTER: Well, the Commission did a block of
18 work on episodes a few years ago, and we looked at an
19 episode that's PAC only, a PAC-only plus hospital stay,
20 long and short. So we've looked at that. I think the
21 Commission didn't come out -- I mean, we didn't come to any
22 recommendations about sort of which bundle type and

1 duration type it had a preference for.

2 I think if you used kind of fee-for-service
3 running -- one of the issues with bundled payment is who
4 gets the money, but if you pay providers as they go based
5 on fee-for-service with using some of the payments as sort
6 of a benchmark, you can sidestep, I think, some of the
7 issues about who's getting the money. We talked about that
8 as sort of virtual bundling, if you will, but that would be
9 maybe a conversation for the summer at the strategic
10 planning meeting about if we were to do another round of
11 bundling work, what would that look like.

12 DR. CROSSON: Okay. I think we've got Kate; is
13 that right? Yeah.

14 DR. BAICKER: Yeah. I'm very supportive of this
15 direction. I think it's moving us along a path that we all
16 would like to travel down, and the question is how quickly.
17 And one of the things that you've been helpful in surfacing
18 and that echoes something Mary said is that really, I think
19 ideally, we would want the payment structure to be based on
20 the efficient delivery of care in the right site of care
21 for that patient rather than the patterns of locations at
22 which patients are getting care now, but we don't yet have

1 the data we would need to do that more globally optimal
2 payment mechanism across sites. And so this moves us great
3 steps in that direction and also highlights the need for
4 greater data collection that can then be incorporated to
5 have a more tailored payment plan, not just to be site-
6 neutral, but to prefer the right site for the right
7 patient. And that's a great direction to be going in the
8 future.

9 DR. CROSSON: Bill Hall.

10 DR. HALL: Carol, I send you my congratulations
11 as well. When I was reading this over for -- I don't know
12 -- the nth time, this time, for another reason, I had to
13 look at the history of Medicare, and there' the famous
14 picture of Lyndon Johnson signing Medicare into being in
15 1965 and presenting to Harry Truman and Bess Truman,
16 Medicare Card No. 1 and Card No. 2. In that picture, Harry
17 Truman seems to have some hesitancy of signing, and the
18 reason is that Johnson explained to him. He said, "What's
19 this other part here? I understand the hospital part," and
20 Lyndon Johnson said, "Well, Harry, that's for health
21 insurance." "How much?" And the price was for him \$3 a
22 month, and for Bess, it was \$3 a month. They looked back

1 and forth at each other, and they weren't sure that they
2 really wanted that type of coverage.

3 I think that reflects kind of the paradigm we've
4 been in, in health care, with the inception of Medicare.
5 If you got sick, you went to the hospital, and you either
6 lived or you died. And you paid your doctor in any way you
7 could, sometimes with barter, sometimes with money.
8 Sometimes you didn't pay at all. And we're stuck with
9 that. Our vocabulary is still in the 1965 mode: post-
10 acute care, long-term care, intensive care. Everything is
11 presumed to start with somebody getting sick and going in
12 the hospital, and then what?

13 I mean, if anything we've learned on MedPAC is
14 that this is probably an old idea that has to change, as
15 several people have mentioned, as Kate just mentioned here.
16 And so I think this is what we're doing here, is actually
17 more than just looking at post-acute care. It's looking at
18 what is going to be the package of health care for this
19 burgeoning population of older adults, the 10,000 a day
20 that turn 65.

21 And as pointed out, I think there are some real
22 roadblocks and danger points along the way. I think the

1 biggest one is, what are the new metrics that we're going
2 to use? Mary mentioned the importance of function, and I
3 think that's going to have to really be pushed very, very
4 hard. Health care that is patient-centered has to be for
5 older people on what you can do, how you can stay
6 independent. It has very little relevance, in a way, to
7 the chronic disease models that we've looked at, and I
8 think this is a wonderful first step.

9 But I do think we're going to have to be very --
10 have a lot of surveillance here. This isn't going to be
11 easy. It's not going to be easy for systems to change this
12 rapidly, as has been mentioned here, but if we keep the
13 goal in mind that the purpose of health care -- who knew? -
14 - is to really help people stay independent, I think that's
15 one of the guideposts that we can use, and I think this is
16 going to be great work, great work for the future of our
17 enterprise here. Thank you.

18 DR. CROSSON: Thanks, Bill. I have that same
19 picture. As a matter of fact, it's the screensaver on my
20 laptop, believe it or not.

21 [Laughter.]

22 DR. CROSSON: A lot of that has to do with

1 technical incompetence, by the way.

2 [Laughter.]

3 SPEAKER: [Off microphone.] It's been there
4 since 1965.

5 DR. CROSSON: Yeah, right.

6 [Laughter.]

7 DR. CROSSON: Oh, no. That was unkind.

8 [Laughter.]

9 DR. MILLER: Wait a minute. You had a laptop --
10 [Laughter.]

11 DR. CROSSON: The only thing I would point out is
12 on the other side of the picture is Wilber Mills, and if I
13 can interpret the look on his face, it is, quick, sign it,
14 before I lose the political deal that I've just made.

15 Anyway, Alice.

16 DR. COOMBS: First of all, Carol, great job, and
17 although we've done this five times recently, we've
18 actually had little children of this coming together to
19 form the big one, and I think the first time I was on --
20 the first year, actually, on MedPAC, and we did the
21 presentation on LTCHs and we started talking about this
22 site neutral and we talked about strokes, and I think this

1 is a really good product to deal with what we called then
2 the stroke syndromes, because all strokes are not the same.
3 And, so, having something that's really tailored to the
4 condition and the resource utilization at the various sites
5 is really important.

6 That being said, I think one of the things is
7 that ICU doctor, me referring a patient to a certain
8 facility, it has a lot to do with the relationship that's
9 established and what kind of results we see from those
10 entities.

11 It's going to involve a culture change, as Bill
12 has said. It's not going to be something that's overnight.
13 But, it's a culture change that will result in industry
14 changes within the various institutions, and I think that's
15 actually good when one institution says, I'm going to
16 increase my breadth so that I can actually take care of
17 these type of patients, so we have to actually educate
18 ourselves.

19 And, it will be interesting to see the
20 transformation that will occur that actually will result in
21 better quality, I think, for all patients in all areas,
22 because you will have almost like a cross-training in a way

1 that diversifies the health care workforce within the
2 various different entities, whereas now they're pretty much
3 siloed into, no, we don't do vents. No, we don't do
4 wounds. We don't do dialysis. There might be some
5 transformation that happens that says, oh, yeah, now
6 they're taking vents and they're doing a pretty good job.
7 They're doing the wound vacs and, guess what, this one was
8 a diabetic, went in there and came out and did very well.

9 So, I think that there'll be a transformation.
10 I'm hoping there's a trickle-down effect that people will
11 begin to see the potential that they can have within their
12 institution. So, I'm really, really encouraged by that and
13 I'd like to say that this is something that I feel like the
14 others. Mary said it better than anything I could ever
15 say, which is that this is a good thing for patients in the
16 big picture and I think it's something that I'm proud to be
17 associated with as a Commissioner.

18 DR. CROSSON: Thanks, Alice.

19 DR. CARTER: Thinking in terms of one thing
20 Warner was talking about in terms of, you know, who -- what
21 kinds of providers would this be hard for, and what you're
22 saying made me realize, if you're small but you have the

1 flexibility to treat a broader range of patients, it sort
2 of counters, maybe, the problem of averaging, because right
3 now, you're only averaging within sort of the types of
4 cases you can treat sort of by your setting requirements,
5 whereas if those are relaxed, you can treat a broader range
6 of patients. So, even though you're small, you might -- it
7 would help, I think, with the averaging.

8 DR. CROSSON: Jack, I think the last word is
9 yours.

10 DR. HOADLEY: So, I'm not sure I have anything
11 really to add beyond sort of reiterating, first of all, the
12 excellence of this report and its clarity, and I think
13 we've used up most of the positive adjectives in going
14 around the table.

15 But, I hope that because it's so clearly written,
16 it will be very clear to our various audiences that changes
17 of the type that this report discusses are very much doable
18 and that they're very much urgent, and I think we've said
19 that very clearly, and I think it really does hit the right
20 points, and people have talked about these, that we have
21 set these guideposts, road map, different terms that people
22 have used, about feasibility and companion policies. We're

1 not recommending the details, as has been emphasized
2 numerous times, but we really have set out a feasible road
3 map that can be followed.

4 And, I think the second point that's been made
5 several times already is the urgency point and that there
6 are potentials, and we've identified these, for moving
7 forward more quickly. And, some of it, I think, you know,
8 Mark talked about sort of the blending. There's a lot of
9 precedence for that back years ago in the original Medicare
10 fee schedule and PPS systems were done -- started out
11 through blends of old systems with new systems. And, we
12 will have the opportunity in the next couple of years, as
13 we talk about our annual updates on the different sectors,
14 to potentially identify places where the principles that
15 we've laid out here, we can find ways to push towards
16 finding that starting point on the guidepath and sort of
17 thinking about all these issues that we've raised about the
18 companion policies and the right kinds of transitions and
19 things.

20 And, so, I think this really does create the
21 basis for those conversations to happen, and let's hope it
22 happens -- hope that it does happen, and hope that it does

1 happen as quickly as possible.

2 DR. CROSSON: Okay. Thank you to the
3 Commissioners for your comments. As you are aware, I think
4 you'll have as individuals one more chance to look at this.
5 We've had some suggestions for perhaps a few changes in
6 emphasis or additions in this discussion. We will be
7 getting the report to you, Jim, in some time --

8 DR. MATHEWS: This one can go very, very soon,
9 potentially as early as tomorrow afternoon.

10 DR. CROSSON: Okay, great. So, you'll be seeing
11 it in time to work on it early next week. If you have
12 additional changes, please get those off to Jim.

13 On the basis of that, I'd like to have an
14 informal show of hands for those Commissioners who are in
15 favor of forwarding this report to the Congress.

16 [Show of hands.]

17 DR. CROSSON: I see that as unanimous. Thank you
18 very much, and again, thank you, Carol, for this terrific
19 work.

20 [Pause.]

21 DR. CROSSON: I'm just waiting for the crowd to
22 settle a little bit here.

1 [Pause.]

2 DR. CROSSON: Okay. I think we can proceed.

3 We're going to move to the next agenda item, which involves
4 Medicare Part D and a series of recommendations, the
5 original version of which we reviewed at the March meeting.
6 We're going to see the final version today, and we will be
7 taking a vote on these three recommendations.

8 Rachel and Shinobu have done this work, excellent
9 work also, and they're going to start by presenting to us
10 now.

11 DR. SCHMIDT: Good morning. Today Shinobu and I
12 will walk you through draft recommendations aimed at
13 preparing Medicare Part D for the challenges ahead.
14 Policymakers consciously designed Part D to use a market-
15 based approach. Private plans deliver prescription drug
16 benefits to enrollees, and the plans negotiate with
17 pharmacies and drug manufacturers over prices. Medicare
18 subsidizes nearly 75 percent of the cost of basic benefits,
19 and Medicare shares insurance risk with the plans. There
20 are currently about 39 million enrollees in Part D and
21 about 30 percent receive Medicare's low-income subsidy,
22 which pays for most of their premiums and cost sharing.

1 Eleven years in, Part D has begun to face
2 challenges that require some restructuring. I'm not going
3 to go over all of the bullets on this slide because Shinobu
4 will pick up on some of them in a minute, but let me
5 address a few. Medicare's population is growing rapidly as
6 the baby boomers retire. Growth in program spending is
7 increasingly driven by enrollees who reach Part D's out-of-
8 pocket threshold. We refer to these as "high-cost
9 enrollees." When an enrollee reaches that threshold, under
10 Part D's current structure, Medicare starts paying for 80
11 percent of benefit costs through reinsurance. Since 2010,
12 the number of non-LIS high-cost enrollees has been growing
13 very fast, and so has their drug spending. Meanwhile, most
14 high-cost beneficiaries are LIS enrollees. About 70
15 percent of total Part D program spending is for the 30
16 percent of enrollees with the low-income subsidy. We've
17 seen substantial growth in prices for older drugs, and many
18 new drugs launched at "orphan drug" levels of prices. We
19 need to find a balance between beneficiary access to
20 appropriate medicines and financial sustainability for
21 taxpayers, but the factors on this slide make financial
22 sustainability an enormous challenge.

1 MS. SUZUKI: I'm going to walk you through three
2 parts of the first recommendation. They all relate to the
3 out-of-pocket threshold. The first piece has to do with
4 the amount of reinsurance protection Medicare provides to
5 plan sponsors. This is driven by a few observations.

6 For several years, we've been pointing to the
7 aggressive growth in open-ended reinsurance spending that
8 is unsustainable. It has grown by about 250 percent
9 between 2007 and 2014. Our report last June describes a
10 bidding incentive that pushes more spending into the
11 catastrophic portion of the benefit, where Medicare bears
12 the vast majority of the risk. This has resulted in
13 Medicare's subsidy that's above the 74.5 percent specified
14 in law.

15 Another observation is that although plans are on
16 the hook for 15 percent of spending, that amount may be
17 less than the rebates plans get on brand-name drugs, so
18 they may not have strong incentives to manage catastrophic
19 benefit spending.

20 Reducing Medicare's reinsurance from the current
21 80 percent to 20 percent addresses these issues by putting
22 greater pressure on plans to negotiate lower prices and

1 manage benefit spending. This would tend to lower costs.
2 But some plan sponsors, particularly the smaller ones, may
3 need to build in risk premiums or purchase private
4 reinsurance, and this would tend to raise costs. On net,
5 we expect this policy would produce a small savings to
6 taxpayers and to Part D enrollees, particularly when plans
7 are given more flexibility with their formularies.

8 The second piece relates to how manufacturer
9 discounts are treated for the purpose of determining when a
10 beneficiary reaches the out-of-pocket threshold. PPACA
11 gradually eliminates the coverage gap, and one part of that
12 includes having brand manufacturers provide a 50 percent
13 discount to non-LIS beneficiaries. That discount is
14 treated like beneficiary out-of-pocket, and this has a
15 significant implication for the program costs.

16 While we understand the goal, this leads to
17 inequitable treatment of brand and generic drugs and
18 reduces incentives for non-LIS beneficiaries to seek
19 generics when they are available. And with more high-cost
20 drugs and general growth in prices, when beneficiaries use
21 brand-name drugs, this policy moves more of them into the
22 cap, and that increases costs to the program and taxpayers.

1 In 2016, an enrollee using only brand-name drugs in the
2 coverage gap would reach the cap at about \$7000 in total
3 spending compared to about \$10,000 for an enrollee using
4 only generics in the coverage gap.

5 A remedy would be to no longer count the 50
6 percent discount toward the cap. In 2013, this policy
7 would have resulted in about half of the high-cost, non-LIS
8 beneficiaries no longer reaching the cap. Those
9 beneficiaries would pay more cost sharing, and
10 manufacturers would pay more in discounts. The other half
11 of beneficiaries would also see increases in cost sharing
12 and manufacturer discounts, but when combined with the
13 catastrophic protection that we'll talk about next, many
14 will come out with lower out-of-pocket spending overall.

15 This policy puts brand-name drugs on more parity
16 with generics. Without this change, the manufacturer
17 discount effectively works like a copay coupon. By filling
18 in the cost-sharing liability for the beneficiary, it
19 disconnects his or her choice from drug prices, and that
20 situation allows drug prices to be set higher without
21 facing backlash from patients. Because fewer non-LIS
22 enrollees would reach the cap under this policy, it results

1 in savings to taxpayers and to Part D enrollees.

2 The last piece would give "real" catastrophic
3 protection by eliminating the 5 percent cost sharing above
4 the cap. Currently, non-LIS beneficiaries have unlimited
5 liability for 5 percent of all spending even after they
6 reach the cap. This is concerning because of the expected
7 influx of new high-cost drugs and biologics coupled with
8 the general rise in prices. It is also concerning because
9 they are exposed to 5 percent of the full price since the
10 50 percent discount in the gap no longer applies, and 5
11 percent of an expensive drug or 5 percent of a lot of drugs
12 can be a substantial financial burden.

13 In 2013, a quarter of the high-cost, non-LIS
14 beneficiaries spent about \$2,600 in cost sharing above the
15 cap. That amount accounted for about 62 percent of their
16 total cost sharing because their drug costs above the cap
17 were very high -- about \$32,000 on average.

18 Adding a real catastrophic cap would protect all
19 beneficiaries from unlimited financial liability, and
20 because this makes the benefit more generous, this policy
21 would increase costs to taxpayers and to Part D enrollees.

22 With that, here is Draft Recommendation 1. It

1 reads:

2 The Congress should change Part D to:

3 Transition Medicare's individual reinsurance
4 subsidy from 80 percent to 20 percent, while maintaining
5 Medicare's overall 74.5 percent subsidy of basic benefits;

6 Exclude manufacturers' discounts in the coverage
7 gap from enrollees' true out-of-pocket spending; and

8 Eliminate enrollee cost sharing above the out-of-
9 pocket threshold.

10 CBO estimates that the combination of all three
11 recommendations would lead to a one-year savings of more
12 than \$2 billion and savings of more than \$10 billion over
13 five years. Separate estimates of each recommendation are
14 not available. Again, the CBO estimate is not just for the
15 recommendation I just described, but also include two
16 others we'll cover next.

17 Lower Medicare reinsurance would have offsetting
18 effects on plan costs and enrollee premiums. Some plan
19 sponsors may need to purchase private reinsurance which
20 would raise costs, but sponsors may also manage spending
21 more effectively and negotiate lower prices.

22 Changes to the "true out-of-pocket" treatment of

1 brand discount would result in higher cost sharing for all
2 high-cost, non-LIS enrollees. In 2013, roughly half of
3 those individuals would no longer reach the cap, and the
4 other half would reach the cap and receive catastrophic
5 protection. All non-LIS enrollees would benefit from more
6 complete insurance protection provided by the real
7 catastrophic cap.

8 The second draft recommendation relates to LIS
9 copays that are set in law. This is motivated by a few
10 observations.

11 Claims data suggests that generic use is lower
12 among LIS enrollees who incur high costs than for other
13 Part D enrollees, even in many common classes such as drugs
14 to treat high cholesterol and diabetes. In 2013, generic
15 use rates were 71 percent for the 17 to 18 percent of LIS
16 enrollees who had high spending, compared with 86 percent
17 for those who had lower spending. Some of that is for
18 clinical reasons, but some of it may also be their limited
19 financial incentives to use lower-cost drugs.

20 Use of brand-name drugs when generic substitutes
21 are available increases program costs because Medicare pays
22 for most of their cost-sharing, and it also increases the

1 number of people who reach the out-of-pocket threshold,
2 increasing the reinsurance costs for the program. A
3 concern going forward is that the current LIS copay
4 structure makes no distinction between biosimilars and
5 their reference products; they would pay the same brand
6 copay. Studies show that financial incentives do matter,
7 and a recent study by CMS confirmed that the effect is true
8 for both low-income and non-low-income individuals.

9 In 2012, the Commission recommended giving the
10 Secretary authority to change LIS copays to encourage the
11 use of generics. The idea is that cost sharing can be
12 lowered for generics and preferred drugs, coupled with
13 higher copays for nonpreferred drugs. We may want to also
14 encourage the use of biosimilars when it is clinically
15 appropriate. This may lead to lower prices for biologics
16 over time.

17 The key is to give the Secretary the authority to
18 apply this policy when it's clinically appropriate and at
19 copay levels that balance affordability with financial
20 incentives. And it would only be in classes where generic
21 substitutes are available.

22 This brings us to Draft Recommendation #2. It

1 reads:

2 The Congress should change Part D's low-income
3 subsidy to:

4 Modify copayments for Medicare beneficiaries with
5 incomes at or below 135 percent of poverty to encourage the
6 use of generic drugs, preferred multi-source drugs, or
7 biosimilars when available in selected therapeutic classes;

8 Direct the Secretary to reduce or eliminate cost
9 sharing for generic drugs, preferred multi-source drugs,
10 and biosimilars; and

11 Direct the Secretary to determine appropriate
12 therapeutic classifications for the purposes of
13 implementing this policy and review the therapeutic classes
14 at least every three years.

15 The budgetary effects of this recommendation is
16 part of the combined estimate, and a separate estimate is
17 not available. Greater use of generics could lower copays
18 for LIS enrollees, particularly if copays were reduced or
19 eliminated for generics. Enrollees who choose not to
20 switch to generics may pay higher copays for brand-name
21 drugs or might not be as adherent to treatment.

22 DR. SCHMIDT: If plan sponsors are going to bear

1 more risk than they do today, they also need greater
2 flexibility to manage benefits through their formularies.
3 Part D has more restrictions on formularies than what you
4 see in commercial plans. We're going to walk through ways
5 in which Medicare could allow more flexibility with
6 formulary tools, which could give plans more bargaining
7 leverage over drug prices.

8 Today, plans have to cover two distinct drugs in
9 each therapeutic class and all or substantially all drugs
10 in six protected classes. In 2014, CMS proposed removing
11 two classes from protected status -- antidepressants and
12 immunosuppressants for transplant rejection -- based on
13 objective criteria. However, the proposal was never
14 implemented. Both of those classes have a number of
15 generic drugs in them, and when generics are available,
16 commercial plans are more likely to offer several distinct
17 drugs on their formularies.

18 A second area for flexibility relates to when and
19 how a plan may change its formulary. Plans submit their
20 formularies to CMS in June before the start of a benefit
21 year, and CMS reviews the formulary to make sure it doesn't
22 discriminate against certain groups of beneficiaries.

1 While CMS wants plans to keep the formularies that they
2 used in their bids, there are situations that could warrant
3 a formulary change, such as if new clinical information
4 came out about a drug's effectiveness. There's a very
5 limited window of time for plans to make changes before the
6 start of the benefit year. We think it would be reasonable
7 to give plans more opportunity to make changes between June
8 and the start of the open enrollment period in October.
9 Midyear changes are when a plan wants to make a formulary
10 change during an ongoing benefit year. Plans can add to
11 their formulary without CMS' approval, but they have to
12 first get approval from CMS before making other changes,
13 and they must give affected beneficiaries 60 days' notice.

14 CMS says that it would generally approve
15 maintenance changes. An example is if a generic enters the
16 market and the plan would like to replace the brand-name
17 drug on its formulary with the generic. One flexibility
18 would be to allow plans to make maintenance changes, the
19 type CMS says it would normally approve, without first
20 obtaining CMS' approval. The plan would still have to give
21 notice to affected beneficiaries and to CMS, and the plan
22 would be subject to enforcement action if it didn't provide

1 sufficient coverage in a drug class.

2 Medicare beneficiaries are starting to use more
3 specialty drugs to treat certain conditions. Because of
4 their high prices, commercial plans use additional tools to
5 manage those medicines. Medicare could permit Part D plans
6 to use selected tools to manage specialty drugs so long as
7 plans maintained appropriate access to those medicines.
8 One example is split fills: dispensing a 15-day first fill
9 of a drug, and then thereafter regular 30-day supplies if
10 the patient does not discontinue treatment. A split fill
11 can reduce waste.

12 Another example involves using two specialty
13 tiers: a preferred one with lower cost sharing and a
14 nonpreferred one, so that the plan can encourage enrollees
15 to use lower-cost biologics. Some plans in the Federal
16 Employees Health Benefits program are doing this.

17 We also think it would be useful to lay out
18 clearer expectations about the clinical rigor that
19 prescribers should use when justifying a formulary
20 exception. Some plans believe that when enrollees appeal,
21 the plan's coverage decisions are reversed routinely, even
22 when the supporting justification is extremely general.

1 This tends to undermine plans' formulary management, and it
2 can affect plans' negotiating leverage with drug
3 manufacturers over prices. At the same time, we want to
4 try to reduce delays that beneficiaries face when they seek
5 an exception for a drug. A beneficiary might not need to
6 appeal if there was a clear supporting justification from
7 the prescriber. We think Part D could use a more
8 standardized approach toward prescriber justifications,
9 including the requested medication, the patient's
10 diagnosis, and the rationale for the exception. If this
11 process were standardized and more predictable to the
12 prescriber, it could limit the administrative burden and
13 ultimately reduce beneficiaries' delays in receiving
14 medications.

15 Part D plans are required to have exceptions and
16 appeals processes for enrollees to help ensure that
17 enrollees have access to appropriate medications, and we
18 know that all stakeholders are concerned about these
19 processes. We recognize that any recommended changes to
20 formulary tools need to be accompanied by steps to improve
21 Part D's exceptions and appeals processes. We've looked at
22 data in the past, and we've seen very low rates of rejected

1 claims and appeals. But we were unable to say whether
2 those findings were cause for concern. Sometimes claims
3 can be rejected for valid reasons, such as exceeding
4 quantity limits based on the FDA label. Sometimes the
5 beneficiary ultimately get an appropriate drug by finding
6 an alternative drug on the formulary. But low rates of
7 rejection and appeals are more of a concern if an enrollee
8 is discouraged from submitting an appeal. We believe there
9 is a need to streamline these processes and make them more
10 transparent.

11 CMS has run a small pilot with plan sponsors to
12 test different approaches at trying to resolve beneficiary
13 issues related to rejected claims at the point of sale.
14 The pilot had mixed results, and plans found the process to
15 be labor intensive. Beneficiary advocates would like
16 enrollees to be able to receive clearer information at the
17 pharmacy counter about why a drug was denied and what steps
18 the enrollee needs to take next.

19 Another longer-term approach is to provide more
20 information about plan formularies at the point of
21 prescribing to help avoid the need for exceptions and
22 appeals. Part D plans have to support electronic

1 prescribing, but e-prescribing is optional for physicians
2 and pharmacies, and electronic prior authorization is not
3 required.

4 Our third draft recommendation reads as follows:

5 The Secretary should change Part D to:

6 Remove antidepressants and immunosuppressants for
7 transplant rejection from the classes of clinical concern;
8 Streamline the process for formulary changes;
9 Require prescribers to provide standardized
10 supporting justifications with more clinical rigor when
11 applying for exceptions; and

12 Permit plan sponsors to use selected tools to
13 manage specialty drug benefits while maintaining
14 appropriate access to needed medications.

15 Again, CBO estimates that the combined effects of
16 all three of these draft recommendations would be to reduce
17 program spending by more than \$2 billion in one year and
18 more than \$10 billion over five years. This is a combined
19 estimate. We don't have separate estimates for the pieces.

20 Dropping the two classes from protected status
21 may, to the extent that enrollees use brand-name drugs,
22 allow plans to negotiate lower prices. In turn, this could

1 help constrain growth in enrollee premiums. Some
2 beneficiaries would need to switch medications, and those
3 who choose to not take the formulary drugs in those classes
4 would need to apply for formulary exceptions.

5 The other parts of Draft Recommendation 3 aim to
6 give Part D plans greater flexibility to manage their
7 formularies, but also improve the exceptions process so
8 that it becomes less burdensome for everyone. If plans are
9 able to manage the formularies more flexibly, it could
10 reduce costs and help to constrain enrollee premiums.
11 However, we recognize that some beneficiaries would need to
12 apply for formulary exceptions and appeals, and some
13 prescribers may find the transition to a more standardized
14 approach to providing supporting justifications as
15 burdensome.

16 Here is a summary of all of the draft
17 recommendations. The recommendations make an interrelated
18 package that's designed to improve Part D's market-based
19 approach for the challenges that lie ahead.

20 DR. CROSSON: Thank you. Rachel and Shinobu,
21 we'll take clarifying questions, starting over here with
22 Craig.

1 DR. SAMITT: So in Draft Recommendation No. 1,
2 all of the materials reference a reduction of Medicare
3 subsidy from 80 percent to 20 percent, and I wonder why we
4 don't reference it as plan sponsor increasing from 15
5 percent to 75 percent. And Jay and I talked about this.
6 It's not clear, especially with the 5 percent above
7 threshold beneficiary percentage. If that goes away, who
8 assumes that 5 percent?

9 So if we use language, 80 to 20, it implies that
10 5 percent shifts to plan sponsors? If we say plan sponsors
11 increase 15 to 75, it implies that that 5 percent shifts to
12 CMS. Can you clarify that?

13 DR. SCHIMDT: Yes. If you have the hard cap, we
14 are assuming that it would shift to the plan sponsors.

15 DR. SAMITT: Okay. Jay and I actually had a reverse
16 discussion, so I think it would be helpful to clarify. Is
17 that 5 percent out of pocket to plan sponsors, or is it to
18 CMS? I think I hear you saying plan sponsors, but I
19 thought Jay had specified CMS.

20 DR. SCHMIDT: If there were a hard cap in place,
21 that means the Part D benefit would become more generous,
22 and so the overall benefit, it still has the 74.5 percent

1 subsidy of the government, right? So that's Medicare's
2 contribution. That's still heavily subsidized. It's just
3 that the amount of spending above that out-of-pocket
4 threshold, now Medicare would be providing 20 percent to
5 reinsurance. The plan would have 80 percent insurance
6 responsibility for that spending.

7 DR. MILLER: The reason I think it might be a
8 little tricky is because to the extent that the cost of the
9 benefit is built into the subsidy that comes from the
10 government, 74-point-whatever percent, and then the
11 beneficiary's premium. Ultimately, the cost of the benefit
12 is paid from those two pots. So exactly who is sharing the
13 cost, depending on what perspective you take from it,
14 whether it's, all right, when you hit the cap, how is this
15 allocated versus what is the cost, where does the cost come
16 from in paying for the benefit, you can get slightly
17 different answers.

18 DR. CROSSON: Jack.

19 DR. HOADLEY: I just want to ask a couple of
20 clarifying questions where I think I know the answer, but I
21 just want to get a little more clearly on the record.

22 On the first recommendation -- and it's

1 specifically the point that came up on Slide A -- the
2 higher level copay for the biosimilars, is that due to the
3 way the statute today is worded as opposed to a policy that
4 CMS has set?

5 DR. SCHMIDT: I think that's correct, yes.

6 DR. HOADLEY: It's a statutory basis. So that's,
7 thus, the recommendation, incorporates making that change
8 to statute.

9 On Recommendation 3, the --

10 DR. SCHMIDT: Jack, actually we're --

11 DR. HOADLEY: Sorry.

12 MS. SUZUKI: We'll get back to you on exactly
13 where that comes from.

14 DR. HOADLEY: Okay.

15 MS. SUZUKI: It may be because of the language,
16 the definitions of multisource drugs, that's included in
17 the lower copay category, but we'll double-check.

18 DR. HOADLEY: Okay, thank you.

19 On Recommendation No. 3, on the second bullet of
20 that, is there any intent in the wording of this
21 recommendation to change the current standards that CMS
22 establishes for allowing formulary changes and particularly

1 the negative formulary changes, the non-maintenance ones,
2 or is it just a matter of the process that plans would go
3 through to request and get those changes approved?

4 DR. SCHMIDT: So we talked about -- we described
5 two varieties. One is for the upcoming benefit year, but
6 for the midyear changes. So that the change in process
7 that we're envisioning is that the plan would be able to go
8 ahead and, for example, if a generic comes out, put the
9 generic on its formulary, remove the brand without getting
10 CMS approval first. Currently, they're supposed to get CMS
11 approval. CMS says if they would generally approve those
12 situations, if they're silent about that for 30 days, they
13 could go ahead. So this is -- that's what we're
14 envisioning there.

15 DR. HOADLEY: Right. So it's things that
16 normally seem as would have approved but may not have done
17 so on a timely basis.

18 On the third bullet on this recommendation -- and
19 again, you talked some about this in the presentation, but
20 I'd just like to hear it again as a statement -- is there
21 any intent to make these exceptions harder to obtain, or is
22 it more about the process and the standardization?

1 DR. SCHMIDT: Yeah. I think the goal is to have
2 broader consistency across prescribers in terms of what
3 sort of clinical information they need to provide, so that
4 the process becomes easier for everyone, so that there is
5 less delay for the beneficiary in getting the medications.

6 DR. HOADLEY: And then on the last bullet on that
7 recommendation, I just want to get it again and say whether
8 the notion of this recommendation is to permit the specific
9 tools that you've talked about in your examples or it's
10 more about encouraging the Secretary to look for -- to add
11 to the arsenal of tools that would be available to plans.

12 DR. SCHMIDT: We would certainly hope that the
13 Secretary investigates these things. We did in particular
14 write about a couple of ideas, split fills and a couple of
15 specialty tiers, but we would expect that the Secretary
16 would investigate these first.

17 DR. HOADLEY: Right. Thank you. That's very
18 helpful. Thanks.

19 DR. CROSSON: Clarifying questions?

20 MS. BUTO: So, Rachel, I'm not sure I totally
21 got, in relation to Jack's question, are the midyear
22 changes for non-maintenance changes in the formulary -- are

1 we recommending that the plans have the flexibility to
2 proceed with those, or is there more of just a streamlined
3 process?

4 DR. SCHMIDT: We actually are silent as to the
5 non-maintenance changes. We have only spoken to
6 streamlining the approach for the maintenance changes.

7 MS. BUTO: Okay. Because I have a concern that
8 the non-maintenance changes could be one of those bait-and-
9 switch kinds of situations where the beneficiary actually
10 went to the trouble of looking at plan finder, finding
11 their drugs, and then something significant happens to take
12 some of those drugs off midyear. So that would be a
13 concern. At least for now, I think it's appropriate that
14 we're silent on that.

15 The second one is for the appeals process. I
16 have to believe that although we would like to see a
17 standardized approach, there would be likely more rigor
18 attached to the appeals. So I guess I'm thinking there
19 would be some reduction in appeals granted, but I think
20 that's, in a way, the purpose, which is to make sure that
21 they're appropriate, if I get that right. And do those
22 appeals approaches also apply to the midyear changes or

1 not? Is that not something that is subject to appeal?

2 DR. SCHMIDT: I think if there were a clinical
3 reason for -- and to take the example of replacing on a
4 formulary, the generic, a new generic that comes out and
5 removing the brand.

6 MS. BUTO: Right.

7 DR. SCHMIDT: If there were a clinical reason to
8 continue with the brand, yes, you could apply for it.

9 MS. BUTO: Okay. Thank you.

10 DR. CROSSON: Rita.

11 DR. REDBERG: Thank you.

12 On page 12 in the mailing materials, there was a
13 reference that the majority of Part D plans in the last
14 eight years are in substantially higher profits than they
15 had built into the plan bids. Do we have any understanding
16 of what was going on behind that?

17 MS. SUZUKI: So one of the things we wrote in the
18 June report last year is that plans receive two subsidies,
19 direct subsidy which covers the lower portion of the
20 benefit primarily, and then there is the reinsurance, which
21 is a cost-based reimbursement. And around the direct
22 subsidy, there is a risk corridor, which protects plans

1 from unusually large losses, but it's symmetric, so that
2 CMS recoups a portion of the payments that are higher than
3 what they had bid for. And the bid includes built-in
4 profits, but plans on average were getting money back,
5 paying CMS back for the extra profits they were making in
6 that direct subsidy portion of the benefit. So that's what
7 we've been observing for pretty much all of the years from
8 2007 through 2013, '14.

9 DR. REDBERG: In the aggregate.

10 MS. SUZUKI: In the aggregate.

11 DR. REDBERG: Maybe I need to work more on it
12 because that kind of relates just to my other question,
13 which was on page 15 on the mailing materials, which then
14 in that second paragraph, it says that the direct subsidy
15 payments on which sponsors bear the most insurance risk has
16 grown slowly, while the other, the benefit spending on
17 which sponsors bear no insurance risk, like the LIS cost
18 sharing, or the limited risk, catastrophic portion, has
19 grown much faster. And I was wondering what was behind
20 that.

21 DR. SCHMIDT: So that's just an observation from
22 looking at growth in program spending. So the pieces of

1 Draft Recommendation 1 related to the reinsurance and
2 changing, putting plans more at risk for some of the higher
3 spending, reflects our reaction to this past work that we
4 had done that we have written about in the June 2015
5 chapter.

6 So we've seen very flat average enrollee premiums
7 over time, especially in recent years in Part D, at the
8 same time that we've seen reinsurance spending growing
9 fairly dramatically, and so that's the genesis behind the
10 first piece of Draft Recommendation 1.

11 DR. MILLER: The three dots that I kind of
12 organize in my head is that if there are price increases
13 and more people becoming eligible, that's going to drive
14 more of your catastrophic cap.

15 The second thing -- and I thought this was her
16 first question, and I wasn't quite sure I followed the
17 exchange, and so I apologize. Based on that work you did
18 last year, we found the structuring of the bids that was
19 also pushing some of the expense into the catastrophic cap
20 and resulting in the government paying more than its fixed
21 percent in loss subsidy.

22 And then the third piece that pushes things into

1 the cap is the discount that we've been talking about, and
2 that accelerates it.

3 At least when I think about this, right before I
4 go to sleep each night, that's the three things that
5 motivated -- and I thought her first question was about the
6 structuring of the bid, but I may not have understood your
7 question.

8 DR. CROSSON: Scott.

9 MR. ARMSTRONG: So my question actually is kind
10 of in the same neighborhood, and I realize what I'm
11 thinking about and you've given a lot of attention to. So
12 how do these changes have an impact on different groups of
13 beneficiaries' out-of-pocket costs?

14 And the way in which these different component
15 parts come together, we know that for a beneficiary who
16 gets into the donut hole that then moves through the spend
17 and the donut hole, they're going to be spending on average
18 more than they otherwise would have under this proposal.
19 But then they get to the end of the donut hole, and they're
20 protected from that point forward, and so there's a smaller
21 number of beneficiaries who would have been paying much
22 more out of pocket if they had gone past that level in the

1 old -- before this proposal would be implemented.

2 But you've made an illusion to there's a third
3 out-of-pocket cost that we haven't really spent much time
4 talking about, and that's the premium that the beneficiary
5 would pay for the insurance to begin with. My
6 understanding, my sense is that, given these exchanges, you
7 would expect that there would be some upward pressure on
8 those premiums themselves, but we don't make any estimate
9 around, well, what kind of pressure would that be, and so
10 I'm just wondering, first, is my assumption right? Am I
11 thinking about that correctly? And then, second, do we
12 have a feel for what that upward pressure would look like?
13 Because that does become a new out-of-pocket cost for
14 beneficiaries who are rolling in the plan.

15 MS. SUZUKI: So the first 80 to 20 percent
16 reduction, that we think is a net reduction in benefit
17 cost. So on net, there would be a lower premium that
18 Medicare beneficiaries would pay from that provision.

19 The two others -- so the true out-of-pocket
20 provision, we said that it reduces the number of people who
21 reach the catastrophic phase, and that is on net a lower
22 cost for the Part D program. So that tends to reduce the

1 premium for the Part D enrollees.

2 The third one is making the benefit more
3 generous, that as to the cost of the program. When we look
4 at the 2013 claims data to see what the magnitude of change
5 would be, it was fairly small, but the two changes in the
6 premiums from the second and third parts of the
7 recommendation, they're about the same size in magnitude,
8 at least with the 2013 data. So on net, for those two
9 things, I think it's a wash.

10 There is the 80 to 20 percent reduction that we
11 still think is a net reduction in benefit cost that lowers
12 premiums.

13 DR. MILLER: Your whole exchange so far -- and
14 again, I want to be sure I'm following your question -- is
15 about the puts and takes of the first recommendation.
16 Across the three recommendations, the net impact is to
17 lower the cost of the program, which should -- did I miss
18 this? -- lower the cost of the premium.

19 So it depends that if your question was,
20 narrowly, tell me about the puts and takes of the first
21 recommendation, that's what she just answered. If you were
22 saying what's the net effect of these three

1 recommendations, it's to lower the cost of the program and
2 should take the premium down for the average beneficiary.

3 Am I correct on this?

4 MS. SUZUKI: Yes.

5 MR. ARMSTRONG: I was thinking just about the
6 first recommendation.

7 DR. MILLER: Okay. Then I apologize.

8 MR. ARMSTRONG: I have actuaries who I love but
9 rarely really fully understand --

10 [Laughter.]

11 MR. ARMSTRONG: -- telling me that the plan
12 responsibilities for above the catastrophic level will
13 create significant pressure to increase the premiums for
14 the insurance product itself. So what you're saying is,
15 well, not necessarily, and all I'm saying is it just might
16 be an area worth making sure we're really tight on.

17 MS. SUZUKI: One thing that I'll clarify is
18 reinsurance that government provides currently is in the
19 premiums now. Beneficiaries pay for that. The only
20 portion that they haven't paid for is the net payment that
21 Medicare makes at the end of a year because the estimated
22 reinsurance that plans submitted were lower than the

1 actual. So that's the part that's not in the premium
2 currently.

3 DR. MILLER: I'd like to say for the record, I
4 appreciate you getting that actuary shot in right before
5 the end of her last meeting.

6 [Laughter.]

7 DR. CROSSON: Of course, of course.

8 MS. UCCELLO: I'm going to butt in. Aside from
9 the character issue --

10 [Laughter.]

11 MS. UCCELLO: I just want to bring up the slight
12 -- I think the idea here is that in terms of net claims,
13 there's not going to be all that much difference with under
14 just the Recommendation No. 1. The one thing that might
15 just slightly put more upper pressure on would be if those
16 plans now have to increase their risk premium, purchase
17 their own reinsurance coverage on the side. So that I
18 don't think that's going to be -- the magnitude of that, I
19 don't anticipate would be huge. So on net, I think it's
20 going to be kind of close.

21 DR. CROSSON: Just to be clear, there is no anti-
22 actuary atmosphere here on this Commission.

1 MS. UCCELLO: Good.

2 [Laughter.]

3 DR. CROSSON: Further clarifying questions?

4 Warner.

5 MR. THOMAS: In Recommendation 3, with the
6 removal of the antidepressants and immunosuppressants, do
7 we have an idea of how many people that impacts? And as
8 we've thought about that, I mean, obviously you could -- as
9 Commissioner, you could be concerned about the impact on
10 beneficiaries, and I know you've done a lot of review and
11 study on this. So why do you feel comfortable with that
12 recommendation, and how many people do you see potentially
13 being impacted?

14 DR. SCHMIDT: So I guess our comfort comes from
15 CMS having done a review itself internally with its own
16 chief medical officer and pharmacist to review all of the
17 protected classes and looking at treatment guidelines that
18 are available and the degree to which those treatment
19 guidelines mention specific drugs versus subclasses of
20 drugs, and in these particular cases, that's the part of
21 the justification that they used to make the recommendation
22 that they did. Ultimately, it wasn't implemented, but that

1 was their position at the time.

2 In terms of numbers of people affected, the
3 immunosuppressants, I don't have an exact number, but it
4 would be very small.

5 For people who had their transplants paid for
6 under Medicare Part B, their drugs are going to be paid for
7 under Part B. There's going to be a small share of people
8 who are going to get them under D. So it will obviously
9 affect them.

10 I think about one in four Medicare beneficiaries
11 has taken an antidepressant according to a CMS study I saw.
12 So it's a large number of people. There are a large number
13 of generics available in that particular class. Again, the
14 treatment guidelines did not mention specific drugs so much
15 as subclasses of drugs, and when we took a look at some of
16 the commercial formularies available and looked at the
17 antidepressant classes, they tended to include several
18 different generics within subclasses.

19 DR. CROSSON: Just parenthetically, Warner, the
20 exception process, of course, is still in place for the
21 rare individual.

22 Alice.

1 DR. COOMBS: With the immunosuppressives, it's,
2 like, we just have a blanket immunosuppressive, but there's
3 subsets of the immunosuppressives, as Nancy pointed out
4 earlier. With the renal failure patients, if they have
5 transplantation, they may get the drug for a defined period
6 of time but may be on lifelong immunosuppressive therapy.
7 But, they lose their status as Medicare beneficiaries
8 because they no longer have end stage renal disease. They
9 are now with a functioning kidney. It might be to our
10 advantage to just look at how small that number is. It may
11 be infinitesimally small, but if it's a significant number,
12 it means a burden, a lifelong burden of having to be in a
13 high-risk drug class.

14 And, the appeals process is another way to
15 address that, but I'm not sure that, you know, the -- it
16 may be burdensome for this particular subset of patients.

17 DR. CROSSON: Okay. I think that is the end of
18 the clarifying questions.

19 So, how we're going to proceed here, as is our
20 custom when there are recommendations on the table, I will
21 start the discussion. We're going to have the discussion
22 focus on one recommendation at a time, and then we will

1 proceed to vote on that recommendation and then we will
2 discuss the second recommendation and then on into the
3 third.

4 So, the Chair is open to comments with respect to
5 recommendation number one. Let's go down this way, then.
6 Craig.

7 DR. SAMITT: Thanks, Jay. So, especially with
8 the clarification that the degree of shift of risk to the
9 plan sponsors is really increasing from 15 percent to 80
10 percent, I think it further underscores the importance, and
11 I know that the recent addition references language of
12 transition. What I'm concerned about is that we don't
13 specify more fully sort of the terms of that transition.
14 This is quite a dramatic change. In prior meetings, we
15 talked about sort of a ten percent transition over a six-
16 year period. I would advocate for us to be a bit more
17 specific because this is such a substantive reversal in
18 risk sharing.

19 And, I also think that it will be very important
20 over that transition period that we very carefully monitor
21 the impact of this, because I think one of the weaknesses
22 of this recommendation is we haven't really studied the

1 impact of this provision on plan sponsors and whether this
2 will significant impact premiums or beneficiary access.

3 And, so, I will reluctantly vote in favor of this
4 recommendation, but I'm not sure we fully understand the
5 impacts of what this global recommendation will do and most
6 certainly feel that we need to have a very careful
7 transition process so that we can measure it, monitor it,
8 and let it settle out appropriately over time.

9 DR. CROSSON: I think, without going back to the
10 text, I think in the discussion of the transition, we can
11 add some of that verbiage, careful monitoring, and make
12 sure that it's not a superficial proposal.

13 Kate.

14 DR. BAICKER: So, I think the package together
15 has some really nice features, and one of the things that I
16 think is important is ensuring that beneficiaries have
17 protection against catastrophic out-of-pocket exposure.
18 And, so, I think it's important not just to think about the
19 average change in spending per person, but think about
20 what's happening out in the tail of potentially very high
21 spending and how that protection is especially valuable
22 relative to changes in the middle of the distribution.

1 So, while I have some concerns about exposing
2 people in that doughnut hole to more out-of-pocket costs,
3 and in isolation, I'm not sure that I would support that,
4 in combination with providing the much greater financial
5 support at the high-spending end of the distribution, I
6 think the combination makes a lot of sense, and I think
7 that the reinsurance -- the reframing of the reinsurance is
8 supported by the data analysis you've done about the
9 predictability of the basket of expenses to the insurer
10 over time.

11

12 So, as a whole, I think that the package works
13 well, even though any individual component might raise some
14 more concerns.

15 DR. CROSSON: Cori.

16 MS. UCCELLO: So, I agree with Kate, and I'll
17 pick up on the second part of this recommendation. So, in
18 terms of the increasing the exposure on the beneficiaries,
19 I think what we need to keep in mind -- and the chapter
20 addresses this and frames it, I think, perfectly -- really
21 putting on a level playing field the generic treatment and
22 the brand name treatment, and the idea here isn't just to

1 simply increase out-of-pocket costs for beneficiaries, but
2 to use their money more effectively, more efficiently,
3 lower program costs. So, when possible, move more to
4 generics.

5 And then, also, providing more pressure on plans
6 and more encouragement for them to negotiate the price.
7 What was added to the chapter about the manufacturers'
8 coupons and how that kind of parallels this here, I think,
9 really kind of makes that more clear about how, as
10 currently structured, there's less incentive for those
11 negotiations, but taking that away would.

12 DR. CROSSON: I could not have said that better
13 if I were an actuary.

14 [Laughter.]

15 MS. UCCELLO: I'm not sure what I said.

16 [Laughter.]

17 MS. UCCELLO: And, on the reinsurance side -- I
18 say this every time, but I'm going to take one last chance
19 to say it -- this really does increase the pressure on the
20 risk adjustment program. You already mention it in the
21 chapter itself, but I just want to say it out loud. So,
22 that whole program needs to be recalibrated, and also,

1 especially because we're giving plans additional tools, we
2 also need to monitor how those are being used to make sure
3 that networks, pharmacy networks, formularies, and those
4 kinds of things don't discriminate against folks with
5 especially high costs that aren't perhaps totally adjusted
6 for through the risk adjustment program.

7 But, thank you. This whole -- I feel like we've
8 been working on some of these issues almost as long as some
9 of those PAC issues. I think it's come a long way. So,
10 thank you so much for your work.

11 DR. CROSSON: Jack.

12 DR. HOADLEY: So, I, too, want to thank the staff
13 for all this analytical work and working through this. And
14 actually, you reminded me that well before I joined the
15 Commission, we did an expert panel on the impact of the
16 reinsurance and the risk sharing provisions and that was
17 probably ten years ago. So, yeah, this has been an issue
18 that's been on the agenda of this Commission for a long
19 time.

20 I also want to thank Jay and Mark and the staff
21 for working through with me some of the potential options
22 and modifications, and I do appreciate a lot of the

1 improvements that we've seen in the chapter in this round.

2 On this recommendation, I still have, you know,
3 pretty serious problems with the second piece of this,
4 because I think we are passing along additional out-of-
5 pocket costs, potentially up to a thousand dollars, to a
6 set of beneficiaries, admittedly a small set, you know,
7 700,000 in total and maybe only half of that who will sort
8 of get net negative. But, those are people who are already
9 facing significant cost burdens, and I think it's
10 unfortunate to be adding out-of-pocket costs to this
11 particular small subset of people.

12 You know, you think about the fact that at the
13 catastrophic point of \$2,700 out-of-pocket, sort of the way
14 it plays out under the current rules, that represents more
15 than ten percent of the median income of a typical -- of a
16 median Medicare beneficiary. So, we are talking about some
17 pretty substantial dollars already incurred, and so people
18 up in this range, I think this is difficult.

19 The problem is, and I tried to think about
20 options for holding these beneficiaries harmless and talked
21 with folks about sort of options in that direction, and the
22 challenge is that we can't seem to come up with a way to do

1 that without increasing government costs and giving up some
2 of the dollars from the manufacturer discounts, and so it's
3 a net loss to do it, even though we would be protecting --
4 so, it right now feels like it would be viewed as too high
5 a cost to protect these people in this particular way.

6 I mean, I do share the notion that sort of doing
7 the counting the right way is a goal that we liked, and I
8 wish we could come up with a way, perhaps continue to look
9 for ways in the future to see whether there's a way to
10 avoid placing this additional burden on these beneficiaries
11 and that we monitor sort of the impact of this as time goes
12 by, because it is clear that, and you guys were very clear
13 about this, you're using the 2013 data, the most recently
14 available data that you have, but the dynamic changes that
15 are going to happen both from the continued phase-out of
16 the coverage gap and the behavioral response of
17 beneficiaries, plans, manufacturers, everybody to these
18 changes will mean that the numbers in the future will look
19 different. We just don't have a good way to tell how.
20 And, so, I do think it would be ideal if we could come up
21 with a way not to add this cost to the beneficiaries.

22 Having said that, I think that pieces one and

1 three of this -- the first and third bullets of this
2 recommendation -- are good ones. As I said, we've been
3 thinking about the reinsurance issue for a long time. I
4 completely agree with Cori that there are corresponding
5 changes in risk adjustment, and you do talk about that in
6 the chapter.

7 I also would point out, because it hasn't been
8 said out loud here today, that we are not proposing any
9 changes to the risk sharing, the risk corridors, and I
10 think we could even maybe make that point more clearly
11 right in that same context, and that continues to provide a
12 protection, both for the government, but also for plans
13 that face unexpected risk, and specifically the kinds of
14 things we saw with Hepatitis C, where a new drug came
15 online after some of the bidding was already thought
16 through, and that's going to happen again in the future at
17 some point, we can be pretty sure of that. So, we are
18 maintaining that system as another protection.

19 I will support this recommendation as the
20 collective package, because I think the net effect of the
21 three policies is a positive one. And I really do think
22 that removing the cost sharing after the catastrophic

1 threshold is going to make a big difference. There are
2 people up there -- you know, we talk about the averages,
3 but as Kate and others have talked about, there are people
4 up there at the tails of the distribution for whom the
5 costs are very, very high, and this is going to be a huge
6 benefit for people at that end.

7 So, yes, I will support this, but I do want to
8 continue to make the point about my concerns on the second
9 piece of it. So, thank you.

10 DR. CROSSON: So, I'm going to interject here for
11 a second. I think this Commission has had a compelling
12 interest, at least for the last two years since I rejoined
13 the Commission, in addressing the cost of pharmaceuticals.
14 It's a public interest. It's also an interest of this
15 Commission. And the concern is, of course, not just with
16 the current costs, but the costs coming down the line with
17 the introduction of new pharmaceuticals, and the net impact
18 of that over a period of years, both on beneficiaries'
19 costs, direct and indirect, and also on the long-term
20 sustainability of the Medicare program.

21 In this session and with this set of
22 recommendations, we are addressing one part of this, the

1 Medicare Part D prescription drug benefit. In other work,
2 which is continuing, we'll be addressing issues with
3 respect to Part B.

4 In both cases, however, these deliberations and
5 the evolution of recommendations have been a good deal more
6 complex than other judgments that we traditionally make
7 here about how Medicare pays for care services, because in
8 the other cases, other than pharmaceuticals, Medicare is
9 the direct pay -- price setter and direct payer. In the
10 case of pharmaceuticals, both in Part B and Part D,
11 Medicare pays indirectly and is not directly involved in
12 setting the prices, for the most part.

13 So, in order to address successfully changes in
14 Part B and Part D, we have much more complicated work to
15 do, and today, in the case of Part D, it involves very
16 complex relationships, in this case, between plans and
17 beneficiaries. And there's no way to escape that.

18 I think that, in sum -- and others have said this
19 -- not just with respect to recommendation number one,
20 which we're addressing now, but the entire package of
21 recommendations, we have -- the staff has constructed and
22 we have helped construct a pretty well balanced set

1 together of recommendations that take into consideration
2 the interests of beneficiaries, the interests of the long-
3 term sustainability of the program, and the long-term --
4 and also the viability of plans.

5 Now, having said all that, the one area I think,
6 and we've heard it expressed already, of concern about the
7 recommendations is the potential impact on beneficiaries
8 within the coverage gap, particularly beneficiaries who are
9 not LIS beneficiaries, but, as Jack maintained, of low
10 income and potentially vulnerable, particularly financially
11 vulnerable.

12 As Jack said, we did explore -- I explored with
13 him some potential solutions to that. It happened that
14 those solutions were rather costly and undermined our
15 mission to protect the long-term viability of the Medicare
16 program.

17 Having said that, I think that there is a valid
18 issue here and I think as we finalize the text supporting
19 this recommendation, I'm going to suggest that we include
20 language to suggest that, assuming that the net, the sum of
21 all our recommendations ends up saving money for the
22 Medicare program, that Congress consider methods to protect

1 this subset of beneficiaries within the coverage gap.

2 Okay. So, we're comments on this side. We'll go
3 up this way. Bill.

4 MR. GRADISON: I'm really picking up on your
5 comment. My understanding is that these are -- not only
6 are these three a package, but the three recommendations
7 are a package, and I'm concerned a little bit about how we
8 can present that. It's easy for people on the outside, and
9 perfectly understandable if they say, well, I like A, but
10 not B and C. Fine. And, maybe what I'm going to suggest
11 is already contemplated, but I would hope that the actual
12 report doesn't say recommendation one, two, and three. It
13 says, here are recommendations, and put them on a single
14 list, which I think will tend to emphasize the idea that
15 it's a package.

16 DR. CROSSON: Do you want to comment on that?

17 DR. MILLER: I don't know about the one, two,
18 three, and what we typically do off the top of my head.
19 But, the notion of saying that we've thought about this as
20 a collective set of actions, I have no problem emphasizing
21 that. It was thought about that way. I mean,
22 recommendation three, you know, I don't know why it's

1 number three, but it's very much because we're asking the
2 plans to take more risk in recommendation one. So, the
3 notion of the connection between these things, I don't have
4 a problem with at all. The actual literal layout in the
5 report, I'll talk to Jim about.

6 DR. CROSSON: Kathy, and then Scott.

7 MS. BUTO: Yes. I would just echo Craig's
8 comment about the reinsurance subsidy transition and trying
9 to be a little more explicit about, even though we may not
10 want to put a number on the number of years transition, I
11 think it is important, because it is a fairly big change
12 that requires plans to either get additional reinsurance or
13 make other adjustments that are fairly complex, and the
14 program they need, I think as Cori mentioned, to do some
15 further work on risk adjustment. So, it just seems to me
16 that taking this step-wise would be a good idea.

17 Like Jack, I have real issues with the second
18 bullet, and what I'm thinking is this, that the additional
19 out-of-pocket cost to the beneficiary, which on average is
20 \$1,000, but, of course, there's a range, as Shinobu has
21 pointed out, that that additional cost will lead some
22 beneficiaries to switch to generics, and that's a very good

1 thing, assuming that they get the same benefit. Some will
2 not be able to switch. And I think that there's a third
3 category of individuals who may not be able to switch and
4 who can't afford it, in which -- and, of course, Medigap
5 does not cover copays in this coverage gap. And, so, they
6 may actually have been in that group that would have
7 reached the catastrophic cap, but won't because they can't
8 afford the medications and so, therefore, won't comply with
9 their medication regimen.

10 And, there really isn't -- as I thought about
11 this in terms of appeals, there's really no appeal to that,
12 because you're essentially saying, I can't afford the
13 medicine. Now, maybe -- I think Jay has suggested there
14 may be a way to devote savings in some way to mitigating
15 the impact on those beneficiaries. But, it's just
16 something I think either that, first, it would be good to
17 mitigate the impact. I don't know how we would
18 discriminate, but in some way trying to address the issue
19 of affordability, because the original intent of the 50
20 percent discount was to reduce the beneficiary out-of-
21 pocket by 50 percent. So, what's happening now is it's not
22 reduced. It's just spread out over a longer period of time

1 and their out-of-pocket will essentially be what it was
2 before the 50 percent manufacturer discount.

3 So, the other thing I'd like to see us mention is
4 monitoring access as part of this change, that if there are
5 changes, adverse impacts, there be some way that that's --
6 the plans or the program tries to get a handle on if this
7 is having an adverse impact on access.

8 DR. CROSSON: Thank you.

9 DR. HOADLEY: Follow up on that, just quickly?

10 DR. CROSSON: Sorry. Jack, on this point?

11 DR. HOADLEY: Yes. I mean, there is an empirical
12 literature that I've contributed to that looked at the
13 original coverage gap and the impact on people stopping
14 their medications. So there's something that we could cite
15 to sort of back up that point, I think.

16 DR. REDBERG: I want to also commend Rachel and
17 Shinobu for this chapter, which is a very interesting and
18 complex area, but very important to the Medicare program
19 because I think we've all agreed that we're clearly facing
20 higher drug prices, higher program costs, and
21 sustainability of the program. Particularly, we know since
22 2009 more than half of the FDA's approvals for new drugs

1 are specialty drugs, and those are very expensive drugs.
2 So I think -- and this trend will continue and become a
3 huge pressure on the program, and so I think we have to
4 think about this in the long term and not just sort of the
5 short term, because in the long term, you know, can we
6 continue the sustainability of the program and providing
7 our beneficiaries what they need?

8 And so I think the package is a really important
9 step towards moving there. On its face, the idea of 50
10 percent brand-name discounts counting as spending that they
11 didn't spend doesn't make a lot of sense, and it does
12 encourage high prices and it encourages brand names,
13 neither of which we're trying to do. We're trying to
14 discourage high prices, encourage lower prices, and
15 encourage generics. So it does make sense to me not to
16 continue that.

17 My hope is that there will be less beneficiaries
18 getting into that coverage gap, because if we are
19 successful in, you know, driving a little pressure on drug
20 prices, which there seems to be very little right now, less
21 beneficiaries would get to that coverage gap, and,
22 therefore, I would hope that they're protected more in that

1 way.

2 And my concern, I would say, isn't -- I'm
3 concerned about access, but I think what we need to be
4 really monitoring is outcomes, because also there's a lot
5 in this chapter, and I commend it on polypharmacy and
6 adherence. But, you know, right now more than three-
7 quarters of Part D beneficiaries are on two or more drugs a
8 month. That's a lot of drugs for a lot of people. And I
9 think we just want to be sure that that's really in their
10 interests, and so we really need to be looking at health
11 outcomes, not just adherence and access, and we want to be
12 sure. So I would hope what we're tracking is actual things
13 that matter to beneficiaries is how are they feeling, are
14 they living longer, things like that, in addition to other
15 things we're tracking.

16 DR. CROSSON: Thank you.

17 MR. ARMSTRONG: So just a couple of brief points.

18 First, I just want to generally affirm that I
19 think it's great work, and I'm thrilled that the Commission
20 is advancing this topic. It's overdue, and we're obviously
21 not the only ones paying attention to this right now. But
22 that's just affirming how important this agenda is. It's

1 messy. Just the complexity of these proposals we're
2 talking about, you know, makes that pretty clear. And yet
3 -- and some things that we will promote will get
4 implemented and will work well. Some things we advance
5 will get implemented and will not work so well. But at
6 least we're advancing ideas, and I'm just thrilled that we
7 are doing that.

8 I want to just piggyback on a couple of points
9 around -- you know, building off my question earlier on the
10 impact on premiums, I like this idea of being a little more
11 explicit about the need for some kind of transition
12 process, though I don't -- I wouldn't delay it. I mean, I
13 would exercise a lot of impatience about moving this
14 forward, but just a little more clarity around what that
15 process would look like I think is a good idea.

16 Bill made this point: We're talking about Draft
17 Recommendation 1, but to me 1, 2, and 3 have to be part of
18 a package deal, particularly some of the tools in part 3
19 are how you make some of these recommendations in number 1
20 kind of work and make sense. And I thought Rita's point
21 particularly around what are we doing to keep people from
22 ever even hitting the coverage gap and how can we do a

1 better job of that is really, I think, an important
2 question to put on the table.

3 And, last, in our comments there has been a lot
4 of concern expressed about the increased out-of-pocket
5 costs for those beneficiaries who get into the coverage gap
6 and who move into it and potentially all the way through
7 it. And I think that is a downside from our beneficiaries'
8 perspective to this package of proposals. But I would just
9 say I'm not that concerned about it. I mean, I would just
10 invite us to put it into perspective and to acknowledge
11 first this is an incredible benefit. I mean, this is an
12 incredible benefit. And, second, relative to the out-of-
13 pocket costs beneficiaries pay in other parts of the
14 Medicare program, whether it's hospital services or
15 premiums for Medicare Advantage benefits or anywhere else,
16 let's remember this isn't the only place where they're
17 incurring costs. It's part of an insurance program. It's
18 part of how it works in our country. And so I think we
19 should be aware of it, sensitive to it, but it's kind of
20 the way the program works, and so let's keep in context.
21 And even comparing Medicare to all the other insurance
22 products in our country, this is still a really excellent

1 benefit on average.

2 So I like the sensitivity and the acknowledgment
3 that we ought to attend to this, but I'd keep it in
4 perspective.

5 MS. UCCELLO: Just quickly, I want to address
6 this transition issue. I know that people are for
7 including more explicit language about a transition, but I
8 just want to caution us before -- you know, I'm fine with
9 it, but I think we also need to consider whether there are
10 any downsides to drawing out a transition, and I can think
11 of a couple, and one of them would be that now this risk
12 adjustment model every year has to really be redone as the
13 plans are taking on greater liability. So you've got some
14 complications there.

15 Also, in terms of plans -- and Scott and Craig
16 are going to know more about this than I do, but as plans
17 are taking on more liability, is it really better for them
18 to take it on gradually and then kind of gradually have to
19 address these issues of, well, can they handle that
20 themselves? Do they need to get their own reinsurance
21 privately outside the system? What kinds of things go into
22 that? I don't think it's cut and dried that it's necessary

1 better to lengthen the time of this rather than to get it
2 all over with it once. Just something to think about.

3 DR. BAICKER: Cori's point about the importance
4 of the risk adjustment rising as you go to this different
5 model is, you know, really important, I think, and it
6 highlights another thing that we might want to be sure to
7 keep an eye on during the transition or the adoption of
8 some of these provisions, and that's the protected classes.
9 We haven't talked much about -- we've talked a lot about
10 concern that beneficiaries have access to the right drugs
11 for them in those circumstances. We haven't talked as much
12 about the implication for cream skimming. You know, part
13 of the concern for the protected classes is that you can
14 try to avoid enrolling particularly expensive beneficiaries
15 by having a stingy formulary in that area, and that's
16 another reason to have protected classes. And we haven't
17 talked much about the implications for that, and that's
18 something that I think the evidence you've presented
19 suggests that that should be not a first-order problem, but
20 that it's something I would want to have in the mix for
21 continuing to keep a close eye on, and also harkens back to
22 the risk adjustment that it's particularly important that

1 the risk adjusters capture the expected costs of those
2 beneficiaries or the removal of the protected class could
3 lead to further cream skimming.

4 DR. CROSSON: I think we are going to add -- if
5 I'm wrong, correct me -- language about monitoring with
6 respect to the protected classes.

7 Seeing no further hands, we will proceed to vote
8 on Recommendation 1. It is before you. I won't read it
9 over again. All Commissioners in favor of Recommendation
10 1, please raise your hand?

11 [Show of hands.]

12 DR. CROSSON: All opposed?

13 [No response.]

14 DR. CROSSON: Abstentions?

15 [No response.]

16 DR. CROSSON: The recommendation passes
17 unanimously.

18 We'll proceed to a discussion of Recommendation
19 2, if we could put that up on the screen. Comments on
20 Recommendation 2, starting here with Craig.

21 DR. SAMITT: So, likewise, I am similarly
22 supportive of this recommendation, and, again,

1 congratulations on the wonderful work with the whole
2 chapter.

3 The two perspectives that I would bring about
4 this recommendation relate to the notion of preferred
5 pharmacies and the relation -- and the notion of our
6 silence regarding brand drugs in the second subcomponent of
7 the recommendation. So let me take them in turn.

8 If I recall correctly from our prior work, we
9 suggested that some of the dramatic increases in drug costs
10 in the LIS population were both due to excessive brand use
11 plus -- but also due to excessive use of nonpreferred
12 pharmacies. And so my observation is it feels as if there
13 is an opportunity here, since we're talking about a
14 differential cost sharing for generic versus brand, that we
15 also develop a mechanism here for us to have differential
16 cost sharing for preferred versus nonpreferred pharmacies.
17 And I recognize the fact that we have some concerns about
18 access or geographic limitation to preferred pharmacies,
19 but I would love to see the data that highlights where we
20 actually have access gaps with preferred pharmacies, or at
21 least what we could offer is the recommendation that
22 there's differential cost sharing in markets where there

1 are adequate network access to preferred pharmacies with
2 exceptions applied to areas where there are not. So it
3 feels to me like we're missing a golden opportunity to
4 influence costs by not including some reference to
5 preferred pharmacy versus nonpreferred.

6 The second sub-recommendation talks about
7 reducing or eliminating cost sharing for generic drugs, but
8 it doesn't talk about increasing cost sharing for brand
9 drugs. And so don't we believe that this would be a more
10 impactful recommendation if we actually do both?

11 So, again, I'm favor of the recommendation, but
12 would propose those two modifications to the recommendation
13 to make it stronger.

14 DR. CROSSON: So, Craig, you're proposing that we
15 alter the recommendation, each of these recommendations?
16 Bullet points. I'm sorry.

17 DR. SAMITT: Or at least the Commission consider
18 that, yes.

19 DR. CROSSON: Okay. Let me take the first part.

20 With respect to preferred pharmacies, I think you
21 raised the point, which is probably the reason that it's
22 not in the recommendation, and that is that at this point

1 we don't have -- we don't feel, Rachel and Shinobu as well
2 as the Commission in reflecting on our conversations at
3 least at the last meeting, we don't have confidence that we
4 know the impact of requiring the use of preferred
5 pharmacies on perhaps the most vulnerable beneficiaries.
6 And I think you acknowledge that.

7 So my sense of that -- and I think I would agree
8 with the intent of what you said, which is that that is a
9 reasonable thing for us to pursue. I'm not sure, though,
10 given the fact that we generally feel we don't have enough
11 data, that I would suggest altering the recommendation
12 today with respect to that point.

13 With respect to the second point, the
14 recommendation is to direct the Secretary to reduce or
15 eliminate cost sharing for generic drugs. If you go into
16 the text, however, that supports the recommendation, it
17 refers substantially to the CBO report, which referenced
18 the potential for the Secretary to do both, as you said.
19 And I think the sense we've had here is that the Secretary,
20 irrespective of what we say in this recommendation, the
21 Secretary, you know, armed with that information from the
22 CBO, she will make the best judgment that she can at the

1 time as to what course to take. But we have not included
2 it in the recommendation. We have included it in the text.
3 And it is, you know, customary for the Commission to do
4 that given the level of certainty and, quite frankly,
5 support for certain phraseology. And that's my answer.

6 But if you would like to change the language of
7 one of these bullet points, we'll take time. Write down
8 the change that you would like to see, and we will vote on
9 it.

10 Okay. Other -- Jack?

11 DR. HOADLEY: So I do support the recommendation.
12 In doing so, I want to point out that, you know, to me the
13 key part of this recommendation is encouraging the use of
14 generics and adding biosimilars which, regardless of
15 whether -- to my earlier question, whether it's
16 specifically statutory or whether it's a more complicated
17 interpretation of the policy, I suppose the term
18 "biosimilar" would not have been in the statute since it
19 hadn't been in use at that time, but that they do appear to
20 require the higher-level copay and they were not specified
21 in our previous 2012 recommendation on the subject. So I
22 think adding that consideration, I think that's going to be

1 an important issue going forward.

2 In contrast to Craig's comment, I like the fact
3 that we focus the recommendation language on the reduced or
4 zero cost sharing for the generics and don't specify the
5 higher cost sharing for brands. I recognize that that may
6 be the inevitable way this policy proceeds. I actually
7 think we would -- my preference would be to focus on
8 lowering -- eliminating the barriers, in fact, going to
9 zero for the generic copay, and I think that's -- you know,
10 the point of this is really sending a signal to
11 beneficiaries that these generics are something that they
12 should be using and figuring out what the best way to send
13 that signal possible and doing it more on the positive side
14 than on the negative side, but, you know, recognize that
15 other policies may pursue.

16 We also specify -- and I think it's significant -
17 - that the revised cost sharing may need to vary by
18 therapeutic class, and this, of course, does anticipate
19 potential for the higher cost sharing for brands, and if
20 so, we would do that only where there are real generic
21 alternatives, because I think that's -- you know, if we
22 simply raise the copay in the class that's solely brands,

1 then we're really just raising costs for low-income
2 beneficiaries that we're otherwise trying to protect, and
3 that those decisions -- and that's the third piece of this
4 -- you know, need to be reviewed regularly because
5 available drugs do change. And so what may work today may
6 not work tomorrow, and so the notion of every three years,
7 or at least every three years, is a good direction to go.

8 To the other issue that Craig raised on the
9 nonpreferred pharmacies, I think, you know, I made points
10 on this at the last meeting. I think the real concern to
11 me is that in all the analysis that CMS has done on
12 geographic access -- and they have found that there are
13 gaps for some plans in geographic access to the preferred
14 pharmacies, I don't think CMS has sort of gone what I would
15 consider the next step with regard to the LIS population,
16 which is are there specific -- they've looked at it broadly
17 as a time and distance kind of standard across the
18 population, and I think one of the concerns I have is that
19 for this low-income population who may be clustered in
20 certain geographic areas with limited availability to
21 pharmacies and individuals who have limited transportation
22 availability, that we may be in a situation where in some

1 of these communities the only pharmacies available to serve
2 them are the independent pharmacies. In almost all cases
3 where plans have adopted preferred pharmacy networks,
4 they're operating with a particular chain of pharmacies.
5 And so they may be -- and I don't absolutely know this is
6 empirically true, but my impression is that in many of the
7 sort of low-income neighborhoods, it's not the CVS or the
8 Wal-Mart or the Walgreens that's in that neighborhood.
9 It's the smaller independent pharmacy that's been serving
10 that neighborhood for a long time. So I think to look at -
11 - before we would ever consider moving forward, I really
12 want to get some sense of those kinds of issues, and I have
13 serious concerns about sort of the access problems that
14 could arise in that. So I hope we don't, at least in this
15 round, go further in that direction.

16 DR. CROSSON: Comments on Recommendation 2?

17 DR. REDBERG: I support the recommendations.

18 Just on the question of access, you know, I think mail
19 order is certainly available to all neighborhoods and is a
20 very convenient way to fill, and I believe preferred
21 pharmacies all mostly have mail-in options. So if we were
22 concerned about access, I would concentrate on the

1 availability of filling prescriptions by mail.

2 The other comment I wanted to make -- and I was
3 trying to find it in the chapter, but was just on
4 biosimilars, a little out of our jurisdiction, but it is of
5 concern to me that there's a great delay in approval of
6 biosimilars. There's, I guess maybe today -- and a second
7 one was finally approved, but until now, only one has been
8 approved, and the delay is way longer than a year. I mean,
9 this was an issue when I worked back on this in 2004. We
10 were looking at -- it seems like it's been a very long time
11 in coming. Clearly, lots of specialty drugs are very
12 expensive, are increasingly being approved, and with this
13 long delay at the FDA for approving biosimilars, it's
14 certainly going to have an impact on CMS costs. And so I
15 guess FDA needs more staffing in the biosimilar approval
16 area, but that is of concern. But I'd support the
17 recommendations.

18 DR. HOADLEY: And I would just add that the FDA
19 still doesn't have standards on interchangeability, which
20 will be an important component in acceptance of some of
21 these biosimilars and how they interact in plan design.

22 DR. CROSSON: Mary.

1 DR. NAYLOR: So I support the recommendation as
2 it is, and I think the issues that Greg raised are really
3 very much worthy of further consideration, but I don't
4 feel, especially given Jack's comments, that we have the
5 evidence available right now to really think about -- there
6 is a real robust evidence in the chapter about the value of
7 eliminating or reducing cost sharing as a tool, and we
8 don't have the parallel data about the adjustments in
9 brand. So I would be concerned moving on that now and
10 equally thinking about the issues around the low-income
11 group and the impact of preferred pharmacy and adjustments
12 without knowing what those specific implications might be
13 related to access.

14 So I support the recommendations as is and think
15 that these other issues are worthy of further
16 consideration.

17 DR. CROSSON: Seeing no more comments, I think
18 what we'll do here is proceed with the amendment that Craig
19 has rendered.

20 I do want to point out one thing before we do
21 that, which I think maybe we should have emphasized but
22 didn't, and that is that this recommendation breaks down

1 into three bullet points, of course. The first bullet
2 point directs the Congress to make changes. The second two
3 provide advice to the Secretary, assuming that the Congress
4 goes ahead and changes the LIS copayment structure.

5 The language we use in the direction to the
6 Congress is broader and would potentially cover -- could
7 cover, depending on how Congress chooses to act -- the
8 concern you have.

9 So I think before we vote on the recommendation
10 as a whole, I am going to read the suggested amendment by
11 complete substitution. That reads: Direct the Secretary
12 to reduce or eliminate cost sharing for generic drugs,
13 preferred multisource drugs, and biosimilars, and maintain
14 or increase cost sharing for brand drugs.

15 Is that clear to everyone? We don't have the
16 time to reject it. Kathy, would you like me to read it
17 again?

18 MS. BUTO: No, no. I'm just trying to figure out
19 how you direct the Secretary to maintain or increase. I
20 mean, you're either directing to maintain -- because direct
21 implies you're telling the Secretary that she has to do
22 something, but you're saying essentially keep things the

1 same or raise them.

2 DR. BAICKER: It's the same as saying don't lower
3 them.

4 DR. NAYLOR: Yeah. I was just wondering about
5 the "maintain" because it sounds like that is what will
6 happen. I mean, the Secretary will do what the Secretary
7 wants, but that's what will happen.

8 DR. SAMITT: Yeah. And I think the purpose here
9 was to include language to offer the option. Since the
10 language is included in the chapter, that opportunity would
11 exist to increase brand drugs, cost sharing, that that be
12 made explicit within the recommendation that this was an
13 option that the Secretary could consider as well, so we can
14 strike "maintain."

15 MS. BUTO: So maybe the Secretary could consider
16 --

17 DR. SAMITT: Right.

18 MS. BUTO: -- something like that.

19 DR. CROSSON: Okay. Second-order amendment,
20 strike "maintain"?

21 [No response.]

22 DR. CROSSON: All right. So let me read it

1 again.

2 Somebody -- did I hear a voice?

3 DR. BAICKER: I just want to make sure I
4 understand the process.

5 DR. CROSSON: Yes.

6 DR. BAICKER: You're going to read the amendment,
7 and then are we going to vote on the amendment first, or
8 are we --

9 DR. CROSSON: Yes.

10 DR. BAICKER: And then if we vote no on the
11 amendment, then we vote on the original?

12 DR. CROSSON: That's correct.

13 DR. BAICKER: Okay.

14 DR. CROSSON: Sorry. I should have been
15 specific. We're going to vote the amendment first, and
16 then either that gets incorporated into the draft
17 recommendation or it doesn't. And then, either way, we
18 vote the recommendation. Everybody clear?

19 I'll read it again: Direct the Secretary to
20 reduce or eliminate cost sharing for generic drugs,
21 preferred multisource drugs, and biosimilars, and increase
22 cost sharing for brand drugs.

1 Everyone clear on that?

2 MS. BUTO: I'm sorry, Jay.

3 DR. CROSSON: That's okay.

4 MS. BUTO: We're directing the Secretary to
5 increase cost sharing for brand drugs? That's the
6 amendment? Okay.

7 DR. CROSSON: That's the proposal.

8 MS. BUTO: That's the whole proposal, or that's
9 the amendment?

10 DR. CROSSON: This is an amendment by
11 substitution means that we replace the one that's there
12 with this, okay?

13 MS. BUTO: Got it.

14 DR. CROSSON: Everybody clear? David. No? Yes?

15 DR. NERENZ: Clear. I was just going to comment.

16 DR. CROSSON: Okay, go ahead.

17 DR. NERENZ: Well, now that it's clear, now it's
18 very strong, and now I'm concerned about it because it
19 allows no exceptions, and it doesn't have any nuance. And
20 it makes a very blunt statement that I think as written
21 that way would probably be interpreted more broadly than we
22 intend or perhaps than the chapter indicated. So now it's

1 clear, but now it's very powerful.

2 DR. CROSSON: And here is a parenthetical by the
3 Commission Chairman. This is why we don't do this, except
4 in important circumstances. All right, okay. Because
5 amendments on the fly are often tricky to understand like
6 that.

7 DR. SAMITT: Well, Jay, let me ask you: How do
8 we memorialize kind of the language in the chapter so that
9 -- so maybe the language needs to be "consider increasing"
10 as opposed to definitively increase, just so that it's a
11 reminder in the recommendation.

12

13 DR. CROSSON: But, Craig, that is exactly what
14 the chapter says.

15 DR. SAMITT: Okay.

16 DR. CROSSON: Consider increasing. Is that
17 right? That's right. No, wait a minute. It's consider --
18 let's take a look. Sorry. The word "consider" is in
19 there. I don't think the word "increasing" is in there.
20 Let's look at how we worded it.

21 MS. BUTO: Jay, is there an objection to creating
22 another bullet that just says "the Secretary should

1 consider whether to increase the copay," instead of lumping
2 it together with all this direction? I think that takes a
3 little of the --

4 DR. CROSSON: Right.

5 DR. SAMITT: I don't want to belabor this. I
6 mean, if you feel that it's sufficiently covered in the
7 chapter, I don't want to wordsmith.

8 DR. CROSSON: Well, wait, wait, wait. Let's
9 check. what page?

10 DR. BAICKER: What page are we on?

11 DR. CROSSON: We're looking here. I know we
12 inserted "consider" in here as we were working this
13 through. Where are we? Here it is.

14 DR. MILLER: The recommendation would have the
15 Secretary -- page 49. Is that right?

16 DR. CROSSON: Yeah.

17 DR. MILLER: Is this the language?

18 DR. CROSSON: All right. Here is how we worded
19 it in the text, and this was a modification from March:
20 The recommendation would have the Secretary consider
21 moderately increasing financial incentives for LIS
22 enrollees to use lower cost medicines, et cetera, generic

1 drugs, et cetera. So it can be read whichever way you'd
2 like to read it.

3 DR. SAMITT: Again, I don't want to belabor it,
4 but certainly the language regarding just reducing copays
5 for generics would sufficiently constitute essentially that
6 language. I certainly don't want to go against the grain.
7 If the balance of the Commission doesn't feel we should
8 have language about both reducing cost sharing for generics
9 and increasing cost sharing for brand, but certainly that
10 would make it more powerful.

11 DR. CROSSON: Okay.

12 DR. SAMITT: I'm happy to retract the amendment
13 if that's not the general consensus of the group.

14 DR. CROSSON: So we have language in the text
15 that can be read in different ways, and that was a
16 modification. I think we have two choices. You can choose
17 to retract the amendment by substitution, or we vote.

18 DR. MILLER: I think he's retracting, isn't he?

19 DR. CROSSON: I don't know.

20 DR. SAMITT: I would rather retract the amendment
21 but modify the language in the report to be a bit more
22 specific about the possibility of either reducing cost

1 sharing for generic or increasing cost sharing for brand,
2 just to make it explicit that it could be one, the other,
3 or both.

4 DR. CROSSON: Okay. I'm seeing what is often
5 called a "bobble-head consensus" on the part of the
6 Commission for that solution.

7 DR. COOMBS: I second the emotion to retract the
8 amendment.

9 MS. UCCELLO: I just want to make clear here that
10 I think we feel -- Jack, you can correct me if I am wrong,
11 but I think that there is a preference, an empirically
12 based preference for reducing, eliminating, as opposed to
13 increasing. So if we do change the way this is in the
14 chapter, I don't want to go too far the other way and put
15 them on equal standing because that's not where I am.

16 DR. CROSSON: Right. Yeah. So that's the
17 conundrum as opposed to dealing with the recommendations.
18 If we're dealing with text changes, remember we have in the
19 text the CBO report, which entails both. So that is put
20 into the text, and it says the CBO says basically this is
21 the impact of doing both.

22 We have inserted, then, language which allows for

1 interpretation on the part of the Secretary that could be
2 read either way, and I think the general sense that we had
3 there was, again, as Scott pointed out earlier, first of
4 all, Congress has to do something before any of this
5 happens, and then the Secretary is most likely going to use
6 her or his, as the case may be in the future, judgment as
7 to what course to take, and that by creating -- by
8 emphasizing one report and by creating flexibility in our
9 language, we have in fact provided the Secretary adequate
10 flexibility.

11 So I said, flippantly, we had a bobble-head
12 consensus. I don't believe that's the case because we just
13 heard one objection, and I see another one potentially
14 getting ready to come on to the floor.

15 DR. MILLER: Well, let me just ask one thing
16 about that. Was your point that under no circumstances,
17 the Secretary could raise it?

18 MS. UCCELLO: No, no.

19 DR. MILLER: So then I do think we still have a
20 consensus.

21 DR. CROSSON: Well, no.

22 DR. MILLER: I think she just --

1 MS. UCCELLO: No, I think that --

2 DR. CROSSON: The question was, do we have a
3 consensus around strengthening the language around raising
4 brand-name copayments? I'm not sure we have that
5 consensus, or do we? Jack?

6 DR. HOADLEY: My preference would be not to -- I
7 mean, I think the language, as it stands, certainly
8 encompasses the possibility of raising brand copays. In
9 fact, the policy community, I think, has read the 2012
10 report as if it recommended that, even though it didn't,
11 because there was enough talk about those kinds of options,
12 as there is here, as one of the part of the menu.

13 But I think -- and Cory put this well. I think
14 what I prefer and what I think the language captures today
15 is that we think the more important case is sending the
16 signal about generics by lowing it or turning it to zero,
17 eliminating it. If a Secretary at some points wants to do
18 -- because of scoring reasons or because of different
19 evidence that might be available at the time this is done,
20 wants to consider brands, there's nothing in our language
21 today that would discourage them from doing that. And I
22 think that's a good place to end up in my mind, and I would

1 not support the amendment of the current policy, and I
2 would encourage us not to -- I think we have language
3 that's good the way it is.

4 DR. CROSSON: Right. So, to get back to
5 something, I don't see a Commission consensus to change the
6 language in the text, and of course, this is very difficult
7 because we're not even clear what the language change would
8 be. So I'd come back to the point -- I'm sorry, but if
9 we're going to make this change in this way or not, I don't
10 see any solution here since we can't discuss vague language
11 in the text, but either withdraw the amendment by
12 substitution, or we vote on it.

13 DR. SAMITT: I would withdraw the amendment.

14 DR. CROSSON: Okay. The amendment is withdrawn.
15 The recommendation is before you. Seeing no further
16 comments, all Commissioners in favor, please raise your
17 hand?

18 [Show of hands.]

19 DR. CROSSON: All opposed?

20 [No response.]

21 DR. CROSSON: Abstentions?

22 [No response.]

1 DR. CROSSON: Passes unanimously.

2 Let's move on to Draft Recommendation No. 3.

3 Okay. Comments on Draft Recommendation No. 3? Craig.

4 DR. SAMITT: Sorry about this. I guess it's my
5 day.

6 So I certainly comment and am in favor of most of
7 the elements of this recommendation for all the reasons
8 that we've discussed, that each of the subsections of the
9 recommendations need to sort of ride together. We
10 shouldn't be accepting them, each in isolation.

11 The one that I have questions about, I guess,
12 that I tried to dig deeper in between the meetings and even
13 in the chapter is the recommendation about the classes of
14 clinical concern, and whether in particular we feel that
15 the benefits of this change outweigh the risks of this
16 change. And it wasn't clear to me the degree to which we
17 would achieve savings to the program in removing these two
18 sets of agents from the protected class, as well as the
19 potential risks.

20 In particular, let's talk about the
21 immunosuppressants, whether we feel that narrowing classes
22 could result in transplant rejection and the costs that

1 would be incurred in other parts of the Medicare program
2 and whether there would be financial risks to making that
3 change.

4 So part of it is a question of how comfortable we
5 feel with the clinical review to assure that there wouldn't
6 be negative consequences either to a narrower class of
7 antidepressants or a narrower class of immunosuppressants
8 in a particular plan and the implications to that.

9 Again, I am certainly in support of tools that
10 will enable plans to manage unsustainable increases in drug
11 costs, but this one of the four gives me pause.

12 DR. CROSSON: Other comments on Draft
13 Recommendation No. 3? Jack.

14 DR. HOADLEY: So, again, I support this
15 recommendation, and I take note of Scott's and others'
16 comments that it is important to do all the pieces of this,
17 and so that's part of the spirit of it.

18 I do have some issues in this case. I have some
19 of the same concerns Craig just talked about with the
20 protected classes or the classes of clinical concern. I do
21 think that choices of drugs in the antidepressant class and
22 the immunosuppressant class can be patient-specific. I'm

1 not a clinician. I can't really speak as much as others to
2 the clinical side of this.

3 I'm also somewhat skeptical that given some of
4 the evidence we've seen and that is repeated in this
5 chapter, how much more plan leverage is going to come out
6 of this particular change and these two classes in
7 particular. On the other hand, I'm comforted by the high
8 prevalence of generics in this class -- and this was talked
9 about in the presentation -- and the fact that in reality,
10 plans include on their formularies, all or nearly all
11 generics in any particular class. And so, as the world
12 stands today, there's going to be a broad range of choice
13 in these classes, and most likely, the problems are going
14 to be infrequent.

15 There is the exceptions process, though. That
16 raises the question of how well that process works. I
17 would suggest that we add in the text that the status of
18 any particular -- and this is really I think in the
19 underlying statute, but we can point to that and
20 reemphasize it, that the status of classes in this regard
21 should be evaluated periodically, especially if new drugs
22 come on the market. So if we have new products in either

1 of these two classes, that might cause a change in thinking
2 down the line. I think that's in the Secretary's current
3 authority on that, although have to make recommendations
4 and go through notice and comment.

5 On the second piece of this, I think it was
6 discussed in the clarifying round, we really aren't trying
7 to change what goes on for the non-maintenance changes.
8 It's really a focus on process things that means things
9 that CMS would be inclined to approve don't make it into
10 approval, either when a plan is planning its formulary for
11 the next year or when there is a new drug at midyear and
12 it's trying to make a midyear change to respond to the
13 availability of a new drug, and we're really just trying to
14 streamline that process. And I think that's fully
15 appropriate.

16 On the exceptions bullet, again, my preference --
17 I talked about this at the last meeting -- would have been
18 to have said more about some of the things that we've said
19 in our 2014 report about greater transparency and
20 streamlining the process, so that beneficiaries and
21 physicians are not discouraged from seeking exceptions for
22 needed medications, that there is a good discussion of that

1 language in the text of the report, and you actually made a
2 very nice point of it in the presentation today. And I
3 think that's -- while I would have probably tried to put in
4 the recommendation, I think that's just an important point
5 that needs to be reiterated as this is talked about.

6 One thought, one of the concerns I've heard is
7 when plans have their request overturned and it may have to
8 do with some of the issues around the right kind of
9 justifications, that that then affects the star rating
10 because one of the star rating factors is the rate of
11 overturn. And maybe that's something in the future we
12 should take a look at, whether that's a particular star
13 rating manager that's having some sort of adverse -- is not
14 meeting the purpose that it's intended to.

15 And I also appreciate the hope that's expressed
16 in the text that a standardized process will actually help
17 -- and this is I think the wording -- help expedite
18 legitimate exceptions requests, and I think that's
19 something, again, we need to monitor as this process goes
20 on, and I hope we'll continue to look at the workings of
21 the exceptions process.

22 And finally, on the last point, again, I do think

1 we want to encourage appropriate tools for managing
2 specialty drugs. That is exactly what we're saying here.
3 We've given some examples for the Secretary to look at, and
4 I think there's some promise in those examples. I think
5 the ideas of two tiers, although it will add complexity to
6 the tier structure and that's the downside, the upside is
7 if it can lower the cost sharing for biosimilars and one of
8 competing products to move market to those products and
9 save everybody money, then that will turn out to be a good
10 thing. We need to think through that and understand that
11 more.

12 So I think with those caveats noted, I definitely
13 do support this recommendation.

14 DR. CROSSON: Thank you, Jack.

15 Further comments on recommendation number three?
16 David, and Scott.

17 DR. NERENZ: A very minor wordsmithing thing on
18 the last bullet. It's not clear as we've written it who's
19 doing the selecting. Then there are two clear options.
20 Either the Secretary is selecting and our chapter is just
21 listing some examples of the range from which those
22 selections might be made, or one could read this to say we,

1 the Commission, have done the selecting, and in the chapter
2 there is a definitive limited list and that's what we mean
3 by selected.

4 I think the intent here is the former and not the
5 latter, and I don't propose that this wording be changed,
6 but just some footnote or something in the text of the
7 chapter might indicate which of these two possible
8 interpretations.

9 DR. CROSSON: It is the former, and we can do
10 that. And, parenthetically, in response to Craig and Jack,
11 I think the notion of monitoring the classes is something
12 we can do, as well.

13 Further comments. Scott.

14 MR. ARMSTRONG: Briefly, it's a little redundant
15 to points I've made before, but I do believe the tools and
16 some of the other component parts of recommendation number
17 three are critical to the success of number one and number
18 two.

19 I also just generally think it's worth reminding
20 ourselves that through payment policy, we're trying to
21 control a cost that is advancing at a pace that is not
22 appropriate. We're not getting the value from this. On

1 the other hand, let's remember, investing in the right
2 drugs improves health and saves costs in other parts of our
3 system, and that really affirms the growing importance of
4 having assurance that our beneficiaries are in a
5 relationship with a care delivery system, where their
6 prescriptions and how their prescriptions are managed as a
7 part of their overall care is, in fact, well managed.

8 I mean, the percentage of inappropriate costs
9 through the prescriptions our beneficiaries are getting is
10 embarrassingly high. The costs of poorly managed drug
11 therapy is incredibly high, not just in terms of dollars,
12 but in terms of poor health.

13 One of the most important contacts that we have
14 with new Medicare Advantage beneficiaries, for example, is
15 to go through the long lists of prescriptions that our
16 beneficiaries have that don't make any sense when you sit
17 down and actually look at it.

18 And, so, plan sponsors should recognize that the
19 importance of engaging, whether it is through these kinds
20 of tools or more generally, in a real relationship that
21 better improves the care for these patients is probably the
22 most profound way of improving the overall cost trends for

1 the use of medications, and we tend to lose sight of that
2 when we're worrying about the mechanics and the complexity
3 of payment policy.

4 So, it's, I know, something we all agree with and
5 would affirm, but I think it's just worth restating.

6 DR. CROSSON: Good points, and what you didn't
7 point out is that this sort of management of the total
8 health care dollar more or less exists within the Medicare
9 Advantage program, and I think a lot of the work that we do
10 here at the Commission, and I think we'll continue to do as
11 we look at delivery system and payment reform, is try to
12 understand whether, in fact, that can take place even in
13 the setting of fee-for-service. It's much more difficult,
14 because Parts A, B, and D are all separate with HIPPA
15 regulations and the like. But, nonetheless, I think it has
16 come up before on the Commission as something to explore
17 and I hope that we will be able to do that, as well.

18 Further comments on recommendation number three.

19 [No response.]

20 DR. CROSSON: Seeing none, we will proceed to
21 vote. All Commissioners in favor of recommendation number
22 three, please raise your hands.

1 [Show of hands.]

2 DR. CROSSON: All opposed.

3 [No response.]

4 DR. CROSSON: Abstentions.

5 [No response.]

6 DR. CROSSON: It passes unanimously.

7 Rachel and Shinobu, thank you very much for this
8 work and your patience during our discussion.

9 We will now proceed to the public comment period.
10 If you wish to make a public comment, please come to the
11 microphone, get in line so we can see who is going to be
12 making comments or how many.

13 [Pause.]

14 DR. CROSSON: Okay. We have one individual at
15 the microphone. I'll just emphasize the fact that although
16 this is an opportunity to provide input to the Commission,
17 it's not necessarily the best or most timely one. The
18 MedPAC staff, both virtually and personally, are available
19 during the period of time when these policies are
20 developed. As well, we receive, both as Chair and
21 Executive Director and Vice Chairman and other
22 Commissioners, receive written information from interest

1 groups up to the time that we make these determinations.

2 So, there are many other ways of making this input.

3 Having said that, please state your name and your
4 affiliation, if any. When this light goes out, again, that
5 will be the end of the two-minute period of time that you
6 have for comments.

7 DR. VOTTO: Okay. I'll make it quick. My name
8 is John Votto. I'm the CEO of Center Special Care in New
9 Britain, Connecticut. It's mainly a long-term acute care
10 hospital that provides all kinds of programs.

11 I think I understand the presentation of the
12 unified payment system. I understand the statistical work
13 that went into this and, you know, appreciate that. I also
14 see the potential benefits of it. But, I also see a
15 possible wild, wild West of players getting into any player
16 taking any patient. That's my big concern.

17 I think I only have four points to make and one
18 would be that the quality measures be across the continuum,
19 and I'm not sure that they're established yet that we can
20 go for ventilator outcomes across the spectrum right now.
21 So, we know LTCHs have known it for a long time, but SNFs
22 and, you know, home health care, I don't know how that

1 would all work. So, that would be one thing, that I think
2 they need to be validated before this is rolled out.

3 The other thing is the regulations were mentioned
4 and also the COPs were mentioned. I think that those have
5 to be clarified, because, again, that would be how do we
6 decide who's a hospital that can take wound patients and
7 vent patients and those things, and those COPs, I think,
8 need to be established.

9 You know, I do have a concern about how it
10 affects beneficiaries, Medicare beneficiaries, because of
11 copayments and coinsurance if you change the whole
12 structure of hospital payments, hospital to hospital, those
13 kind of things. So, I'm concerned about that.

14 And, the last thing is that payments do need to
15 be aligned with the burden of care from the provider, so
16 that if we're going to say that you're going to take vents,
17 for instance, and you're going to be -- you're going to
18 upgrade to this, you know, area, and we're going to pay for
19 that infrastructure, which is not inconsequential, then
20 there should be an understanding that that payment -- and I
21 know high-cost outlier payments were mentioned, but we have
22 to be careful about how we do that, because those can be

1 tweaked, but they may not be enough.

2 So, those are my --

3 DR. CROSSON: Thank you for your comments.

4 Seeing no one else at the microphone, we are
5 adjourned for lunch and we are due back here at one
6 o'clock.

7 [Whereupon, at 12:30 p.m., the Commission was
8 recessed, to reconvene at 1:00 p.m. this same day.]

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1 I'll recap the Part B drug payment policy options that
2 we've been exploring, including an idea to restructure the
3 six percent add-on to ASP as well as broader policy options
4 that could have the potential to increase price competition
5 among Part B drugs or put downward pressure on ASP.

6 Next, we'll discuss the Part B drug dispensing
7 and supplying fees and Commissioners will vote on a
8 recommendation to reduce these fees.

9 Finally, Nancy will review four case studies on
10 improving efficiency of oncology services. Recall that the
11 plan is that all of these ideas will get written up in a
12 June report chapter.

13 Before we begin, I'd like to note that we've made
14 modifications to the mailing materials in a number of
15 places to reflect your discussion in March, some of which
16 we'll highlight as we go through the presentation.

17 In addition, there was one question from that
18 meeting that I'd like to address now. Kathy, you asked
19 about how new drugs are paid under the ASP payment system
20 when ASP data are not available. For the first six months,
21 when ASP data are not available, a new drug is generally
22 paid 106 percent of the wholesale acquisition cost,

1 referred to as WAC. If WAC data are not available, the
2 drug is contractor priced if furnished in the physician
3 office or paid 95 percent of AWP if furnished in the
4 outpatient department.

5 This next slide has background on the ASP payment
6 system. You've seen it before, so I'm not going to go
7 through it now.

8 So, first, we'll talk about the ASP add-on. As
9 we've discussed, the six percent add-on to ASP may create
10 an incentive for use of higher-priced drugs, although it's
11 hard to know if this is occurring because few studies have
12 looked at this issue.

13 We modeled a policy option that converts part of
14 the percentage add-on to a fixed fee that generates
15 savings. The option we modeled is 103.5 percent of ASP
16 plus \$5 per drug per day. Overall, this approach is
17 estimated to save about 1.3 percent, or about \$270 million
18 annually, and that's based on 2014 data, assuming no shifts
19 in utilization in response to the policy.

20 The policy option has the effect of increasing
21 the add-on for drugs with an ASP per administration of less
22 than \$200 and decreasing the add-on for higher-priced

1 drugs. The net effect of these changes would be to reduce
2 Part B drug revenues for hospitals and specialties that
3 tend to use high-priced drugs and to increase Part B drug
4 revenues for physicians that tend to use lower-priced
5 drugs.

6 In terms of other implications of the policy
7 option, overall, changes to the add-on may increase the
8 likelihood that a provider would substitute a low-priced
9 drug for a high-priced drug when therapeutic alternatives
10 exist. To the extent that this occurred, it would save
11 more money than we estimated on the earlier slide.

12 Since these policies reduce the add-on payments
13 for expensive drugs, it's possible that some small
14 practices may have difficulty purchasing expensive drugs at
15 the Medicare payment rate, but this would depend on how
16 drug manufacturers respond to the policy change.

17 Some Commissioners have asked about how this
18 policy option would affect the trend toward more hospital-
19 based oncology care. It's possible that it could
20 contribute toward that trend, depending on whether oncology
21 practices had difficulty purchasing expensive drugs at the
22 Medicare payment amount.

1 Next, we'll discuss three options that may
2 increase price competition among Part B drugs or put
3 downward pressure on ASP. The first one relates to ASP
4 inflation growth. Increase in the ASP+6 payment rates for
5 individual drugs are driven by manufacturer pricing
6 decisions. In theory, there's no limit to how much
7 Medicare's ASP+6 payment rate for an individual product can
8 increase over time.

9 Among the 20 highest expenditure drugs, the
10 median ASP growth has exceeded inflation since 2010. A
11 policy option that could be considered is to limit how much
12 Medicare's ASP+6 payment rate can increase over time. This
13 could be done through a manufacturer rebate or a limit on
14 how much Medicare's payment rate to providers can increase.
15 These two approaches differ in terms of which entity bears
16 financial risk. Under a rebate, the manufacturer would
17 bear financial risk for price increases. Under a limit on
18 provider payment rates, providers would bear the financial
19 risk for payment increases -- or, excuse me, price
20 increases.

21 Kathy and Bill Gradison, I just want to note, we
22 expanded the mailing materials here to talk more about the

1 implications of these policy options for beneficiaries and
2 drugs in shortage.

3 So, next, we have consolidated billing codes.
4 Under the ASP payment system, most single source drugs and
5 referenced biologics receive their own billing code and are
6 paid based on 106 percent of their own ASP. This structure
7 does not promote strong price competition among products
8 with similar health effects.

9 In other work, the Commission has maintained that
10 Medicare should pay similar rates for similar care. Given
11 that principle, a policy option that could be considered is
12 to place products with similar health effects in the same
13 billing code and pay them the same rate. This would be
14 expected to spur price competition and generate savings for
15 beneficiaries in the Medicare program.

16 This type of policy could be considered for a
17 couple different areas. One place is biosimilars and the
18 reference product. Under current policy, all biosimilars
19 associated with the same reference product are in one
20 billing code, but the reference product remains in its own
21 billing code. Instead, a potential policy could be to
22 place all these products in a single billing code based on

1 the FDA's determination that they're biosimilar.

2 This kind of approach could also be considered
3 more broadly beyond biosimilars and applied to other drugs
4 and biologics with similar health effects. In this case,
5 the Secretary could develop a process to obtain clinical
6 input to identify products with similar health effects that
7 would be appropriate to include in the same billing code.

8 Another approach that could be considered to spur
9 price competition for Part B drugs is to restructure the
10 competitive acquisition program. Medicare implemented a
11 CAP program from 2006 to 2008. Physicians who chose to
12 enroll in that program obtained drugs from a vendor rather
13 than buying and billing Medicare directly for the drugs.
14 The program faced challenges due to low physician
15 enrollment and the vendor having little leverage to
16 negotiate favorable prices.

17 Options to restructure the CAP program could be
18 considered. For example, several steps could be taken to
19 encourage physician enrollment. Physicians could be
20 offered the opportunity to share in any savings from the
21 CAP program. At the same time, the ASP add-on percentage
22 could be reduced or eliminated in the traditional buy and

1 bill system, making it less attractive. And to reduce
2 administrative burden on physicians, the program could be
3 changed to a stock replacement model or a GPO model.

4 Second, to give the vendor negotiating leverage,
5 the vendor could be permitted to operate a formulary and
6 any savings could be shared with the vendor, too.

7 Finally, to the extent that the program led to
8 lower prices, the savings could be shared with
9 beneficiaries through lower cost sharing.

10 Next, we have the issue of the dispensing and
11 supplying fees, an issue you will vote on today. As you'll
12 recall, in 2014, Medicare and beneficiaries spent about
13 \$155 million on the Part B dispensing and supplying fees.
14 In 2014, the inhalation drug dispensing fee is \$33 per 30-
15 day supply and \$66 per 90-day supply of inhalation drugs.
16 The supplying fee is \$24 for the first prescription in a
17 30-day period and \$16 for each additional prescription in
18 that 30-day period for three categories of Part B furnished
19 pharmacy drugs.

20 These dispensing and supplying fee rates were
21 established in 2006 based on limited data. OIG reported
22 that Medicare Part D and Medicaid paid dispensing fees of

1 less than \$5 for these categories of drugs in 2011.

2 So, this brings us to the draft recommendation,
3 which reads: The Secretary should reduce the Medicare Part
4 B dispensing and supplying fees to rates similar to other
5 payers.

6 In terms of implications, this draft
7 recommendation would reduce Medicare program spending by
8 between \$50 million and \$250 million over one year and by
9 less than \$1 billion over five years. The draft
10 recommendation would reduce total Medicare revenues to
11 these suppliers by less than five percent. And we do not
12 expect an adverse impact on beneficiary access or
13 providers' willingness or ability to serve Medicare
14 beneficiaries.

15 So, now, I'll turn it over to Nancy to talk about
16 oncology services.

17 MS. RAY: So, now, we are going to turn to the
18 four case studies of approaches used by Medicare and other
19 payers and providers that have attempted to improve the
20 value of oncology drug spending. These case studies will
21 be included in the June report chapter.

22 We focus on oncology drugs, chemotherapy, and

1 supportive drugs because Medicare spending is substantial,
2 roughly \$11 billion in 2014. Our preliminary bundling
3 analysis included in our June 2015 report found that
4 oncology drugs accounted for nearly half of a total six-
5 month episode spending.

6 The case studies we are discussing today is a
7 continuation of our June 2015 report chapter that began to
8 explore approaches for bundling oncology services.

9 The first two case studies are relatively narrow
10 approaches that affect the drug price and drug selection.
11 Outcomes-based risk sharing agreements are made between
12 payers and product manufacturers and oncology clinical
13 pathways are used by some commercial payers and providers.
14 The broader case studies attempt to redesign the delivery
15 of care by affecting the use of drugs as well as other
16 services, an oncology medical home implemented by CMS and
17 an oncology episode of care approach implemented by a
18 commercial payer. These are the same four case studies we
19 discussed during the March meeting, so I'm going to
20 describe them pretty quickly, but I'm happy to answer any
21 questions at the end of the presentation.

22 So, regarding outcomes-based risk sharing

1 agreements, from the payers' perspective, these agreements
2 are intended to improve the value of drug spending by
3 linking the price of a drug to its effectiveness. In your
4 briefing paper, we summarized an arrangement in the United
5 Kingdom between the National Health Service and the product
6 developer for Velcade, bortezomib, a product used to treat
7 multiple myeloma, administered in the office or hospital
8 outpatient setting. Under the agreement, the product
9 developer refunds the full cost of the product to the payer
10 for patients who have less than a partial response. The
11 response is based on a biomarker for disease progression.

12 Outcomes-based risk sharing agreements have also
13 been implemented for non-oncology drugs. Because these
14 agreements are usually proprietary, we were not able to
15 find current information online about the level of rebate
16 or product replaced under this agreement.

17 Our next case study is oncology clinical
18 pathways, and their goal is to reduce prescribing
19 variability, maintain or improve quality of care, and
20 reduce costs of care. Pathways are detailed evidence-based
21 treatment protocols that identify specific treatment
22 options based on maximizing survival benefit, minimizing

1 toxicity risk, and then cost. Pathways are more specific
2 than guidelines, but often based on guidelines. Some
3 providers have linked financial incentives to the use of
4 pathways. For example, payment could be adjusted based on
5 pathway adherence.

6 Rita, in response to your comment, the draft
7 chapter summarizes some of the issues raised by researchers
8 and stakeholders about the processes used to develop
9 clinical guidelines and pathways.

10 Moving to the two broader approaches, the first
11 is CMS's oncology medical home. Its goal was to improve
12 health outcomes and through improvements in access and
13 coordination of care, reduce admissions and ED visits and
14 total cost of care. The oncology medical home builds on
15 the concept of patient-centered care under which a
16 designated provider is responsible for complying with
17 several requirements, such as integrated care and enhanced
18 access.

19 CMS provided a grant to test the Community
20 Oncology Medical Home, COME Home. The demo ran between
21 2012 and 2015. Seven practices participated. Practices
22 had enhanced capabilities, including same-day appointments

1 and extended and weekend hours. We are still awaiting for
2 CMS's evaluation of the program that compares the outcomes
3 of participants to a control group to see what type of
4 effect the program had on outcomes and spending.

5 Herb, in response to your question, Medicare's
6 local coverage determinations apply during the demo.

7 The last case study is an episode of care
8 approach implemented by United Healthcare. Its goal was to
9 reduce potential financial incentives to prescribe one drug
10 versus another. The pilot paid participating practices
11 ASP+0 percent and repurposed the ASP add-on as an episode
12 fee. Practices were eligible for shared savings that was
13 linked to improving the survival rate or decreasing cost.

14 Under the three-year pilot, total spending
15 decreased, and this was linked to decreases in
16 hospitalizations and radiology. However, drug spending
17 increased. The larger scope of the episode means if a more
18 expensive drug or longer chemotherapy regimen is
19 appropriate, oncologists have the flexibility to do so
20 without jeopardizing overall savings.

21 The upcoming CMMI oncology care model will test
22 an episode of care approach for participating practices.

1 So, this concludes our presentation. You will be
2 voting on the draft recommendation on dispensing and supply
3 fees that Kim will put back up on the screen. This slide
4 lists the other topics we discussed today, which will be
5 included in the June report chapter.

6 Please let us know if there are any additional
7 work on these topics that you would like us to pursue.

8 DR. CROSSON: Okay. I'm going to ask for
9 clarifying questions. I also want to talk a little bit
10 about how we're going to do this.

11 First of all, time is a little tight.

12 Secondly, we've got the recommendation, and I'm
13 going to suggest we take that first, because while we're
14 doing that, you can think about the next piece, because I
15 think what I'd like to do is take a clue from the
16 Millennial generation here and we're going to do this like
17 Facebook. We've got eight ideas up there on the slide, and
18 in the discussion, of course, period, we don't have time to
19 analyze all the pros and cons of this. It's going to take
20 us a good part of the next term to do that. But, what I
21 would like to get is an indication of, "I like this one,"
22 and for ones that are not on your immediate "like" list,

1 what would you suggest -- what information or analysis
2 would you suggest we need in order to move up some other on
3 onto your "like" list, okay.

4 So, let's have the slide on the recommendation
5 first. So, you have the draft recommendation before you.
6 I won't read that. We have presented it at the March
7 meeting, as well. Any comments or questions from
8 Commissioners on the draft recommendation.

9 MR. ARMSTRONG: So, you're not going to entertain
10 any amendments to this?

11 [Laughter.]

12 DR. CROSSON: Oh, yeah, sure. Go ahead.

13 MR. ARMSTRONG: Actually, I just rescinded my
14 proposed amendment.

15 [Laughter.]

16 DR. CROSSON: I'm sorry, I'm getting ahead of
17 myself. I think that -- let me just ask, are there any
18 clarifying questions on this recommendation? Alice.

19 DR. COOMBS: What's on the laundry list up here,
20 bottom line? Has ASCO done any work surveying their
21 membership with the medical homes in terms of any data that
22 they may have prematurely, the oncology, professional --

1 DR. CROSSON: Alice, excuse me. I serve to
2 confuse you here. We're taking the recommendation first,
3 and then we're going to go back to the list. Sorry.

4 Clarifying questions on the recommendation?

5 [No response.]

6 DR. CROSSON: Comments on the recommendation?

7 [No response.]

8 DR. CROSSON: We will now take the
9 recommendation. All in favor of the recommendation, please
10 raise your hand.

11 [Show of hands.]

12 DR. CROSSON: All Commissioners opposed?

13 [No response.]

14 DR. CROSSON: Abstentions?

15 [No response.]

16 DR. CROSSON: The recommendation passes
17 unanimously.

18 Okay. Now, clarifying questions on the range of
19 choices that are on that slide.

20 I'm sorry. If looks could kill. Alice, sorry.

21 MS. RAY: Can you repeat your question?

22 [Laughter.]

1 DR. COOMBS: It's okay. I'm sure ASCO has done
2 something in this area, but I'm wondering about the
3 literature. You did a great job identifying those four
4 cases. Has there been a preponderance of literature on the
5 medical homes in terms of just comparing? I have some
6 preliminary data from an oncologist, but I'm wondering if
7 there's been some published data on just cost savings that
8 exist with any pilots or anything.

9 MS. RAY: There's been an initial evaluation of
10 the COME HOME model, the CMS's model, but in that
11 evaluation, they're not comparing costs or outcomes to a
12 control group. It was just of the study participants.

13 We do cite other literature that does discuss
14 some outcomes with other oncology medical homes, but I
15 think that there's a lot of interest in learning about what
16 the effect is of the CMS model.

17 DR. COOMBS: Is there going to be a Round 2?

18 DR. CROSSON: Yes.

19 Clarifying questions on this? That is everything
20 except for the recommendation.

21 [No response.]

22 DR. CROSSON: Seeing none, do we have comments?

1 Alice.

2 DR. COOMBS: Thank you so much.

3 For the laundry list and going down the laundry
4 list, can I do that really quickly?

5 DR. CROSSON: Yeah.

6 DR. COOMBS: Okay. So in terms of the things
7 that I rank are the low-hanging fruit is the consolidated
8 billing codes I think is someplace that we can go, easy
9 enough to do, although I know that there's some struggles
10 and challenges within -- because it sounds like to me the
11 RUC codes and the family of codes and putting them all
12 together and saying these two or these three or four go
13 together versus the other. So it's going to take a little
14 bit of deliberation on that.

15 The clinical pathways, I think no one is in
16 question about that. I think the adherence to them is
17 pretty good amongst the community.

18 Medical homes, I think is unquestionable. The
19 episode of care, I'd be interested to see, because in the
20 United Healthcare model, I think that was problematic in
21 terms of looking at the individual cost, overall cost
22 versus cost due to drugs.

1 The CAP limit on ASP growth, I think that's where
2 the money is right there because we're looking at things we
3 can do in terms of prioritizing how we can stop the actual
4 growth of the cost of drugs, and I think that does us
5 justice in terms of feedback to the manufacturers as well
6 as the plans.

7 The things that I'm concerned about are many.
8 Small providers within oncology practices with the CAP
9 program before accessing the shelf life for a lot of the
10 chemotherapeutic agents and being able to -- and be able to
11 get the drugs in a timely fashion to treat patients, and so
12 some oncologists had expressed the concern that patients
13 come in, come into their offices to receive an agent, and
14 the agent is not there. And so it necessitates a patient
15 coming back again, and these protocols and clinical
16 pathways are time-based, so that, you know, you might have
17 the nadir of your white count at a certain point so that
18 it's really important to have a timely -- that's strict
19 adherence to being able to get the chemotherapeutic agents
20 on time, so I think that's important.

21 And then the question of is this going to force
22 somewhat of a repeat of what happened with the

1 cardiologist. I am told that the newly trained oncologists
2 that come out of training, they may go into a group
3 practice, and then shortly afterwards, someone comes along
4 with 100K increase on their salary from a hospital base,
5 and they say, "Goodbye." And they leave the solo
6 practices. The unintended consequences of the hospital-
7 based care in oncology via physicians is more expensive. I
8 really think so, and so that it could be problematic of
9 doing the very thing that we want to do, which is to keep
10 patients in the community setting and oncology practices.

11 So I think I have a couple more, but in respect
12 for the rest of the Commissioners, I'll yield my time.

13 DR. CROSSON: Hey, I kind of like this formality
14 thing.

15 Let's see. I saw Craig. Let's come up this way.
16 Let's go to Jack and then come this way.

17 DR. HOADLEY: So, I mean, I think this is --
18 first of all, I think we've got a really good chapter here
19 for this year's round, and I think one of the advantages
20 that we've accomplished, both last year and will accomplish
21 with this is to continue to identify a range of options,
22 which really helps people in the policy community as well

1 as ourselves sort of work through relative merits and
2 disadvantages of different approaches. So I think the
3 general approach we're taking here is very positive.

4 In sort of your sense of yes or no on the
5 options, I definitely want to see us continue to look at
6 the adjustments to the 106 percent of ASP. I think in
7 addition to this 103.5 plus \$5, we could potentially look
8 at other variants, like I think was mentioned sort of a
9 lower percentage without an add-on or some kind of a lesser
10 of, to sort of balance out what happens on the less
11 expensive drugs and the more expensive drugs. I don't
12 know. We could go crazy just sort of inventing other
13 variants. We have to be careful, obviously, there.

14 I really do think the limit on ASP growth has got
15 a lot of potential, and personally, I like the approach
16 that tries to help -- well, I think we've got to work out
17 on the impact on what it does to coinsurance versus sort of
18 who bears the cost, and sort of we've laid out that
19 contrast and I think continuing to think that through. I
20 won't go any further on that.

21 I think the consolidated billing codes, I like.
22 I guess my question there continues to be -- it makes a lot

1 of sense for biosimilars. I think it's more unclear how it
2 will play out for other classes of drugs, both the politics
3 that we've seen with some of the other approaches to least
4 costly alternative and so forth, of trying to define what
5 are the competing products and sort of the ability for CMS
6 to find enough clinical consensus to establish that these
7 really do work together, and there's always going to be
8 pushback from both patient groups, provider groups,
9 manufacturers on that point. And then it doesn't really
10 address the sort of single drug in class kind of situation.

11 So I think it's at least a good tool for
12 biosimilars in the point we've already made, I guess, in
13 our comments, putting the biosimilars together with
14 original product, and I think it's worth looking at another
15 context. But I think there are definitely practice
16 problems.

17 I continue to be skeptical about the camp
18 restructuring. I mean, I'm willing to continue to look at
19 it as an option to see how it could be made to work, but I
20 just have trouble getting there right now.

21 And I think the other four, I think they're great
22 topics to continue to look at. I don't right now have sort

1 of reactions of one versus another. I mean, I just have
2 random questions -- not random, but particular questions,
3 like on clinical pathways, how does it end up generating
4 savings. But I think all of these are worth continuing to
5 consider, and I think in general, I feel like I'm going to
6 need more information if I was trying to pick among them.

7 And maybe in the end, this isn't a question of
8 picking one out of four as much as are there models out
9 there. So those are some reactions.

10 DR. CROSSON: Thank you. Coming up, Bill.

11 DR. HALL: Thank you. Are we doing Facebook now?
12 Is that okay? I want to have a big shout-out for the
13 oncology medical homes.

14 Just briefly, geriatric oncology is a relatively
15 new field, and it's turning up some very interesting
16 information. One is that as the care of cancer patients
17 becomes more complex and particularly for older adults
18 where the decision is often do/don't do, modify/not modify,
19 the oncologist becomes the de facto, the primary care
20 provider for these people, and that's a good thing. And
21 it's an area where what Mary calls other providers really
22 excel.

1 If an older individual has to go back to a
2 primary care physician because of a rash, not knowing
3 whether it has something to do with the cancer chemotherapy
4 or maybe a new manifestation of disease, it results in two
5 or three redundant visits. So at least that model has the
6 potential for actually reforming the way that we provide
7 cancer care for older patients. So I think it really needs
8 or deserves a really good luck. So if we could nudge
9 whoever is trying to analyze this data to see what's
10 happening, I think that would be a giant step forward.

11 DR. BAICKER: Of the potential items on the list,
12 the one that probably makes me the most uncomfortable is
13 the limit on ASP growth. It strikes me as potentially
14 quite arbitrary, disconnected from murky conditions and
15 circumstances that would normally, we think -- we would
16 like competitive pricing to vary based on those market
17 circumstances. There are all sorts of reasons to think
18 we're not getting competitive prices now, and I'm very much
19 in favor of trying the items on the menu that move us
20 towards competitive prices. I worry that this moves us
21 away from it in a way that's arbitrary with all sorts of
22 consequences under many different circumstances that some

1 might be good, some might be very bad, and with a rule like
2 this, this mix is quite uncertain. So I'm just voting
3 thumbs down, like the economist I am.

4 DR. CROSSON: Craig.

5 DR. SAMITT: So the two on the list that I would
6 single out that I'm interested in learning more about would
7 be clinical pathways and oncology medical homes as well.
8 Clinical pathways, just because we've had very good success
9 with clinical pathways within our organization, and I think
10 there are added advantages to clinical pathways, especially
11 if the development of the pathways is continuous and even
12 somewhat automated, given the complexity of oncology care,
13 that to have a vehicle to kind of stay on top of true best
14 practice and clinical oncology is conducive to what we
15 would want for beneficiaries.

16 The one concern I have about clinical pathways,
17 the chapter talks about sort of the proprietary nature of
18 some of these pathways with certain organizations, and I
19 would like to understand how do we get past that
20 proprietary nature because that seems to be something that
21 should be used more broadly.

22 Then what I like about medical homes is just the

1 notion that it rises above, yet again, this notion of just
2 thinking of care as episodes, that it is truly a population
3 health focus, and maybe an episode is really not the right
4 choice for the beneficiary. There are other, more
5 palliative approaches or caring approaches.

6 And certainly, the cost of oncology care goes
7 beyond just the drug costs of any particular episode.
8 There are other considerations -- avoiding
9 hospitalizations, rehospitalizations, and the like.

10 So those would be the two I would be most
11 interested in learning more about and hearing about.

12 DR. CROSSON: Over this way. Rita.

13 DR. REDBERG: So I like the consolidated billing
14 codes because the idea that we're sort of looking at the
15 outcomes and paying for sort of beneficial outcomes is one
16 that we've used before, and I see that as aligned with it.

17 The risk-sharing agreement, I have concerns
18 about. I don't know. You mentioned outcome-based, but
19 certainly in the example that we saw on Slide 14 where the
20 patient response is based on a biomarker -- a biomarker, so
21 surrogate outcome is very unclearly, if at all correlated
22 to actual clinical, meaningful outcomes. So I wouldn't

1 favor risk-sharing agreements if they're based on
2 meaningless surrogates.

3 And this clinical pathways, as we have talked
4 about before, a lot of the oncology studies are also based
5 -- and approvals of drugs are based on surrogate outcomes
6 that have not been correlated to survival, which is really
7 what we're looking for. So I would have concerns about
8 using the clinical pathways for that reason.

9 Thank you for adding the detail to the chapter
10 about the quality of evidence in the clinical pathways, but
11 it looks like, uniformly, it didn't come out well. They
12 all were rated as low quality, low rigor of development,
13 didn't meet the standards the IOM set forth for clinical
14 practice guidelines.

15 And the other issue in the clinical pathways is
16 that I think what seems to me limited in the data for
17 oncology is actual -- we get a lot of new drugs, and so we
18 tend to use them in succession as opposed to figuring out
19 actual rational course of one compared to another, and also
20 the alternative of no treatment because clearly there are
21 patients that would have been better off without any of the
22 chemotherapies than the ones that they actually got,

1 because they're all toxic. And if they're not extending
2 life, then we have reduced quality of life without
3 improving outcomes, and so an outcomes-based pathway
4 perhaps would be good, but currently, I don't think that's
5 the way they're focused. And when I say outcomes, I mean
6 survival benefit.

7 DR. CROSSON: Thank you, Rita. Mary? Kathy?
8 David.

9 DR. NAYLOR: Mary, Kathy. Okay.

10 DR. REDBERG: Just one last thing, we also talked
11 before about the bundled, but we didn't really get a lot
12 into it in this chapter, unless I missed it.

13 MR. RAY: Right. That --

14 DR. REDBERG: Well, not the UnitedHealthcare.

15 MS. RAY: Right. In the June 2015 report, we
16 talked a little bit more about bundling and the issues that
17 would have to be considered in developing an oncology
18 bundle.

19 DR. MILLER: And that is still on the list. If
20 you want to say "I don't like it" or "I do like it," just -
21 - it is still up there.

22 DR. REDBERG: It seemed worthy of further

1 discussion.

2 DR. CROSSON: Mary.

3 DR. NAYLOR: So I want to give two thumbs up to
4 an approach which is more comprehensive, whether it's
5 called the oncology medical home or the oncology geriatric
6 something. I was on the IOM, now National Academy of
7 Medicine, delivering high-value cancer care, and much of
8 our attention was on the fact that new diagnosis of cancer
9 are occurring much more frequently, in fact, predominantly
10 now in the Medicare population, but in the context of
11 people who have heart failure and diabetes and depression.
12 And so to think about where you're going to get the value
13 from high-value care coordination, long term, focus on
14 palliative care, and all of that, I think is really central
15 to getting to high-value payment.

16 DR. CROSSON: Kathy.

17 MS. BUTO: So, on the first one, 103.5 plus \$5, I
18 think somebody else mentioned this, maybe Jack, lesser of
19 106 percent of ASP or that, because I think we point out
20 there is some real low-cost drugs that would actually
21 increase in cost, and there's no reason for that. So I
22 think we ought to think about that as we refine the policy.

1 On the ASP limit on growth, that's growth in the
2 price, and I guess one unintended consequence I think is
3 going to be higher launch prices, which I think has also
4 been an area of concern, so I would point that out.

5 And also, that of the two options that were laid
6 out, one was a rebate approach, and the other was limit on
7 Medicare payments, which I think we're very much used to
8 through hospital payments and other things, even the SGR,
9 that that's an approach that would benefit the beneficiary
10 more directly, although I noted in the chapter that you all
11 came up with a way or some possible ways to have that
12 benefit under rebate go to the beneficiary as well. But I
13 think it's a little, maybe slightly tortured, and so we
14 might want to think about that as we develop this option
15 further.

16 On consolidated billing codes, I'm very much
17 opposed to this, and the reason is that I generally like
18 the options that look at limiting overall drug payments or
19 payment levels without trying to, in some sense, bias a
20 clinical decision towards a lower cost drug. So I am
21 nervous about that and something like this, and I think
22 Jack didn't quite say this, but that would be my biggest

1 concern about the therapeutically equivalent, where the
2 patients -- this is just a drug. It's not like a whole
3 DRG.

4 I think you pointed out in your paper where there
5 are a number of different services that can be traded off.
6 It's a drug, and if the patient needs that one and it
7 happens to fall above the median price or whatever the rate
8 is set for that bundle or that category, I think we are
9 going to see therapeutic clinical decisions driven by that
10 because otherwise a physician has to bear the cost of the
11 higher, more expensive drug.

12 So I know there's been a little research outside
13 the U.S. on what happens when that happens, and one thing I
14 would ask is that you all take a look at the literature on
15 reference pricing and its impact on both clinical decisions
16 and ultimately costs and whether it really saves money.

17 And I guess, thirdly, incremental innovation,
18 which there's a little -- again, I think it's in Germany or
19 somewhere else that they've shown that there's less
20 inclination to invest in that category once it's put into a
21 reference grouping.

22 So, again, I think the U.S. is a whole different

1 deal because we're such a big market, but there have been
2 some glimmerings that this reference pricing does have an
3 impact, and I think we just want to be understanding what
4 those impacts are.

5 On restructuring CAP, I would just say that CMS
6 has been successful in DME competitive bidding now for
7 seven or eight years. It's a different deal, but I think
8 there are lessons to be learned from how -- what obstacles
9 they had to overcome to do that kind of competitive
10 bidding. Competition and the ability to attract in
11 different vendors is critical to making that an effective
12 approach, and of course, the way it was structured because
13 of the legislation and otherwise made that difficult. So I
14 think looking at it fresh and then looking at some of the
15 private sector approaches would also help us. So rather
16 than starting only with the CMS sort of failure, if you
17 will, I would look at where it's been successful and what
18 we might suggest in that area.

19 And then oncology medical homes and episodes of
20 care, I am particularly interested in because I think
21 ultimately that it's the episodes-of-care approach, the
22 more bundled, if you will, approach that goes across the

1 care that's involved in a service is really where we're
2 going to see tradeoffs made at the level of practice and
3 care management rather than our trying to figure out how to
4 correctly price individual products.

5 DR. CROSSON: Thank you. David.

6 DR. NERENZ: A couple of loose-end issues about
7 the chapter, and both of them relate to the first bullet
8 about the 103.5 percent.

9 One is I don't know we're quite as clear as we
10 could be about what the policy intent of that plus 6
11 percent was or is, and there are at least three options,
12 and they're all in front of us. I'm not quite sure what
13 the blend really is.

14 One of the headings in the report talks about
15 profit margin, and we never say that that actually was an
16 explicit intent of the plus 6, but at least it's in there
17 in the chapter. You asked the question: Is it actually
18 effectively a profit margin? So that kind of raises a
19 question of: Well, is it supposed to be one?

20 Then in one of the letters that came to us,
21 there's the concept of buffer, the idea that it serves as a
22 buffer at the individual provider/hospital level because

1 the actual acquisition price isn't always the same as the
2 standard national price, so there's a buffer concept.

3 Then there's also some mention of drug handling
4 costs that are different from the separate administration
5 fee, and there's some talk about difficult handling and
6 hazardous and this and that.

7 So it seems like there are at least three
8 distinct underlying rationales for this, and I don't know
9 that the chapter is clear about is the policy intent to
10 cover all three, is it one of the three, all the way back
11 to the origin in Congress, is it none of the three. Just
12 anything we can say about that I think would be useful,
13 because then it kind of tees up where do you go with it,
14 because if you're trying to solve this problem, you do it
15 or don't do it this way.

16 Then the second related thing is kind of an
17 obvious point, that if part of the problem with plus 6 is
18 that there's an incentive to prescriber higher-priced
19 drugs, the incentive goes down a little bit when you go to
20 3.5, but it does not go away, and it certainly doesn't get
21 turned around.

22 So when we talk about that as an example option

1 and we talk about possible consequences, we might be able
2 to say more about do we actually expect behavior to change,
3 and if so, why. Is that change big enough to actually
4 change the underlying incentive and motivation? Or do we
5 think behavior really won't change because the incentive is
6 still in the same direction, but it will, in fact, change
7 the payment?

8 So, again, I'm just looking for a little clarity
9 about do we or don't we think that this incentive for
10 higher-priced drugs is going to actually change behavior --
11 I'm sorry, I should say would the change of this type
12 change behavior.

13 DR. CROSSON: David, I would just like to
14 underscore the first point you made, because, you know,
15 personally, as I have thought about that and talked about
16 it, I've thought about it in all those three ways. And I
17 think, you know, if we're going to proceed with this
18 direction, which I think -- and I hear a fair amount of
19 support for it, I think in addition to trying to understand
20 what the policy thinking was, it would also be helpful --
21 and here we go, more work. It would be helpful to try to
22 figure out, if we can, empirically what the justification

1 is with those three ideas in mind. In other words, you
2 know, how much variation -- I realize I'm saying things
3 that we may not be able to do, but how much variation in
4 acquisition price is there really and what does that look
5 like. What is the cost for handling? And is it uniform
6 across drugs, or is it concentrated in only a small number
7 of drugs? And then I forgot the third one, David. The
8 buffering, the handling, and the -- well, yeah, I mean, so
9 -- I don't know there's any empirical analysis one can do
10 on what the right profit ought to be. But I think at least
11 with those two, if we could kind of understand that a
12 little bit more, and I realize that some of this
13 information is likely proprietary and not easily
14 accessible. But I would just ask you to think about that.

15 DR. HOADLEY: Yeah, on that last point, I mean, I
16 think, you know, we have gotten some empirical data that
17 you've included in here that gives us some sense of the
18 spread and, you know, what the acquisition prices relate
19 and sort of how much of that 6 percent may be eaten up. So
20 I think that's a really good effort, and maybe I don't know
21 if there's more we need to do on that.

22 But I think on the other side, you know, one of

1 the things that we haven't mentioned, in this conversation
2 at least, is one of the other changes that was made back in
3 whatever legislation it was that created this whole ASP
4 system was to build in more administration fees because in
5 the old days it was viewed that the AWP-based price was,
6 you know, one of the rationales, at least post hoc, was
7 that it helped to cover the administration of the drug, and
8 there was no separate administration fee. So now there is,
9 and maybe one of the questions is to look at those admin
10 fees, and are they sort of calibrated correctly? And I
11 don't even remember now how much they vary by specific
12 drugs and so forth because, clearly, there should be
13 products within this array of products where there's a lot
14 more. And is it only relating to the actual
15 administration, or is it also covering the cost of storage?
16 You know, because one of the versions of that rationale is
17 it's at least that 6 percent some people would say was
18 supposed to cover, you know, the cost of going out and
19 purchasing it, the more administrative cost, and/or maybe
20 the storage, and sort of where does the administration fee
21 relate to those things. So I think that's actually a
22 really good notion of where to get a little more

1 understanding.

2 The other thing I would just mention based on
3 what Kathy said, I mean, I think one of the issues around
4 the coding, the common coding, is what's the manufacturer's
5 price response, because certainly some of the experience
6 overseas has been that when reference prices are set, the
7 manufacturer response is to change their price, either come
8 down to the reference product's price or at least to move
9 in that direction. And so, you know, you have to think
10 about what are the price response to these kinds of things,
11 and, again, relating to how the particular rules of a
12 reference pricing or a common coding system are set up. So
13 I think that's part of it.

14 And I think there is some research -- there's
15 something that should be available soon I've heard about --
16 that will draw some illustrations from what's going on
17 overseas on some of these issues that may be useful to us,
18 so we can talk offline about that.

19 DR. MILLER: Can I say just a couple of things?
20 And, by the way, on that very last point that you made,
21 yes, we would be interested, if you're aware of something,
22 just on the off chance that we missed it.

1 So David asked this question about do we think
2 this was all about profit, is it the distribution or the
3 buffer, whatever language was used, or was it to cover
4 other costs? And then everybody way saying, yeah, we
5 should definitely understanding those things better. So
6 I'm guessing that the two of you are having a heart attack
7 right about now. Is that correct?

8 [Laughter.]

9 DR. MILLER: And so I just want to -- yeah, so we
10 have two ways to proceed. I can sort of externalize what
11 some of the issues are or Nancy and I can agree that Kim
12 will do this and we'll just walk away.

13 [Laughter.]

14 DR. MILLER: I'm for the latter, Nancy. Go and
15 get a drink and -- okay. So the thing is you are correct
16 that we did present some information on acquisition costs,
17 and it was kind of a difficult analysis to process, and
18 there are reasons for that, which is it's proprietary data,
19 and we have to be very careful about the level that we can
20 use it at. And that's going to bear very directly on
21 profit and the buffering issues. And so getting the line
22 of sight that you may in theory want will be hard.

1 And then on the pricing points, like the
2 additional costs that occur in the delivery chain, my
3 sense, you know, the discounts that occur, prompt pay and
4 that type of thing, that stuff I also am under the
5 impression can be hard to get your hands around it.

6 So the only thing I want to say is we're not
7 saying, you know, absolutely not, we're not doing it, but
8 we are trying to set your expectations a little bit
9 differently. Okay?

10 DR. NERENZ: And just to be --

11 DR. MILLER: I was surprised you guys let all
12 those comments go by without --

13 DR. NERENZ: And just to be clear, the intent of
14 the question was not to induce a heart attack or even
15 extended work. I just thought if the legislative and
16 regulatory history of the plus 6 is known, okay, then --
17 then you could just say it's not known or it's not clear.
18 Either way, I just saying a statement. Either it's known
19 and here it is, or it's not known and it's not known.

20 MS. NEUMAN: And I thought what your question was
21 not just what did they think about then in terms of
22 creating it, but what do we think it should be about and

1 how does that bear on this policy option. And so we can't
2 answer the first question. We have some -- we had a
3 writeup in last year's, which we could include this year,
4 that goes through all the theories. But no one agrees on
5 what it was for originally. But that doesn't mean your
6 second piece can't be thought about, which is what should
7 it be for?

8 DR. MILLER: And that's the way I took your
9 question, and no problem asking it, because those were all
10 completely rational thoughts. I just want you to
11 understand that our ability to penetrate may be some --

12 DR. HOADLEY: Yeah, and I totally get the data
13 issues, and I think part of my point was that what you've
14 already done actually goes a fair distance towards
15 answering the distribution and cost question. And I don't
16 -- and when I was thinking about the administration, it
17 isn't so much some of those financial considerations, but
18 it's more the internal to the physician practice or
19 whatever in terms of -- and I realize that still may be
20 hard to do, but I don't know if there's been any look at
21 that since the law first went into effect.

22 DR. MILLER: I don't remember how far back your

1 memories go, but we did some of that way, way back, and it
2 was very difficult trying to extract that out, because,
3 again, there's not -- like the hospitals, you have a cost
4 report --

5 DR. HOADLEY: Right.

6 DR. MILLER: -- you can start to disaggregate,
7 and then the physician office world, we don't have a lot of
8 that.

9 DR. HOADLEY: But it may be just a matter of
10 looking back at what was done and seeing if that gives us
11 any clues or whether anybody -- the same way some of the
12 group practice groups or whatever have sometimes done
13 internal surveys, whether there's anything that can be
14 gleaned on that, obviously stakeholders have a stake, so
15 there's that issue.

16 DR. COOMBS: I might be in the minority, but I'm
17 wondering why there's a problem with the limit on ASP
18 growth. I mean, you might rationalize that it's
19 innovation, but I'm trying to think of the beneficiary, the
20 providers, and from that standpoint, from the beneficiary
21 and the provider standpoint.

22 DR. CROSSON: Do you want to take this outside?

1 No. I'm sorry.

2 [Laughter.]

3 DR. BAICKER: Debate rules, if you're referenced,
4 you're allowed to jump back in? She was very careful not
5 to use my name.

6 [Laughter.]

7 DR. BAICKER: So it strikes me as an artificial
8 price control that may or may not bear on the market
9 conditions that are underlying it. We don't say the price
10 of computers can go up by 2 percent a year. I don't care
11 what new capabilities it has. I don't care who enters the
12 market. I don't care how expensive it is to produce it.
13 Two percent a year, that's the answer. And the odds that
14 that's the right answer strike me as pretty low.

15 DR. COOMBS: I actually like that rationale, but
16 we don't apply that rationale to other industries around
17 this table. So I'm just thinking about -- well, no, I'm
18 just thinking about --

19 DR. BAICKER: You mean within health care.

20 DR. COOMBS: Yeah.

21 DR. BAICKER: Well, yeah, but we're busy trying
22 to introduce more competition and market pricing into other

1 things. We're saying, gee, fee-for-service isn't working
2 so well because we have to pick these numbers for the
3 prices to go up and we're guessing about a lot of things;
4 and, gee, if it was only more like a competitive market
5 where people were going where the highest value was and how
6 can we introduce better pricing and pricing that matches
7 value into those other sectors. So I'm in favor of
8 introducing that same logic elsewhere rather than saying we
9 have something here that is intended to be based on market
10 signals, let's just not.

11 DR. COOMBS: Okay. This is not a cat fight, but
12 I just wanted to bring that up.

13 [Laughter.]

14 DR. BAICKER: Nor did I think it was.

15 [Laughter.]

16 DR. HOADLEY: And there is some evidence -- I
17 mean, two points. One is we do this in Medicaid, so
18 Medicaid's rebate system does build in this same kind of
19 factor, so it's not like we haven't looked at that before.
20 And, obviously, people can argue whether it's working well
21 there.

22 Part of the issue is that there's evidence --

1 there's been a couple of studies in certain classes of
2 drugs where the trend is upward, and when a new product
3 comes in, the old products price themselves up to that new
4 higher price. And so, I mean, there's a lot of sense that
5 the market isn't working, and the question is: Is this a
6 method that would tame the market's failures? Or is there
7 another method that would address the market failures
8 better? And, you know, that's the notion -- some of these
9 common coding things, if we really had a sense that
10 politically we could throw these things into one category
11 when there are competing products. But there are some
12 issues. I mean, when we tried to do that with least costly
13 alternative, you know, it ended up in court and got kicked
14 out.

15 And so I think that's exactly the tradeoff that
16 this menu of options is getting us at, but I wouldn't want
17 to take this one off the table prematurely.

18 DR. BAICKER: And I completely agree that we are
19 not in any way at perfect competition in these markets, and
20 I think you're both raising that important point. And so
21 the solutions to that that seem most appealing to me are
22 more along the lines of bundled payment and value-based

1 pricing or reimbursement rather than just picking a number.
2 But I'm very much in agreement that we don't -- we're
3 nowhere near competitive equilibrium in these markets now.

4 DR. CROSSON: Thank you very much, Kim and Nancy.
5 More to come.

6 [Pause.]

7 DR. CROSSON: Okay. Our next topic is using
8 encounter data for risk adjustment in Medicare Advantage.
9 It's a topic we have had as a discussion item before.
10 We're going to get a little bit more in-depth in that.
11 Andy Johnson and Dan Zabinski, and who is starting, Andy?

12 DR. JOHNSON: Yes, thanks, Jay.

13 Good afternoon. In this session, Dan and I are
14 going to discuss the risk adjustment model used to pay MA
15 plans. In particular, we're going to focus on issues to
16 consider if the risk adjustment model was modified to take
17 into account MA plan cost information rather than provider
18 costs from fee-for-service Medicare.

19 We are going to trade off presenting three
20 topics. I will begin with an overview of how payments to
21 MA plans are risk adjusted and how fee-for-service Medicare
22 cost data is used to develop the current risk adjustment

1 model. Then Dan will discuss theoretical issues to
2 consider if the risk adjustment model was modified to be
3 based on MA plan costs from encounter data. Finally, I
4 will discuss the state of the MA plan cost information in
5 encounter data and some practical issues related to using
6 the MA encounter data for risk adjustment.

7 Now to start with an overview of MA risk
8 adjustment. Medicare pays a monthly payment to MA plans
9 for each enrollee. These payments are the product of two
10 factors: a base rate that is plan and locality specific,
11 and a beneficiary-specific risk score. The base rate
12 represents the average spending for the fee-for-service
13 beneficiaries in a given locality. The risk score adjusts
14 the base rate by increasing payment for beneficiaries with
15 expected medical expenditures that are higher than average,
16 and vice versa. A risk score is calculated for each
17 beneficiary based on his or her demographic characteristics
18 and whether he or she has certain medical conditions. The
19 CMS-HCC risk adjustment model groups medical conditions
20 into hierarchical condition categories, or HCCs, which are
21 identified by diagnosis codes.

22 The first step in risk adjustment is calibrating

1 the CMS-HCC model. Through model calibration, CMS
2 estimates the expected medical cost associated with a
3 beneficiary having a particular demographic characteristic
4 or HCC. Each expected medical cost is then divided by the
5 average fee-for-service spending amount, generating a
6 coefficient that is proportional to average fee-for-service
7 spending. The middle column of this table shows the
8 expected medical cost for a few example demographic
9 characteristics and HCCs. In the right column, the
10 expected medical costs have been divided by average fee-
11 for-service Medicare spending of \$9,050 to generate a
12 proportional coefficient for each characteristic and HCC.

13 The second step in risk adjustment is calculating
14 a risk score for each MA enrollee. CMS identifies the
15 relevant medical conditions or HCCs for each enrollee and
16 then adds together the relevant coefficients. The risk
17 score for a beneficiary with average expected medical costs
18 is 1.0. In this table you can see that the risk score for
19 an 85-year-old male with congestive heart failure is 1.077.
20 This risk score represents expected medical costs that are
21 7.7 percent higher than the average fee-for-service
22 beneficiary.

1 To calculate the payment rate for this
2 beneficiary, CMS multiplies the risk score by a local base
3 rate. If this beneficiary were enrolled with an MA plan in
4 a county with a monthly base rate of \$1,000, the Medicare
5 payment to the plan would be \$1,077, which is the product
6 of the risk score and the base rate. Because the risk
7 adjustment model that is used to pay MA plans is currently
8 based on fee-for-service cost information, \$1,077 is also
9 the monthly amount that this MA enrollee would have
10 expected to cost if he was enrolled in fee-for-service
11 Medicare.

12 This chart shows the flow of risk-adjusted
13 payments with the vertical arrows and the two sources of
14 medical cost data that could be used to calibrate the risk
15 adjustment model with the horizontal arrows. Risk scores,
16 shown in yellow, adjust the capitated payments that
17 Medicare pays to MA plans. In the current risk adjustment
18 model, risk scores are calibrated using fee-for-service
19 Medicare payments to providers, shown in green, and,
20 therefore, reflect treatment costs in fee-for-service
21 Medicare.

22 However, CMS has been collecting encounter data

1 which includes information about MA plans' payments to
2 providers, shown in blue. A risk adjustment model could be
3 calibrated on this data and would reflect MA plans' costs,
4 which is our term for the aggregate of a plan's payments to
5 providers. CMS is working toward calibrating risk scores
6 on MA plan payments to providers using the encounter data.

7 Now Dan is going to discuss some theoretical
8 issues to consider if such a risk adjustment model were
9 implemented.

10 DR. ZABINSKI: An important point from what Andy
11 just talked about is that CMS currently uses data from fee-
12 for-service beneficiaries to calibrate the CMS-HCC model
13 and then uses that model to determine risk scores for MA
14 enrollees. And this difference between the population the
15 CMS-HCC model is calibrated on and the population that it's
16 applied to has resulted in two incentives for the MA plans.

17 First, the plans have an incentive to encourage
18 more intensive coding of conditions than what you have in
19 fee-for-service Medicare because all MA payments depend on
20 the conditions that are coded while fee-for-service
21 payments for most services don't. And research, such as an
22 analysis by Kronick and Welch, indicates that plans have

1 responded to this incentive, and this leads to higher MA
2 risk scores and payments. In response, CMS applies a
3 uniform downward adjustment to all MA payments.

4 Second, Newhouse and colleagues made the
5 comparison of the cost of treating conditions in a large MA
6 plan to the cost in fee-for-service Medicare, and they
7 found that some conditions -- such as diabetes and cancer -
8 - were less costly in the MA plan while other conditions --
9 such as major organ transplant -- were more costly in the
10 MA plan. They identified factors that explain these
11 differences in costs between MA and fee-for-service
12 Medicare, and it's plausible that these factors also apply
13 to most other plans. Therefore, differences between MA and
14 fee-for-service Medicare in the cost of treating conditions
15 may be widespread. And to the extent there are widespread
16 differences in the costs between these two sectors, there's
17 an incentive for the MA plans to avoid beneficiaries who
18 have conditions that are more costly to the plan than to
19 fee-for-service Medicare and to attract beneficiaries who
20 have conditions that are less costly to the plan.

21 Now, earlier, Andy discussed risk adjustment that
22 is calibrated using encounter data from MA plans rather

1 than fee-for-service mc. And now we're going to discuss
2 the pros and cons of using encounter-based risk adjustment
3 in place of the current fee-for-service-based model. Doing
4 this would end the need to adjust MA payments for the more
5 intensive coding in MA because there would no longer be a
6 difference in the coding intensity between the population
7 used to calibrate the model and the population that the
8 model is applied to. But plans still have an incentive to
9 code intensively because MA payments still depend on the
10 conditions that are coded.

11 Also, the incentive for MA plans to avoid
12 beneficiaries who have conditions that are more costly in
13 MA than in fee-for-service Medicare would be eliminated
14 because the coefficients on the conditions in the CMS-HCC
15 model would now reflect the cost of treatment in MA, not
16 fee-for-service. However, plans would have an incentive
17 then to compare their costs to the costs of the average
18 plan because the CMS-HCC coefficients would then reflect
19 average costs. So for a given plan, it may then be
20 beneficial to avoid a new set of conditions.

21 A final issue concerning using encounter-based
22 risk adjustment is that it is inconsistent with MA payments

1 that are financially neutral with fee-for-service Medicare.
2 In the past, the Commission has supported financial
3 neutrality, where payments for MA enrollees equal 100
4 percent of local fee-for-service spending after adjusting
5 for risk. This has the benefit of encouraging care to be
6 provided in the sector that is more efficient, MA or fee-
7 for-service Medicare. For me, it's easiest to explain
8 financially neutral MA payments with the formula that's in
9 the second primary bullet. In a given county, you need a
10 base payment amount that equals what the national average
11 fee-for-service beneficiary would cost in that county. And
12 for each beneficiary who enrolls in MA, you multiply that
13 base amount by a risk score from a model that is based on
14 fee-for-service data. If either or both of these two parts
15 of this formula are not used, financially neutral payments
16 will not occur. Therefore, if an MA enrollees' risk scores
17 are from a model based on encounter data rather than fee-
18 for-service data, MA payments will not be financially
19 neutral with fee-for-service Medicare.

20 Now Andy will discuss our evaluation of the
21 encounter data that we have.

22 DR. JOHNSON: So far, our evaluation has focused

1 on assessing the feasibility of using MA encounter data to
2 calibrate a risk adjustment model. We evaluated 2013 MA
3 encounter data and found that information about
4 beneficiaries' conditions, or HCCs, are generally of good
5 quality. However, there are several issues to address
6 regarding plan payments to providers, as recorded in the
7 encounter data.

8 First, it is important to note that only medical
9 costs are included in the encounter data. Information
10 about plans' administrative costs and profits are not
11 included. Therefore, a risk adjustment model using
12 encounter data would be based only on payments to
13 providers, and all other costs would be reimbursed
14 proportionally.

15 A potentially more serious issue results from the
16 fact that many MA plans do not pay providers on a service-
17 by-service basis. For example, group model HMOs generally
18 pay a capitated rate to a medical group or independent
19 practice association, and staff model HMOs generally employ
20 physicians on salary. In either of these arrangements,
21 plans do not make individual payments for services or
22 encounters, making it difficult to determine the payment

1 for a specific encounter.

2 In the MA encounter data, CMS does not require
3 encounters provided under a capitated arrangement to have a
4 payment amount. A payment amount of 0 dollars is recorded
5 for these encounters. To get a sense of how common this
6 was, we compared an estimate of the aggregate amount MA
7 plans paid to providers in 2013 with the aggregate payments
8 to providers recorded in the encounter data, and we found
9 that the amount in the encounter data was about 30 percent
10 less. In a separate analysis, we confirmed our expectation
11 that encounters paid under capitation, and, therefore,
12 without a payment amount recorded, were concentrated among
13 certain plan types.

14 Before MA encounter payment data can be used to
15 calibrate a risk adjustment model, a method needs to be
16 developed to address the capitated encounters without
17 payment amounts. From a practical perspective, we
18 identified three broad approaches.

19 The first method would not use MA encounter
20 payment information at all, but would use prices from fee-
21 for-service Medicare fee schedules and payment systems to
22 estimate the cost of each MA encounter. A risk adjustment

1 model incorporating fee-for-service Medicare prices, or
2 some other standardized pricing mechanism, would reflect MA
3 utilization patterns, but the cost structure of MA plans
4 would be lost. This method would be difficult to implement
5 as every encounter would need to be assessed under fee-for-
6 service payment policies.

7 A second method would calibrate a model using
8 only MA enrollees with complete payment information in the
9 encounter data. This method would incorporate both MA
10 utilization patterns and plan cost structure, but only for
11 plans with fee-for-service provider arrangements.
12 Beneficiaries receiving services from providers paid under
13 capitation would be excluded, and plans that are pure group
14 or staff model HMOs would be excluded entirely.

15 Finally, CMS could help plans develop a method
16 for allocating MA capitated payments to MA enrollees
17 receiving those services. Calibrating a risk adjustment
18 model only requires knowledge of each enrollee's annual
19 medical expenditures. Therefore, a plan's MA capitated
20 payments would only need to be allocated to an MA enrollee
21 and would not need to be allocated to individual services
22 or encounters. Developing and implementing such an

1 allocation method consistently across plans would have
2 significant challenges and would require additional time
3 and effort for plans with capitated provider arrangements.
4 However, this method would also offer the most
5 comprehensive representation of both MA utilization
6 patterns and cost structure.

7 In summary, using MA encounter data to calibrate
8 a risk adjustment model would have the following
9 implications: It would generally address the impact of
10 differences in MA and fee-for-service coding intensity on
11 Medicare spending. MA plans would still have incentive to
12 code more intensely, but doing so would only draw Medicare
13 payments away from other plans, creating competition among
14 plans based on coding. Although Medicare's budget would be
15 insulated, the incentive may produce inefficiency if plans
16 expend effort on coding that does not result in a
17 corresponding benefit to MA enrollees.

18 Second, an MA-calibrated model would generate
19 payment for a medical condition that is proportional to
20 average MA plan costs and thus would create competition
21 among plans to be among the most efficient for their
22 enrollees and the conditions they cover. This is in

1 contrast to the current model under which plans compete
2 with fee-for-service Medicare and can expect to generate
3 sufficient revenue by focusing on conditions that they can
4 cover more efficiently.

5 A third issue is that with an MA-calibrated
6 model, financial neutrality is no longer possible. In
7 other words, it would mean that Medicare expenditures for a
8 particular beneficiary would be different if the
9 beneficiary enrolls in MA or receives care through fee-for-
10 service Medicare. This situation may generate need for
11 additional policies. For example, under a premium support
12 program, beneficiaries would select MA or fee-for-service
13 Medicare based on cost signals. These cost signals would
14 differ by sector, potentially introducing incentives to
15 beneficiaries and plans that have unknown consequences.

16 The final issue presented today is that there are
17 several data and implementation challenges that would need
18 to be addressed before an MA-calibrated risk adjustment
19 model can be produced. These include developing a method
20 to address encounters paid under capitation, as well as a
21 process for validating encounter payment information before
22 using the data as the basis for risk adjustment.

1 Now I'll mention our plan for continuing to
2 assess the MA encounter data.

3 For risk adjustment, our plan is to assess the
4 feasibility of allocating MA plan capitated payments to MA
5 enrollees and then consider calibrating a risk adjustment
6 model with the complete set of MA plan cost information.
7 We would like your input on this direction, and we plan to
8 report back to you with our progress during the next
9 meeting cycle.

10 In the second set of work, we are continuing to
11 assess utilization patterns in MA and differences with fee-
12 for-service Medicare. We also plan present on those
13 findings during the next meeting cycle.

14 That concludes our presentation, and we look
15 forward to your discussion. Thanks.

16 DR. CHRISTIANSON: Thanks, Andy and Dan. This
17 was a really interesting chapter to me, but humiliating,
18 all the stuff you brought up that I hadn't thought of about
19 using MA encounter data.

20 [Laughter.]

21 DR. CHRISTIANSON: We'll do a first round of just
22 clarification questions, and I think the second round will

1 be more along the lines of what direction (should this go
2 at this point. We'll start here and go down.

3 MR. ARMSTRONG: So, first of all, unlike Mark,
4 I've been giving a lot of thought to the July retreat
5 agenda.

6 [Laughter.]

7 MR. ARMSTRONG: And I think we just landed on the
8 topic.

9 DR. REDBERG: Oh, it's just because you're not
10 going to be there.

11 MR. ARMSTRONG: I think you just landed on the
12 topic. Excuse me.

13 I guess my first question is -- I mean, this is
14 really complicated, but what's the problem that we're
15 trying to solve with this? Is it the accuracy of the risk
16 adjustment methodology? Or is it sort of the problems we
17 run into with trying to balance fee-for-service with
18 Medicare Advantage payment -- or neutralize?

19 DR. JOHNSON: I think it depends on who you ask.
20 I think some people have presented it as a way forward on
21 addressing the coding intensity adjustment, and others have
22 looked at it more towards the balancing of MA reimbursement

1 with plans' costs. So I think that is probably one of the
2 most important issues for you to discuss today and that we
3 would appreciate feedback on about what parts of moving to
4 MA encounter-based risk adjustment would be -- you know,
5 what would be the rationale and what would be the most
6 important reasons?

7 MR. ARMSTRONG: So maybe a quickly follow-up. So
8 we know that we are seeing higher risk scores in the
9 Medicare Advantage plans relative to the same population in
10 the same marketplace. But have we ever done a study as to
11 which one is more accurate? Is Medicare Advantage higher
12 intensity but actually more accurate? Or are we concerned
13 that it's overcoding and less accurate?

14 DR. JOHNSON: I don't think we have done a study,
15 but the two -- the differences in language I think are used
16 by different people at different times. And I don't know
17 that, you know, there's necessarily something negative
18 going on with Medicare Advantage coding. I tend to look at
19 it just as a fact that right now the only available data or
20 source of data for diagnostic information and costs for the
21 same set of beneficiaries is fee-for-service; and,
22 secondly, that there are coding differences given the

1 different incentives in the two sectors. So as a result of
2 those two, an adjustment is necessary. But I do take your
3 point about the type of language used to describe them,
4 yeah.

5 MS. BUTO: Just a follow-up to that, Andy. Can
6 you be more specific about where in fee-for-service the
7 coding accuracy is not where it might otherwise be?
8 Because I know that inpatient hospital coding is king,
9 right, in terms of getting the right DRG payment? It's one
10 of the big pots of money. Where exactly -- because I think
11 you contrasted and said the MA plans have a greater
12 incentive to code and I guess reflect intensity. But I'm
13 just wondering where are we not seeing that on fee-for-
14 service?

15 DR. JOHNSON: You're definitely right on the
16 inpatient hospital as also having similar incentives to
17 code completely inaccurately. I think that the number of
18 diagnoses that go into the risk adjustment model, whether
19 or not they are the sole source, 80 percent of them come
20 from physician claims and outpatient. So, there is -- to
21 the extent that there is an effect from the inpatient
22 diagnostic information, that's only a small set of the

1 total diagnoses going into the HCCs.

2 MR. ZABINSKI: And, I'll add to that. There's
3 been a number of studies done on sort of consistency of
4 coding chronic conditions over time in MA versus fee-for-
5 service, including by MedPAC, and, you know, it's clear
6 that the consistency of coding the chronic conditions is
7 steadier in MA than fee-for-service. In other words, you
8 have somebody who's got, for example, diabetes. It doesn't
9 go away. They always have it. But, on fee-for-service
10 claims, appear in one year but not the next year. Well,
11 MA, it's pretty consistent, and I think primarily, as Andy,
12 I think, was alluding to, is that that's because the
13 physician and the OPD, which are two big factors in
14 determining the conditions, there's no incentive in the
15 fee-for-service side to actually code conditions because
16 every payment is on the basis of what's done, not what the
17 conditions that the beneficiaries have.

18 DR. CROSSON: We're going down this way. Mary.

19 DR. NAYLOR: So, my question really relates to
20 principle, because after that, I wouldn't have a clue.
21 But, as you're thinking about, you know, the value of
22 severing a principle of financial neutrality in order to

1 get to risk adjustment for MA, with that principle of
2 financial neutrality driven, undergirded by the opportunity
3 to get to a more high-value Medicare program overall, I'm
4 wondering, you know, if you've assessed what's the
5 potential loss from severing that principle to the
6 potential gain from a better system of risk adjustment, if
7 that makes any sense.

8 MR. ZABINSKI: Okay. I think Andy wants me to
9 handle that one. Okay.

10 [Laughter.]

11 MR. ZABINSKI: I'm looking at him. He's looking
12 at me.

13 Well, I'm not sure if this is going to be
14 helpful, but I'll try. Okay. You know, you have the
15 financial neutrality, and the idea there is that it causes
16 incentives to go to the more efficient sector, or not
17 incentives, necessarily, it encourages the more efficient
18 sector. And, you know, you need fee-for-service-based risk
19 adjustment to do that.

20 Now, what -- you know, the problem with the fee-
21 for-service -- this is speaking largely from my own
22 viewpoint -- is that you have these coding incentive

1 differences between the two sectors, and you've got the MA
2 being higher intensity coding. So, the payments end up
3 being higher than what you would expect. And when you get
4 down to it, that actually defeats financial neutrality
5 right there.

6 So, there's this -- you've got to weigh -- those
7 are the two trade-offs, you know, getting to the more
8 efficient sector or sort of paying what the beneficiary is
9 actually expected to cost.

10 DR. NAYLOR: [Off microphone.] Thank you.

11 DR. CROSSON: Okay. Bill.

12 MR. GRADISON: Perhaps this is in this paper or a
13 prior one, but do you have any data with regard to the risk
14 adjustment for beneficiaries who have left MA to come to
15 fee-for-service, not necessarily come back to fee-for-
16 service, but there is a certain amount of movement in that
17 direction now and then, and I would just be interested in
18 any data that you might have that would compare the risk
19 adjustment that had been assigned by the MA plan to the
20 people who left it to come to fee-for-service versus how
21 they would be rated once they come back to fee-for-service.

22 MR. ZABINSKI: Well, I've done some work, and

1 others, as well, in terms of looking at that population in
2 terms of what they actually cost. They tend to be real
3 high-cost people with real severe conditions. As far as
4 coding of conditions, I've never done anything and I'm not
5 really aware of any -- you know, I'm looking over at
6 Carlos, if he's aware of any --

7 DR. MILLER: I would say there were actually a
8 couple parts to this question. Just to nail down the first
9 part that he answered, it sounded like the first part of
10 your question, and you tell me if this is right, is if
11 someone leaves a managed care plan and returns to fee-for-
12 service, what kind of a -- in a risk profile, what kind of
13 patient is that? They tend to be, Dan, the more sick, more
14 expensive patients, and he did some work on this, I don't
15 know, four years ago, something like that. We could pull
16 that back up and put it in front of you. There are not
17 huge percentages of people who leave the plan on that
18 basis, but when they do, they look like they are sicker.
19 And, Dan, my recollection is you've found that, and to the
20 extent other people have looked at it in the literature,
21 it's pretty consistent, what's found there.

22 MR. GRADISON: Well, that is a different question

1 than --

2 DR. MILLER: Oh, then I --

3 MR. GRADISON: -- the question of how they were
4 rated, how they were --

5 DR. MILLER: Well, then I was going to go to the
6 coding part, because there was sort of a leave part of your
7 question and then a coding part. And, Scott and Carlos
8 should be -- don't be shaking your head. You did do
9 something on this.

10 [Laughter.]

11 DR. MILLER: And, also, the whole shaking and
12 nodding is after I ask something, okay. That's the plan.

13 [Laughter.]

14 DR. MILLER: What I thought you guys did recently
15 -- and Carlos covers his face. All right, they're being
16 less than constructive.

17 [Laughter.]

18 DR. MILLER: So, what they were saying is that
19 what you find, when somebody enters the managed care plan,
20 they tend to look like they are more healthy, or their
21 codes are lower, right. Then as they stay in managed care,
22 their code goes up. And, of course, this is the other

1 side, and I want to say this very gently to the managed
2 care folks, but this is always this phenomenon of, like,
3 well, we're not coding more. We're just coding more
4 accurately. But, it also can look like you join managed
5 care and you become sicker, and we don't think that's
6 what's going on. You join managed care, and as they very
7 clearly pointed out, there is a real strong incentive to
8 code that diabetic every time they show up, whereas in fee-
9 for-service, since it's the office visit, not so much.

10 And, so, the phenomenon is you enter, in a sense,
11 looking more healthy, less codes, and then over time, that
12 code and your risk profile goes up over a series of years.
13 Now I get a nod? Okay. Thank you.

14 So, that's sort of the pieces of your question.
15 So, they kind of enter, you know, lower than average, and
16 then creep up above average over time.

17 MR. GRADISON: But, that's not really the
18 question. The question is --

19 [Laughter.]

20 MR. GRADISON: When they -- that particular --

21 DR. MILLER: It was a good answer.

22 [Laughter.]

1 MR. GRADISON: That was a good answer, a good
2 answer to a different question.

3 [Laughter.]

4 MR. GRADISON: But, when this particular small
5 group moves from MA to fee-for-service, how were they at
6 that most recent year coded when they were in the MA plan
7 and then how did they become coded in fee-for-service once
8 they made the move?

9 This has nothing to do with -- when you say, as
10 some folks here have said, going back to fee-for-service.
11 They may never have been in fee-for-service, so I'm not
12 phrasing it that way.

13 DR. JOHNSON: I don't know of any research that
14 has looked at that, but it's --

15 DR. MILLER: Right --

16 DR. CROSSON: Can we have that ten minutes back?

17 [Laughter.]

18 DR. MILLER: But, by inference, if it goes up
19 when they enter MA, you would almost expect it to come down
20 when they exit.

21 DR. JOHNSON: You would expect that, yeah.

22 DR. CROSSON: David.

1 DR. NERENZ: A quick check. Are we separating
2 round one and round two here?

3 [Laughter.]

4 DR. NERENZ: I don't think so, but I --

5 DR. CROSSON: Yeah. Clarifying questions.

6 DR. HOADLEY: So, one small question on the
7 coding thing. Has there been any sense of that pattern of
8 less coding in fee-for-service changing as more use of
9 electronic health records, where you would think there was
10 the potential for the diagnoses just to be in the system
11 and then to be kicked out on the claim?

12 DR. JOHNSON: There is some. I don't know that
13 we have done a comprehensive look, like an overtime look to
14 see if the rate is going up. We have not done that. But,
15 there are elements in discussion of pathways in which that
16 seems to be happening in fee-for-service.

17 DR. HOADLEY: So, at some point, one could
18 imagine that the differential that we're sort of thinking
19 about, how the coding, could be reduced, go away,
20 something. I mean, that's too much to say empirically.

21 DR. JOHNSON: Right.

22 DR. HOADLEY: My other question, on the Newhouse

1 study that you talked about, the statement in the chapter
2 was that the cost of treating specific conditions differs
3 widely between, and I guess they looked at one MA plan
4 versus fee-for-service. Any sense of the -- can you
5 characterize in any better way the magnitude of that
6 difference, and then how much it's just in a few conditions
7 versus lots and lots of conditions?

8 MR. ZABINSKI: Oh, the differences were in most
9 conditions --

10 DR. HOADLEY: Okay.

11 MR. ZABINSKI: -- and the differences were wide
12 in some of them.

13 DR. HOADLEY: Okay.

14 MR. ZABINSKI: How to say -- and, some were
15 higher in MA, some were lower in MA. I mean, you've got to
16 think -- realize, everything's done in relatives here --

17 DR. HOADLEY: Sure.

18 MR. ZABINSKI: -- so, everything's sort of like a
19 fraction or decimal. And, so, it's sort of -- that's a key
20 thing to understand. So, yeah. But, there were really
21 wide differences between --

22 DR. HOADLEY: Okay. That's helpful. And, I

1 guess one of the interesting questions, and maybe this is
2 something more in round two, in the work plan, is the
3 extent that we can see, you know, was that one plan typical
4 and how much variation. Are there some kinds of plans
5 where you wouldn't see those wide differences? I mean, one
6 could imagine integrated systems having a much wider
7 difference than systems that are more sort of internally
8 fee-for-service.

9 MR. ZABINSKI: Well, you know, they sort of
10 talked about, in the paper, sort of three factors that they
11 identify for creating these differences, and I sort of
12 thought about it, and, like, it seems like they should be
13 applicable to most, if not all, plans. So, my guess is
14 might be pretty widespread.

15 DR. CROSSON: Next, Cori.

16 MS. UCCELLO: So, also on the Newhouse study,
17 it's both price and utilization that varies between them
18 that's causing those. But, is there anything that's -- and
19 those vary by condition. It seems like some conditions
20 could be more price is dominating the difference, and in
21 others, it's utilization. But, are there any patterns at
22 all on which overall seems to be more important, or is it

1 just really all over the place?

2 MR. ZABINSKI: I mean, can you --

3 MS. UCCELLO: Meaning, you know, at the end of
4 the day, is price or utilization more important?

5 MR. ZABINSKI: From the paper, I couldn't glean
6 anything in that respect, no.

7 DR. CROSSON: So, just on that. So, in the
8 paper, there's no -- which I haven't read yet -- there's no
9 differentiation between so-called discretionary procedures
10 and non-discretionary?

11 MR. ZABINSKI: No. No.

12 DR. CROSSON: Bill.

13 DR. HALL: Is there any proprietary data that you
14 could mine on this subject? It seems to me that any
15 insurance company with a vested interest in MA might want
16 to understand the differences when they see a MedPAC report
17 that says we're taking a look at this whole situation. Is
18 there any possibility of getting access to any of that?

19 DR. MILLER: Look at what, the price utilization
20 difference or some other --

21 DR. HALL: Yeah. Yeah. Doing exactly what we're
22 doing, but from the perspective of the insurance company.

1 DR. MILLER: Umm, well, I mean, we're going to
2 pursue this using the encounter data, which will be a
3 pretty good data source but for the problem of the
4 capitation stuff that Andrew walked through at the end,
5 which, in theory, could preclude the need to do this -- to
6 go to another insurer.

7 That distinction that Cori was just talking
8 about, whether we could get more information about price
9 and utilization, might be something that we could get more
10 precision on if we went out to an insurance company. I
11 would have some reservations about how generalizable that
12 is. You know, the prices are negotiated between that
13 particular payer in that particular part of the country,
14 depending on what their spread is and all the rest of it,
15 and whether it would tell you what you would expect to find
16 in all the rest of the industry, which is not a way -- you
17 know, it's not, hell, no, it's just I would have to think
18 about the value.

19 DR. JOHNSON: I think the other way that we've
20 looked at that is that leads to sort of the three broad
21 approaches that we presented, and that instead of looking
22 at one specific plan, we can use MA utilization information

1 and tack onto it fee-for-service spending, which has its
2 own pros and cons. We could look at just the plans for
3 which we have complete information, the encounter data,
4 which also has its own pros and cons. Or, we can try and
5 sort of fill in or allocate the capitated spending. So, I
6 think that seems like a more -- that's our plan, I guess,
7 for heading forward rather than a specific plan, so --

8 DR. CROSSON: Kate.

9 DR. BAICKER: So, just -- I want to be sure I'm
10 clear on the use of financial neutrality as you're using it
11 now, that that's different from budget neutrality in that
12 you could, for whatever rearrangement of the schedule you
13 did for people -- for the risk adjustors, you could then
14 scale it such that it was budget neutral between MA and
15 fee-for-service writ large. But for any individual person,
16 the way you're using financial neutrality is the Medicare
17 program is paying the same for that person regardless of
18 whether he or she is in an MA plan or a fee-for-service
19 plan. And then the problem you're potentially trying to
20 solve is that generates differential incentive to enroll
21 people in MA because some people can be treated more cost
22 effectively in MA and some people are more expensive in MA,

1 and so the fact that the risk adjustors are done off of
2 fee-for-service creates differential incentives across
3 people, but it's not an issue of program budget neutrality.

4 DR. JOHNSON: That's correct.

5 DR. BAICKER: Okay. Good.

6 DR. MILLER: [Off microphone.] I just want to
7 say, she did that in two minutes -- when we did that
8 internally. That was that conversation we had. Good job.

9 DR. CROSSON: Craig.

10 DR. SAMITT: So, just a small clarification. On
11 Slide 11, when you talk about the third category of a
12 method for addressing the capitated encounter gap, would
13 you have each plan independently determine how to allocate
14 their capitated payments to their various clinicians, or
15 would there be a standard methodology by which all plans
16 would do that?

17 DR. JOHNSON: Ideally, it would be a standard
18 methodology across plans. There are several complicating
19 factors to address and it's unclear just how feasible that
20 is or what sorts of -- the magnitude of those issues as
21 they are able to be sorted out or not.

22 DR. SAMITT: All right. I'll come back to that

1 in round two.

2 DR. JOHNSON: Okay.

3 DR. CHRISTIANSON: Another quick question. On
4 Slide 10, at the top, you talk about the HCC data is good
5 quality. Could you remind us of the metrics that you use
6 to decide whether data is good quality or not?

7 DR. JOHNSON: We took a look at the risk score
8 file as it is identified through the RAPS data, which is
9 the submission process that's been going on for several
10 years, and looked at HCCs as identified in the encounter
11 data and did a comparison, and they tended to be -- have a
12 decent amount of overlap and, I guess more importantly, the
13 total number of payments identified based on those HCCs or
14 the risk scores themselves in some were very similar.

15 DR. CHRISTIANSON: So, it's completeness that
16 you're using as --

17 DR. JOHNSON: Correct.

18 DR. CHRISTIANSON: -- relative to the other data
19 sets.

20 DR. JOHNSON: That's correct.

21 DR. CHRISTIANSON: Okay.

22 DR. CROSSON: [Off microphone.] Clarifying

1 questions.

2 MS. BUTO: Just a quick question. Does this --
3 how does this complicate that comparison that we were doing
4 a while ago within certain market areas, looking at which
5 is more considered a better value for the beneficiary -- a
6 better value, period, whether it's MA, fee-for-service, or
7 potentially ACOs? I mean, how does this complicate that?

8 Let's take the hypothetical of a MA plan that has
9 a high risk score using MA data, somehow. So, it actually
10 costs the program more, but may still be an efficient and
11 high value provider of care vis-a-vis a more unconnected,
12 uncoordinated fee-for-service system. I just wonder how
13 you -- does that make the comparison just that much more
14 complicated?

15 MR. ZABINSKI: I think it does, yes. It adds an
16 additional -- I think what you're getting at, it adds an
17 additional, at least one layer of, you know, another
18 variable to consider when thinking about which sector is
19 more efficient. So, yes, it does.

20 DR. JOHNSON: And the other area we've discussed
21 that with respect to is with premium support, where in
22 those given markets you're looking at whether the average

1 of MA plans is more or less efficient relative to fee-for-
2 service Medicare, but that may depend for an individual
3 beneficiary who now has a different risk score or an
4 expected set of program payments, whether they enroll in
5 fee-for-service or MA. It definitely complicates the
6 incentives and how the budget works out in the end.

7 DR. CROSSON: Okay. I think we're ready to go to
8 general discussion. So, I think what would be most helpful
9 here is to try to provide guidance to the staff in two
10 areas. Are there some, you know, fatal flaws or poison
11 pills that have been developed that you heard in the
12 presentation that would suggest this is a really big
13 problem with proceeding, and then if that's so, what could
14 be done, if anything, to overcome that.

15 And then maybe the second part is, assuming
16 that's not the case, and we're getting -- this is going to
17 be a technical discussion, I think, for those who think
18 that way -- you know, what advice would you give to the
19 staff so that when we come back to this the next time, the
20 choices are honed as well as they can be, something like
21 that.

22 Craig.

1 DR. SAMITT: So, I actually would have rather
2 spent the whole time talking about your very last bullet,
3 which was utilization patterns, because, frankly, I think
4 that's where the meat of the opportunity will be in the
5 encounter data, more than risk adjustment. So, I'm looking
6 forward to the next presentation.

7 But, that being said, I actually am in favor of
8 the direction here. I think that looking at encounter data
9 provides progress for us, frankly, because of all the
10 reasons that we've described that the current HCC-based
11 risk adjustment model has inaccuracies, whether it is that
12 we under-predict payments for the very ill or that we over-
13 predict payments for the well, or that there's concern
14 about driving higher intensities of coding that don't
15 necessarily match the clinical condition.

16 Although, I must say, as one of the MA guys in
17 the room, in the defense of MA, coding is viewed in our
18 world very much as a documentation resource to identify
19 those patients that have the highest needs for which we
20 need to allocate supplemental resources and care
21 coordination. So, there's a wealth of additional services
22 that MA plans provide that are based upon sort of the more

1 accurate coding representations. So, yes, a side effect is
2 that it affects risk adjustment, but I think the primary
3 purpose is to assure that we have the resources necessary
4 to support the needs of those members.

5 So, given my comments that I think I'm in favor
6 of the progress we've made, I'm not a whole lot more
7 confident about the encounter data, given all of the gaps
8 that you described. I'd love to learn more about the
9 three, you know, potential scenarios to address them, but I
10 have to admit, I don't like any of them. None of them
11 sound very good. So, using fee-for-service Medicare
12 information feels as if -- it feels like we're confounding
13 the separate risk adjustment methodology we're trying to
14 create.

15 In terms of excluding MA plans that actually
16 subcapitate their provider groups, I think that's a
17 terrible idea, because, frankly, I would imagine that you
18 would see the most efficient care and the best outcomes in
19 those groups that do receive capitation from MA plans. So,
20 I think we'd see that in the utilization data. So, I don't
21 think that's good.

22 And, then, as someone who in the past has tried

1 to allocate capitation payments to various specialties and
2 providers and determining a methodology to do that, it's a
3 crazy methodology to try to even start to think about, and
4 more power to you if you can come up with a methodology,
5 but I think many folks have tried that unsuccessfully, to
6 figure out what the right methodology would be.

7 So, I take a step back and I jump on Scott's
8 recommendation. Maybe this is a good topic for us to
9 discuss in July, because I'd be in favor of stepping back
10 and saying, is there a better way to think about risk
11 adjustment? How do we use HCC? How do we use encounter
12 data? I think we would all agree that we don't really have
13 a clinically relevant and clinically accurate risk
14 adjustment methodology. What are we missing, and is there
15 some other approach?

16 Maybe we can use encounter data to make this
17 better, but I feel like we need a more inclusive,
18 transparent risk adjustment development methodology with
19 experts from the field. I think there are a lot of people
20 that I talk to around the country that are trying to get
21 their arms around what more accurate risk adjustment would
22 look like. It feels to me like we should be thinking more

1 broadly and at a higher level about how we accomplish what
2 we're trying to accomplish with risk adjustment.

3 Finally, you know, I'm trying to figure out how I
4 feel about this notion of financial neutrality and whether
5 we really care about linking creating financial neutrality,
6 especially as it relates to our discussions about premium
7 support. You know, everyone's going to be incented to
8 deliver the highest quality outcomes at the lowest cost,
9 and so everyone is going to need to care about the cost of
10 services. And so I don't know why we would need to assure
11 financial neutrality, if beneficiaries will select the
12 highest value alternative, whether it's MA or fee-for-
13 service. So maybe I'm missing something, but I'm not sure
14 why we would have to link neutrality in this particular
15 case.

16 DR. CROSSON: Kate.

17 DR. BAICKER: So there's a lot to chew on here
18 that I think is really interesting, and I am trying to
19 think through along the lines Craig was saying about which
20 way of doing the adjustment promotes what we're trying to
21 do. And I think what we're trying to do is the
22 beneficiaries we want to most move over into MA are the

1 ones where the efficiency of the resource use is going to
2 change the most. There is where there is the most return
3 to getting people to move over.

4 So one small implication of that is that even
5 though it seems it may be impractical -- and I'm very much
6 open to persuasion on that front, but applying the fee-for-
7 service prices rather than the MA prices seems like it
8 would further that because you want strong incentives for
9 the MA plans to negotiate lower prices. You don't want to
10 take that back from them in the adjustment, but it may be
11 impractical. Conceptually, it seems like that makes sense
12 to me, and conceptually, you want to maintain the incentive
13 for returns to the plan of better managing care in reducing
14 resource use conditional on achieving high-quality, good
15 outcomes for people.

16 So, in some ways, the problem that seems the most
17 important to solve is the coding intensity one, and the
18 question is how do you solve the incentive to the return to
19 coding more without undermining the return to manage
20 resources better. And that's the part that I'm having
21 trouble thinking through right now, and I don't know if
22 there's some hybrid of these options where you take the

1 average -- you know, you use the coding from the encounter
2 data, but then somehow use average utilization. I'm having
3 trouble thinking about how to take the coding intensity out
4 while not undermining the incentive to use resources
5 better. So that's not a suggestion that's actionable in
6 any way, except for the hard -- except for the impractical
7 one about the pricing.

8 But that's the goal I'd be trying to achieve in
9 thinking about which parts of the encounter data to use in
10 combination with the fee-for-service data. Maybe Dave will
11 figure it out by the time it gets to him.

12 DR. CROSSON: David, you had a point over here
13 before.

14 DR. NERENZ: I was going to follow on Craig's
15 point, but now I find I can follow on both, and I would
16 just do a slightly different pathway but get to the same
17 point.

18 When we talk about the risk adjustment, we
19 appropriately talk a lot about incentives. We don't want
20 to create bad incentives. We want to provide good
21 incentives.

22 But another way of just using words to talk about

1 risk adjustment is protection, and now we don't think about
2 what plans actively do. We think about what they can't
3 control, and that's also one of the strongest rationales
4 for risk adjustment. You want to protect plans or provider
5 against variations that they cannot control, and if we
6 assume that plans, for example, don't have a lot of control
7 about who comes in, that's why you do this kind of risk
8 adjustment. Okay.

9 Now, when we look at the description in the text
10 about the study, page 12 and 13, I think it is, when you
11 talked about why District of Columbia this MA plan have
12 lower cost, the things in there were things that were under
13 their control, that they did better negotiating of networks
14 or they did better care coordination or did something.

15 Now, here's now where it's going to tie back in.
16 I don't think you want to adjust that away. I think you
17 want to reward that. So I think that's why I was nodding
18 when you said -- I'm using different words, but I think
19 it's the same point. This difference is not something that
20 is outside the plan's control. The difference is within,
21 and in a good way within. So that leads me to say maybe
22 the way to do this is to go ahead and use the fee-for-

1 service data to set sort of the expected cost or the sort
2 of uncontrolled cost or the unmanaged cost, and then you
3 bring that in. And if the MA plan or plans, plural, can do
4 a better job managing those conditions, good. Good for
5 them. You don't want to adjust away that action, or you
6 don't want to discourage it.

7 So take it to extreme. Let's say that that
8 happens, and now plans can act. And so now what happens is
9 the people who can be treated very efficiently end up more
10 than average in MA plans, and those who can't be treated
11 efficiently end up more than average in fee-for-service.
12 Why is that bad? That's probably a really good thing, and
13 if a net result of that on a large scale is that the MA
14 plans are now all of a sudden making a lot of money, well,
15 now you go back and you deal with the base rate. You don't
16 necessarily need to deal with the HCC calibrations. That's
17 really about the -- among plan adjustment.

18 Anyway, I was feeling I was in agreement with
19 both places, but slightly different paths to get there.

20 DR. BAICKER: And just to close the circle on
21 that, the productive part of moving the patients from one
22 plan to another is the change in real resource use. If

1 it's just a shell game about differential coding and it's a
2 race on coding, but there's no change in actual health care
3 resources used, there's no gain. And that's what's
4 underlying this financial neutrality tension in some ways,
5 is the whole purpose of this exercise is that there's a
6 difference in resource, in real resource use between MA and
7 fee-for-service. If they were the same, we wouldn't be
8 worried about all of these incentives, and so that's
9 another avenue in thinking about the premium support
10 question that you raised.

11 I don't think this difference is problematic
12 necessarily for premium support, introducing this gap,
13 because the marginal incentives are still going to be the
14 same. You're changing the per-person dollar amount for any
15 given person, but for that person, there's still the
16 incremental gain to going to the plan that is offering the
17 highest value care at the lowest cost. So I think it's all
18 about finding the patients who would benefit most from
19 being in an alternative plan and setting up the incentives
20 to reward that.

21 DR. MILLER: Can I ask one thing? And I'm having
22 a bad day, so I'm afraid to ask this, but the other thing

1 in your comments -- and I did follow your summation there,
2 but when you went through your first round and we were
3 talking about these methods and Craig was -- I don't think
4 any of them was unhappy with all three of them -- you're
5 point on the first one was, "Well, you know if you use fee-
6 for-service prices, in a sense, you are tracking the
7 utilization, which is what you want to track, and not
8 necessarily including the variation in price and
9 negotiations, and maybe that's a good thing because they
10 still will have all the motivations to do that."

11 And that's at least a thought that occurred to us
12 when we were talking among ourselves, and I wanted to just
13 nail down: You did say that and you think that. Did I
14 catch that?

15 DR. BAICKER: That feels like a trap.

16 [Laughter.]

17 DR. MILLER: Well, then you got off into some
18 more complex conversation, and I wanted to make sure that I
19 didn't lose things.

20 DR. BAICKER: Yes. I think we're on the same
21 page.

22 DR. MILLER: Okay.

1 DR. SAMITT: And I would jump in and say that of
2 the three, that would also likely be my favored alternative
3 if we could understand more fully what the implications
4 would be of using that approach. I think the other two
5 have far greater flaws than the first one.

6 DR. CROSSON: Cori.

7 MS. UCCELLO: Thank you. So Kate and Dave, I
8 think said much more coherently what was going through my
9 head when I read this, so thank you for, I think, putting
10 forward what I think I thought.

11 So just to add kind of one more thought, this
12 idea on -- which may or may not actually be relevant at
13 this point, but the admin cost issue, we shouldn't be risk-
14 adjusting admin costs that aren't claims variable. So, to
15 the extent that that stuff is taken out, I think is a good
16 thing.

17 And I think I might come up with stuff later, and
18 I'll get back to you.

19 DR. CROSSON: Alice.

20 MS. UCCELLO: And if you wanted me to be a guest
21 at July, I'd be happy to come.

22 DR. COOMBS: So I had a question about the

1 capitating encounters with zero payment and data. I am
2 curious about what that group looks like that 30 percent
3 looks like, relative to the 70 percent, because if you can
4 find some internal comparison, then that gives you a little
5 bit more confidence in the populations being similar,
6 whether it's -- you get some information, proprietary
7 information, just some trends or something that you can
8 actually compare even with a pilot, with utilization in
9 terms of services, because that group is important. That
10 capitated group is really important for extrapolation.

11 And I think the reason why we're looking at this
12 is that we wanted to have some kind of true comparison for
13 efficiency and pricing and cost and all of that.

14 DR. JOHNSON: I think that's right. We do have
15 the utilization information for those encounters that are
16 capitated. It's just the dollar amount that was paid to
17 the provider.

18 So if we wanted to go forward with a method that
19 incorporated to the greatest extent possible, both the
20 utilization and cost structure of the MA environment, we
21 would want -- one method would be to try and allocate
22 capitated dollars to a beneficiary to incorporate those

1 differences. But we could do some other comparisons on the
2 utilization front.

3 DR. COOMBS: I mean, not just a concern, that
4 they kind of look similar in terms of some of the factors
5 and indices, and maybe some, even, quality benchmarks of
6 some gross things like admission rates and things like
7 that. I don't know if you can pull that, but I would
8 imagine that you can pull that information out of those two
9 groups because the comparison probably is going to be
10 powerful in terms of telling you what you're looking at and
11 then being able to extract right to the next level, whether
12 or not you correlate this with fee-for-service.

13 DR. CROSSON: Jack and then Jon.

14 DR. HOADLEY: So, like Cori, I was going to try
15 to say something about some of these issues that I think,
16 in the end, Craig and Kate and Dave kind of covered. I
17 guess my other question -- so I won't say more about that.
18 My other question on your menu up here, when you talked on
19 your last bullet about utilization patterns, were you
20 proposing that narrowly in the context of risk adjustment-
21 related or really much in the broader context of just
22 fundamentally looking at utilization pattern differences

1 between the two sectors?

2 DR. JOHNSON: That's a much more broad context.

3 DR. HOADLEY: Okay.

4 DR. JOHNSON: Sort of a separate body of work
5 started earlier.

6 DR. HOADLEY: Got it. That's good. That's where
7 I was hoping you were going, and I think this is also where
8 I think it's going to become important to look within the
9 MA sector and trying to understand because, I mean, I think
10 one of the things that I found challenging in many of the
11 discussions we have is that we lump MA as if it's one
12 undifferentiated group. Obviously, there's a correlation
13 with some of the data issues in terms of group and staff
14 and more integrated HMOs that tend to be the capitated
15 payment models and the salary payment models and so forth.

16 But particularly if you're looking at the
17 utilization side only, without the dollars, you don't have
18 that issue, and so I think trying to understand, give us
19 some insight into whether there really is a big difference,
20 as I think many of us suspect there is, across these
21 sectors. And then at some point down the road, what are
22 the implications of that for payment policies and anything

1 else, I think that's going to be potentially very powerful.

2 DR. CROSSON: And you have made that point
3 several times, Jack, and I think it's a good one.

4 Did you have something on this?

5 DR. BAICKER: So I feel like I've rambled my way
6 into something potentially actionable on this, but getting
7 closer.

8 So I realize the problem I'm struggling to
9 reconcile is that if you do the risk adjustment just within
10 the MA plans, as you've highlighted, then you really limit
11 the incentive for more intensive coding, but you dull the
12 incentive to get the people where you have the greatest
13 resource improvement. Whereas, if you use the fee-for-
14 service, there's this coding intensity problem, but you've
15 got great incentives to pick off the people with the
16 greatest resource use.

17 The problem, my wish that we could separate out
18 the coding intensity from the resource use, you can't, and
19 that's the whole crux of the problem, which it took me till
20 now to realize. Sorry.

21 But then that -- so there's a tradeoff there, and
22 the question is, what's the magnitude of the tradeoffs?

1 And so then my potentially answerable question, not today,
2 but going forward is, what's the within-MA across plan
3 variation in cost per people, per person, with that MA risk
4 adjustment, MA encounter database risk adjustment, versus
5 the between MA and fee-for-service difference in the
6 resource use, using a common set of risk adjustors? Now,
7 that may require either looking at movers between the two
8 sectors, which there is a critical mass of along the new
9 house lines, or some imputation about what they would have
10 looked like in the counterfactual, which is going to be a
11 little fraught, but holding risk adjustment methodology
12 constant, how big a gain is there in the people who move
13 versus doing just the encounter-based risk adjustment, how
14 much variation is there across plans, because it could be
15 that there's this tradeoff. But the real return is within
16 MA competition. If the difference there is much bigger,
17 then if you're doing the coding intensity to expenses on
18 the aggregate in MA, if the real return is that within MA,
19 they're still competing to get people into the most
20 efficient plans and that the dollar amount, the dollar-
21 valued benefit of that is the big piece, then you can
22 say, "Okay. So I'm letting go of this emphasis on

1 selection between MA and fee-for-service," versus if the
2 within-MA-sector spread is relatively small, then you say,
3 "Well, I'm not sure I want to let go of the strong
4 selection pressure between the two things.

5 That's a thing.

6 [Laughter.]

7 DR. MILLER: I think I'd probably want to follow
8 up because I did understand you were setting up the kind of
9 within variation or within variation and seeing what --
10 right. Where I lost you was in the second half of the
11 comment, whereas what it told me when I found it, but
12 that's just me, and it's late in the day.

13 And I can ask: Did you follow what she was doing
14 there at the end?

15 DR. JOHNSON: I have a question, so --

16 DR. MILLER: Oh. Well, we'll find out.

17 DR. ZABINSKI: I'm fine.

18 DR. JOHNSON: Dan's got it.

19 DR. MILLER: [Speaking off microphone]

20 DR. JOHNSON: Just to clarify for everyone else
21 at the table, if we were able to identify what risk scores
22 would be under fee-for-service calibrated model and MA

1 calibrated model and then look at who actually switched
2 from fee-for-service to MA are the people who were the more
3 efficient and would have the resource gains. Is that what
4 you're talking about? Okay.

5 DR. CROSSON: Jon.

6 DR. CHRISTIANSON: So I think I'm with Craig and
7 what I think Jack was saying too in terms of where I would
8 like to see you focus, and that is I think one of the
9 things we really hope to get out of the encounter data is a
10 better understanding as Commissioners about -- for similar
11 patients in two different kinds of delivery systems. I
12 know within MA, it's multiple kinds of delivery systems.
13 What kind of services do they get? How is treatment
14 different? I think that's still for me where I'd like to
15 see the emphasis going forward.

16 And given all the limitations that you point out
17 in the data, as you go about doing that, I would like to
18 have you inform us about, well, here's the difference that,
19 given what we know about the data, we think you can take to
20 the bank, but here's a difference given what we know about
21 the data that just seems kind of -- it's there. We're not
22 quite sure what to make of it because of some data issues.

1 It's to help us sort of be wise about reaching conclusions
2 about whether something has gone on differently in MA plans
3 and different kinds of MA plans and not just here's a
4 difference, MA, fee-for-service. Okay?

5 DR. CROSSON: Okay. We're running a little short
6 of time here, so let's try to be efficient. Scott.

7 MR. ARMSTRONG: Okay. So, very briefly, actually
8 first, I would reiterate a point I made earlier. I really
9 think a full day of the July retreat on this topic would be
10 worthwhile. In case you wondered, I already checked. I'm
11 not available.

12 [Laughter.]

13 MR. ARMSTRONG: I also just think we should
14 embrace, I mean, we should celebrate over-coding. This is
15 to Craig's point, and that is relative to fee-for-service.
16 I think, actually, my experience is it's far more accurate,
17 and it's for the purpose well beyond just payment. It's
18 for the purpose of having well-documented information that
19 improves the quality of clinical information or clinical
20 decisions.

21 So I hope as we move this forward -- and I think
22 we should -- that we find a way. I don't know, out of this

1 dialogue over here, really how to respond, but I would just
2 encourage the group to keep trying to find some path
3 through it all because we're just so stuck in this fee-for-
4 service, MA comparison, and I understand how it becomes a
5 lever we don't want to get rid of around setting payment
6 policy that sort of controls cost, but I just think there
7 are better levers. And my real hope is with this encounter
8 data that we can discover what they are, and I will be
9 cheering you on.

10 DR. CROSSON: Okay. Kathy.

11 MS. BUTO: Okay. So I'm wondering whether, as
12 you continue your work, you can look at maybe those
13 opportunities where we think that MA is being underpaid to
14 risk adjustment is insufficient to adequately compensate
15 for the kind of care that is being given and in some sense
16 is appropriate, and to think about whether if we can never
17 come up with the perfect, you know, MA risk adjuster system
18 and we don't want to give up the comparison to fee-for-
19 service because it gives us extra dollars to provide in
20 payment to MA plans, that is there a way to then look at
21 those cases and use MA risk adjuster information, encounter
22 data to make adjustments, maybe selectively, to the fee-

1 for-service data? So is there some hybrid that you could
2 come up with?

3 And then the other comment I would make is, as we
4 look at APMs and MIPS, is there some way -- which I know is
5 not your bailiwick per se, but it just strikes me that one
6 other thing we have an opportunity to do is to try to get
7 better encounter data on the fee-for-service side. And as
8 the requirements are being developed under MACRA, there may
9 be some ways that that could be built into it so that,
10 going forward, the data will be of higher quality coming
11 from fee-for-service. Because it seems to me we need that
12 in the alternative payment models, anyway, as better
13 encounter data.

14 MR. GRADISON: First, a disclaimer or a
15 confession. I'm really troubled of finding an article of
16 faith really that I strongly believe in being undermined in
17 this discussion, which is the notion that we know how to
18 have payments that are roughly equivalent for the two
19 different systems. A lot of us had to swear on a Bible
20 practically that we believed in that, and now I'm finding
21 out not only that we don't know how to do it really, but
22 that we don't do it.

1 But, more specifically, I want to quickly hit on
2 two points. One, it's just my phraseology but I want to
3 make sure to make this point of something that has been
4 mentioned before. There's an across-the-board adjustment
5 to correct for what is considered overcoding of 5 or 5.5
6 percent, whatever it is, applied uniformly. My question in
7 that connection is: Does that create problems of fairness?
8 Not just fairness in the theoretical broad sense, but in
9 the ability to finance necessary care. Does that affect
10 care that that is done on a uniform basis rather than on
11 some system which might be more tailored to the individual
12 MA plan? That is just for the future.

13 And the second thing -- and this may seem off
14 point, but it's been bothering me for a long time, so let
15 me say it as clearly as I can -- from a policy point of
16 view, should we care whether an MA plan pays its providers
17 by volume-based fee-for-service or by capitation? I think
18 that might be something worth giving a little thought to.

19 DR. ZABINSKI: Just a question on your first
20 question, just to clarify that. You're asking about, you
21 know, does this uniform adjustment create some degree of
22 unfairness? Are you talking about unfairness across plans

1 that some will code more intensively than others, so if you
2 hit them all by the same amount, one will --

3 MR. GRADISON: Yes.

4 DR. ZABINSKI: Okay. I just wanted to be sure.

5 DR. CROSSON: Okay. Thank you very much. I
6 think that has produced some valuable information for you,
7 and we'll eagerly await the next iteration.

8 [Pause.]

9 DR. CROSSON: Okay. We'll wait a second for the
10 crowd to clear out.

11 [Pause.]

12 DR. CROSSON: Kim, you are getting double duty
13 today at least, huh? So we're going to come back to our
14 evaluation of the evolution of the hospice benefit and its
15 impact on Medicare costs. And Kim is going to take us
16 through this.

17 MS. NEUMAN: So today we are going to talk about
18 hospice and Medicare spending. Over the years, when the
19 Commission has talked about hospice, a question that often
20 comes up is: What is hospice's effect on overall Medicare
21 spending? Most recently, at the January meeting Kathy
22 asked this question.

1 As we've discussed previously, hospice's net
2 effect on Medicare spending is a reflection of a couple of
3 dynamics. Hospice reduces spending on acute-care services
4 like inpatient hospital stays in the last days of life. At
5 the same time, Medicare spends money on hospice services --
6 paying hospice providers a daily rate for each day a
7 beneficiary is enrolled. Whether hospice results in net
8 savings or net costs depends on how the amount Medicare
9 saves on avoided acute care compares to the amount Medicare
10 pays hospice providers.

11 So today we're going to discuss this issue of
12 hospice's effect on Medicare spending in more detail, as I
13 will update you on findings from a contractor report that
14 MedPAC commissioned on this topic. In addition, we did
15 some further analysis of a finding from the contractor
16 report that may have policy implications.

17 Before we discuss the findings from the
18 contractor report, I have some background on hospice for
19 you.

20 As you know, hospice is a holistic model of care
21 that provides palliative and supportive services to
22 terminally ill beneficiaries who choose to enroll. To be

1 eligible, a beneficiary must have a life expectancy of six
2 months or less if the disease runs its normal course.

3 At the start of each hospice benefit period, a
4 physician must certify that the beneficiary's life
5 expectancy meets this criteria. There is no limit on how
6 long a beneficiary can be in hospice as long as he or she
7 continues to meet this criteria.

8 A second requirement of the hospice benefit is
9 that the beneficiary agree to forgo conventional care for
10 the terminal condition and related conditions.

11 Hospice offers a number of positive benefits to
12 patients.

13 First, hospice offers terminally ill patients a
14 choice of what type of care best fits with their
15 preferences. It's up to the patient and family whether
16 they want to enroll in hospice or remain with conventional
17 end-of-life care.

18 Second, hospice focuses on patient quality of
19 life, with an emphasis on patient comfort, less invasive
20 care, and psychosocial supports.

21 Third, hospice helps make it possible for
22 patients to die at home or in another place of their

1 choosing according to their preferences.

2 Awareness of hospice and what it has to offer
3 patients has increased. Over the last 15 years, we've seen
4 substantial growth in the share of decedents that enroll in
5 hospice before the end of life.

6 Besides the positive effect of hospice on patient
7 care, there was a presumption when the hospice benefit was
8 enacted that it would also be less expensive than
9 conventional end-of-life care.

10 There have been a number of changes in hospice
11 care over the years that may have implications for its
12 effect on Medicare spending.

13 There's been greater awareness of hospice as an
14 option for patients with non-cancer diagnoses, and this
15 population is more likely to have long hospice stays.
16 Also, MedPAC and others have expressed concern that some
17 providers have been entering the hospice field in recent
18 years and may be pursuing revenue generation strategies.

19 So now moving to the issue of hospice's effect on
20 Medicare spending, the evidence in the literature on this
21 question has been mixed.

22 Some studies show modest effects of hospice on

1 Medicare spending, either small net costs or savings
2 associated with hospice, or savings only for certain
3 subgroups, for example, those with cancer.

4 On the other hand, a few studies have found
5 hospice is associated with substantial savings for a wide
6 range of patients. To investigate this further, MedPAC
7 contracted with Christopher Hogan of Direct Research LLC to
8 review the literature and conduct further analysis.

9 The contractor report examined the effect of
10 hospice on Medicare spending in three ways.

11 First, the contractor examined national trends;
12 then the contractor reviewed and replicated the literature;
13 and, finally, the contractor report developed a new market-
14 level approach to assessing the effect of hospice on
15 overall Medicare expenditures.

16 So first the national trends. The report found
17 that over a period from 2002 to 2012, use of hospice
18 increased and Medicare spending on the last year of life
19 also increased. During this period, the share of elderly
20 fee-for-service beneficiaries who used hospice grew from 26
21 percent to 47 percent.

22 Over this same time period, controlling for

1 changes in age, gender, and death rates among the Medicare
2 population, the share of Medicare fee-for-service spending
3 for elderly beneficiaries in their last year of life
4 increased about 1.1 percentage points.

5 While an analysis of these national trends is not
6 a strong test of hospice's impact, nothing in the national
7 trends suggests that hospice reduced Medicare costs for
8 beneficiaries in the last year of life.

9 It is also important to note that the study found
10 roughly one-third of hospice spending occurs prior to the
11 last year of life. So, in other words, out of the \$15
12 billion Medicare spends on hospice in a year, about \$5
13 billion of that spending is for care furnished prior to the
14 last year of life.

15 Next the study reviewed and replicated the
16 literature on hospice's effect on Medicare costs. There
17 were two types of studies that the contractor looked at:
18 fixed period studies and enrollment/pseudo-enrollment
19 studies.

20 So in the fixed period studies, what the
21 researcher does is compare spending for decedents who did
22 and did not enroll in hospice over a fixed period,

1 typically the last 6 or 12 months of life. And these
2 studies in the literature have found small costs or small
3 savings for hospice users compared to other decedents,
4 depending on the time period studied and the patient's
5 diagnosis.

6 So the contractor replicated this methodology on
7 current Medicare claims data and found that overall hospice
8 was not associated with an aggregate reduction in Medicare
9 spending, but by diagnosis, hospice was associated with
10 significant savings for cancer decedents and significant
11 costs for non-cancer decedents.

12 Then the contractor took a look at a few studies
13 that use an enrollment and pseudo-enrollment approach.
14 Here the researchers look only at the period of hospice
15 enrollment and compare it to a pseudo-enrollment period
16 that the researcher creates for decedents that did not
17 enroll in hospice. Using this approach, the contractor
18 report, like the literature, found a substantial reduction
19 in spending associated with hospice for a wide range of
20 patients.

21 So the contractor then took a look at the two
22 methodologies to figure out why they were giving

1 contradictory results, and this graph helps illustrate the
2 explanation.

3 So if you look at the right bar, we have hospice
4 decedents' spending in the last year of life. And that
5 spending is broken into spending before hospice enrollment
6 (the orange part) and spending after hospice enrollment
7 (the blue part).

8 For decedents who do not enroll in hospice, the
9 folks on the left, researchers can try to create a hospice
10 pseudo-enrollment period to compare with spending of
11 hospice enrollees post-enrollment. But what the contractor
12 report finds is that the creation of this pseudo-enrollment
13 period may be problematic.

14 Beneficiaries often enroll in hospice after a
15 high-expenditure hospitalization or post-acute-care episode
16 where the beneficiary decides conventional care no longer
17 offers them benefits. With the best of intentions,
18 researchers can try to identify beneficiaries in the non-
19 hospice population who are similar to hospice enrollees
20 through a random or propensity-matching approach and assign
21 these beneficiaries a pseudo-enrollment date. But what's
22 very difficult to match on between hospice and non-hospice

1 beneficiaries is the timing of that high-expenditure event
2 that leads the beneficiary to decide now is the time to
3 enroll in hospice. And you can kind of see this in the
4 chart.

5 So if you look at the blue bars, which reflect
6 spending in the enrollment or pseudo-enrollment period, it
7 appears hospice decedents have lower spending than non-
8 hospice decedents. But when you look at the orange bar,
9 which is spending in the pre-enrollment or pre-pseudo-
10 enrollment period, hospice enrollees actually have higher
11 spending than non-hospice enrollees. And over the entire
12 last year of life, the full bar, hospice enrollees on
13 average have higher spending than non-hospice enrollees.

14 So the contractor then sought to go at this
15 question in a completely different way, using a market-
16 level analysis rather than a person-level analysis. He
17 examined the relationship between hospice use in a market
18 and decedents' costs in the market.

19 The idea is if hospice reduces aggregate Medicare
20 expenditures, then greater hospice market penetration would
21 be expected to be associated with lower end-of-life costs.

22 So what the analysis found was that higher

1 hospice penetration in a market was actually associated
2 with modestly higher costs per decedent; higher costs were
3 due to hospice use among non-cancer decedents and were
4 mostly attributable to patients with very long stays.

5 So based on the three sets of analyses, the
6 report concluded that overall hospice does not appear to
7 result in a reduction in aggregate Medicare spending
8 relative to conventional end-of-life care.

9 Hospice may be associated with lower spending for
10 cancer patients, but higher spending for non-cancer
11 patients and for patients with very long stays.

12 These results are not dissimilar from other
13 studies that came out around the same time. Two studies
14 from 2015 showed higher aggregate costs associated with
15 hospice for certain populations -- the nursing home
16 population and patients with Alzheimer's disease and
17 related dementias.

18 Now, when the hospice benefit was enacted, there
19 was a presumption that it would result in lower spending
20 for patients at the end of life. As hospice has matured
21 and gained greater acceptance among beneficiaries with a
22 wider range of conditions, the greatest benefit of hospice

1 appears to be its effect on patient care, not costs.

2 For some populations, hospice appears to cost the
3 program more than conventional end-of-life care, and this
4 stems from long hospice stays among a subset of enrollees.
5 Some of this is likely the byproduct of the
6 unpredictability of life expectancy. But also we've noted
7 over the years that some providers appeared to have pursued
8 revenue generation strategies, enrolling some patients for
9 very long stays who may not meet the eligibility criteria.

10 The contractor report found that roughly one-
11 third of hospice spending is for care prior to the last
12 year of life.

13 Hospice is covered for beneficiaries with a life
14 expectancy of six months or less if the disease runs its
15 normal course. We would expect to see some patients with
16 hospice care prior to the last year of life because life
17 expectancy is unpredictable.

18 But as we noted, we've also been concerned about
19 unusual patterns of care among some providers. When we've
20 looked at long stays in hospice, we've seen these stays
21 being more prevalent among certain providers.

22 So similar to that work, today we have for you an

1 analysis of the share of hospice payments for care prior to
2 the last year of life by beneficiary and provider
3 characteristics and by individual provider.

4 So here's what we found. In 2013, about 35
5 percent of hospice payments were for care prior to the last
6 year of life. This varied by level of hospice care. About
7 38 percent of hospice payments for routine home care (the
8 default level of hospice care) were prior to the last year
9 of life. A much lower share of payments for general
10 inpatient care and continuous home care -- high acuity
11 levels of care -- were for care prior to the last year of
12 life.

13 There was also variation by beneficiary and
14 provider characteristics. About 16 percent of hospice
15 payments for beneficiaries with cancer were prior to the
16 last year of life, compared to 40 percent for non-cancer
17 patients.

18 About 29 percent of payments to nonprofit
19 hospices was for care prior to the last year of life,
20 compared to 40 percent of for-profits.

21 Hospice providers that began participating in
22 Medicare before 2000 had a smaller share of their payments

1 for care prior to the last year of life than newer
2 providers.

3 So we also looked at individual providers and
4 their share of payments for care furnished prior to the
5 last year of life, and we found variation across providers.
6 The chart gives you data on the share of routine home care
7 payments for care prior to the last year of life.

8 And what the last line in the chart shows is that
9 the top 20 percent of hospice providers received 46 percent
10 or more of their routine home care payments for care prior
11 to the last year of life.

12 Medicare paid these 20 percent of hospices about
13 \$2.3 billion for routine home care in 2013, of which \$1.2
14 billion (52 percent) was for care prior to the last year of
15 life.

16 So that concludes the presentation. I'd be happy
17 to answer any questions. Also, it would be helpful to get
18 your feedback on directions for future work.

19 For example, one implication of this work might
20 be to use it to help focus program integrity efforts. For
21 example, medical review efforts could focus on providers
22 with a high share of their payments for care prior to the

1 last year of life.

2 We could also think about these issues from the
3 perspective of payment policy and explore whether a payment
4 adjuster linked to the share of a providers' payments
5 outside the last year of life would be beneficial.

6 DR. CROSSON: Okay, Kim. Thank you very much.
7 That's an excellent presentation, and what I'd like to do
8 is ask for clarifying questions. Then when we're done with
9 that, I'm going to ask who would like to start the
10 discussion. So you may want to think about that. Wait, I
11 got lost. Who was raising their hand to start the
12 discussion? Bill -- two Bills. Double Bill, okay.

13 Now, clarifying questions?

14 DR. REDBERG: Thanks for a great presentation and
15 chapter. On Slide 2, can any physician certify prognosis
16 or do you have to have had some existing relationship to
17 that patient?

18 MS. NEUMAN: So when a patient first elects
19 hospice, their attending physician, if they have one, and
20 the hospice physician both must certify. And then as the
21 patient goes into continued benefit periods, it's just the
22 hospice physician that certifies.

1 DR. REDBERG: My other clarifying question: It's
2 a very interesting finding that one-third of payments are
3 prior to the last year of life, because even allowing for
4 six months, you can't be exact, that's a lot longer. And
5 you noted that a lot of those were for non-cancer
6 diagnoses, which I assume was heart failure. Is that
7 correct? And can you be more specific about what kinds of
8 services were in those hospice services that were driving
9 up costs?

10 MS. NEUMAN: So I think we've got a breakdown in
11 the paper by some very broad diagnosis categories. So, you
12 know, for heart conditions and circulatory conditions,
13 which is a broad category, about 39 percent of payments
14 were outside or prior to the last year of life.
15 Neurological is a little higher at 44 percent. But you can
16 see COPD, debility, they're all in that range.

17 In terms of what services they were getting, it's
18 an interesting question. We haven't looked to see if the
19 services -- the amount of visits somebody gets when they're
20 getting hospice care prior to the last year of life is, you
21 know, less or more or the same amount as people who are
22 closer to the end of their life. We know in general that

1 people who have shorter stays have a higher visit intensity
2 than people who have longer stays, but we've never caught
3 it in this way with where are you relative to the end of
4 your life. So we could look at that.

5 DR. MILLER: And just to be clear, what they have
6 is the summary.

7 MS. NEUMAN: This is in the summary -- it is
8 Table 3 on page 12.

9 DR. MILLER: In the middle, right [off
10 microphone].

11 DR. CROSSON: Clarifying questions?

12 DR. NAYLOR: So I thought in that same table, one
13 of the most interesting findings was that 39 percent of
14 beneficiaries who received hospice greater than one year
15 were under 65, and I'm wondering if you might help us to
16 understand a little bit more the characteristics of that
17 population. I'm assuming some are in nursing homes and
18 some -- but just to try to get a sense of who they are.

19 MS. NEUMAN: Yeah, I don't know that I can give
20 you an answer right now on the characteristics of the
21 under-65 hospice population, but that is something we could
22 look at.

1 DR. NAYLOR: Thank you.

2 DR. CROSSON: Coming down this way, Bill, did I
3 see --

4 MR. GRADISON: Later.

5 DR. CROSSON: Later? Okay. Jack.

6 DR. HOADLEY: This is partly a follow-up to
7 Rita's question on the certification by the physician. The
8 hospice physician who is doing that certification, is that
9 an employee of the hospice? Is this, like -- I mean, what
10 kind of fiduciary relationships do they have with the
11 hospice organization typically?

12 MS. NEUMAN: It would be an employee of the
13 hospice, yes.

14 DR. HOADLEY: And I wonder if there are some
15 issues there that are worth trying to think about. I'm not
16 sure quite where to go with that, but --

17 DR. CROSSON: Clarifying questions. Sue -- oh,
18 Bill, Sue, Craig, and Jon.

19 DR. HALL: Just a technical question. The
20 contractor calibrated costs of hospice versus non-hospice
21 care in real and pseudo situations, how do they do that?

22 MS. NEUMAN: So, what --

1 DR. HALL: How do you -- okay. Just -- I'll stop
2 my question there. Go ahead.

3 MS. NEUMAN: So, you can look at the hospice
4 population and you can see what the length of time they
5 enrolled prior to death, and you can have a distribution of
6 lengths of time in hospice, and then you can create that
7 same distribution among non-hospice enrollees, you know,
8 cut off their service use at the same time period so that
9 the distribution of length of time in the hospice
10 enrollment population is the same in the non-hospice. And,
11 so, you can compare them over similar time periods, similar
12 lengths of time prior to death.

13 DR. HALL: Okay. And, in that scenario, they
14 found that at least in some of the instances, it costs more
15 to be in hospice than to be in non -- or to be in
16 conventional care?

17 MS. NEUMAN: So, overall, a couple of the
18 different approaches used in the study found that hospice -
19 - that the overall costs were higher for hospice enrollees
20 than non-hospice enrollees, and that's in the aggregate,
21 right. That's total spending, not on a per beneficiary
22 basis. And, what's driving that is long hospice stays.

1 DR. HALL: Right.

2 MS. NEUMAN: So, hospice is costing somewhere
3 between \$4,500 to \$6,000 a month, and so if you have
4 someone in hospice for a long time, those costs can
5 outweigh the savings at the end of life when they're not
6 hospitalized. And, so, that is what's driving the fact
7 that in the aggregate, you don't see a reduction in
8 spending.

9 DR. HALL: Yeah. I'd like to come back to that
10 in round two.

11 DR. CROSSON: Sue.

12 MS. THOMPSON: Within the definition of hospice,
13 in the opening definition, you're including palliative
14 care. So, palliative care services as well as hospice
15 services are in that dollar spend around hospice?

16 MS. NEUMAN: I was using the term palliative care
17 to mean services that are intended to palliate the symptoms
18 rather than -- I know what you're meaning. There's another
19 use of palliative care, which is non-hospice providers who
20 provide these services to a range of patients. And, so, I
21 didn't mean that. I'm sorry if it was confusing.

22 MS. THOMPSON: Well, I'm curious, because with

1 the advent of and the more broad utilization of palliative
2 care, as we identify folks with chronic disease,
3 particularly folks not necessarily with cancer, to enter
4 into a palliative care coordination relationship, I think
5 we not only see a lengthening of life, but also an
6 improvement of quality, and I'm wondering how that's
7 driving not only the spend, but the, perhaps, longevity of
8 life. That's my question. Does that make sense?

9 MS. NEUMAN: No. So, you want to understand the
10 effects of non-hospice palliative care on spending --

11 MS. THOMPSON: On the overall spend.

12 MS. NEUMAN: -- and quality.

13 MS. THOMPSON: Mm-hmm.

14 MS. NEUMAN: Okay.

15 MS. THOMPSON: Mm-hmm. Yes. Thank you.

16 DR. CROSSON: Craig.

17 DR. SAMITT: So, my question is about the one-
18 third/two-thirds and whether -- and how we know whether
19 that's the right percentage or not for the decedent's last
20 year of life or the year prior to the last year of life.
21 So, are we looking at a benchmark? Is there an
22 international benchmark? Is there something that can tell

1 us what the right percentage would be?

2 MS. NEUMAN: So, no, right. We don't know what
3 the appropriate number is. I think that when we see
4 variation across providers and it cutting in certain
5 directions, you wonder if there's a portion of it, not all
6 of it, but a portion of it that might not be driven by the
7 unpredictability of life expectancy but other things.

8 DR. CROSSON: Historical trend?

9 MS. NEUMAN: Historical trend? So, the
10 contractor report found that in 2002, it was about 25
11 percent, and by 2012, it was in the one-third range.

12 DR. SAMITT: This is a follow-up question. Have
13 we looked at differential -- you alluded to it a second ago
14 -- differences between systems. Have you looked at
15 differential utilization of hospice in last year of life in
16 provider-sponsored health plans or other different system
17 types to see if there's differences in the numbers?

18 MS. NEUMAN: So, we know -- we know, in general,
19 that Medicare Advantage enrollees are more likely to use
20 hospice at the end of life than fee-for-service
21 beneficiaries. But, we haven't gone down into finer detail
22 than that. We could look at that.

1 DR. CROSSON: Okay. So, we're now going to try
2 to help the staff think about policy options based on this
3 point in the analytical framework that has been developed,
4 and so we're going to start with Bill Gradison and then
5 Bill Hall and then others.

6 MR. GRADISON: I asked to start because I was
7 there at the beginning and was one of the strong advocates
8 for it. Many of you have heard this story, but some may
9 not have.

10 There were people who believed that it would be
11 costly, so your statement that it was assumed to save money
12 depended on who you talked to. I argued that it would save
13 money.

14 At one point, representatives of the Office of
15 Management and Budget came up to my office and they spread
16 out a bunch of spreadsheets and were arguing that it would
17 be more costly. Where they lost me, and the meeting went
18 totally downhill after this, is when they referred in their
19 numbers to use the term -- when they used the term units of
20 production, which, I think, most of us in the room would
21 say might more appropriately been patient or beneficiary or
22 something of the sort. But, that was -- but, I do want to

1 stress the point that it was not totally -- there was not
2 total agreement. But, that's historical.

3 I think that our assumption, the assumption of
4 some of us that it would save money may have been correct.
5 I mean, these data are for relatively recent years, and in
6 those -- and I think the main difference, as I think about
7 it, and you may have some thoughts on this now or later,
8 had to do with the mix of the decedents that were -- in
9 general, but also of those who signed up for hospice. It
10 started very slowly. Patients didn't know much about it.
11 Doctors were reluctant to tell families that somebody only
12 had -- had less than six months to live. There were a lot
13 of factors going on.

14 But, the big growth was in cancer, and the cancer
15 diagnoses then were more predictable, let's say, than some
16 other condition -- than the diagnoses of some other
17 conditions might be today. And, even now, I think one of
18 the things that many of us have pointed out is that the
19 stays in hospice for cancer patients are too short because
20 they wait until the last four to six days or something like
21 that to come into it.

22 So, my point is that the mix of conditions that

1 cause people to die may have changed some over the years in
2 ways that have affected hospice. I can't demonstrate that
3 for sure, but I think it's worth taking a look at.

4 I'll give you kind of a classic case, because
5 this is a condition that wasn't even known when the
6 legislation was passed, called AIDS. And when AIDS came
7 along, it was kind of a one-way trip. It is, thank God, it
8 is not the case today, and many of these folks may continue
9 -- may or may not continue under hospice. But, the stays
10 weren't very long in those days for people who had AIDS.
11 And, the conditions were shifting.

12 I suppose there were folks who knew more about
13 health care than I did in those days that used the term
14 Alzheimer's. I do not remember hearing it bandied about.
15 I heard a lot about senility in those days. Again, that
16 has become a more --

17 So, anyway, anything that would be available to
18 show the mix of the -- of conditions of the people in
19 hospice at a few points of time over the years might be
20 informative about this, because the mix of patients, the
21 mix of conditions has several implications in terms of
22 cost, which is what we're talking about here, and in

1 particular has an impact on the long stays -- or may have
2 influence on the long stays. These long stays may be in
3 conditions where it's harder to be sure, but also where
4 there may be more of an incentive to sign up people, where
5 after the fact, at least, six months may not have been the
6 correct number to use.

7 So, that's my specific suggestion, is take a look
8 at the conditions. And the other thing that I would
9 welcome, not today, but in terms of our next go-around, is
10 your thoughts on whether CBO has gone far enough in the
11 change in the payment for the long stay versus the short
12 stay. So, I mean, my reaction is they probably have not
13 done enough to bring about the kind of meaningful change
14 that we recommended ourselves here in the past. That's a
15 value judgment. But, I think it -- and it's maybe too
16 early to get data on it, but I think it's something we
17 should be monitoring, because if there is anything to that
18 hypothesis, we may want to have another word to say about
19 that in some future report. Thank you.

20 DR. MILLER: All right. So, we did -- CMS did
21 finally get around to implementing some of our
22 recommendations here, and I think, and we try to pay very

1 close attention to the language that we put in the comment
2 letter, I think, basically to agree with you, Bill, that we
3 think it was a step in the right direction and we will be
4 closely monitoring it. No, it wasn't quite probably what
5 we would have done if Kim were in charge of the world.

6 The other thing I wanted to gently take back a
7 little bit in your comment is we did go through -- and we
8 haven't -- I don't know if the last time we did it, but we
9 have gone through some of the growth in lengths of stay,
10 and you're absolutely correct that changes in the mixes of
11 conditions that have gone into hospice have driven some of
12 that change.

13 But, the other thing that we found is that
14 there's been a great influx of different types of for-
15 profit provider, and what we show there is consistent
16 differences in the lengths of stay between for-profit
17 providers and not-for-profit providers by any condition.
18 And, so, there's more phenomenon than just the change in
19 the conditions. There's also the change in the providers
20 who are actually entering this particular field.

21 MR. GRADISON: I totally agree with what you just
22 said and would point out that at the time this legislation

1 was passed, there were no for-profit providers at all. The
2 first big one, in Connecticut, of course, was a not-for-
3 profit, and we hadn't even thought about this. So, that is
4 a major change and I'm glad you brought it up and I'm sorry
5 I didn't.

6 DR. CROSSON: Bill Hall.

7 DR. HALL: I have really been very interested in
8 the work you've been doing on hospice, and it's been
9 excellent work. Each report has been very insightful and
10 enlightening, to me, at least.

11 Hospice, the whole trend in hospice care has
12 been, I think, one of the greatest innovations in medicine
13 in the last 50 years, compared to the way that providers,
14 me and others, handled people with terminal illnesses.
15 This is a precious concept. It may have some flaws and
16 some improvements, but I don't think that we should
17 approach this entirely from a cost basis, I guess is what
18 I'm -- I know that's not news.

19 We just finished looking at perhaps another
20 example of where we do comparisons, the MA and fee-for-
21 service scenario that we just talked about, where we took
22 reasonably comparable groups of patients and we say, if we

1 look at them in one scenario or the other, what are the
2 cost implications. And we even said, what happens if they
3 switch back and forth. And, the integrity of that type of
4 analysis is that, by and large, we're looking at the same
5 group of people, and reasonable people would make the same
6 kind of decisions. It's really a question of
7 administration and how we structure services.

8 You can't really take that and put it into the
9 hospice world. I mean, nothing teaches us humility as a
10 physician more quickly than trying to sort of guesstimate
11 when a patient is going to die. Believe me, anyone who
12 thinks they are good at that just hasn't done very much of
13 it -- not dying part, but the analysis part.

14 So, honestly, I think the real challenge here is
15 not that hospice might be a bad thing. I know we don't --
16 but, if I were to read this report as someone who never
17 came onto it before, I would say, well, hospice isn't
18 really very good, you know. I mean, the patients cost us
19 more and ultimately the result in the same is the end,
20 right. They both die. And, if you take that to its
21 logical conclusion, it's absolutely frightening. No one is
22 going to do that.

1 But, I would say, let's assume for the moment
2 that the hospice is a good thing and then we can say, where
3 are the -- where can we make constructive changes? This is
4 what I really want to get to. And the constructive changes
5 would be, I would concentrate very, very much, as you've
6 already mentioned, on the profit versus nonprofit sector
7 here, and also the whole question of who decides? We say
8 there's a physician who's hired. That's true, but it's
9 true, but, then -- let me just say that I have been told
10 that in some parts of the country, the certification is
11 actually filed well -- without actually seeing the patient.
12 I can tell you that. And maybe they're going to see them
13 next week or something like that. It's not a precise
14 science, either.

15 So, I think we should spend a lot of time on
16 looking at the profit/nonprofit part of this and be very,
17 very careful about saying that hospice is an unreasonably
18 expensive way to practice medicine. I know we're not
19 saying that, but one could reach that conclusion.

20 DR. CROSSON: Let me just make a bit of a comment
21 here. So, I think -- I mean, I'm going to oversimplify a
22 lot, but my sense of this is sort of like this. The

1 hospice movement and then the hospice benefit had something
2 in mind. Here, we go back to what did people have in mind,
3 and it was something like we wanted to provide an
4 alternative higher quality of life option for people who
5 had roughly six months to live. And, as a side effect of
6 that, there was an expectation that since there would be
7 less intensive treatment, then the Medicare program would
8 save money, in addition.

9 And now, we're sort of observing the fact that
10 the application of the hospice benefit has morphed over
11 time, and you've talked about the reasons for that. But,
12 it's morphed in a couple of ways that are uncomfortable.
13 One is the fact that individuals with cancer, who, among
14 other diagnoses, have maybe a more predictable lifespan --
15 not always, but maybe -- are accessing the benefit late, a
16 lot later than what we might have thought they should be,
17 and whether that ends up with more expense for Medicare or
18 not, that late accessing of the benefit. One effect of it
19 is a lower quality of life for these individuals.

20 And then on the other side, we have the
21 introduction of new diagnoses that were not probably
22 contemplated at the time, whether they are actually new or

1 they just have new names, like debility and neurologic
2 disorders and Alzheimer's. Those seem to be increasing in
3 use and generate higher costs and end up, then, changing
4 the total cost for the Medicare program of caring for those
5 individuals, at least in that cohort, or in the total
6 cohort.

7 So, Kim has proposed here, has given us a nice
8 analysis of this, and our job is to try to figure out what
9 priorities we would recommend for policy changes that might
10 address one or the other or both of these problems. And,
11 she suggested a couple, but I'd like to see us hone in on
12 that notion. What sort of can we do about this, if
13 anything, to get it back to where it was intended to be in
14 the first place. Okay.

15 DR. HALL: You said it much better than I did,
16 but that's exactly right.

17 DR. CROSSON: So, let's start with Rita.

18 DR. REDBERG: So, to try to pick up on that,
19 because I think there are a lot of important issues and
20 certainly a lot of potential benefits, and I agree a lot of
21 it isn't realized when hospice care comes so late, but
22 particularly looking at the slide, Slide 8, and the high

1 cost just before entering hospice, you know, I think we
2 perhaps need to do something to kind of encourage a more
3 informed decision making.

4 I actually think it relates somewhat to the last
5 discussion we were having on oncology care and bundled
6 payments, because what I see is a lot of hospices who are
7 not really aware when they're offered chemotherapy in a
8 very poor progress metastatic cancer situation that's going
9 to be very toxic what their actual -- you know, they think
10 of it, this could save my life, when the truth is a lot,
11 unfortunately, less optimistic than that and the chances --
12 perhaps they would get a few weeks of progression-free
13 survival or some biomarker would change, but the chance of
14 it saving their life is just very low and the toxicity is
15 significant. And, those are the people that, you know, you
16 said they've exhausted everything else, so they go into
17 hospice.

18 But, I think if we had better informed
19 discussions and patient decision making before offering all
20 of that, a lot of patients would not choose to get that
21 very expensive and very toxic chemotherapy and would go
22 into hospice sooner. And, so, if we can think about, you

1 know, I don't know if it's bundled payment or informed
2 decision making or -- but some way to sort of encourage the
3 informed discussion sooner, before all of the things happen
4 that are very high cost and not really benefitting patients
5 where they then go into hospice, but they had the choice
6 and they at least could make an informed choice sooner,
7 that would accomplish a lot of our goals of improving care
8 and would probably decrease program costs.

9 DR. CROSSON: Right.

10 Mary.

11 DR. NAYLOR: So, first of all, I think this is a
12 really important report in helping to target and understand
13 how a benefit evolves and is used, and I think that the
14 framework used of a market analysis and trends and kind of
15 replicating studies, that multiple approach, multiple
16 methodological approach is really quite wonderful.

17 I guess a couple of things, I would comment, one
18 is I think there are real challenges with the data here.
19 It has nothing to do with direct research. It has to do
20 with, in many ways, we are dealing with very limited data
21 and very old data. So watching what's happened -- you
22 talked about 26 to 47 percent growth since 2002 to 2012,

1 but the data on some of these big studies are a decade
2 earlier than that, so we just have to make sure we frame
3 it.

4 I think what could be most compelling here to
5 help make the case about what we're seeing in terms of use
6 of hospice dollars in the last year of life that may have
7 no implications for what the benefit was intended to
8 accomplish is to really look -- is to take that information
9 and augment it with "Well, what if we look at what happens
10 to people who get the benefit as it was designed?" kind of
11 stratify a group that gets four to six months or something
12 like, or to Jay's point, the group that gets it in the last
13 10 days, but maybe acknowledge simplifications and
14 stratifications, to make the case, maybe, that if we do it
15 right, we get the intended benefit, which is better quality
16 of care, better outcomes, and better use of Medicare
17 dollars.

18 I think there's some evidence. Zeke Emanuel and
19 his team had a paper in New England Journal just a couple
20 of weeks or months ago showing that the U.S. and
21 Netherlands are doing the best in cancer patients, 65 and
22 older, and making sure that they don't die in the hospital.

1 So there's some evidence that we're making progress, and I
2 think what we need to do is to say how is it that this kind
3 of work can illuminate, well, if you don't put your dollars
4 where it really was intended or we don't get people early
5 enough into the benefit to have the benefit achieve what
6 it's intended, that that really does affect how program
7 dollars are used.

8 So one way to think about it is a stratification,
9 so just a thought.

10 DR. CROSSON: Kathy.

11 MS. BUTO: So I do have a question. I know
12 that's how it was intended, and it was originally intended
13 really to serve as an alternative for cancer patients, but
14 I do have a question about these other conditions and
15 whether if they've been sort of exposed to clinical
16 analysis to see whether, in fact, clinicians would agree
17 that they in fact are good candidates for hospice. And it
18 could be that they are good candidates, but it's not a 6-
19 month thing, that really if they're willing to forego
20 standard medical care and go into hospice, it's not such a
21 bad thing, but maybe there needs to be carved out a
22 different and maybe lower routine home care benefit for

1 those categories. In other words, think about it not just
2 as how do we get back to cancer, but maybe do we need to
3 modify anything to accommodate these other categories.

4 And then I liked your suggestion in the paper
5 that maybe if we look at that and say, "You know what? No.
6 There are a number of people in these categories who really
7 are just living with a heart condition or a circulatory
8 condition. They don't really require hospice. They don't
9 require ongoing medical care except for monitoring, and
10 that there is some overuse or overuse by that population,"
11 the suggestion you made in the paper that maybe one option
12 could be to look at some kind of value-based adjustor after
13 the fact, to look at those hospices that tend to, in a
14 sense, go after that population.

15 So I like that option, but I'd first ask the
16 question of, are these all really inappropriate, or really,
17 should we be looking at ways to hone in on those
18 individuals and those categories who really could use the
19 hospice benefit instead of standard medical care?

20 DR. CROSSON: Herb.

21 MR. KUHN: So lot of good information, Kim.
22 Thank you for this.

1 On the directions for future research, I saw
2 something recently that indicated that when hospice is
3 recognized as conventional end-of-life care, only then will
4 we see savings in the program.

5 Right now, according to the information I saw is
6 that a third die within two days of admissions. The median
7 length of stay is 18 days, and so the savings opportunities
8 are getting people to enter the hospice program at the
9 right time instead of doing through all this additional
10 care and then coming in very late in the program. And I
11 think that's the opportunity.

12 So having said that, I think some of the research
13 should look at that option, and one of the things I'd like
14 to see, maybe look at the future, is Medicare payments for
15 advanced care planning, or is there a rise, or is there
16 movement for additional palliative care consultations in
17 acute care hospitals? What's going on with that benefit,
18 and are those consultations occurring at the right time
19 where people are looking at advanced care planning or
20 palliative care early on in the process to manage that?

21 The second thing I'd look at is the MA experience
22 with hospice. What's their experience? This came up a

1 little while ago, but their experience with live
2 discharges, length of stay, savings. Scott made a very
3 impassioned point that the MA plans collect all this great
4 data. They know their patients very well. Is that
5 translating into something, better care or better
6 opportunities for advanced care planning with that
7 population? Is there something we can learn there?

8 The fourth thing I'd look at, particularly
9 dealing with these long lengths of stay, is what kind of
10 quality improvement programs do these programs have, or do
11 we only see mostly the QI in the not-for-profit and less so
12 in the for-profit ones? As I read the research and
13 listened to your presentation, I think what we see hospice
14 falling into is a chronic disease management program.
15 People might be entering the program for the proper
16 diagnosis, but it's morphing into a chronic disease
17 management program. And if they had good QI programs
18 through a COP, through the Medicare program, I think they
19 would be considered for discharge at the right time, and we
20 would be manage this population I think a little bit
21 better, so that's something to look at.

22 And then the final thing I'd look at is a core

1 measure set, have core measures for hospitals, for others
2 out there, but end of life, performance, quality metric
3 domains, different things like that. I think if we had a
4 set of core measures, the tide could lift all boats in this
5 area, and we could then improve some opportunities there.
6 So those would be the areas I would recommend for
7 additional research.

8 DR. CROSSON: Okay. Further comments? Jack.

9 DR. HOADLEY: So it seems like there's two
10 different tracks that we've been talking about. One is
11 sort of this whole notion of getting the right people to
12 hospice care at the right time, and a lot of that is about
13 patient education, provider education, informed decision-
14 making, and that sort of thing. And that makes a lot of
15 sense, and that includes this notion of sort of maybe just
16 understanding better the right model outside the cancer
17 situation, and I've seen data in the past on the patterns.
18 Most people understand the patterns are just different, and
19 you can't really predict. So that's fine, as long as we
20 understand it and figure out sort of the right pattern.

21 But it seems like the other track is the issues
22 that are more specifically addressed in this research,

1 which is what certainly appears to be some bad performance
2 from the hospice industry and parts of the hospice industry
3 and whether -- you mentioned targeting for integrity kinds
4 of issues, maybe looking at this question of whether there
5 is a better model of physician certification in terms of
6 whatever might be -- one might call conflict of interest or
7 just where are the -- is that -- the way it's being done
8 now, it feels like it doesn't really do the job that it was
9 intended to do, at least doesn't do it very well.

10 And then looking specifically at the for-profit
11 side, I don't know that we've ever looked specifically at
12 payment differentials and for-profit and not-for-profit,
13 but it just feels like that's such a big dimension of this
14 problem that we should potentially take that on more
15 directly. We kind of look at the differential impact and
16 we try not to do policies often that sort of target on
17 that, but it feels like that's just such a big part of an
18 issue here. I think we should probably think about what's
19 the right way to take that on and try to be more explicit
20 about that.

21 DR. CROSSON: Alice.

22 DR. COOMBS: So, recently, I had two patients

1 with end-stage congestive heart failure who actually was
2 referred to hospice, but it's very interesting. I don't
3 think that you can say that if someone gets the hospice,
4 three days later and passes away, the family is very
5 content with the whole process that that was too late. And
6 certainly, looking at these patients, they were doing
7 pretty good, reasonably well in terms of their home
8 existence, and they came into the hospital for an acute
9 event.

10 But what I've noticed is recently the MOLST --we
11 have a MOLST form. It's the Medical Order for Life-
12 Sustaining Treatment, and in states where you have -- it's
13 either MOLST or a POLST or whatever -- you actually may
14 change that second bar because when the patient comes in,
15 those expensive interventions may be altered because that's
16 what you're really talking about. You're way up here.
17 You're not talking about certification of any kind of
18 providers. You're way up here. You're saying discuss with
19 the patient prior for those interventions, and when that
20 episode happens, then you can actually make a different
21 decision in terms of going to hospice at that time.

22 So I think that there probably is some

1 correlation with -- and I don't think all states have it.
2 I was just looking to see. I think it's between 40 and 43
3 or so states that actually have state regulatory mandates
4 that when someone comes in with one of those forms, you
5 have to honor their wishes, and if you change it, you need
6 to go through the process of the full documentation.

7 So not just that, but primary care doctors will
8 feel compelled to speak with patients who -- especially the
9 ones with -- I mean, most of the time, they're talking with
10 the oncology patients, but the ones I see in the ICU with
11 end-stage CHF or end-stage COPD, they don't have the
12 conversation because they could think, they could talk, and
13 they can eat, so people think, "Okay, everything is okay."

14 But there's nothing more beautiful than being in
15 the presence of a family that really expects appreciation,
16 on matter what time they pass away, and you say to them,
17 when the good Lord says come fourth, you don't come fifth,
18 and they're very pleased with the fact that this was a good
19 death. And I think that's what we're talking about, so the
20 patients are comfortable and they're in the right
21 environment.

22 Whether or not for-profit and non-profit is

1 different in terms of how they process that piece, it might
2 be interesting to look at the length of time. I think we
3 have some information on that, but I think that's probably
4 an issue that I have, and I think that with the congestive
5 heart failure, you might see more of it if you don't have
6 the discussion. And in several cases, the patients have
7 actually gone home with PleurX catheters because the end-
8 stage failure is so bad that you can't even diurese the
9 fluid off, and every couple of days, they take the fluid,
10 and it just prolongs things where you actually have a nurse
11 going. And at some point, the family says, "Okay. I think
12 this is the time." And so I think that looking at time
13 alone can be a very complex thing, but I would look at
14 state regulatory underpinnings, how that happens, and does
15 that influence what happens with patients in the long run.

16 DR. CROSSON: Thank you. Comments? Craig.

17 DR. SAMITT: So I am struggling with this a
18 little bit. I recognize that there are problems here that
19 this analysis has pointed out, but I'm somewhat reluctant
20 to pursue the standard policy recommendations that we would
21 pursue because I'd be afraid we'd get them wrong because
22 there will be certain hospice stays prior to the end-of-

1 life year that certainly may be appropriate.

2 So I'm curious to see whether there are any ways
3 that we can address this issue through greater
4 accountability by the referring clinicians who would want
5 to be attentive to the clinical circumstances and
6 maximizing the quality, maximizing the quality at the end
7 of life, attentive to the efficiencies as well.

8 So, in essence, I can't recall how the hospice,
9 the costs of hospice are included kind of in the ACO
10 dimension. I can't remember where we stand in terms of the
11 carving in of hospice into the MA benefit and creating
12 greater alignment which was disconnected. So it feels to
13 me that hospice remains somewhat fragmented, whether it's
14 from MA or Part D or ACO, and creating that greater
15 alignment and accountability at the referring provider
16 level would help resolve some of the concerns that we're
17 seeing here.

18 DR. CROSSON: Can somebody MA-wise remind me? I
19 remember we talked about this the last time we did the MA.
20 Did we make a recommendation for hospice to be subsumed?

21 DR. MILLER: We did, and it hasn't been taken up
22 as of yet. Correct?

1 MS. NEUMAN: And then just to answer your
2 question on ACOs, hospices' cost do count in the ACO mod.

3 DR. CROSSON: Okay. Bill, last.

4 MR. GRADISON: I just want to stress the
5 sensitivity of cultural, religious, and frankly, to some
6 extent, racial attitudes towards hospice. Certain groups
7 are more likely to agree to participate than others, and we
8 have to be sensitive to the choices that they make. That's
9 one point.

10 The second point is that the remarkable progress
11 being made through the development of new pharmaceuticals
12 may very well have an impact on the way people think about
13 this in the future. In other words, maybe it isn't a death
14 sentence if you have a particular kind of cancer. We were
15 talking about oncology drugs earlier. I am not talking
16 about the clinical side, but the cultural, the attitudinal
17 side of this in terms of where should grandma be and what
18 are her chances of being around for a couple more years.
19 So I think that both those factors, the developments, the
20 remarkable developments that are taking place with regard
21 to treatment through use of pharmaceuticals, and some
22 really pretty fundamental attitudes -- cultural, I refer to

1 them -- needs to be factored into our thinking about this.

2 DR. CROSSON: Okay. The real last comment.

3 Scott?

4 MR. ARMSTRONG: Just briefly wanted to add and
5 reinforce a couple of comments people made about how
6 hospice is one label for services that are provided in the
7 context of an overall system that our patients are cared
8 for within. I had some of my staff look into our own
9 experience with this, just to try to understand whether our
10 experience was similar to or really inconsistent with the
11 data that you are reporting, because it seemed very unlike
12 what our own experience was. And I would just assure you
13 that for patients in hospice in the last 50 days of their
14 life cost us tens of thousands of dollars less than
15 patients who are not formally entered into that program,
16 that when we look at the average length of stay, there's
17 less than 10 percent of our patients who are in hospice for
18 more than 200 days. And some of the other things that you
19 found that are really disturbing are just so different, and
20 I think it would be interesting for us to try to discover,
21 well, what is different.

22 There are systems where a hospice is working the

1 way it was envisioned way back when it was first started.
2 How is that happening, and how might that also inform some
3 of the policy considerations that we have pursued?

4 DR. CROSSON: Absolutely.

5 Kim, thank you so much.

6 [Pause.]

7 DR. CROSSON: Okay. Our last presentation and
8 discussion today is on measuring low-value care. We have
9 talked around this issue. Now we're going to talk about
10 this issue. Ariel, you're up.

11 MR. WINTER: Thank you. Good afternoon.

12 I want to begin by thanking Aaron Schwartz and
13 Michael McWilliams of Harvard Medical School, who helped us
14 with our analysis.

15 There has been increased interest in recent years
16 in measuring and reducing the use of low-value services,
17 including interest from Commissioners. And here is the
18 outline for today's presentation.

19 I'll be offering a definition of low-value care.
20 I will then discuss the development of claims-based
21 measures of low-value care by a team of researchers. We
22 applied their measures to Medicare claims data from 2012

1 and 2013, and I'll describe the results of our analysis,
2 and then conclude with some potential policy directions.

3 Researchers define low-value care as services
4 with little or no clinical benefit, or care in which the
5 risk of harm from a service outweighs its potential
6 benefit.

7 Low-value care is a concern for two reasons:

8 First, it has the potential to harm patients:
9 both directly, by exposing them to the risks of injury from
10 the service itself, for example, exposing patients to
11 radiation from imaging; and indirectly, when the initial
12 service leads to a cascade of additional tests and
13 procedures that contain risks but provide little or no
14 benefit; and it may also displace higher-value care.

15 And, second, it increases health care spending.

16 So I'll say a few words about our motivation for
17 exploring this issue.

18 First, there is a growing literature that
19 examines the use and growth of low-value care. In
20 addition, practitioners are making efforts to identify and
21 reduce low-value services through the Choosing Wisely
22 campaign, an initiative of the American Board of Internal

1 Medicine Foundation.

2 Thus far, over 70 medical specialty societies
3 have identified more than 400 tests and procedures that are
4 often overused. As part of our recommendation in June 2012
5 on redesigning the Medicare benefit, the Commission
6 supported value-based insurance design, in which the
7 Secretary could alter cost sharing based on evidence of the
8 value of services.

9 Under this approach, cost sharing would encourage
10 beneficiaries to use high-value services and discourage the
11 use of low-value services. Therefore, CMS would need
12 information on how to define and measure low-value care.

13 In addition, some Commissioners, including Rita,
14 have said that when we measure quality, it's important to
15 look at overuse as well as underuse.

16 A group of researchers that included two
17 physicians developed 31 claims-based measures of low-value
18 care and published their findings in JAMA Internal Medicine
19 in 2014 and 2015.

20 Nineteen of their measures are based on Choosing
21 Wisely guidelines; other measures are based on the U.S.
22 Preventive Services Task Force recommendations, the medical

1 literature, and other sources.

2 They developed two versions of each measure: a
3 broader one with higher sensitivity and a narrower one with
4 higher specificity.

5 Increasing the sensitivity of a measure captures
6 more potentially inappropriate use, but also is more likely
7 to misclassify some appropriate use as inappropriate.

8 Increasing a measure's specificity means that it
9 is less likely to misclassify appropriate use as
10 inappropriate, but is more likely to miss some instances of
11 inappropriate use.

12 To explain this concept, we'll look at a specific
13 measure, and the full list of measures is in your paper.

14 The first measure on the slide detects
15 inappropriate imaging for patients with nonspecific low
16 back pain. The broader version of this measure includes
17 all patients who received imaging for low back pain and,
18 therefore, captures more inappropriate use, but also some
19 appropriate use.

20 The narrower version of this measure excludes
21 patients with certain diagnoses, such as cancer and trauma,
22 and is limited to imaging provided within the first six

1 weeks of the diagnosis of low back pain.

2 Although the narrower version identifies fewer
3 cases of inappropriate imaging, it is less likely to
4 misclassify appropriate use as inappropriate, and the same
5 principle applies to the other measures on this slide.

6 Last year, we contracted with the authors of the
7 JAMA Internal Medicine articles to obtain their measures
8 and the algorithms to calculate them. We applied their
9 initial set of 26 measures to 2012 data, and spending
10 estimates were based on standardized prices from 2009.
11 These prices adjust for regional differences in Medicare
12 payment rates.

13 We presented these results to you last April and
14 also published them in our 2015 data book and our 2016
15 March report. For the analysis we're presenting today, we
16 applied the 26 measures from the original work plus the 5
17 new measures to 2012 and 2013 data. We also updated the
18 standardized prices from the base year of 2009 to 2012.

19 So here are the aggregate results from our
20 analysis of all 31 measures for 2013; the results for 2012
21 were similar so we are not presenting them separately.

22 Based on the broader versions of the measures, 38

1 percent of beneficiaries received at least one low-value
2 service. A single beneficiary can receive more than one
3 service, which explains why there were 74 low-value
4 services per 100 beneficiaries. Medicare spending for
5 these services was about \$7.1 billion.

6 Based on the narrower versions of each measure,
7 23 percent of beneficiaries received at least one low-value
8 service, and there were 35 low-value services per 100
9 beneficiaries. And total Medicare spending for these
10 services was about \$2.6 billion.

11 We grouped the measures into six larger clinical
12 categories, using categories created by the authors of the
13 JAMA Internal Medicine articles. This table shows which
14 categories accounted for most of the volume and spending,
15 and it is divided by the broad and narrow versions of each
16 measure.

17 Under the broader version (in the first column),
18 imaging and cancer screening accounted for most of the
19 volume of low-value care, but cardiovascular tests and
20 procedures and other surgical procedures made up most of
21 the spending.

22 Under the narrower version of the measures (in

1 the second column), imaging and diagnostic and preventive
2 testing accounted for most of the volume, but other
3 surgical procedures and imaging comprised the majority of
4 the spending.

5 This indicates that if you wanted to reduce
6 spending on low-value care, you probably want to focus on
7 cardiovascular tests and procedures, other surgical
8 procedures, and imaging services.

9 Here are results for some of the individual
10 measures, and results for all the measures are in your
11 paper.

12 The first row on the slide shows back imaging for
13 patients with nonspecific low back pain. Based on the
14 broader version of measure, the number of cases per 100
15 patients in 2013 was 11.9 and spending was \$236 million.
16 Based on the narrower version, the number of cases per 100
17 patients was 3.4 and spending was \$68 million.

18 The second measure is PSA screening for men age
19 75 and older. The number of cases per 100 patients ranged
20 from 9.2 under the broader version to 5.2 under the
21 narrower version.

22 The third measure on the slide is colon cancer

1 screening for older adults; the number of cases per 100
2 ranged from 8.4 to 0.4.

3 These results show that the volume of low-value
4 care that we detected can vary substantially based on the
5 measures' clinical specificity.

6 In addition, the measures on this slide account
7 for a relatively high share of low-value care; there are
8 other measures -- not shown here -- that account for very
9 small shares.

10 Our results probably understate the volume and
11 spending on low-value care, and thus they represent a
12 conservative estimate of the actual amount of low-value
13 services, and this is for the following reasons:

14 First, there are a limited number of measures of
15 low-value care that can be calculated with claims data.
16 This analysis used 31 measures, while the Choosing Wisely
17 campaign has identified over 400 tests and procedures that
18 are often overused.

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

1 In addition, our spending estimates probably
2 understate actual spending on low-value care because they
3 don't include downstream services that may result from the
4 initial low-value service.

5 For example, a PSA test with an abnormal result
6 can start a chain of events that leads to prostate biopsies
7 and prostate cancer treatments.

8 A recent study estimated Medicare spending on PSA
9 tests and downstream diagnostic services related to the
10 test. For men age 75 or older, average annual spending for
11 the PSA tests and follow-up diagnostic services was \$145
12 million.

13 PSA tests accounted for only 28 percent of the
14 \$145 million. Half of the cost was related to biopsies,
15 and about one-fifth was related to pathology.

16 This research raises the question of whether
17 changes in payment policy and delivery systems can
18 influence the use of low-value care.

19 In one of the articles we referenced earlier,
20 Schwartz and colleagues compared changes in the use of low-
21 value care between beneficiaries in Pioneer ACOs and a
22 control group of other beneficiaries.

1 The study used the same 31 measures that were in
2 our analysis, and it excluded Medicare Shared Savings
3 Program ACOs.

4 The authors found that Pioneer ACOs had a greater
5 reduction in volume and spending for low-value care
6 relative to the control group. These results suggest that
7 changing financial incentives at the organizational level
8 can discourage overuse.

9 I would like to conclude by laying out some
10 potential policy directions for addressing low-value care.

11 First, you could think about payment and delivery
12 system reform, such as ACOs.

13 Second, quality measurement could incorporate
14 measures of low-value care, although it would be difficult
15 to apply these indicators to groups with a small number of
16 beneficiaries.

17 A third issue to consider is CMS' coverage
18 policy.

19 And, finally, you could think about encouraging
20 greater beneficiary engagement through changes in cost
21 sharing or use of shared decisionmaking.

22 In shared decisionmaking, providers communicate

1 with patients about the outcomes and uncertainties of tests
2 and treatment options, and patients discuss with providers
3 their values and the importance they place on risks and
4 benefits.

5 This concludes my presentation. I'd be happy to
6 take any questions.

7 DR. CROSSON: Thank you, Ariel. Very clear.

8 Let's start with clarifying questions.

9 Clarifying questions for Ariel?

10 MR. GRADISON: On Slide 12, it's kind of a
11 subjective question, but these percentages, while important
12 and in the proper direction, are relatively small. Do you
13 think that the definitions that are used in measuring this
14 are specific, that these numbers are meaningful? And, of
15 course, a follow-up question is: Can you get data from
16 larger managed care plans that might shed additional light
17 on this?

18 MR. WINTER: So one thing to keep in mind in
19 terms of the numbers is that the analysis was comparing
20 three years of data before the Pioneer ACO contract went
21 into effect with only one year of post data, after it went
22 into effect. And so the authors suggest that the changes

1 could be greater over time as the Pioneer ACO becomes more
2 -- implements, you know, its changes to how care is
3 delivered.

4 On the second question, you're asking about the
5 specificity of the measures and how that might affect the
6 changes we're seeing. That can certainly play a role, and
7 if you had a bigger set of measures or if your measures
8 were more broadly defined, you might see bigger changes.
9 But it's hard to predict how that might go.

10 Then the third question was about looking at
11 managed care organizations, and I'm going to infer that
12 you're maybe about asking using encounter data for Medicare
13 Advantage plans, and that's something that we can think
14 about doing. We certainly would want to talk to the
15 measure developers and explore the encounter data,
16 particularly how complete the data is. That's something we
17 can think about for the future.

18 MR. GRADISON: Thanks. The reason I raise that
19 obviously is that issue here, in part at least, is trying
20 to influence the decisions that are made by practitioners,
21 and there may be a little bit more leverage in the
22 organized plans.

1 DR. CROSSON: Bill, I'll just make one point,
2 probably the same one that Scott's about to make. I can
3 tell you from my own experience in my former life, with my
4 former organization, I had data like this, and the
5 differences were vastly greater than what we see here.

6 MR. GRADISON: Thank you.

7 MR. ARMSTRONG: Actually, I had a clarifying
8 question.

9 [Laughter.]

10 DR. CROSSON: [off microphone] violation.

11 MR. ARMSTRONG: I think it's a great piece, and
12 the analysis that has been done around this I think is
13 really interesting and very important. You talk about the
14 estimated cost, and I presume you're really looking at the
15 cost of the services that were low value, given the
16 definitions. But is there any estimate that's been done of
17 like the broader harm or the subsequent procedures or
18 subsequent costs, which could be quite a bit more than
19 that? I just don't know if we have any feel for that at
20 all.

21 MR. WINTER: This earlier question, that's
22 something we talked about last year as well when we

1 presented the data from 2012. I don't have -- the short
2 answer is no, I'm not aware of an estimate of the broader
3 downstream effects, but -- and it's difficult to link
4 downstream services using claims data to an initial
5 service. And it's something that I've talked about with
6 the contractors from Harvard Medical School, and they
7 agreed it's very difficult to do, but -- which is why I
8 looked at the literature in particular with regards to PSA
9 tests and brought to you the study which looked at the
10 costs of both the PSA tests and the downstream diagnostic
11 services, which was a larger number than we were finding
12 for this side group of men over age 75.

13 Then there's another study which we cite in the
14 report, but I didn't mention in the presentation, which
15 found that -- which looked at the total lifetime costs of
16 prostate cancer screening and treatment and found that the
17 diagnostic part of that cost is only about between 2 and 8
18 percent -- I'm sorry between 4 and 8 percent of the total
19 lifetime costs. So the treatment costs are a much bigger
20 part of the total costs.

21 DR. CROSSON: Other clarifying questions?

22 DR. HOADLEY: You measure these various things.

1 I'm thinking like the imaging, for example. If one
2 beneficiary has multiple cases of imaging that's rated as
3 inappropriate, do you count all of those? Or are you
4 counting whether a particular imaging occurs for that
5 person as one as opposed to if it happened three times you
6 count it as three?

7 MR. WINTER: I don't remember how their algorithm
8 works in that regard, so I'll look into it and get back to
9 you. They can certainly have multiple different kinds of
10 low-value services, but if they have three imaging studies
11 from low back pain --

12 DR. HOADLEY: Repeating a month later --

13 MR. WINTER: Yeah, I don't know, and it might
14 vary by service also, so I'll look into that.

15 DR. HOADLEY: Okay.

16 DR. SAMITT: So I think this is a clarifying
17 question, but it may morph into Round 2. How effectively
18 do you feel Choosing Wisely recommendations are a proxy for
19 low-value care?

20 MR. WINTER: So, I mean, these are determined --
21 developed by the specialty societies, so it's based on
22 their judgment. They're supposed to be evidence-based, and

1 each one of them cites a literature that backs up their
2 recommendation. But, you know, there is sometimes
3 disagreement among different specialty societies. For
4 example, for PSA tests you have groups like the Academy of
5 Family Medicine saying it should not be done -- PSA tests
6 should not be done routinely, and you have the American
7 Urological Association saying they should be done but only
8 with shared decisionmaking.

9 So there is a range of recommendations even for
10 the same test, and we've talked about where the Preventive
11 Services Task Force came out, which most recently said that
12 -- they recommended against PSA tests for men of any age.
13 So there's clearly some differences, and not being a
14 clinician, it's hard for me to say, you know, how many of
15 them are -- to what extent they are valid. But just to --
16 I'm sorry. I should have said earlier that the team of
17 researchers that we've relied on for these measures, they
18 reviewed, you know, each of the Choosing Wisely
19 recommendations and picked the ones that they thought were
20 most valid and most relevant for the Medicare population
21 and could be detected with claims data.

22 DR. CROSSON: Craig, there's a point there that

1 you have, and it was my observation, you know, in looking
2 at at least the first iteration of the Choosing Wisely, the
3 choice of the Choosing Wisely issues, that they seemed to
4 lack the presence of the most highly remunerative issues
5 almost by specialty. And, I have to admit, I haven't seen
6 the most recent ones, but I think there's a point there.

7 DR. SAMITT: And, I think this is where I was
8 going, and this may move into round two, but in my new
9 role, I've become very much steeped in the whole world of
10 evidence-based medicine and the use of evidence-based
11 medicine to really help make policy decisions about what's
12 high value and what's low value.

13 And, so, I wonder to what degree Choosing Wisely
14 syncs up with the true evidence about high value/low value,
15 and I'd be curious to know, and I'm not sure if we've ever
16 done this, when we look at large managed care plans or
17 large national plans and we look at coverage determinations
18 and their view of high value/low value, how does that sync
19 up and match policies that sit with CMS?

20 And, I don't know if there's ever been a
21 comparison to really identify where the greatest
22 distinctions are. And, I would imagine a lot of what's in

1 Choosing Wisely is included. You know, those 400 things, I
2 would imagine, are common to both CMS and large plans.
3 But, my guess in all reality is it's more like 2,000 things
4 that are considered low value, not 400, that would identify
5 that this opportunity in low value is far bigger than we're
6 possibly talking about here if we studied it correctly.

7 DR. CROSSON: Hey, Rita, would you like to begin
8 the discussion?

9 [Laughter.]

10 DR. REDBERG: Sure. I have just a few things to
11 say.

12 [Laughter.]

13 DR. REDBERG: But, I did want to, just to
14 clarify, and maybe you already knew, but in Choosing
15 Wisely, which ABIM Foundation says was a start, which is
16 true, certainly, there was no requirement for an evidence
17 review and there was no requirement that they look at more
18 commonly used procedures. And, certainly, one of the
19 criticisms has been that it was some of those procedures
20 were already not done or not done very much anyway.

21 But, getting -- and, so, I agree. Actually, my
22 first point, it was a great presentation and chapter and I

1 think there is a lot in here for us to look at, because to
2 eliminate things that are harming our beneficiaries and
3 cost a lot of money seems like a no-brainer to me. And, I
4 agree, it's a small fraction here of what is actually being
5 done in terms of low-value care.

6 Even, for example, if you look at the cancer
7 screening list -- well, first of all, for whatever reasons,
8 I mean, I'm sure they took things that were easily
9 attainable for administrative data, but mammography is not
10 on here and mammography is not recommended for women over
11 75. Colorectal cancer screening, you know, the other issue
12 is the frequency of colonoscopy. It's only supposed to
13 happen every ten years, but we know that Medicare pays for
14 it more frequently than that.

15 And then the whole PSA testing. So, here, the
16 recommendation, the broad one was over 75, but, you know,
17 in 2012, the test was updated that to a Grade D for PSA
18 testing full stop. So, that's huge. And, you're right,
19 that's only a few percent of the actual cost of PSA
20 testing, and so it's true that there's a wide range of
21 recommendations. I have to say, you know, because so much
22 of the PSA testing leads to a lot of treatment, and the

1 Urologic Association, of course, has been most positive
2 about it, but that is also -- I mean, financially, they are
3 very busy with a lot of the downstream.

4 There was a New York Times article a few years
5 ago on PSA testing that just gave the numbers, and I'm just
6 going to -- I brought it up. I mean, this would be sort of
7 the informed discussion, I think, if they wanted to go
8 ahead with the informed discussion. It says, imagine
9 you're one of 100 men in a room. Seventeen of you will be
10 diagnosed with prostate cancer and three will die from it,
11 but no one knows which one. So, then someone comes -- a
12 doctor comes in and has 17 pills, one of which will save
13 the life of one man with prostate cancer. So, you know,
14 there, you're at one in 100.

15 But, then it says, after handing out the pills,
16 the same doctor in the white coat randomly shoots one of
17 the men dead and then shoots ten more in the groin, leaving
18 them impotent or incontinent, because that's what we do
19 with the treatment for prostate cancer. Well, you know,
20 knowing that, then do you want to go ahead and have the
21 PSA, and that would be the informed discussion. I
22 guarantee you, that's not happening.

1 [Laughter.]

2 DR. REDBERG: So, you know, and actually, the
3 doctor who discovered PSA in 1970, Richard Ablin, has
4 written a book called The Great Prostate Hoax: How Big
5 Medicine Hijacked the PSA Test and Caused a Public Health
6 Disaster. But, yet, Medicare is still paying for PSA. I
7 mean, we're obligated. Medicare has to pay for tests for
8 its Grade A and B. But, why do we have to pay for Grade D?
9 We don't, obviously, have to, but, you know, there's no
10 tradition of take back, clawback, or -- and I would suggest
11 that it doesn't make a lot of sense to me that Medicare
12 would pay for a Grade D cancer screening that we know is
13 leading to tremendous harm.

14 That's not to say if men want to get PSA
15 screening, they can certainly get it, but why should
16 Medicare pay for it when the recommendation from the task
17 force is not to do it and we know -- and we know that
18 payment policy does influence medical testing.

19 And, I was just -- in the mailing materials,
20 there was a commentary from Gail Wilensky on understanding
21 responses to reductions in CMS payment, but she notes that
22 part of the Affordable Care Act was that CMS is supposed to

1 reduce amounts paid by Medicare for overvalued services.
2 So, I think there's already the regulatory authority to do
3 that. And, she particularly notes that CMS should consider
4 using this strategy for other potentially overvalued
5 services -- her commentary is on nerve conduction studies -
6 - particularly those that have a high cost, such as the use
7 of proton beam therapy, which is a very expensive
8 intervention with little clinical evidence supporting its
9 use. And we know that proton beam therapy is used for
10 prostate cancer.

11 So, you know, those millions that you showed us
12 are just a small fraction of the actual spending on
13 prostate cancer therapy, and that there are a lot more
14 harms and hundreds of millions, if not billions, of dollars
15 being spent. So, I think there's a lot of opportunity
16 there.

17 It also occurs to me it's an opportunity in these
18 overvalued services to introduce, again, that concept of
19 reference pricing, so that if you have a lot of different
20 therapies, say, for prostate cancer, you pay the same
21 amount for all of them, because they differ very much in
22 price, but they all would have the same sort of outcomes.

1 That's another opportunity to sort of drive higher-value
2 care.

3 And, again, looking at that, because one of the
4 higher spends were in cardiac care, it said, for PCI for
5 stable coronary disease. Well, we know a lot of the PCI
6 for stable coronary disease is done in patients who are not
7 on medical therapy, which is equally effective for stable
8 coronary disease. So, again, the concept of reference
9 pricing, where we pay for treatment of stable coronary
10 disease, but the same amount. It would take away the
11 incentive that there is in the current fee-for-service
12 system where procedures are reimbursed much higher than
13 medical therapy.

14 And, so, I think that there's a lot of
15 opportunity for really a win-win in terms of improving care
16 and decreasing cost and decreasing harms, because these
17 procedures that have -- and imaging. I mean, all of this,
18 really, it's only touching the surface. The imaging tests,
19 you know, the back pain, they lead to billions of dollars
20 of back pain procedures of unclear benefit.

21 So, again, I think that we should -- seem to have
22 the authority, and that is a very fruitful area, because we

1 can improve care for our beneficiaries.

2 DR. CROSSON: So, thank you, Rita.

3 Let me -- could you put up -- yeah, you've got
4 it, Slide 13. So, I want to have a little bit more
5 discussion about relative weighting of these policy
6 directions. I have to admit, when I first looked at the
7 list, I said, yes, because it seems like they're all
8 fruitful and I couldn't rule one or the other out at the
9 moment. But, I wanted to get a sense of where the
10 Commission is.

11 Kathy, and then Mary and Scott.

12 MS. BUTO: So, I want to add one to the list.
13 First of all, Medicare coverage policy is a good one to
14 have up there, but it's a tough one to actually use on a
15 procedure by procedure, technology by technology basis.
16 You can use it, but when you're trying to differentiate
17 which imaging can be used for what things and so on and so
18 forth, it's cumbersome. It takes a while.

19 What I wanted to add up there is prior
20 authorization, which we never bring it. It also, on the
21 same issue with the consolidating coding approach on drugs,
22 one of the things I forgot to mention is if you're

1 concerned that individuals are using high-cost drugs
2 inappropriately, a good tool is to have some kind of, you
3 know, prior authorization or something that is more
4 sensitive to what their clinical need is, and if they don't
5 need it, then you've got an avenue to go down.

6 But, I think that's a tool that is not available
7 right now in fee-for-service, and particularly for a number
8 of these where you might approve imaging for certain
9 patients and not other patients, or it's okay to start with
10 a non-coverage decision for a whole category, but it's also
11 true that you might want to have shades of some kind of
12 coverage policy that allows for oversight, but not a total
13 ban on coverage for this thing.

14 So, I just wanted to add that to the list,
15 because I just don't think payment -- we can use payment
16 exclusively to drive to the appropriate treatment. I mean,
17 payment has its place, but there are other things and we
18 ought to have some way to look out for what's being
19 provided on a, you know, more of an ongoing basis. It is a
20 cost, but we're already spending a lot of money in this
21 area.

22 DR. CROSSON: Mary, Rita, and Scott.

1 DR. NAYLOR: So, I think this is a terrific
2 report and highlights a tremendous opportunity if we can
3 get our arms around it. Even if you stick with the 31 and
4 the narrower definition, you're still talking 2.6 billion.
5 And then if you can grow it to 2,000, that's extraordinary.
6 But, I think it's a critically important signal to start
7 somewhere, and this makes a great deal of sense given the
8 body of work.

9 In terms of -- I should acknowledge that I am on
10 the American ABIM Foundation, and just to clarify that
11 Choosing Wisely was always intended as a campaign to
12 stimulate conversations between physicians, other health
13 professionals, and patients about this, not to come up with
14 the 31 of these measures.

15 That being said, I think what we can learn from
16 the Pioneer, the Schwartz work and the evaluation about how
17 they were successful in getting to probably the behavioral
18 changes as well as what incentives they used would be very
19 helpful. The Robert Wood Johnson Foundation is funding
20 multiple demonstrations of efforts to do this, get to pay
21 for high-value care, somewhat stimulated through Choosing
22 Wisely. So, I'm happy to help connect you with that.

1 I do think all of these apply, but I would say,
2 you know, and I know we go to beneficiary engagement early,
3 but it's really tough. I mean, I think it's -- you know,
4 if I were to build, it would be a sequence of trying to get
5 the providers to change their behavior through whatever
6 coverage or value-based outcomes that suggest that this was
7 worth the investment. But, getting beneficiaries to go
8 from health literacy to informed decision making and shared
9 decision making, to me, is a tool in the toolbox, but it's
10 not where I would direct a lot of energy first. I would go
11 really directed toward those who are ordering these tests
12 or services.

13 DR. CROSSON: Rita.

14 DR. REDBERG: Thank you. I actually didn't have
15 my hand up, but there was something I wanted to mention in
16 terms of quality measurement. I do think Medicare coverage
17 policy, as I mentioned, is an effective means, and
18 certainly not covering low-value tests, even cancer
19 screening, would be very important.

20 In terms of quality measurement, I would say CMS
21 did just introduce a quality measure related to PSA testing
22 and then has dropped it.

1 DR. CROSSON: Right.

2 DR. REDBERG: So, that is of concern, I would
3 say.

4 DR. CROSSON: Yeah. If I remember correctly, it
5 was pretty extreme. No -- what was it, no PSA testing at
6 all, or no PSA testing --

7 DR. REDBERG: I have to look it up. I wouldn't
8 want to --

9 MR. WINTER: I can address that, if you want,
10 Jay.

11 DR. CROSSON: Go ahead.

12 MR. WINTER: So, the proposed measure -- they
13 were developing this with Mathematica and there were
14 supposed to be electronic clinical quality measures for
15 eligible professionals, so for PQRS or the HR incentive
16 program. And, so, the measure -- it would have measured
17 the share of all adult men who received a PSA screening
18 test, and there were exclusions for patients with a history
19 of prostate cancer or a prior elevated PSA test result and
20 a couple of other exclusions. And, they temporarily, as
21 you were saying, they temporarily suspended development of
22 the measure -- these were their words -- after they

1 received many comments opposing limits on PSA screening.
2 And, they said, they'll continue to solicit input from
3 stakeholders.

4 DR. REDBERG: I would say that didn't sound
5 extreme to me. I mean, they had their appropriate
6 exclusions. I mean, you could put in a few percent, but I
7 can imagine where the comments came from.

8 DR. CROSSON: Fair enough. Scott.

9 MR. ARMSTRONG: Yeah, just very briefly. I think
10 I would focus on the first and the fourth bullets. I think
11 I'd argue a little with Mary and say I think our tendency
12 has been really to live in the first bullet around payment
13 reform and there's been all this around MA and ACOs and
14 bundles and so forth, and that I actually think probably
15 through as much as anything the way you've designed the
16 benefit through cost sharing or whatever, but also creating
17 some expectation that -- I mean, your metaphorical
18 situation, it's, like, that's all about being informed
19 about what is the likelihood that this will help you or
20 hurt you, that we understate the impact that that can have.
21 It doesn't happen well if you don't have a delivery system
22 that's capable of it.

1 But, I think one and four are really the two
2 areas I would focus on, with four too often not getting the
3 amount of attention here that I think it deserves.

4 DR. CROSSON: Bill Hall.

5 DR. HALL: Just one observation. I agree with
6 the one and four choices. If I take a hundred patients
7 that I've counseled on this, on any of these topics here,
8 PSA testing, X-rays for low-back pain, et cetera, 99 out of
9 100 will say one response to me, after my pitch. They'll
10 say, well, does Medicare pay for it? And, that just erases
11 the last ten minutes of my life.

12 DR. CROSSON: Herb.

13 MR. KUHN: So, let me make first an observation
14 on something Kathy raised, because I thought it was pretty
15 important, the prior authorization issue. Just -- it's
16 used in Medicare sparingly, but mostly in the program
17 integrity area. And right now, CMS has, or they finished
18 comments on an initiative they were looking at doing a
19 hundred percent prior authorization, I think, on home
20 health in five states. And, what I think concerned a lot
21 of folks is that you have the CJR Initiative that began on
22 April 1, and so here you've got a 90-day bundle for hips

1 and knees and one of the primary things you're trying to do
2 is discharge those folks, hopefully, into home health, the
3 lowest-cost setting. But now, all of the sudden, you've
4 got a pre-auth that might cost you days back up in the
5 hospital waiting for that pre-authorization. So, pre-
6 authorization is a good tool, I think, in the program
7 integrity area, but as we get more into these bundled
8 payments and other things out there, it could get
9 complicated, and just to put that on the table as we move
10 it out there.

11 Also, it's an incredibly resource intensive
12 thing, and whether CMS has the bandwidth to manage
13 something like that. So, I think if you think about that
14 one in the future, do think about CMS resource allocation
15 and the complexity of an organization that really has never
16 used this tool before in this way. It would be brand new
17 to them, since mostly it's been in the program integrity.

18 MS. BUTO: [Off microphone.] -- contractor.

19 MR. KUHN: Yeah. The contractors would
20 ultimately have to do it. Kathy is right.

21 So, having said that, I agree with Scott. I
22 think one and four are the real opportunities, you know,

1 particularly, as I just mentioned, on the CJR Initiative,
2 people are going to be trying to get rid of frivolous
3 activities and try to really focus on the value that's out
4 there. And, so, I think the payment and delivery system
5 reform holds real opportunity.

6 And, then I was curious about, ultimately, the
7 work of comparative effectiveness and the work of Cori, and
8 are there any learnings from there that ultimately can
9 migrate into some of this work to help us.

10 DR. SAMITT: See, I'm more inclined with you,
11 Jay, to think that all four categories have potential
12 merit, and I think we should at least keep talking about
13 them and evaluate the levers that we could pull in all four
14 because I'm concerned that the strength, for example, of
15 the payment alignment isn't sufficient to sort of
16 countervail the intentions to still generate volume that
17 may be unnecessary, and that sort of having a belt-and-
18 suspenders approach to really aligning interests around
19 high-value care makes sense. And so I think multiple
20 categories, including Medicare coverage policies, should
21 not be discounted as we evaluate ways to do this.

22 The one that's missing, though, on here -- and

1 maybe we just assume that delivery systems would do this
2 because of the other four levers -- are things like
3 decision support and really requiring delivery systems to
4 integrate decision support. I think one of the reasons why
5 we're not seeing some of the Choosing Wisely
6 recommendations more broadly implemented is that there
7 isn't a sort of a point-of-service reminder for clinicians
8 that this is a Choosing Wisely issue that really should be
9 rethought, and so I don't know to what degree CMS would
10 ever think about either requirements for decision support
11 or even evaluating some methodologies to prompt clinicians
12 at the point of delivery regarding Choosing Wisely
13 guidelines.

14 There's some organizations out there that are
15 developing methodologies to do exactly that. I think that
16 having the tool to complement the incentive is much more
17 effective than just the incentive alone.

18 MR. WINTER: Can I Just address something that
19 you just said, Craig? In terms of clinical decision
20 support, there was recent legislation that mandated that
21 imaging providers consult with clinical decision support
22 software about the imaging order in order to get paid for

1 it, and CMS has begun the process of identifying --
2 certifying clinical decision support software for that
3 purpose, so that will go into effect in the next couple of
4 years for imaging.

5 DR. HOADLEY: So I guess as I look at this list,
6 I can sort of feel like I can articulate the limitations of
7 each of these tools. I mean, some of them have been said.
8 Coverage policy is bulky. It's hard to do. A lot of
9 individual measures, quality measurement, there's just
10 always a question of how much it really changes behavior.
11 So it may not be a helpful comment.

12 I mean, I think on the beneficiary engagement,
13 the thing I worry about is it becomes a matter of just
14 increasing cost sharing for a set of services that we think
15 are undesirable. If it's put in partnership with some
16 lowerings of cost sharings elsewhere that are burdensome
17 and don't seem to be related to decisions, whether to do
18 care like some of the hospital stuff, make more sense.
19 Obviously, it's got the aspect of being blunted by the
20 Medigap coverage as well.

21 I think with each of these, we're really got to
22 think through if we really want to see an impact on the use

1 of these services. I don't know if we've got the right
2 solutions on this list at all, but I don't, fortunately,
3 have anything to add to it.

4 And prior authorization, which was added, you can
5 talk about those issues there too with -- again, the item
6 by item, I think Herb made some of these points, as well as
7 the potential, is it like on the drug area where you have
8 to then think about exceptions and how do beneficiaries
9 that really need it sort of get to it, and so you have
10 potential access here.

11 MS. BUTO: Just to follow up on something that
12 Jack was saying, I'm wondering -- and I think it was Herb
13 who mentioned to Cory -- if something that we might think
14 about I this context would be a process for CMS to get
15 advice on an ongoing basis, the way they do with the
16 Preventive Services Task force; in other words, instead of
17 putting it on them to come up with the list and then go
18 through a coverage process, if there was a more kind of
19 systematic way for an evidence-based group, whether it's
20 PCORI or otherwise, to identify low-value services for the
21 Medicare population that then gives CMS a little bit of
22 cover in proceeding to either go forward with a limited

1 coverage or whatever it is, I think that would be helpful,
2 so, as you flesh this out, if you could think about those
3 bodies or entities.

4 And I think we've mentioned like the Coverage and
5 Evidence Development workgroup and so on, but there may be
6 others as well that we can tap into.

7 DR. CROSSON: Cori.

8 MS. UCCELLO: So I don't have an opinion on these
9 four, but I do have a comment on what categories of low
10 services. On Slide 9, you broke things up into categories
11 that account for the volume, most volume, and those that
12 are most -- the spending. And I don't think we necessarily
13 want to focus solely on those that account for the most
14 spending because those high-volume, low-value services
15 still have the potential for those screenings and imagings
16 themselves to cause harm, and they will also have potential
17 high cost downstream. So I don't think we want to kind of
18 eliminate those from consideration as this moves forward.

19 DR. CROSSON: On that point Ariel, has anybody
20 done that sort of categorization, taking a look at both the
21 low volume and the high cost and then looking at the
22 downstream cost? I mean, it seems like that would be

1 important but a lot of work.

2 MR. WINTER: Yeah. I'm not aware that anyone has
3 done that, and these categories were the categories created
4 by the folks from the Harvard that we contracted with, and
5 when they do the analysis, they came up with a similar set
6 of categories that were high volume and high spending, but
7 they did not look at what the downstream costs were of
8 these high-volume categories.

9 DR. CROSSON: Great input for Ariel and the
10 staff. Thank you very much. We will be hearing more about
11 this in the future.

12 Now we have the second opportunity today for
13 input from the public. If there are any individuals in the
14 audience who would like to make a comment, now is the time
15 to come to the microphone, so we can see how many people we
16 have or if we have any.

17 [No response.]

18 DR. CROSSON: Seeing none, we are adjourned,
19 then, until 8:30 tomorrow morning. Thank you.

20 [Whereupon, at 5:05 p.m., the meeting was
21 recessed, to reconvene at 8:30 a.m., Friday, April 8,
22 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, April 8, 2016
8:27 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
KATHY BUTO, MPA
ALICE COOMBS, MD
WILLIS D. GRADISON, JR., MBA, DCS
WILLIAM J. HALL, MD, MACP
JACK HOADLEY, PhD
HERB B. KUHN
MARY NAYLOR, PhD, FAAN, RN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc
CRAIG SAMITT, MD, MBA
WARNER THOMAS, MBA
SUSAN THOMPSON, MS, RN
CORI UCCELLO, FSA, MAAA, MPP

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P R O C E E D I N G S

[8:27 a.m.]

1
2
3 DR. CROSSON: Welcome to our last session of this
4 Commission year. I'll just take this brief opportunity in
5 public to thank once again the five Commissioners who will
6 be leaving us and who have contributed so greatly to the
7 success of this Commission.

8 This morning, we are going to take up again the
9 issue of access to care services, particularly emergency
10 care services, in rural areas. We've got a presentation
11 from Jeff Stensland and Zach Gaumer, and it looks like,
12 Jeff, you are going to start out.

13 DR. STENSLAND: As Jay said, we're going to
14 revisit our October discussion of ways to improve
15 efficiency and preserve access to emergency care in small
16 rural communities. We expect that your mailing materials
17 on this topic will be revised based on your discussions
18 today and then become a chapter in our June report. And
19 the idea is not to have formal recommendations at this
20 point, but to get policymakers and those in the hospital
21 industry to start talking about alternative models for
22 efficiently preserving access in some sparsely populated

1 rural communities.

2 Before I start, I want to thank Anna Harty for
3 her excellent work on this project.

4 Since the start of the prospective payment system
5 in 1983, Medicare has made special payments to certain
6 rural hospitals with the objective of preserving access to
7 care.

8 However, the current models are all inpatient
9 centric. They pay higher inpatient rates for small rural
10 PPS hospitals and cost-based payments to critical access
11 hospitals for inpatient and outpatient services.

12 There are two main problems with these models:

13 First, as inpatient volumes decline, these models
14 become increasingly inefficient. Costs per unit increase,
15 and the literature points to concerns about the quality of
16 care when clinicians have few inpatient cases to gain
17 experience with.

18 Second, the models are not always successful in
19 preserving access, and some hospitals have been closing.

20 I will briefly review these two problems and then
21 discuss some alternatives.

22 There are four key Medicare programs that are

1 intended to preserve access in rural areas by increasing
2 inpatient payment rates to rural hospitals.

3 The sole community hospital program increases
4 payments by about \$900 million per year to over 300
5 hospitals, primarily by increasing their inpatient rates.

6 The Medicare-dependent hospital program increases
7 inpatient rates by over \$100 million to 150 hospitals that
8 have high Medicare shares in rural areas.

9 In addition, the MDH and SCH hospitals can also
10 qualify for a low-volume add-on if they have fewer than
11 1,600 Medicare discharges, and most of them do.

12 Finally, the majority of rural hospitals right
13 now are critical access hospitals, and they receive cost-
14 based reimbursement for inpatient and outpatient services.

15 And the takeaway point from this slide is that
16 existing special payments to rural providers all require
17 that they provide inpatient care.

18 The inpatient focus of the existing models in the
19 foundation of their limitations. As hospitals have lower
20 volume, their unit costs go up. Lower volume, as I said,
21 also raises questions about the quality of care. There is
22 a fairly consistent literature on the concerns regarding

1 the relationship between volume and outcomes. With higher
2 unit costs and questions about quality, there is a concern
3 that low volumes may lead to low value.

4 Second, most rural hospitals are critical access
5 hospitals that receive cost-based reimbursement, and there
6 are three issues with cost-based reimbursement I would like
7 to highlight.

8 First, hospitals with higher profits on their
9 non-Medicare business tend to have higher costs, and we
10 discussed this and showed some quantitative information in
11 your mailing materials.

12 Therefore, cost-based reimbursement can direct
13 higher payments to CAHs that are better off financially.
14 In contrast, if a critical access hospital is struggling
15 financially and tries to reduce its cost structure to stay
16 afloat, Medicare payments decline due to the reduced costs.
17 So higher payments for the better-off hospitals, lower
18 payments for the worse-off hospitals.

19 Second, it encourages non-emergency services such
20 as MRI services and post-acute care. These services have
21 higher shares of Medicare and private patients which can
22 generate cost-based reimbursement or high private rates.

1 In contrast, emergency services tend to have more uninsured
2 individuals which makes them less profitable under a cost-
3 based system, as we discussed in your mailing materials.

4 Finally, cost-based reimbursement reduces the
5 incentive for cost control, and we illustrated this in your
6 mailing materials by showing the higher cost growth at
7 critical access hospitals than at PPS hospitals in recent
8 years.

9 So the two limitations we discussed here are
10 greatest for critical access hospitals with really low
11 volumes, and this problem of low volumes at critical access
12 hospitals is evident when we look at the following chart.

13 This graph shows that the admissions have
14 declined by one-third for the average critical access
15 hospital over the past decade. This is the yellow line
16 showing volume down to less than 400 admissions or about
17 one per day at the median CAH.

18 For the 10 percent of CAHs with the lowest
19 volume, the red line, volume has dropped in half with about
20 10 percent of CAHs admitting fewer than 90 patients per
21 year. That is about two patients per week. It is
22 difficult to efficiently staff a hospital at that low a

1 volume, and there is also a concern that clinicians may not
2 have the advantage of gaining experience with large numbers
3 of inpatient cases.

4 Now, as admissions have declined, we have seen
5 some increase in closures. In rural areas, 41 hospitals
6 have closed over the past three years. The distance from
7 the closed hospital to the nearest open hospital varies
8 widely. Three of the closures were within 10 miles of
9 another hospital, 24 from 10 to 20, 13 from 20 to 30 miles
10 away, and one was more than 30 miles away from another
11 hospital.

12 Unlike the early years of the critical access
13 hospital program, some CAHs are now closing despite
14 receiving cost-based reimbursement from Medicare. This
15 tells us that while cost-based reimbursement has increased
16 payments to many providers, it does not always keep the
17 hospital doors open. As we show in your mailing materials,
18 there were seven CAHs that closed in 2014. In the year
19 prior to closure, the median closed critical access
20 hospital received inpatient and post-acute payments that
21 were \$500,000 above PPS rates. However, the extra \$500,000
22 was not enough to keep the hospital doors open. That was

1 absorbed by the higher inpatient costs at these hospitals.
2 This raises the question: Is there a way to direct
3 existing Medicare subsidies toward emergency services in
4 order to improve efficiency and access? Could we offer
5 these rural hospitals the option of a financially viable
6 outpatient-only facility?

7 The goal of an outpatient-only model could be as
8 follows:

9 First, we have always stated this would be an
10 option, not a requirement for small rural communities.

11 Second, the model should preserve access to
12 emergency services.

13 Third, it should improve efficiency.

14 Fourth, we want to have community commitment to
15 the option, and this could be assured by requiring matching
16 grants from the county or local sources.

17 The first option is a freestanding emergency
18 department model. In this case the facility would maintain
19 an emergency department that is open 24 hours a day, 7 days
20 a week. Medicare would pay the facility outpatient PPS
21 rates just like it was a hospital-based ED. This would
22 level the payment rates between freestanding EDs and full-

1 service hospitals in these isolated rural areas. However,
2 as we discussed, that may not be enough given the really
3 low volumes at some rural facilities. Therefore, there
4 would be a fixed grant to help with the standby capacity
5 costs of the facility.

6 In order to receive the fixed grant, the hospital
7 would have to be willing to give up acute inpatient
8 services and give up cost-based reimbursement of its post-
9 acute-care services. It could still lease the hospital
10 beds to a SNF that would then receive regular PPS SNF
11 rates. And the conversion of rural hospitals to SNFs is
12 not an uncommon phenomenon.

13 Finally, this would be seen as a choice for the
14 hospital and not a requirement. Many hospitals will
15 continue with their critical access hospital or PPS status.
16 But this would provide a clear option for those who are
17 struggling with declining inpatient volumes.

18 The second option is for smaller communities that
19 cannot support a 24/7 emergency department. In these
20 communities there may simply not be enough patients, or
21 there may not be enough clinicians -- physicians, PAs, or
22 NPRs -- to cover an ER 24/7.

1 In this case there could be primary care clinic
2 that has an affiliated ambulance service. The clinic would
3 be open 8 or 12 hours a day; the ambulance service would be
4 available 24/7. A similar model is being evaluated by the
5 Kansas Hospital Association.

6 The clinic would get two types of payment. One
7 is a PPS rate per unit of service. The second is a fixed
8 grant to help with the standby capacity of the ambulance
9 and the facility. For example, they could use the fixed
10 grant in part to help cover the cost of hiring a paramedic
11 to coordinate the volunteer ambulance service.

12 While special payments may be needed to keep
13 hospitals open and keep the emergency department operating,
14 we made it clear in our 2012 report on rural health care
15 that special payments should be targeted at providers that
16 are needed for access. We specifically said Medicare
17 should make eligibility limited to isolated providers.

18 For example, if two hospitals are 5 miles from
19 each other and they are both struggling with low volumes
20 and both struggle to recruit physicians and other
21 clinicians to cover their emergency department, it does not
22 make sense to split the emergency volume between these two

1 facilities. To avoid duplicative services, the special
2 payments would only be available to isolated emergency
3 departments.

4 What this means in practice is that freestanding
5 emergency departments would have to be some distance from
6 full-service hospitals and other freestanding emergency
7 departments in order to get this extra financial support.

8 Now, there are some issues to be worked out with
9 both these models.

10 With the first model, it is clear that the
11 product we are buying is 24-hour standby capacity at an
12 emergency department. With respect to this option, a key
13 question will be minimum staffing levels. For example,
14 will hospitals receiving the grant be required to have
15 physicians, PAs, or NPs in the hospital or in the emergency
16 department 24 hours a day? What will be the maximum
17 response time for the on-call physicians who may be backing
18 up the NPs or PAs?

19 In addition, will the hospital be allowed to
20 convert back to CAH status if the community changes its
21 mind and decided, oh, we really did need inpatient capacity
22 in this community?

1 Now, the second model, the clinical and ambulance
2 model, has some more difficult issues.

3 First, it is not quite as clear what the product
4 we are buying is. Is it primary care and ambulance
5 service? But what level of primary care? Will it be open
6 7 days a week? What will be the minimum staffing levels?
7 Will there be minimum ambulance response times or levels of
8 technical training?

9 Finally, it may be more difficult to set
10 eligibility limits on the second program. In the first
11 case, there is a limited number of freestanding emergency
12 departments right now and a limited number of hospitals
13 that would want to convert to this model. However, as
14 Kathy mentioned last October, there could be somewhat of a
15 woodwork effect in the second model. Even if the program
16 was limited to isolated communities, there are small
17 communities that already have ambulances and a primary care
18 practice, and they may all want to feel like they should
19 receive the grant funding, too. So existing rural health
20 clinics, in addition, may feel they should receive some
21 grant funding just like the freestanding EDs. Therefore,
22 limiting eligibility may be more challenging in that second

1 model.

2 So let's talk about the potential effects of
3 these models. For the beneficiaries, there would be three
4 primary effects.

5 First, and most important, it would preserve
6 access to emergency services.

7 Second, the patient would have to travel further
8 for inpatient care. There would no longer be inpatient
9 care in their community. But you should recall that many
10 rural patients are already bypassing their rural hospitals
11 for inpatient care. Recall that 130 critical access
12 hospitals have fewer than 90 admissions per year.

13 Finally, as we showed in your mailing materials,
14 coinsurance would be substantially lower under this model
15 than under the critical access hospital model. The
16 coinsurance would be the same as at PPS hospitals.

17 For the providers, there are four key points.

18 The first thing to remember is this is an
19 optional program. So if they want to continue with the
20 status quo, they can.

21 However, for those that are at financial risk or
22 simply operating inefficiently under the current model,

1 this could provide financial viability and greater value to
2 the community.

3 In addition, the next point is hospitals often
4 play a key role in recruitment of physicians to small
5 communities. And it is important that under this model
6 there will still be a local health care entity there to
7 recruit physicians. And, in fact, the entity may be seen
8 as a more desirable place to work given the financial
9 stability provided by the grant funds to the entity.

10 Finally, cost structures will be lower. As we
11 discussed in your mailing materials, critical access
12 hospitals are now currently paid over \$1,800 per post-acute
13 day. This can make care in the critical access hospitals
14 look expensive in any type of ACO model or any other model
15 where providers are taking responsibility for the overall
16 cost of care. Moving these communities to PPS rates will
17 make it easier to incorporate these communities' physicians
18 into accountable care organizations and other models that
19 take responsibility for the cost of care, because the
20 overall costs per unit of service will be much more
21 competitive.

22 Now, there are several discussion issues:

1 First, we could discuss the two models. What are
2 the products the program would be buying under each mode?
3 Are there minimum staffing levels we should require? Is
4 there one model that looks more plausible than the other?
5 And are you concerned about what the eligibility standards
6 would be for the different models?

7 Also, to assure community commitment, we could
8 require a local or county grant to match part of the
9 Medicare grants. We can discuss that.

10 Finally, in October several of you suggested that
11 a facility that converts from critical access hospital
12 status to a freestanding ED status should have the ability
13 to convert back for a limited number of years, say five
14 years. And the idea here is this might reduce some of the
15 anxiety that these community boards would have about
16 converting their hospital from a full-service hospital to
17 an outpatient-only facility and may facilitate actually
18 more conversions by having the option of going back.

19 We will now open it up for discussion of these
20 issues and other thoughts you may have on efficiently
21 preserving access to emergency services in rural areas.

22 DR. CROSSON: Thank you, Jeff and Zach. Very

1 clearly constructed, as usual.

2 Right now we're going to take clarifying
3 questions, and then we're going to have a general
4 discussion, and Herb and Sue will be leading the
5 discussion.

6 Clarifying questions?

7 MR. THOMAS: Do we have any idea how many
8 facilities we think may fall into this type of category
9 that would be potentially impacted by this policy or
10 opportunity?

11 DR. STENSLAND: If you look at the opportunity to
12 move to a 24-hour freestanding ED, I think that one's a
13 little easier. I don't know, maybe something like 100
14 hospitals or something. There are 130 of them right now
15 that have fewer than 90 admissions per year, and maybe
16 there would be 100, maybe 200, something like this, in the
17 whole country.

18 MR. THOMAS: And I guess if you look at those
19 that have 90, I mean, if you think about -- have you
20 thought about what is kind of the scale that you would want
21 to see this type of option used? You know, so if you think
22 of 90, that's pretty small, obviously. I mean, you would

1 think that probably even a larger facility than that, this
2 may be a good option for them. Have you thought about how
3 that would scale up and what that might look like?

4 DR. STENSLAND: I haven't -- at least the way
5 I've thought about it, I haven't thought about it as
6 prescriptive of saying, okay, this is who should do it and
7 who shouldn't. I thought of it more in the way as if we
8 took the funds that we're already spending for critical
9 access hospitals, say this half a million dollars, and we
10 said, here, you can have this as a fixed grant, and then
11 they can make their own decision of saying, okay, if we had
12 this fixed grant, could we provide more value to our
13 community than we are now with this model, and I think kind
14 of leave it up to them, saying here is your pot of money,
15 do the most you can for your community with this, and if
16 they feel we can do more on an outpatient-only basis and
17 actually be better probably at recruiting physicians, they
18 would choose that model rather than the other one.

19 DR. MILLER: And, Jeff, the other criteria about
20 how many might get picked up has to do with what distance
21 requirement ultimately gets imposed as well, or defined.

22 DR. STENSLAND: Right. So there wouldn't be

1 grants for those that are like right next to each other.
2 You know, in the extreme, you have critical access
3 hospitals that are two miles, five miles from another
4 hospital, and we wouldn't want to say, oh, you need two
5 emergency departments in this small -- you know, you're not
6 going to say this town of 10,000 people needs two emergency
7 departments with two CAT scanners and two MRI machines. We
8 wouldn't be promoting that.

9 DR. SAMITT: That was my question as well. Of
10 the 90, how many meet the definition of "isolated," as you
11 described? Or do all of them?

12 DR. STENSLAND: I don't know. We'll have to go
13 back and look at those distance measures. I also should
14 say we haven't picked a measure of isolated yet. That's
15 kind of a thing for discussion. So if people around the
16 table thought, well, isolated is 15 miles from another
17 provider, a lot of them are going to qualify. If people
18 around the table thought it's 30 miles, not that many will
19 qualify. And so that is something that's clearly a
20 judgment call, and that's something that we can empirically
21 say is the right or wrong distance.

22 DR. MILLER: The reason I ask the question is

1 just to draw a couple of these points out. I don't want
2 the Commissioners, but also people sitting in the audience,
3 to think this is 130 hospitals, and the 90 refers to the
4 numbers of admissions during the course of the year. So I
5 just wanted to clarify those two numbers. And precisely
6 this question of how you think through the distance will
7 define what this -- the availability of this option.

8 I'm sorry, Jeff.

9 DR. CROSSON: Okay. So, I'm going to take the
10 order of hands I've got. I have Bill, and Kathy, then
11 David, Jack, Alice, and Bill, and Jon.

12 MR. GRADISON: On page -- you said Bill? Or did
13 you?

14 DR. CROSSON: I'm sorry. Yes, Bill. Bill
15 Gradison. Sorry.

16 MR. GRADISON: Okay. I guess that's me. On page
17 15, it says, towards the bottom, due to the 35-mile
18 restriction associated with provider-based facilities, most
19 isolated rural hospitals could not become OCEDs. As a
20 result, there are currently very few rural OCEDs. I
21 understand that. Are there any? Are there enough that one
22 could learn perhaps some things from taking a closer look

1 at perhaps the handful that are out there?

2 DR. STENSLAND: Yeah, and we've talked to a few
3 of them. There are a few that are operating as
4 freestanding EDs. In the cases that I'm aware of, they
5 have one of two things going for them. Either they're
6 getting some local support from the county or some sort of
7 a, like a hospital district type thing, where they say,
8 we're going to kick in a half-million dollars a year to
9 preserve emergency access, and some of these places, you
10 know, have emergency trained physicians in there 24 hours a
11 day, and so there's a certain cost to that stand-by
12 capacity that they've got to cover.

13 The other ones I'm aware of are close enough to
14 another hospital, so they're seen as a satellite of that
15 hospital, and then they get the facility rate for the ED.
16 I can't think of any of them that operate in a rural area
17 that don't get the facility rate for being ED and don't
18 have any outside support.

19 DR. CROSSON: Kathy.

20 MS. BUTO: Two questions, Jeff. One is, could
21 you explain a little bit more about coinsurance, because I
22 think I heard you say that it would be less than existing

1 inpatient, but I'm curious about that.

2 And then the second one is, what do we know about
3 primary care access and access to outpatient services in
4 some of the same areas? In other words, you know, with a
5 limited number of health professionals in an area, I'm
6 wondering whether we're just moving -- sort of like a shell
7 game, we're moving those health professionals to another
8 setting or site, but they're already pretty occupied
9 providing primary care. So, I'm just trying to understand
10 what -- I understand the emergency department part and the
11 fact that you want to maintain that capacity, but I'm just
12 trying to understand whether we're really just moving
13 professionals to a different setting that might actually
14 end up costing more than existing payments for primary
15 care.

16 DR. STENSLAND: So, I'll start the coinsurance
17 one first. So, the way coinsurance works for Critical
18 Access Hospitals and also for rural health clinics is --
19 well, I'll stick with Critical Access Hospitals now -- is
20 the beneficiary or their Medigap provider is billed
21 coinsurance equal to 20 percent of charges. And, they take
22 the coinsurance -- so, if your bill for the -- let's say

1 you're charging \$2,500 for an MRI at the Critical Access
2 Hospital, all right. So, the coinsurance for that will be
3 20 percent of the full charge, or 20 percent of the \$2,500,
4 or \$500, okay. So, that's the coinsurance, is \$500.

5 Then the net amount that the hospital will get
6 from the beneficiary and the program is equal to their
7 costs. So, if their cost of delivering that service was
8 \$500, and they got \$500 in coinsurance from the
9 beneficiary, then the program actually wouldn't pay
10 anything additional. The beneficiary would be pulling the
11 full weight.

12 And, because charges are a lot bigger than costs,
13 coinsurance tends to be about, on average, about half --
14 about half of the total payment that the providers are
15 getting in these rural areas, and it tends to be growing a
16 bit over time because charges tend to be growing faster
17 than costs.

18 MS. BUTO: Okay. And under the OPPS method, what
19 you're saying is they'll be paying a percentage of the --
20 and that's been declining over time, because it used to be
21 50 percent --

22 DR. STENSLAND: Yes.

1 MS. BUTO: -- also based on charges.

2 MR. KUHN: FIDO.

3 MS. BUTO: Yeah, FIDO.

4 [Laughter.]

5 MS. BUTO: So, now it's 20 percent or some
6 percentage of the fixed payment.

7 DR. STENSLAND: And that's been almost brought
8 down to 20 percent. So, basically, the CAHs are kind of on
9 the old method.

10 With respect to the recruitment, I think this is
11 a very serious issue for all these rural communities. It's
12 a big deal to them. But, I think if you kind of walk
13 through what's happening, right now, 40 percent of rural
14 hospitals employ hospitalists, okay. So, you have some
15 people that are just working out there as a hospitalist,
16 even in some small hospitals. In other cases, you have the
17 primary care doctor having his primary care practice. He
18 might also cover the ED. He might also go into the
19 hospital at night to cover the hospital beds if somebody's
20 having some medication management issue or they'll call him
21 up at night.

22 So, the idea that as the hospital converts to a

1 freestanding emergency department, they'll still have the
2 need for the outpatient care and the emergency care, but
3 they won't have the need for somebody actually doing the
4 inpatient care anymore. So, their actual needs for
5 physician, NP, and PA services will go down a little bit.

6 And, I think in my mind -- some people may have
7 different opinions -- is you actually might be able to
8 recruit a little bit easier than you can now. At least
9 when I talk to some of the rural physicians out there,
10 especially the younger physicians, they're not so keen on
11 this job where they say, you're going to see the people all
12 day in your practice, and then at night, we want you to
13 cover the ED, and if somebody has an issue at night at the
14 hospital, they're going to call you up and ask you if they
15 should be adjusting their meds.

16 And, by having -- eliminating at least that
17 inpatient part, I think you're going to reduce the needs
18 and maybe potentially reduce some of the burnout for some
19 of these physicians. Sue would probably have more of a
20 hands-on impression of this issue of recruitment and
21 burnout and difficulty with young physicians wanting that
22 lifestyle.

1 MS. BUTO: So, Jeff, just in your view and based
2 on the work and the site visits that you've done, you don't
3 think that we're talking about shifting primary care
4 physicians into this new ED/stand-by capacity, in a sense,
5 raising costs for the same services, you think that's
6 really going to be -- the ED part of it will be an
7 enhancement that's not there now and will leave primary
8 care physicians and their practices.

9 DR. STENSLAND: Yes. I don't think there's going
10 to be enough business in a lot of these EDs to keep
11 somebody fully staffed. Maybe some of them might have a PA
12 in there 24 hours a day. You would probably have to have
13 some sort of rules, like you would say, you know, for all
14 scheduled visits, we're only paying the regular fee
15 schedule rate, or if you're an FQHC, the FQHC rate, or the
16 rural health clinic rate, whatever it happens to be. For
17 the unscheduled emergency thing that comes in the emergency
18 department, well, then you'll get the emergency facility
19 fee and the professional fee, something like that to
20 separate it so it's not everything all of the sudden shifts
21 into the hospital as a facility fee case.

22 DR. CROSSON: David.

1 DR. NERENZ: Bill asked what I was going to ask.

2 DR. CROSSON: Jack.

3 DR. HOADLEY: So, my question -- a couple
4 questions about the grants, and I realize these may be just
5 open policy questions, but when you think about the grants
6 from the government to these new kinds of facilities, are
7 you assuming that these are Medicare grants as opposed to
8 coming from HRSA or something like that?

9 DR. STENSLAND: Yeah. I think there is some
10 Medicare grants that go out right now just for some things
11 like the -- what's the program -- the post-acute care
12 coordination-type program.

13 DR. HOADLEY: Okay.

14 DR. STENSLAND: So, the idea is it would be a
15 Medicare program grant, and part of this, in my mind, might
16 be it might be a little easier to think of it as the
17 Medicare program has already given these supplemental
18 payments --

19 DR. HOADLEY: Right.

20 DR. STENSLAND: -- out to the Critical Access
21 Hospitals. So, the same program could be sending the same
22 amount of money, just directing it in a different

1 direction.

2 DR. HOADLEY: And, would you envision this as
3 some kind of a formula that you would create to determine
4 an amount? Would it be more of a, like a grant
5 application, where they would indicate what their needs are
6 and that would be evaluated? Do you have a vision for that
7 kind of structuring?

8 DR. STENSLAND: You could do it either way. You
9 could have a grant process. I think, also, the numbers
10 aren't so big that it might be easier to just say, here is
11 -- set the criteria and say, if you have this distance
12 criteria in your hospital and you decide to go to an
13 outpatient facility, you're going to automatically get
14 this. It would kind of eliminate one hurdle, and I don't
15 think it would be that many more, and it would also be
16 difficult, I think, for any federal agency to tell rural
17 communities, you get it, you don't get it.

18 DR. HOADLEY: Right.

19 DR. STENSLAND: And the other part was --

20 DR. HOADLEY: Well, and then sort of the amounts.
21 I mean, is it going to be said, this is a certain volume,
22 therefore, that creates, you know, some kind of formula

1 that creates an amount?

2 DR. STENSLAND: I think I am more inclined to
3 just give a set number and give that same number to
4 everybody --

5 DR. HOADLEY: Okay.

6 DR. STENSLAND: -- and say, this is the set
7 amount that we think you need to help stabilize your stand-
8 by capacity. I'm reluctant to tie it to costs, because as
9 I said before --

10 DR. HOADLEY: Yeah.

11 DR. STENSLAND: -- you know, if you're in a nice
12 ski resort community, your costs are going to be high
13 because you can afford high costs. I don't want to say
14 that the ski resort community gets more than this poor
15 hospital in Alabama. So -- and I don't necessarily want to
16 tie it to volume.

17 DR. HOADLEY: Right.

18 DR. STENSLAND: I don't want them to think that
19 what we're trying to do is, oh, if you're really ginning up
20 the volume, you're going to get a bigger grant, or
21 something like this. I think by keeping it fixed, you can
22 say, really -- again, this gets back to the product we're

1 buying --

2 DR. HOADLEY: Mm-hmm.

3 DR. STENSLAND: What we really want is for people
4 in those rural communities to have somewhere to go when
5 they have an emergency, and we're not stepping beyond those
6 bounds. But, that's just -- but, that's certainly a
7 discussion point for you guys.

8 DR. HOADLEY: Right. Right. No. And, in terms
9 of a commitment, I mean, once you get that grant, you're
10 kind of getting it as long as you're still operating that?
11 There's not, like, a -- I mean, presumably we have some
12 quality standards and some minimum something.

13 DR. STENSLAND: In my mind, I think if you're
14 going to get these people to buy in, I don't think this can
15 be, like, a one-time capital grant.

16 DR. HOADLEY: Right.

17 DR. STENSLAND: I think you're going to say, you
18 know, your fundamental problem is this is about people, and
19 you have, you know, PAs, NPs, physicians who are providing
20 important emergency access and you just don't have the
21 volume to cover all the costs of those individuals without
22 a little extra support, and so that -- and we don't think

1 that volume problem would go away unless somehow the
2 community grew a lot --

3 DR. HOADLEY: Right.

4 DR. STENSLAND: -- and then they would become a
5 hospital. But, otherwise, it would -- I think it would
6 have to continue on if you're going to actually -- if
7 you're going to get this small town board to say, you know,
8 we built this hospital with Hill-Burton grant funds in 1955
9 and it's been going like this for 50 years and now we're
10 going to make this change to be an outpatient-only
11 facility, which might be a little scary for these guys,
12 unless you say that, here, you're going to get this grant
13 moving on forward into the future, it might be hard to get
14 them to do it.

15 When Sue comments, she might have more thoughts -
16 -

17 DR. HOADLEY: Yeah. And, I think it would
18 probably be similar questions, and we can get into this in
19 round two, on the community grant, if that ends up being
20 part of the requirement, because there, I think it would be
21 more challenging to say for either the community itself or
22 for some private foundation funder that might assist a

1 community to commit beyond some fairly limited amount of
2 time, but we can come back to that.

3 MR. GAUMER: I just want to underscore one thing
4 with Jack's first question about the grants. Just in case
5 it got by people, there is a precedent for this, for a
6 grant to come out of the Trust Fund, the Medicare Trust
7 Fund, and go directly to a hospital. There's a precedent
8 for this out there, the Community-Based Care Transitions
9 Program.

10 DR. CROSSON: Alice.

11 DR. COOMBS: Jeff, I was curious. If we look at
12 the potential options, what happens to the patient flow of
13 the inpatients, and say you give an example, possibly 90 or
14 100 hospitals being interested in this, because we're
15 making some basic assumptions that people that are in those
16 Critical Access Hospitals are going to go somewhere. And,
17 so, from the non-Critical Access Hospitals, there must have
18 been a pattern flow of when those EDs were set up in terms
19 of what happens to -- if there are patients that need
20 hospital services. They're in Critical Access Hospitals
21 now. You take and you convert them to freestanding EDs,
22 there's some corpus of volume. I mean, it may be low

1 volume, but it may be indications to have them in a
2 hospital setting. What happens to that?

3 DR. STENSLAND: This could actually be a positive
4 thing for the other hospitals, because most of the Critical
5 Access Hospitals are not going to convert to this. They'll
6 still be out there in rural areas operating --

7 DR. COOMBS: Right.

8 DR. STENSLAND: -- ones that have a little bit
9 more volume. But, even if you're a 200, 300, 400, 500
10 discharges per year, you still probably have some low-
11 volume issues in terms of efficiency and maybe even in the
12 practice that your people get.

13 So, if this hospital here ends up converting to
14 outpatient only, some of its patients will go to the
15 neighboring communities that have kept a Critical Access
16 Hospital or kept a PPS hospital. Some will probably bypass
17 and go to the urban area for their care. But, when this
18 hospital becomes an outpatient only facility and maybe
19 reduces some of its outpatient services, like, it doesn't
20 have an MRI, visiting MRI anymore, we would expect those
21 inpatients and those MRI patients to, in large part, go to
22 these other small communities, and it might actually help

1 these other small communities which might themselves be
2 struggling with low volumes.

3 DR. COOMBS: Okay. So, we're making an
4 assumption that there are some other hospitals in the area.
5 And, some rural -- but, some of them have distances of 50
6 miles and greater before another hospital --

7 DR. STENSLAND: So, the idea is you would have to
8 be stabilized in that emergency department and then be
9 transferred out.

10 DR. COOMBS: And then the second question is,
11 have you guys looked at EMTALA provisions and how that
12 would impact some of these hospitals wanting to convert to
13 EDs?

14 DR. STENSLAND: I would assume -- this is a
15 discussion for you, and when the regulations we set up.
16 But, I would assume if you're going to give them a grant,
17 you would say EMTALA holds. You would say, you know, if
18 you're an indigent patient and you come in and you need
19 care, you have to take care of them. This can't be a
20 program just for the insured.

21 DR. COOMBS: I was just wondering about the
22 infrastructure that you would have to meet to be compliant

1 with EMTALA provisions.

2 MR. GAUMER: You know, there is wide variation on
3 the state level about what emergency departments have to do
4 and what they have to meet. So, that is something that the
5 state level would deal with, as well.

6 DR. CROSSON: Bill Hall.

7 DR. HALL: The problem of access, rural access,
8 transcends Medicare. I mean, the whole population has this
9 that live in these areas. Are there any precedents for an
10 innovative state or county subsidy of these facilities?
11 What's the role of the states in keeping these hospitals
12 alive or coming up with a solution? Why does this fall
13 just to Medicare?

14 DR. STENSLAND: That could be an open discussion.
15 Right now, with Critical Access Hospitals, a lot of states
16 also pay cost-based reimbursement for Medicaid.

17 DR. HALL: Mm-hmm.

18 DR. STENSLAND: In some cases, there might be
19 some other hospital district financing that the local
20 government provides to the hospital to help with their
21 costs of indigent care. And, I don't think there's
22 anything that precludes those same flows of dollars going

1 to these freestanding EDs. Like, if you have a -- you
2 could call it a hospital district and everybody is paying
3 an extra \$100 a year on their property taxes on their home
4 to keep the hospital going. They could be paying \$100 the
5 next year to keep the freestanding ED going.

6 DR. HALL: Thank you.

7 DR. MILLER: [Off microphone.] I've been waiting
8 for one version of this question to come up. I figured it
9 would be Jon. Jon has raised this in the past, too. What
10 we're doing here, and I just want to put this in your head
11 and you think about it as we go forward on this, what we're
12 doing here is we're saying there's already a set of
13 subsidies that go out under Critical Access Hospital, and
14 we can talk about how to potentially target that more
15 accurately.

16 But, the other thing we're doing, and when you
17 think about this in high philosophy, is we're saying this
18 Medicare dollar would be exactly what you said. It's a
19 subsidy for any patient who walks into that emergency room.
20 And, there's a couple places in the Medicare program where
21 this is starting to happen -- the uncompensated care fund.
22 We are implicitly having this discussion here. And a high

1 philosophy question is, what is the Medicare dollar for?
2 Is it for a Medicare patient or is it for all patients, and
3 this is something that we need to keep our eye on as we go
4 forward, because there's a sort of a Balkanization that
5 we're actually discussing here. So, I was waiting for a
6 question like that to come along.

7 DR. HALL: [Off microphone.] You told me last
8 night --

9 [Laughter.]

10 DR. MILLER: I had had a lot to drink, so I
11 forgot.

12 [Laughter.]

13 DR. CROSSON: And, we also have the same question
14 with GME.

15 DR. MILLER: Right.

16 DR. CROSSON: It's come up before.

17 DR. MILLER: Exactly. It's the same issue.

18 DR. CROSSON: I have just one question. So, when
19 you think about geographic access in urbanized communities,
20 there's also an issue of travel time, because 30 miles in
21 the Bay Area or here around Washington, D.C., can have very
22 different impacts depending on where you're trying to go

1 and time of day and everything like that. Are we assuming
2 here, because we're dealing with rural areas, that travel
3 time is kind of moot, or is that not the case?

4 DR. STENSLAND: I think people have traditionally
5 brought up this issue of, well, if it's winding roads or
6 are they impassable, or what about winter. From a
7 practical standpoint, I think distance is a pretty close
8 proximity to time. But, I don't think there's anything
9 that would say -- you know, we could shift and say it has
10 to be within a certain number of minutes of travel time for
11 another facility, and that would be fine. That would
12 probably be more theoretically appropriate. But, then you
13 have some sort of more of a judgment call going on with CMS
14 saying what is the travel time from A to B as opposed to
15 what is the distance from A to B, and if you're willing to
16 put that extra burden on CMS, you can move to travel time.

17 DR. CROSSON: My guess is that depending on what
18 part of the country we were having to research, CMS folks
19 would be much happier to go to certain places and drive
20 around than others, probably a little bit of added work.

21 Other clarifying questions? Yes.

22 DR. BAICKER: Just following up on Jack's

1 question, I was interested that there are some other
2 examples of grants of this kind. Are there other examples
3 of matching grant requirements where Medicare is requiring
4 a locality to contribute?

5 DR. STENSLAND: Not that I'm aware of.

6 DR. CROSSON: Okay. So we're going to move to
7 our discussion. We've got the discussion slide up behind
8 us. These are some questions to address as well as others,
9 and I'm going to ask Herb and then Sue to begin the
10 discussion.

11 MR. KUHN: Thank you. And, Jeff and Zach, thank
12 you for our work, the conversation we had in October and
13 the conversation we had today.

14 In Missouri, we're probably like other states.
15 We've had several rural hospitals close over the last
16 couple years. I will say when that happens, it really
17 rattles a community, and I have had the opportunity to both
18 attend and participate in town hall meetings when one of
19 these events happen. And I will tell you, it's like going
20 to a funeral, and the five stages of death and dying are in
21 full display in the entire community when this happens.
22 You see denial. You see anger. You see bargaining. You

1 see depression and then reluctantly acceptance of what's
2 happening in their community.

3 And the challenge that we have is that right now
4 under the programs, you either have the hospital or you
5 don't have the hospital. What I like about this
6 conversation is it gives another option that there is
7 something else out there to kind of hang their hat on, and
8 so I think this is a good conversation.

9 I know when we publish this information, there
10 will probably be some folks in rural communities and others
11 that won't like this work. They won't like the tone of the
12 report. They won't like the options. They might think
13 they're too narrow, but I would just, hopefully, disabuse
14 people of focusing on those minutia parts and instead look
15 at what we're trying to do here, an optional program.
16 We're not touching the critical access hospital program,
17 and we're trying to begin a conversation, not with
18 recommendations, but begin a conversation to give people
19 options, so that it's not a death-and-dying scenario in a
20 rural community; it's something else.

21 So let me share with you, just answer some of the
22 questions you have here, and maybe focus on some others.

1 So first, I'm going to talk about telehealth, and on the
2 Option 2 that you put forward, I see telehealth as a major
3 contributor to make that option work. And we have a
4 telehealth paper that we finished up last meeting that will
5 be published in the June report along with this one, but
6 there is no linkage between the two. Now, there's no
7 recommendations in that one. There's no recommendations in
8 this one, but there ought to be some kind of linkage at
9 least showing that telehealth could be an important factor
10 for this as we go forward.

11 And on that regard on that Option 2 is -- and I
12 think you said, Jeff -- it could be a clinic with maybe two
13 days a week, four hours a day. I don't think that's really
14 what we envisioned here. I think it's more of a center,
15 not a clinic, that really has regular hours of 12 hours a
16 day and it's there to serve the community as part of that,
17 so I would make that offering.

18 The second thing would be in the area of I guess
19 what I'm calling regulatory form and the use of the grants.
20 I think we ought to try to think about maximum flexibility,
21 and I appreciate Jack and Kate asking the questions about
22 the grants, but maximum flexibility -- because if you are

1 running an emergency department, you're going to get a
2 number of behavioral health patients, and the fact that you
3 need flexibility in order for your organization with those
4 funds to make sure you can deal with behavioral health,
5 population health, deal with promoting new technology, new
6 efficiencies, quality, a whole variety of things, so I
7 think the grant ought to be as flexible as possible to deal
8 with those kind of factors that are out there.

9 On the issue of reverting back, that question
10 that you had, I know Warner and I talked about this at the
11 October meeting. I think that's absolutely essential.
12 Over the last three weeks, I've had the chance to visit six
13 different critical access hospitals across our state, and
14 just Wednesday of this week, I spent an hour with the
15 board, with one hospital. And I can't think of a more
16 difficult job in health care right now than being a trustee
17 in a rural hospital, particularly a critical access
18 hospital. Those are hard jobs for those folks, and they're
19 quite perplexed of what to do. So I think creating an
20 option for them for almost a mulligan to do over, if things
21 change, and put a limitation of five years like you said on
22 there makes sense, but I think that's an important thing to

1 have out there.

2 The other thing what I was thinking about -- not
3 thinking about a third option, but maybe some flexibility
4 in these options where these facilities might have a way of
5 partnering with successful regional providers.

6 I know at the last meeting, Warner talked about
7 some things that they've got going on with critical access
8 hospitals. I know Sue does, and maybe they can talk about
9 that more. But I think if we really kind of want to
10 support population health, bring it to these rural areas,
11 the fact that bigger entities could avail themselves of
12 those grants and those opportunities to make sure they keep
13 that capacity in those rural communities, I think would be
14 really important.

15 Two additional things here to think about, as I
16 looked at this. One is, are there ways in additional
17 regulatory reform that we can think about? And what I'm
18 thinking about is the three-day prior hospitalization stay
19 for access to SNF facilities. If someone presents
20 themselves in an ED, the option that they have is maybe to
21 transfer to a larger tertiary, quaternary hospital in the
22 urban area, but what if they were able to just keep that

1 person for observation for 12 or 24 hours or put them in a
2 SNF for two days? It saves that inpatient stay on the
3 other end, and it's a way I think to kind of manage that
4 care more effectively in that local community. So, again,
5 I think flexibility, regulatory reform, just to make sure
6 that we have that option out there.

7 And then the final thing I'd just mention is
8 about quality. On page 5 and 6 in the paper, there's a
9 discussion about NQF and the fact that the low end, the low
10 number of patients in these facilities, so it's hard to get
11 the quality measures, and maybe kind of merging groups
12 together so you can get a better view of what's going on in
13 rural hospitals. But I'd think about that a little bit,
14 and then you kind of merge good as well as poor performers
15 together, and does that give us the accuracy that we need?
16 I think I'd rather see us maybe have a bigger conversation
17 about low-volume measures for the relevant type of patients
18 these facilities are seeing and that the service is being
19 provided. I think if we could talk to the measure
20 developers or encourage them to look at measures for these
21 types of facilities and these types of patients, it would
22 be far better than trying to merge all of that stuff

1 together that might not give us as accurate a picture as
2 possible.

3 DR. MILLER: And can I just say one thing before
4 you go? Because I would be curious about either of your --
5 anybody's comments on this, but as long as you're leading.
6 I think sometimes in my mind I feel like I see a connection
7 between the second two points, which is you do give them
8 the option to go back. But if you ask for some
9 contribution from the community, the community actually
10 goes to through the process of thinking it through, and
11 maybe you have less -- either option or reversing that
12 option if the communities had to go through the stages of
13 whatever they've had to go through to make this decision.
14 So I'd be curious if you think about it that way.

15 MR. KUHN: I think having the community have some
16 skin in the game, whether it's a hospital district -- I'll
17 tell you a story that just played out in Missouri just two
18 weeks ago. We had a critical access hospital close about
19 five weeks ago. There was another one not too far away --
20 well, 45 minutes, 50, about an hour away -- that was at
21 risk as well, and they had a local sales tax on the ballot
22 to make a determination to keep that hospital going. I

1 think before the other one closed, that sales tax would
2 have lost. I think it won by 90 percent because they saw
3 the consequences. They saw what's happened. They put skin
4 in the game. So I think it's important for them to have
5 that action.

6 DR. NERENZ: Can I just quickly ask a question?
7 Since we're on this, what is the rationale for any
8 restriction on going back five years or whatever? Why have
9 any restriction at all?

10 DR. STENSLAND: I think the idea in the
11 restriction is right now there is some of these critical
12 access hospitals -- it would all hinge on what the decision
13 is, what you folks think and what Congress decides and what
14 the limit is in the distance.

15 So right now, there's a 35-mile distance criteria
16 for critical access hospitals. The vast majority of them
17 don't meet that criteria. So, essentially, if you had some
18 smaller distance criteria for them to convert over to a
19 freestanding emergency department, they would only have a
20 limited time to go back and kind of be grandfathered into
21 being a critical access hospital that's closer than 35
22 miles from another facility. And the idea is that maybe it

1 is not a good idea to have that many full-service hospitals
2 closer than 35 miles from each other, but maybe it would be
3 okay to have a freestanding emergency department within 35
4 miles of another freestanding hospital, if that makes
5 sense. It all kind of hinges on that, and that's a
6 judgment call all for discussion.

7 DR. CROSSON: I was trying to think what was
8 behind your question because I could imagine, for example -
9 - and we've seen this recently -- all of a sudden, a
10 corporation, say an automobile manufacturer, lands a
11 facility nearby a rural community. That community just six
12 years ago converted, and now they need a hospital. So I
13 think once you got to the regulatory stage, for example,
14 you could write in some exceptions to this that if there
15 was a rapid population growth over a period of time,
16 something like that.

17 DR. NERENZ: Well, that is one example, or else -
18 - Herb's comment prompted it. What if the second community
19 had also closed, and now, for some reason, the first
20 community says, "Well, now in that circumstance, maybe
21 we're back in business again"? And I'm just wondering why
22 we would want to restrict any of those?

1 DR. STENSLAND: I just want to be clear. The
2 community, no matter what, could always set up a PPS
3 hospital. There would be no question about that, and if
4 they are more than 35 miles away from other hospitals, they
5 could always set up a critical access hospital. The only
6 question is, how long do we let them continue to waive that
7 distance requirement?

8 DR. CROSSON: Thanks. Thank you. Sue?

9 MS. THOMPSON: Thank you, and, Zach and Jeff,
10 thank you for this work. I appreciate it very, very much,
11 and, Herb, you did a great job outlining I think the
12 sensitivity and the difficulty this question raises in
13 these communities. And I won't be redundant, but just to
14 underscore the very sensitive nature of this issue that we
15 take on.

16 However, there's so many things about what you
17 have done that is very, very good, and I just want to
18 underscore I love the fact that you're thinking about
19 giving the hospitals an option to go back. I think that's
20 going to be very critical.

21 I love the fact that you have called out -- and
22 we won't go into this in great detail today, but I think

1 the ability for these organizations to align with value-
2 based contracts and ACOs is going to be very important into
3 the future.

4 But last and not least, the recognition that
5 likely the root cause of this situation that we're in is
6 the difficulty in recruiting health care professionals to
7 these communities. It's not just a fact of the difficulty
8 of managing finance. If there is no prescribing provider
9 to order the services that a hospital provides, it doesn't
10 matter.

11 And you referenced the Hill-Burton hospitals that
12 were built and the loyalty and the pride in that. In the
13 State of Iowa, of our 118 hospitals, 80 of them are
14 critical access, and I believe 98 percent or more of those
15 80 have had significant capital upgrades to their
16 facilities in the last five or seven years. So we have
17 many of these communities that are sitting on beautiful
18 facilities that have a very difficult time finding
19 physicians and advanced practitioners to come and serve
20 their communities.

21 So my question is, do we have an opportunity here
22 for the community and the Medicare beneficiary to think

1 about how do we improve not just access, but access to
2 quality care? And I do worry about these small numbers and
3 these isolated providers.

4 Now, my experience, again, in the state of Iowa
5 is that most of our critical access hospitals are aligned
6 with one of the two big systems. There are a few, not
7 many, but there's a couple independent critical access
8 hospitals that are still there. But most of them have
9 aligned with a larger system, and that does provide for
10 them access to specialty -- not only specialty services to
11 help bring out patient opportunities to their facilities,
12 but also quality oversight and just a broader community to
13 work with. And I think that's an important piece here.

14 And I think as we think about the broader
15 continuum that these critical access hospitals -- and they
16 do serve an important role -- how do we put these pieces
17 together from a policy standpoint that incentivizes them to
18 understand? We're not just talking about access, but we're
19 talking about access to quality. And I think our Medicare
20 beneficiaries deserve that.

21 So I would invite us to think more broadly, and
22 in that broad thinking, I worry about this definition of

1 distance. And I wonder if we can look into the future.
2 Whether you're 2, 5, 20, 30, or 50 miles from another
3 provider, is there a runway we need to give these
4 facilities in the spirit of how do we improve quality?
5 Because in these stand-alone, isolated, very few provider
6 organizations, I think we have some real opportunities
7 there.

8 I definitely agree with the comments about
9 telehealth. I thought about the chapter we did last month.
10 There's opportunities to link that work.

11 And just last but not least, there's so many
12 opportunities here, and I do invite us to think more
13 broadly.

14 DR. CROSSON: Okay. We'll continue the
15 discussion now. I see Warner and David, Bill -- I'm sorry.
16 Oh, Jon. Jon had his name in and had to leave momentarily.
17 Jon, why don't you start, and then we'll go with Warner and
18 come up this way.

19 DR. CHRISTIANSON: Yeah. So this is just a quick
20 comment. I understand Herb's feelings about skin in the
21 game and so forth, but I also -- if we really want to make
22 this an option, there's a huge variation in the financial

1 situations of these counties and where these hospitals are,
2 and it's not really an option in some counties, depending
3 on the size of the matching grant. So I think we need to
4 think carefully about this. There's plenty of counties
5 that are subsidizing their community access hospitals now
6 and continue to do that, and we could say, "Okay. They
7 have skin in the game, then," but what about the small
8 rural counties that are really probably the ones who are
9 most interested in having -- consider this option? And
10 then if we erect too large of a matching grant barrier to
11 this, we preclude maybe participation by some counties in
12 hospitals that we really would like to have consider this
13 option seriously. So I think we need to think carefully
14 about this matching grant.

15 I'm not sure. I think a county that goes through
16 this process and says, "All right. After a history of 70
17 years or whatever of inpatient capacity, we're not going to
18 have it anymore," that's going to be a really tough
19 decision for them to make. And by the time you reach that
20 decision, I think you've got some community commitment to
21 that direction, and I'm not sure why we necessarily need to
22 tie some more dollars from those communities to assure, as

1 you put in here, assure community commitment.

2 So I think the matching grant program has to be
3 thought through carefully. There's just a lot of variation
4 in the situation of these counties and hospitals.

5 DR. CROSSON: Go ahead.

6 DR. BAICKER: Sorry. But just following up on
7 that point, I have mixed feelings about the principle of
8 the matching grant as well. Having the communities have a
9 stake in it sounds like a great idea, and in other
10 programs, whether it's Medicaid or the old version of
11 welfare, there was this matching grant component to induce
12 extra dollars to come in. For Medicare, we spend a lot of
13 time trying to say we're not cross-subsidizing Medicaid.
14 If Medicaid is not paying enough, we're not paying more to
15 make up for that. We're trying to target the Medicare
16 dollars towards the Medicare beneficiaries, and there's
17 already a bit of a "How do you allocate fixed cost?"
18 problem. But that, I'm willing to engage in because fixed
19 costs are always then going to benefit more than the
20 specific beneficiaries we're funding, and that's okay. But
21 drawing in a tie to state or local spending strikes me as
22 potentially opening up a whole avenue of entangled

1 financing that we may not be comfortable with the long-term
2 implications of or the distributional implications of, as
3 Jon said.

4 So, while I can see it's a good avenue to get
5 more community buy-in and resources, it's a pretty big
6 change from how we view the principle of the allocation of
7 Medicare resources in general that ought to be done with
8 great care.

9 DR. CROSSON: All right. Warner. And then we
10 will come up this way and go around.

11 MR. THOMAS: Just a couple of comments. First,
12 on the matching grant, I think Jon's points are well taken
13 that when an organization is going to make this transition,
14 I think it's -- usually do have the community involved. I
15 think maybe the way to think about a matching grant is
16 actually if you want to go back, if you want to convert
17 back from an outpatient facilities, maybe that's where the
18 matching grant could take place because you're once again -
19 - I think if you're downsizing one of these organizations,
20 that's a very sensitive thing, and to ask the community to
21 chip in to make that happen, that could be a big -- a big
22 lift.

1 Secondly, how many critical access hospitals are
2 in the U.S., roughly?

3 DR. STENSLAND: 1,300.

4 MR. THOMAS: 1,300, okay. So I guess I would go
5 back to just underscoring a couple of comments from Herb
6 and from Sue.

7 The telemedicine piece is critically important
8 here. I agree tying those chapters together, and going to
9 Sue's point that we don't have enough providers in these
10 communities, and telemedicine is a way to help solve that
11 issue. So I think incentives around use of telemedicine in
12 these areas is -- could be critically important.

13 I think the other thing is, as I think about the
14 24/7 ED or the freestanding ED, I would encourage us to
15 think a little bit more broadly about those services.
16 Probably, a lot of these organizations, they really can't
17 handle inpatient. They've got a very low inpatient census,
18 but they may be able to have other outpatient diagnostics
19 and imaging. It doesn't necessarily have to be complex
20 imaging, but I think we ought to think about how it's a
21 diagnostic center, not just an ED. And once again, not
22 having to have people travel 30, 50 or more miles for

1 diagnostic care is something that ought to be considered in
2 the scope of services.

3 And the other thing that I would challenge us to
4 think about is our incentives or paths to repurpose
5 facilities. One of the things -- and I think I've shared
6 with some folks here -- is that we actually have taken what
7 was really an inpatient hospital, ran a census of 10. We
8 shut the inpatient census, have converted to essentially a
9 freestanding ED. We run the ED and run the imaging, and
10 now we're converting the inpatient to psychiatric beds
11 because there's a real need for psychiatric beds in the
12 area.

13 So I think if there could be thoughts around the
14 repurposing or paths that could be created for the
15 repurposing of many of these facilities -- I go to Sue's
16 point. A lot of these facilities are very nice, probably
17 nicer than some of the facilities we have, quite frankly.

18 [Laughter.]

19 MR. THOMAS: So it would be nice to think about
20 how we repurpose them and have them take on another
21 purpose.

22 I guess the last piece is to perhaps create

1 incentives or think about how we could create incentives
2 for large organizations to approach and be collaborative
3 with the critical access hospitals and to have larger
4 integrated systems or whatnot be part of the solution in
5 this process. And I think if there could be thinking or
6 comments about that in the chapter as we go down this road
7 -- because we're talking maybe about 100 today, but if
8 there's 1,300, I can tell you we're going to be talking
9 about more than 100 over the next 3, 5, 10 years, so
10 thinking about what that path looks like is really
11 important.

12 And my final comment, I think it's critically
13 important that we not change the reference to these
14 facilities as "hospitals." Even though they may be
15 emergency departments with imaging and what not, I think it
16 is critically important to communities to think that they
17 have a hospital. Whatever the definition of the hospital
18 is for that community, that is an important psychological
19 factor for communities, and I would encourage us not to
20 necessarily change the definition, the brand of these
21 facilities, even though we may change the definition of the
22 services provided in that hospital. And that may seem like

1 a minor issue, but I think you will find that's a major
2 issue for communities.

3 DR. CROSSON: Thank you. David?

4 DR. NERENZ: I was just thinking about some of
5 the challenges there might be in the daily operations and
6 management of the 24/7 ED option, and this follows, I
7 guess, a bit from Bill's initial question about are there
8 examples of this.

9 You know, our prototype of an ED is often the
10 busy urban ED with its long wait times and things are busy,
11 and the description you have in the chapter about the
12 freestanding EDs are generally -- it says they're in urban
13 and suburban areas; they're driven by population growth.
14 They're typically in areas where things are busy.

15 Now, here we're talking, I think on purpose,
16 about the opposite. We're talking about situations where
17 there's not enough patient flow to support an inpatient
18 facility, and I'm wondering if the same challenges would
19 apply then to the ED. And I'm envisioning a wonderful,
20 nice facility with the equipment and the rooms and no
21 patients, or at least not enough patients to really keep
22 people busy in them, which then would seem to lead, at

1 least in part, to Sue's problem of, you know, who's going
2 to want to work in such a place.

3 Then it seems like part of the solution to that
4 problem, if it's real, is you have to graft this onto
5 something else so that trained professionals can be
6 available there, but also be busy and productive doing
7 something else, which could touch on Warner's point of the
8 imaging or diagnostics.

9 I don't know what the answer is, but I am --
10 again, to Bill's, do we have examples of -- or in other
11 countries, even, of situations like this where you can have
12 the emergency care capability but in areas where the flow-
13 through is really very low?

14 DR. STENSLAND: So I think in all these examples
15 -- and I probably should change the chapter to make it more
16 explicit -- at least in my mind, we were thinking there
17 would always be a primary care clinic there. So you would
18 have a primary care clinic. You would have basic
19 diagnostic, basic lab, CT scan, X-rays. That would always
20 be there. But the difference between this and, say, just
21 being an FQHC or this and being a rural health clinic would
22 be the 24/7 ED.

1 So I wouldn't imagine that you would ever have
2 one of these things that's a 24/7 ED and then there's no
3 clinic or there is no X-ray machine in town. You know, it
4 would be part of that. And I think the ones that operate
5 generally have physicians that are going to be doing two
6 different things. I'm going to schedule some appointments
7 in the rural health clinic, but then maybe I'll also cover
8 the ED. Or maybe they'll have an NP in the ED that's 24
9 hours a day, and then the physician will come over there
10 when needed. You know, there's some flexibility there.

11 DR. NERENZ: Okay. Well, and maybe our
12 discussion and further writing can be a little more
13 explicit about that. I presume it's necessary. I'm also
14 just thinking that there may be some minimum volume
15 standards or some volume to quality relationships in the ED
16 environment the way we know about them in the inpatient
17 environment that could be woven into this. Somehow there's
18 got to be an image of how we deal with that challenge.

19 MR. GRADISON: First, I want to thank Warner for
20 mentioning this question of the definition of a hospital.
21 I believe some of the states have been grappling with this.
22 Georgia comes to my mind. You might take a look because I

1 think they have been, if I recall correctly, talking about
2 or discussing whether to redefine a hospital for purposes
3 very similar to what we're talking about here.

4 I am not a demographer, and I appreciate there
5 are going to be some sparsely populated rural counties and
6 communities that are going to grow. But my sense of it is
7 that the trend is going to be just in the opposite
8 direction.

9 But the better the training programs we have for
10 young people to learn technical skills, the quicker the
11 movement will take place out of those areas because the
12 jobs aren't going to be there. There really aren't a lot
13 of opportunities to be computer programmers -- I had to
14 pick an isolated example, but to make my point -- in some
15 of these areas, but there might be 100 miles away or 50
16 miles away in larger communities. The significance of that
17 in terms of what we're talking about, coming back to
18 Warner's excellent point, is that I think the numbers will
19 grow as the population of many of these -- not all, but
20 many of these areas declines.

21 Next point. Distance versus time. I'm really
22 troubled by the use of distance. I physically have seen

1 situations where there is a mountain in between. What I
2 would suggest, which I think may be a little more helpful
3 than that comment, is take a look at the VA's experience,
4 because they were given a really hard time in the last year
5 or two when they said, well, you can go outside the
6 network, but it has to be within 50 miles, or whatever it
7 was. And so I don't know how they worked that out, but
8 when -- we're not trying to have CMS people drive all over
9 the country with stopwatches, but you might learn something
10 from the VA experience.

11 And, finally, about the question of a match, much
12 of the -- not all, but much of the discussion so far around
13 the table with regard to a match has had to do with the
14 local community's match. I think that there should -- I'm
15 inclined to think there should be a match, but I think the
16 -- and that that ought to be part of the grant application,
17 but that the funding could come from any source -- state,
18 county, hospital district, private contributions, private
19 foundations, some combination.

20 There are a lot of reasons I think that would be
21 useful. I appreciate that it raises a host of policy
22 questions in other areas, and I'm not suggesting we should

1 reach a decision on it. I am suggesting that when we talk
2 of a match, it should have the broadest possible definition
3 of where that match might come from.

4 Thank you.

5 MS. BUTO: On the matching grant issue, I'm not
6 so enthusiastic about it, mainly because a lot of problems
7 occur to me. Probably the principal one that occurs to me
8 is that we seem to want low-capacity, low-utilization
9 inpatient facilities CAHs to actually convert. So if we
10 want them to convert, why create a barrier to that
11 conversion, is my question.

12 The other question that arises is: What happens
13 if the match is there the first year and the second year
14 they can't get it? Do we pull the certification and close
15 the facility? I mean, I just think of all these practical
16 issues that are going to arise within individual cases. So
17 we're not saying it, but I think we think this is going to
18 be a better use of capacity and actually lower overall
19 costs at the same time. And if we think that, why would we
20 create a barrier? So that's just a question I would raise.

21 The other one is about I think there's a real
22 challenge in the area of staffing these facilities, even

1 though they're more modestly set up. And we ought to at
2 least mention the fact that whatever the conditions of
3 participation are for outpatient facilities and EDs, maybe
4 there needs to be more flexibility for these entities,
5 because I can't imagine a fully staffed ED waiting for the
6 patient to come in with an urgent or emergent situation in
7 these locations.

8 So there's already locum tenens and other things,
9 but I think we need to at least mention the fact that if
10 these are going to be successful, given the challenges of
11 actually getting health professionals to these areas, there
12 may need to be some other adjustments that are made to make
13 them successful.

14 DR. STENSLAND: Just to follow up a little bit on
15 that, because I think there are some -- at least for the
16 critical access hospitals, like the conditions of
17 participation are really quite low in that if you don't
18 have any inpatients now, you can lock the door and have no
19 one in there. So if somebody follows the big blue sign and
20 they get there and the door is locked, then, you know, they
21 call the ambulance and they come and somebody opens the
22 door. Or you could staff it with just an RN, or if you're

1 in some frontier areas, you might arrive, follow the blue
2 signs, and get there and the highest trained person is an
3 LPN.

4 So, you know, in terms of flexibility, the
5 critical access hospitals are kind of, you know, extremely
6 flexible in what we demand of them, and then so the
7 question is -- I'm thinking you're thinking higher than
8 that, but maybe not --

9 MS. BUTO: Right.

10 DR. STENSLAND: -- to the full extent of you want
11 a --

12 MS. BUTO: Well, I didn't know what conditions
13 you were --

14 DR. STENSLAND: -- board-certified physician.

15 MS. BUTO: -- going to have apply to the ED-only
16 model.

17 DR. STENSLAND: Yeah, I think that would be a
18 discussion question.

19 MS. BUTO: Okay. So that's my point. Let's at
20 least discuss that.

21 DR. STENSLAND: Yeah.

22 MS. BUTO: Because I don't think we want to leave

1 that vague and -- it actually could be perceived as a
2 challenge.

3 And, thirdly, I guess these things don't exist in
4 nature yet, you know, so I'm wondering whether if CMS were
5 to proceed down this road -- and it sounds like it's a good
6 option, a good series of options to pursue -- they might
7 want to test it first rather than make it available to
8 everybody because you know there are going to be issues
9 that we haven't thought of.

10 DR. CROSSON: Okay. Coming up this way, Mary.

11 DR. NAYLOR: Actually, that was -- I just want to
12 reinforce --

13 MS. BUTO: [off microphone] nature.

14 DR. NAYLOR: Yeah. I don't know if they exist in
15 nature, but I absolutely -- it sounds like Kansas is doing
16 some work in modeling and so on. And it does seem to me
17 that we should allow for rigorous assessment of a few of
18 these alternatives that really engage the community in the
19 design and really place a premium on the community's
20 commitment to make sure the Medicare population is well
21 served by Medicare dollars. So I don't know if we have
22 enough of these models, CMMI is making that kind of

1 investment. I don't know.

2 DR. STENSLAND: There are some of these out
3 there, and so -- there's just a handful, and so, for
4 example, there was one that we talked to not far from -- it
5 was in Arkansas we talked to one of these, and they --
6 before they set up, they went to go talk to the one in
7 Tennessee, there was one of these in Tennessee, let's go
8 talk to them how they're operating it, and then they kind
9 of set up theirs. There's another in North Carolina. I
10 think there's one in Wyoming. There's some more that are
11 starting now. They're saying, you know, we're going to
12 close the hospital, that we're going to try to keep this
13 open as a freestanding ED because the hospital is not
14 financially viable, but we don't want to give emergency
15 services -- we're going to give this a whirl.

16 So these things are existing in nature in terms
17 of functioning health care entities. I think what isn't
18 there is a clear payment model for them, and they're kind
19 of, you know, trying to cobble something together to work
20 it, and this would be kind of a little -- the medical model
21 I think is there. What's missing is the payment model,
22 which might make it easier for these things to move

1 forward.

2 DR. HALL: Not to be redundant, just to focus on
3 the unique needs of the Medicare population in rural areas,
4 just as in non-rural areas. A lot of the problems that
5 present themselves acutely to the ED in people who are 70,
6 75, 80 years of age don't really require a lot of high-tech
7 stuff. What they do require, though, is the ability to do
8 a pretty fast and accurate assessment of cognitive
9 function. A lot of behavioral issues are often there. And
10 one also has to be able to make some kind of assessment of
11 the degree of independence people have. If you're going to
12 send them out the door and they're going to fall and break
13 their hip on the way across the prairie or the tundra, you
14 want to make sure that you've ruled that out. We're
15 talking -- I -- never mind.

16 And the most ideal gizmo on the block right now
17 is telemedicine, because right now, without any investment
18 in other equipment other than the ability to do real-time,
19 relatively high-speed Internet connection, you can do all
20 these things. It's being done in a lot of places. So I
21 think we can also focus then -- if our vested interest here
22 is in Medicare, there are a lot of patient care issues that

1 can easily be handled through telemedicine and some kind of
2 a remote facility where people can come to. So we should
3 keep that in mind.

4 The other is, this may sound a little bit out of
5 the box, but for another reason, but I've visited a number
6 of the Western states where they're trying to develop
7 geriatrics programs out of regional medical centers in
8 Arizona, Utah, and New Mexico. This was in the last six
9 months. And there are some interesting examples of what is
10 going on in any places that have a large Indian Health
11 Service. Some of them have been disasters, but some have
12 been very, very useful in terms of using telemedicine. At
13 least I know in those three states it would be worth taking
14 a look at what's going on. If I were to pick one state, it
15 would probably Arizona that seems to be the farthest along
16 in this.

17 DR. COOMBS: Thank you. Herb, I was really moved
18 by you this morning and some of the things you said, and
19 you really kind of changed my attitude about just the whole
20 nature of this, the hospital that's really under full
21 cardiac arrest. And so as I was thinking about it coming
22 into the room, I thought, okay, if there's a volume there

1 for ED, it should be there regardless, right? So something
2 must have been -- at the particular rural hospital, it must
3 be that the flow is occurring, so there must be a business
4 plan or some kind of operational success with that before,
5 because there's a demand for it. I was having a hard time
6 understanding, first of all, the hospital volume and where
7 would it go. And then, secondly, this is a new flux of ED
8 patients that just -- they just didn't appear there, but
9 they would be -- by having an increase in the number of
10 EDs, it would be that you would keep people from traveling
11 long distances to go to other emergency rooms.

12 So one of the questions I have is: Is it
13 possible for us to actually classify rural hospitals in
14 different categories as to what you might do for them as a
15 solution to their struggles financially so that in some
16 cases, if it's volume, if it's the proximity to the closest
17 institution, you might have a different kind of solution to
18 those kind of problems compared to a hospital that's in
19 full -- needs full life support? So if we were to do a 911
20 call for that kind of place that is just about to -- but
21 then there's other solutions to the problems, like
22 telemedicine, with Sue having the brick and mortar but

1 without the personnel to kind of complete it. So I'm
2 wondering if we can go a step farther in terms of just
3 breaking out, seeing if there's some broad categories that
4 the solutions to the problems would be very different,
5 because I'm thinking about the quality piece of it, and,
6 Sue, what actually scares me, because you talk about door-
7 to-balloon time with someone I in who needs, you know, the
8 strep and stretcher, you know, the tPA and the stroke
9 patient and the access to -- because if you don't have the
10 personnel there to address the telemedicine person, then
11 you still -- the patient doesn't have access to quality
12 care. And, you know, my brother was in the middle of
13 California and a very richly endowed health resource area
14 where he did not get tPA. And it was because there was no
15 neurologist on call, and that's in a very robust system.
16 So I know it must be even worse in a situation like that.

17 So I'm just wondering if we could kind of
18 separate some of these entities out and then have different
19 solutions to them.

20 DR. CROSSON: Thank you, Alice.

21 DR. HOADLEY: So I want to pick up on two of the
22 themes that we've been talking about. One is this question

1 of what exists in nature, and I was thinking back to a
2 Health Policy Forum session that I ran probably 25 years
3 ago, and I remember that the situation at that point was in
4 Colorado, and there were like five counts all kind of in a
5 row with each their little hospital, none of which were
6 profitable. And I don't remember the specifics now, but
7 the solution was repurposing I think at least three of the
8 five and then concentrating the more traditional inpatient
9 hospital volume into one or two of them.

10 And, Jeff, of course, you just gave us some other
11 examples of things, and I guess it might be useful to see
12 if there's some things we can learn. I assume most of
13 these have happened without any particular Medicare
14 involvement if they fall into a new category that Medicare
15 pays for, like having a SNF or just operating an ED or an
16 outpatient facility that they fall under those categories.
17 But, you know, is there some -- and, obviously, we've heard
18 examples over the years of things that converted themselves
19 to SNFs or clinics or all these other kinds of things. But
20 particularly on this ED side, are there lessons that we can
21 learn from some of what's out there in terms of a bunch of
22 these questions that people have talked about? Does that

1 help with the staffing issues, quality, you know, long-term
2 sustainability of some these that have been around for five
3 or ten years? So it just seems like maybe there's some
4 ability to learn from that.

5 The other is on the matching funds, and I'm not
6 going to at the moment try to put an opinion on sort of the
7 pros and cons. But the thing I was thinking about was
8 matching fund commitments or fund -- and maybe the word
9 "matching" is not necessarily the right word because that
10 kind of brings up the Medicaid, you know, we're going to
11 have a formula that's this many dollars versus this many,
12 but whatever we want to call it. But there's at least two
13 categories that I think of. One is sort of an ongoing
14 support, and that, you know, is Herb's examples of the tax
15 districts, the special sales tax where, you know, you put
16 it into place. And, obviously, politics being what it is,
17 you've never committed it permanently into the future, but
18 at least maybe permanently until the next vote and somebody
19 decides they no longer support it, versus sort of more on
20 the startup funding kind of category, and, you know, are
21 there funds that are needed from some outside source to
22 help get this thing designed and off the board -- off the

1 ground. And at the very least, we ought to just make sure
2 we're thinking which we mean if we do want to go down that
3 road and ask for local commitment. Is it about creating
4 some ongoing source of funding that will kind of supplement
5 what Medicare is providing? Or is it more like a one-time
6 thing? And when you start thinking about some of the
7 private foundation kinds of things, they generally aren't
8 going to support ongoing -- you know, maybe over time that
9 will work out, but more and more the foundation world is
10 sort of startup notions or we'll give you three years to do
11 something and then you've got to be self-sustaining.

12 So, you know, however we want to think of a local
13 commitment, we should at least be very explicit about
14 whether we're thinking of it as ongoing support versus
15 startup kind of support, and then maybe by the time we
16 think of this again I'll have more of a sense of -- I've
17 heard some interesting pros and cons on whether having that
18 is worthwhile.

19 DR. CROSSON: Warner, last comment.

20 MR. THOMAS: Yeah, just a brief comment. You
21 know, as I look at the issues up there, I come back to I
22 think the biggest issue here is telemedicine, because the

1 biggest issue facing these facilities is access to clinical
2 knowledge and capability. And I think if we really want to
3 facilitate people staying closer to home and getting more
4 services in these facilities, we've got to sort out the
5 right economic model and incentives around telemedicine.
6 Maybe we start with these facilities because it could be a
7 smaller pilot and really try to think about how we invest
8 resources there, because that is going to help solve a
9 major issue for these facilities. I tend to think that's
10 the leading issue and indicator of whether these
11 initiatives will be successful.

12 DR. STENSLAND: Could I just follow up on that a
13 little bit? Because we're -- would you see addressing your
14 concern if we said, you know, this grant money could be
15 used to help support telemedicine capacity? They would
16 also get the facility fee for telemedicine just like anyone
17 else would be, and the distant physician would get the same
18 fee they do now if they see somebody face-to-face. So you
19 would have -- you know, you'd have like the face-to-face
20 fee, just like in PPS; the additional facility fee which
21 they could qualify for; and then the third pot of money
22 would be the grant money that could also be used to support

1 telehealth.

2 MR. THOMAS: I think that could be -- that
3 definitely could help. I think once again, thinking about
4 how it could make economic sense for that facility to have
5 folks stay at home, that sounds like that's a model that
6 could potentially work.

7 I think the other is are there -- getting back to
8 the idea that there's other systems around, large systems
9 around like Sue's that can help, you know, a lot of these
10 facilities, what incentives around telemedicine could they
11 be given to do the outreach to help these facilities. Then
12 you could look at both sides of that equation.

13 DR. CROSSON: Other comments?

14 MS. BUTO: Yeah, very briefly. It occurred to me
15 that we probably shouldn't, following up on Jack's comment,
16 rule out considering asking facilities -- or asking HRSA to
17 put money down. In other words, if HRSA and CMS, in
18 conjunction with the community, decide this is a good
19 investment, that might be one way to deal with the basic
20 funding issue, particularly for communities that have
21 different abilities to raise money. It's a way of
22 validating from another entity that, yes, this community

1 capacity is really needed. So just something to think
2 about.

3 DR. CROSSON: Okay. Excellent presentation, good
4 discussion. Jeff and Zach, I hope you have some help there
5 to get you to hone this, and we'll be back to this issue a
6 little later. Thanks.

7 [Pause.]

8 DR. CROSSON: Okay. I think we're ready to move
9 on to the next presentation. Eric Rollins is here to give
10 us a status update on the CMS dual eligible demonstration.

11 MR. ROLLINS: Thank you, Jay.

12 Before I start my presentation, I'd like to
13 follow up on an issue that Kathy raised at the November
14 meeting when I briefed the Commission on the Medicare
15 savings programs. Many low-income beneficiaries who are
16 eligible for the MSPs do not participate, and Kathy had
17 asked if there was research on which strategies for
18 increasing participation seemed to be most effective.

19 There have been some studies on this issue,
20 looking both at the MSPs and other low-income programs.
21 Most of the studies were done shortly after the start of
22 Medicare Part D in 2006 and are now a few years old. The

1 studies generally found that state efforts to streamline
2 the enrollment process were most effective at raising
3 participation, for example, by simplifying applications,
4 eliminating the use of an asset test, and making it easier
5 for beneficiaries to recertify their eligibility. Efforts
6 by community organizations to help beneficiaries enroll can
7 also be effective, especially if they provide one-on-one
8 assistance throughout the enrollment process, but they are
9 hard to conduct on a large scale. Finally, the studies
10 found that advertising campaigns by themselves were not
11 very effective.

12 Now, I'll turn to the update on the financial
13 alignment demonstration for dual eligible beneficiaries.
14 This update includes our findings from site visits and
15 phone interviews with stakeholders in four states, and I'd
16 like to thank Andy Johnson and Carlos Zarabozo for their
17 help in preparing this status report.

18 I'll begin by providing some background. There
19 are about ten million individuals who qualify for both
20 Medicare and Medicaid and are known as dual eligibles.
21 Most dual eligibles, about seven million, are eligible for
22 the full range of Medicaid benefits covered in their state

1 and they're the focus of the demonstration. For this
2 group, Medicaid covers long-term services and supports,
3 wrap-around services, and Medicare premiums and cost
4 sharing. The other three million dual eligibles only
5 receive assistance with Medicare premiums and cost sharing
6 and cannot participate in the demonstration.

7 Dual eligibles are generally in poorer health
8 than other Medicare beneficiaries and they account for a
9 disproportionate share of spending in both programs. They
10 are also vulnerable to receiving fragmented care, because
11 Medicare and Medicaid have relatively little incentive to
12 coordinate care across the two programs.

13 The demonstration aims to improve the quality of
14 care and reduce spending for dual eligibles by better
15 aligning Medicare and Medicaid.

16 Under the demonstration, CMS is working with
17 states to test two new models of care for dual eligibles.
18 The first model is a capitated model that uses managed care
19 plans to provide all Medicare and Medicaid benefits, with
20 the plans receiving a blended capitation rate.

21 The second model is the managed fee-for-service
22 model. In that model, states provide additional care

1 coordination through Medicaid to dual eligibles who have
2 fee-for-service coverage in both programs. States can
3 receive retrospective performance payments from CMS if they
4 reduce federal Medicare and Medicaid spending.

5 Moving now to Slide 4, CMS has approved a total
6 of 14 demonstrations in 13 states as part of this
7 initiative. No other states are expected to participate at
8 this point. As you can see, most of the participating
9 states are testing the capitated model. Only two states,
10 Colorado and Washington, are testing the managed fee-for-
11 service model, while another state, Minnesota, is testing
12 an alternate model that integrates some administrative
13 functions for Medicare Advantage special needs plans that
14 serve dual eligibles.

15 The start dates for the demonstrations vary, but
16 all are now underway, except for Rhode Island, which should
17 start later this year. The demonstrations were originally
18 going to last for three years, but CMS has announced that
19 states can extend them for two additional years.

20 As of last month, about 450,000 dual eligibles
21 were enrolled in these demonstrations.

22 The remainder of this presentation focuses

1 primarily on the capitated model, but we will touch briefly
2 on the managed fee-for-service demonstrations, as well.

3 Under the capitated model, the states decide
4 which dual eligibles can participate in the demonstration,
5 so the specific eligibility criteria vary. However, both
6 disabled and aged dual eligibles can participate in most
7 states. In addition, most states are only conducting their
8 demonstrations in certain parts of the state, usually
9 counties around large metropolitan areas.

10 The centerpiece of the capitated model is the
11 Medicare-Medicaid Plan, or MMP, which provides both
12 Medicare and Medicaid benefits to its enrollees. There are
13 currently a total of 61 MMPs participating in the
14 demonstration. Most MMP sponsors had prior experience with
15 Medicare Advantage, Medicaid managed care, or both.

16 Enrollment in the MMPs has been lower than many
17 observers expected prior to the start of the demonstration.
18 Overall, about 30 percent of eligible beneficiaries are
19 currently enrolled in an MMP. Participation rates vary
20 widely across states, from almost 70 percent in Ohio to
21 less than ten percent in New York and South Carolina.

22 Under the demonstration, states are allowed to

1 passively enroll dual eligibles in MMPs, and most have done
2 so. However, many beneficiaries have chosen not to
3 participate, either by opting out before passive enrollment
4 takes effect or by disenrolling from their MMP.

5 During our site visits, stakeholders identified
6 three reasons why so many beneficiaries had chosen to opt
7 out: Satisfaction with their existing care, including the
8 desire to continue seeing their current doctors; a lack of
9 information about the demonstration and how it might
10 benefit them; and resistance from health care providers,
11 particularly primary care physicians and LTSS providers,
12 such as nursing homes and personal care attendants. With
13 the benefit of hindsight, stakeholders believe that passive
14 enrollment should have been implemented more slowly and
15 that outreach efforts to educate both beneficiaries and
16 providers should have been more extensive.

17 Looking now at Slide 7, MMPs are required to
18 provide extensive care coordination for their enrollees.
19 This care coordination has three key elements: The
20 completion of an initial health risk assessment shortly
21 after enrolling; the development of individual care plans
22 using interdisciplinary teams of providers; and ongoing

1 help from care coordinators.

2 The plans that we interviewed on our site visits
3 all had difficulty completing the assessments because they
4 often could not locate enrollees. In many cases, plans had
5 been unable to reach about 30 percent of their enrollees.

6 The exact strategies that MMPs use to coordinate
7 care vary, and many plans that we interviewed have been
8 modifying their approaches as they gain experience.
9 Broadly speaking, though, plans stratify their enrollees
10 into high, medium, and low risk categories. High-risk
11 enrollees, such as beneficiaries who live at home but are
12 at risk of going into a nursing home, receive the most
13 extensive care coordination, such as regular calls and
14 visits from their care coordinators and help scheduling
15 doctors' appointments. Low-risk enrollees, such as
16 relatively healthy beneficiaries who do not receive LTSS,
17 may only receive monthly or quarterly calls from their care
18 coordinators.

19 One particular challenge for MMPs is caring for
20 enrollees who have behavioral health conditions. As a
21 group, dual eligibles are much more likely to have
22 behavioral health conditions than other Medicare enrollees,

1 and care coordination can potentially reduce their use of
2 costly services, like inpatient hospital care.

3 During our site visits, stakeholders said that
4 plans have encountered a number of challenges in trying to
5 care for this population. Plans said that it was
6 particularly important for care coordinators to develop
7 trusting relationships so that they could effectively
8 engage beneficiaries about their care goals and needs.

9 Some enrollees are either homeless or have
10 unstable living arrangements, and several interviewees said
11 that finding adequate housing for them was a recurring
12 challenge.

13 Many interviewees also said there was a shortage
14 of outpatient treatment options in their area, which made
15 it more difficult to reduce the use of inpatient care.

16 Finally, some interviewees said that federal
17 regulations that limit the disclosure of information about
18 substance abuse treatment made it harder to share
19 information among providers.

20 The three states that we visited were among the
21 first to start their demonstrations, and each demonstration
22 had been underway for at least 18 months. However,

1 stakeholders said it was too early to tell if MMPs would be
2 able to modify their enrollees' service use, for example,
3 by reducing inpatient hospital and nursing home care, and,
4 thus, realize savings. Numerous stakeholders provided
5 examples where plans had reduced the use of high-cost
6 services for individual beneficiaries, but no systematic
7 data is yet available.

8 The MMPs that we interviewed believed that it was
9 unrealistic to expect any significant savings in the first
10 two to three years of the demonstration due to such factors
11 as the need to complete initial health assessments,
12 continuity of care requirements that preserve enrollees'
13 access to their existing providers for a period of time
14 after joining an MMP, and the difficulty of reshaping
15 patterns of service use that had largely developed in the
16 unmanaged fee-for-service environment.

17 There is also no data available at this point on
18 the quality of care provided by MMPs. CMS is requiring
19 plans to submit a variety of quality data, but the data is
20 not yet public. Even when that data does become available,
21 our ability to assess quality will be hampered by the lack
22 of measures for long-term services and supports, which are

1 very important for many dual eligibles.

2 Turning now to Slide 10, CMS and states pay MMPs
3 through a blended capitation rate that has three
4 components, one for Part A and B services, one for Part D
5 drugs, and one for Medicaid services. Unlike MA and Part D
6 plans, MMPs do not submit bids with their estimated cost of
7 providing Part A, B, and D benefits. Instead, CMS pays
8 plans for Part A and B services using county-specific base
9 rates that reflect historical costs for dual eligibles and
10 are risk adjusted in the same manner as payments for MA
11 plans. Payments for Part D drugs are based on the national
12 average of all Part D bids.

13 In addition, the payment rates for Parts A and B
14 and for Medicaid are reduced as part of a quality withhold
15 that is later paid to plans if they perform well on certain
16 quality metrics. The quality withhold for most states is
17 one percent for the first year of the demonstration, two
18 percent in the second year, and three percent in the third
19 year.

20 Finally, the payment rates for Parts A and B and
21 for Medicaid are reduced to reflect the savings that MMPs
22 are expected to generate. The expected savings vary from

1 state to state, but are typically around one percent in the
2 first year of the demonstration, two percent in the second
3 year, and three to five percent in the third year.

4 During our site visits, stakeholders in Boston
5 said that their payment rates had initially been too low,
6 which resulted in large financial losses for some of its
7 MMPs and led one plan to drop out of the demonstration.

8 In contrast, the stakeholders that we interviewed
9 in Chicago and Los Angeles generally thought that payment
10 rates were sufficient, although some did think that the
11 initial savings assumptions were unrealistic.

12 CMS has also announced that it plans to raise
13 payment rates for Part A and B services based on analysis
14 that the current risk adjustment model for MA plans tends
15 to underestimate costs for full-benefit dual eligibles.
16 The increase for most MMPs will be between five and ten
17 percent.

18 I'd also like to touch briefly on the two managed
19 fee-for-service demonstrations in Colorado and Washington.
20 Under this model, the state assigns dual eligibles who have
21 both fee-for-service Medicare and fee-for-service Medicaid
22 to entities that provide care coordination. Beneficiaries

1 are not required to receive care coordination and they
2 remain enrolled in fee-for-service regardless.

3 We conducted a series of phone interviews with
4 stakeholders in Washington State to get a better
5 understanding of their demonstration. Their demonstration
6 operates in all but two counties in the state and is aimed
7 at beneficiaries who have had at least one chronic
8 condition and are considered high risk. The state provides
9 care coordination as part of its Medicaid Health Homes
10 Program and uses entities such as Area Agencies on Aging to
11 assist beneficiaries by first developing a health action
12 plan and then providing ongoing care coordination as
13 needed.

14 Stakeholders said that the share of dual
15 eligibles who have chosen to receive care coordination
16 services has been relatively low, between ten and 15
17 percent. As with the capitated model, the entities
18 providing care coordination in Washington have often found
19 it difficult to locate enrollees. Given those
20 difficulties, some interviewees expressed concerns that
21 care coordination entities do not receive any payment from
22 the state until they have completed a health action plan.

1 In January, CMS issued a report which estimated
2 that Washington's demonstration had reduced Medicare
3 spending by six percent relative to a comparison group
4 during its first 18 months of operation and had saved the
5 program about \$22 million. That estimate is preliminary
6 and will be updated as part of CMS's final evaluation. We
7 believe that savings of that magnitude are too high, given
8 the relatively small number of dual eligibles, about 1,700,
9 who actually received care coordination during that period
10 of time.

11 The next slide outlines our plans for future work
12 related to the demonstration. First, we are in the process
13 of getting enrollment data for the MMPs and will use it to
14 compare beneficiaries who have enrolled to those who have
15 opted out. For example, we are interested in comparing
16 average risk scores for the two groups and seeing how much
17 risk scores vary across MMPs.

18 Second, we plan to make additional site visits to
19 participating states and are particularly interested in
20 learning about service use, access to care, and the
21 effectiveness of care coordination. Given the interest of
22 several Commissioners, we also continue to pay -- plan to

1 continue to pay close attention to issues related to
2 behavioral health.

3 Third, we plan to take a closer look at the
4 payment methodology for Part A and B services and assess
5 how payment rates for MMPs compare to rates for MA plans.

6 Finally, we plan to assess the usefulness of the
7 MMP quality data when CMS makes it public.

8 Moving now to the last slide, I'd like to close
9 with some potential topics for discussion. The first is
10 the use of passive enrollment. How does the experience of
11 the demonstration inform our thinking about when and how it
12 should be used? During our site visits, stakeholders
13 reported that many plans had difficulty absorbing large
14 waves of passive enrollment, beneficiaries were often
15 poorly informed about the demonstration, and some providers
16 encouraged their patients to opt out. However, most plans
17 that we interviewed said that passive enrollment had been a
18 key factor in their decision to participate in the
19 demonstration.

20 Second, if MMPs become permanent, what process
21 should CMS and states use to select and pay them? For the
22 demonstration, states have chosen the participating plans,

1 subject to CMS approval, and plans are governed by three-
2 way contracts with CMS and the state. CMS currently pays
3 MMPs using base rates that reflect historical costs for
4 dual eligibles, but their accuracy is a measure of what
5 Medicare would have spent without the demonstration and
6 will become increasingly limited over time. Should MMPs
7 ultimately be required to submit bids like MA plans?
8 Should other plans ultimately be allowed to participate?
9 And if the number of plans will be limited, how much say
10 would CMS and the states each have in deciding which plans
11 participate?

12 Third, how should CMS calculate performance
13 payments if the managed fee-for-service model becomes a
14 permanent feature in Medicare? Like the base rates for
15 MMPs, the current methodology is based on estimates of what
16 Medicare and Medicaid would have spent without the
17 demonstration, which will become increasingly hard to
18 estimate over time.

19 Finally, what are the potential implications of
20 the MMP model for the Medicare Advantage program,
21 particularly for special needs plans that serve dual
22 eligibles? As a whole, D-SNPs do not integrate Medicare

1 and Medicaid as extensively as MMPs and they are also not
2 subject to the same requirements for providing care
3 coordination. Should the requirements for D-SNPs
4 eventually be strengthened so that they become more like
5 MMPs, or should D-SNPs continue as a separate option for
6 states that are not interested in completely integrating
7 care for their dual eligibles? And if Medicare offers both
8 types of plans, how should payment rates for D-SNPs compare
9 to the rates for MMPs?

10 That concludes my presentation. I will now be
11 happy to take your questions.

12 DR. CROSSON: Thank you very much, Eric. Very
13 nice elaboration of the issues, particularly given the fact
14 that you're working off a relatively slim fact base at this
15 point in time.

16 We're going to do clarifying questions in a
17 minute. I'm going to ask Jack if he would be willing to
18 start the comment period in a few minutes. Okay.

19 Clarifying questions?

20 DR. CHRISTIANSON: Herb.

21 MR. KUHN: Thank you for this information. I
22 agree with Jay that there's not a lot yet to go on. It's

1 early in the process, but it's good to get as much baseline
2 information as we can.

3 I was curious about the enrollment and the
4 information in the paper and others about the educational
5 materials, and the reason I'm confused a little bit about
6 this -- and any of the light you can shed on it -- is that
7 Medicaid plans have been enrolling people in managed care
8 for years. MA has been enrolling for a long time now. CMS
9 has a very thorough process of how to clear that
10 information and the content. Same thing with PDP, and now
11 we're in year 11 of that program. Why all of a sudden
12 problems with putting together enrollment materials on a
13 program like this when they've had such great experience in
14 all these other areas?

15 MR. ROLLINS: I think, to some extent, while
16 they've had experience in these other areas, they haven't
17 really had to deal with this specific kind of context where
18 you've got a plan that's serving specifically the duals and
19 providing the breadth of services that the MMPs are
20 providing.

21 Also, in a lot of states, they were relatively
22 new to the use of managed care, and so there was definitely

1 a learning curve on the state side in terms of getting up
2 to speed and getting their materials ready.

3 DR. CHRISTIANSON: Cori.

4 MS. UCCELLO: So you mentioned that one of the
5 reasons for opt-outs or low enrollment was the providers
6 had resistance, and I was wondering if -- and I don't
7 remember if this was actually discussed in the chapter, but
8 was there -- did the programs undertake any outreach or
9 activities to get provider buy-in among providers that
10 treat this particular group of benes?

11 MR. ROLLINS: I think all of the states have
12 engaged in some sort of outreach in education activities.
13 The impression we got from our visits and our interviews,
14 it wasn't that nothing had happened. It's just that
15 looking back, they wished that a lot more had been done,
16 and they realized in particular, a lot more specifically
17 focused on the provider community could have made a
18 difference.

19 DR. CHRISTIANSON: So I have a clarification
20 question, I guess, for Mark. Could you clarify kind of the
21 role of the Commission with respect to this demonstration?
22 Are we trying to -- are we assuming this will be part of

1 Medicare in general in the future and we're trying to get
2 heads-up? Are we being called on to give particular advice
3 to the people running the demonstration as it moves
4 forward, or what's the goal here?

5 DR. MILLER: So the reason that I wanted to come
6 back to this is a couple things. First of all, this is
7 very large and the first time the integration of the -- or
8 at least when it was originally conceived, it was
9 relatively a large demonstration, and it brought this
10 integration of Medicare and Medicaid together and the
11 notion that the dollars could be used for social services
12 and medical services, and so it was different in that sense
13 and pretty large scale.

14 And at that time, the Commission had a fairly
15 extensive conversation and gave a fairly extensive set of
16 comments along the entire range here -- financing passive
17 enrollment, information for beneficiaries.

18 I expect that this is going to continue to turn
19 out in the environment, even though it's not as big as it
20 started off, and that I think it helps us to stay closer to
21 it and potentially either give advice or get information
22 from it because it deals with an issue that there's always

1 been a very -- there's been something of a black box where
2 people say, "Oh. Well, some of these populations are
3 precisely the kind of population that could benefit from a
4 managed environment," but as it turned out, lots of managed
5 environments didn't have a lot of experiences with these
6 populations. And so I think watching this and watching it
7 carefully to see if we can learn something is really
8 important for the Commission. It connects to the
9 behavioral health concerns that people have.

10 So I see it as kind of a two-way street that
11 there may be things happening out there where we see good
12 ideas that we want to support, and I'm sorry. I know this
13 is longer than you might have expected, but there is some
14 thought here.

15 And it's often -- it's not unlike what Jeff says.
16 If you see a model out there that's working and you just
17 think the payment system is getting in the way, that might
18 be something that we could do something about, or two, if
19 we think this is really leaving the tracks and the
20 financing is all wrong or something like that, we may want
21 to comment to CMS.

22 DR. CHRISTIANSON: So we may want to in fact

1 comment on the demonstration and suggest changes or things
2 that we think would be --

3 DR. MILLER: If that's what we start to see out
4 in the field, yes.

5 DR. CHRISTIANSON: Okay.

6 DR. MILLER: I see it as a two-way street. Yes.

7 DR. CHRISTIANSON: Okay. Building off of Herb's
8 comment, I was kind of, I guess, underwhelmed by the
9 findings to date, and given what we should already know
10 about all this and particularly the notion that, gosh,
11 these are hard people to reach, I think we pretty much knew
12 that from a lot of other work in this area. It's early, so
13 a lot of this stuff that I think we're given to react to,
14 my first reaction was we knew that a lot of this stuff was
15 going to happen before they went ahead with it.

16 Kathy.

17 MS. BUTO: Picking up a little bit on your
18 comment, Jon, I think we also have mentioned over and over
19 and again, the disproportionately large share of Medicare
20 expenditures that go to the dual eligibles, just Medicare
21 expenditures. And in the back of my mind also is the
22 question of, since this is a state -- really state-directed

1 initiative using the combined funds, whether ultimately the
2 dual eligibles are going to be treated more as low-income
3 beneficiaries in state-defined programs, even though they
4 are entitled to the Medicare benefit, or whether they may
5 remain as fundamentally Medicare beneficiaries.

6 So, for me, there is a real issue of who are
7 these beneficiaries, and particularly if we go down this
8 road more extensively, are they becoming more Medicaid
9 beneficiaries? And I think that is a very basic question
10 having to do with how much oversight, quality standards,
11 and other things will the Medicare program have. So I
12 think there is a deep Medicare interest in this issue is
13 what I wanted to get back on.

14 MR. GRADISON: Just curious as to what steps
15 you've taken or MACPAC has taken to coordinate your views
16 and exchange information on this subject.

17 MR. ROBBINS: So we do have regular discussions
18 about sort of the work we're doing on the financial
19 alignment demonstration. One of our colleagues from MACPAC
20 is actually accompanying us on a couple of these site
21 visits, so there are discussions back and forth between the
22 two, the two groups.

1 MR. GRADISON: Thank you.

2 DR. CHRISTIANSON: Are there others who want to
3 comment on Eric's presentation or what we've learned so
4 far?

5 DR. REDBERG: So I think it was a good
6 presentation. The data is a little sad, but I was struck
7 in the report and also on Slide 8 at the frequent theme of
8 the lack of adequate and stable housing, and it makes it
9 hard to do care coordination, and it makes it hard to do
10 care. I mean, you do wonder what kind of care they were
11 in, but maybe they were just in a changing housing
12 situation.

13 But it occurs to me -- and it occurs to me when I
14 was on service recently and we have some dual eligible
15 patients, and they get very expensive devices and things
16 that -- I'll leave it at that. It's unclear how much it's
17 really helping their overall health, for their 30,000,
18 40,000. But then we have to discharge them to the street
19 because they have no housing. And I just wonder if we
20 should think about housing as a health benefit because it's
21 very hard to do care coordination in somebody that you have
22 nowhere to discharge them to. The chance that they're

1 going to take these -- one patient that I was thinking of
2 last time I was on service got several drug-eluting stents,
3 was supposed to be taking dual antiplatelet therapy. We
4 had nowhere -- we sent him out with his medications, and he
5 didn't show up. He had nowhere to go, and I just think
6 housing, it becomes pretty clear that it's really a health
7 issue. It's not just a housing issue, and I feel like it's
8 a better -- it's an important consideration as part of
9 health care.

10 And actually, I think you had an example of maybe
11 a kind of facility in Massachusetts that was supposed to
12 provide some kind of 24-hour care, but even that was \$600 a
13 day. I mean, just providing some not-supervised housing
14 for people that really have such inadequate or nowhere to
15 go, I think would be a big improvement in their health
16 care.

17 DR. CROSSON: Clarifying questions?

18 [No response.]

19 DR. CROSSON: I see no hands. So, Jack, would
20 you like to kick us off in the comment section?

21 DR. HOADLEY: So thank, Eric, for bringing this
22 to us, and it was very helpful.

1 I was thinking about the question that Kathy and
2 Jon were talking about in terms of sort of the importance
3 of this, and it does strike me that we are really looking
4 at sort of a sector of Medicare beneficiaries who also
5 happen to be Medicaid beneficiaries and trying to figure
6 out how to do a better job of caring for this generally
7 vulnerable population, and part of what's I think
8 distinctive about a lot of these demos is they did bring in
9 a fairly high number of people who are getting long-term
10 supports and services, so again, sort of a measure of the
11 vulnerability.

12 I do think the question of how much is this a
13 Medicare versus a Medicaid responsibility is an interesting
14 one. The experience in Virginia where I did a site visit -
15 - and I hadn't kept up with it, but it's interesting that
16 they are now the one state that is sort of phasing out of
17 this because they are doing managed long-term care,
18 mandatory managed care in their Medicaid side. So they're
19 sort of saying, "Okay. We're going to deal with the
20 Medicaid part, and" -- to some degree, I'm being cavalier -
21 - "let the Medicare fall where it may."

22 So just sort of going to some of the issues that

1 you raised on the discussion slide but then at least one
2 other one, I think this whole issue of the passive
3 enrollment and the opt-out is a good opportunity for us to
4 learn, with consequences not just for this particular
5 population, but every time we talk about how to engage
6 beneficiaries and things like ACOs or other kinds of
7 demonstrations, we always come to the decision, how do you
8 get people to understand the consequences of something that
9 is going to affect their care, but where it's not sort of
10 in that old-fashioned model of "I'm going to pick a plan to
11 go into, and then that's my route," even though in some
12 ways, this is ultimately picking a plan to go into. But
13 it's really what's involved is trying to engage these
14 beneficiaries in a way to understanding.

15 I think the things that you're seeing in this is
16 that educating beneficiaries for something that's more
17 complex and more involved does involve a level of
18 engagement that's different than sort of the traditional
19 marketing experience in health plans and Medicare Advantage
20 plans and PDPs and so forth, especially when it's involving
21 people getting long-term supports and services or other
22 kinds of complex needs for behavioral health or whatever,

1 where they have a fairly involved network of providers that
2 they're already working with. And I think this is where
3 engaging the providers -- and, Eric, I think you're right.
4 From what I've seen, states have done this, that it was on
5 their agenda, but probably didn't do it thoroughly enough.
6 And what I saw in Virginia was that it was often the
7 nursing homes that were the source of some of the mass opt-
8 outs because, of course, they have even more ability to
9 sort of work with their population.

10 And it was particularly some of the smaller
11 independent nursing homes who may have attended a seminar
12 or something or had the state people come and visit them,
13 but probably didn't really absorb it and were mostly afraid
14 of the unknown, understandably. In some cases, there was
15 follow-up, outreach, and then they did get a better
16 solution, but I think figuring out ways to the providers --
17 and again, I sort of think of the analogy to the ACO world
18 where trying to both think about how the providers got to
19 think about this new way of doing things and interact with
20 their patients on it. So the patient -- the beneficiary is
21 hearing from their providers, but they're also hearing from
22 plans or the program about this, and so there's all these

1 routes on how to coordinate that and make sure.

2 We could have a long discussion about sort of the
3 opt-out numbers and some of that. I won't spend more time
4 on that right now, but there were issues in terms of the
5 passive enrollment. And you highlighted some of this in
6 terms of just the data, and if the concept of passive
7 enrollment was supposed to be done with a sort of
8 intelligent passive enrollment kind of approach and states
9 found that they couldn't get hold of the information from
10 Medicare in terms of who the primary care doctors or who
11 the additional doctors -- the states owned the information
12 on what nursing home somebody belonged to, so they could
13 handle that part, but they often had -- and some of that
14 may be transition. It may have gotten better over time.
15 But it does raise a lot of issues, and I think there's a
16 lot of really complicated practical issues about timing and
17 transitions between programs, if somebody opts out of this
18 whole issue of going back into Part D and going back into
19 either a Medicare Advantage or traditional Medicare. So I
20 think there are some really useful issues.

21 I think the other one that I paid on -- and it
22 wasn't one of the ones on your last slide, but it was just

1 the whole area of what's the success of these programs at
2 delivering and coordinating care. And I think your main
3 finding was that it's too early to assess. It's an
4 interesting question. As programs get into their second
5 and third year and we still can't tell whether they're
6 accomplishing anything, that is a bit worrisome.

7 On the other hand, coordinating care for this
8 population is hard. It involves a lot of different actors.
9 We've heard comments about coordinating the coordinators
10 because you've already got care coordinators out in
11 provider settings, and then add the plan.

12 And this goes go to one of your points on the
13 last slide. The plan players in this -- and I think one of
14 the things that I've really tried to focus on is, what's
15 the value-added for a plan, and how does that change across
16 types of plans? And where I've seen examples in a couple
17 of projects I've done has been where the more provider-
18 based plans, whether it's a community health center-based
19 plan or health system-based plan, seem to be the ones that
20 can truly integrate the providers who are probably the ones
21 that really know the patients the best, know the
22 beneficiaries the best, and the sort of plan perspective of

1 managing the finances.

2 And when it's been the outside, the freestanding
3 plans come in. They're trying to figure out -- and they're
4 the ones, I'm suspecting, have more of the challenges and
5 actually finding the people. If you're affiliated with a
6 clinic and the clinic has a relationship -- yeah, the
7 clinic does still have problems with some of their patients
8 who are homeless, who are transient, and they lose track of
9 them, but they've got a better shot than the plan coming in
10 from the outside, is either trying to rely on the last
11 state information that was available or trying to figure
12 out a way to coordinate with their network providers. And
13 so I think we may want to look at whether these kinds of
14 initiatives should be targeted more to either provider-
15 based plans or plans that come in with a real strategy for
16 how to coordinate with providers and not just try to
17 operate from the outside.

18 And I think a part of that is do the particular
19 plans that come into this kind of an enterprise have the
20 degree of experience with behavioral health services, with
21 long-term supports and services, and the kind of clients
22 that need those services. And I think that's been one of

1 the challenges here, is a traditional managed care plan may
2 not have done much with long-term care. They've had to
3 obviously deal with behavioral health, but that may not be
4 something that they've got great experience in.

5 I could keep going, but I think I'll stop and
6 leave those as themes for follow-up.

7 DR. CROSSON: Thank you, Jack. So we'll have
8 further comments. I have David.

9 DR. NERENZ: Just a couple points and to
10 reinforce the excellent comments that Jack made, and it
11 also speaks to Cori's question, I think, of why would there
12 be resistance to this or why would there be opt-out.

13 In this population, although we do have some
14 people who have sort of fragmented, loose connections to
15 care, at least our experience in Michigan is that most of
16 these folks do have established and long-standing care
17 relationships, many of which would be disrupted in this,
18 and there's a lot of the opt-out. Each state is a little
19 different.

20 Where we are, there's kind of two distinct
21 components, even though they're brought together under one
22 program. There's essentially the medical care side, but

1 then there is the long-term behavioral but long-term
2 community support services. And for a lot of the disabled
3 duals, particularly those who rely on those long-term
4 support services, there is a strong sense of loyalty, of
5 bonding and commitment to those agencies, and at least in
6 our state's dynamic, there's a sense of threat that these
7 new managed care entities that have not been active in that
8 arena are now not only active in that arena, they
9 essentially control that arena. And one way, if there's
10 fear or resistance to that, is simply to opt out.

11 So when I saw the multistate opt-out numbers, I
12 wasn't completely surprised because I think that's part of
13 where it comes from.

14 That leads us into this larger question. Jack,
15 you talked about coordinating the coordinators. I think as
16 we sit around this table and we think about this project
17 and others that have some feature of enhancing care
18 coordination, our general sense, "Well, that should be a
19 good thing," people should like that, well, maybe yes,
20 maybe no. It depends on where you're coming from.
21 Depending on exactly one's circumstances of dual eligible,
22 before this thing comes on the scene, you might already

1 have a plan-based care coordinator -- or at least you can
2 shortly get these folks a plan-based care coordinator, a
3 primary care and medical home-based care coordinator, a
4 medical specialty-based care coordinator if you have a
5 serious ongoing condition. You can have a psych care
6 coordinator, and you can have a long-term community service
7 care coordinator. Now, either they exist, or they come to
8 exist as part of this initiative, and then now it becomes
9 parity after a while of who's running the show.

10 Now, some of the resistance to the thing is
11 situations where a good care coordination relationship
12 already exists, particularly in the long-term support
13 services role, and the participants in that relationship
14 don't want that disturbed. So the reason I highlight that
15 is I think as a broader topic of discussion for us going
16 forward, we could have some discussion about care
17 coordination and what models do we think are successful,
18 what models are less successful, if you can't determine
19 that how do you sort out these issues, because we typically
20 think we're solving a problem of not enough care
21 coordination. But then often the solution creates
22 overlapping care coordination.

1 The last thing is there were a couple of comments
2 about, well, maybe the states haven't yet tried hard enough
3 or they haven't been through enough. That's not
4 necessarily the issue. Some of these conflicts are deep
5 and conceptual and in some ways irreconcilable.

6 I sat in a number of planning meetings in
7 Michigan as this was getting off the ground where folks on
8 the long-term community support side expressed active overt
9 hostility to the medical model. And in their view of the
10 world, you don't talk about patients; you talk about
11 perhaps clients. And it became clear this isn't a matter
12 of just sort of bringing people together through a program
13 and nothing but good things then follows. You have to
14 recognize that there are very different views of what the
15 human being's issues are, whether you call that person a
16 "patient" or a "client," and then how the pieces fit
17 together for that person.

18 So there's an attraction of bringing all these
19 pieces together, but it is very, very hard to do it.

20 DR. CROSSON: Thank you. Other comments?

21 DR. SAMITT: Thanks for the great chapter. It
22 was very informative.

1 So my organization has had some real-time
2 experience with this. I think we enroll a little bit less
3 than 1 percent of the total national enrollment at this
4 point, and it's early innings, as others have said. I
5 think there's a lot we still need to learn. But I think
6 what you highlight in the report is very much aligned with
7 our own experience in that the program is going through
8 growing pains and sort of has a lot to learn and has some
9 issues in various dimensions. And the ones that I would
10 highlight would be the enrollment issues are certainly
11 real, and the disenrollment issues are certainly real. In
12 fact, what we've experienced is many beneficiaries opted
13 out of MMPs without realizing that they did so, and so
14 there seemed to be issues of communication challenges
15 regarding enrollment and disenrollment, marketing
16 challenges with enrollment and disenrollment, and
17 coordination challenges, especially between things like MMP
18 and Part D that feel clunky. It feels as if it's sort of a
19 completely separate piece that in no way has connected in
20 with existing programs, which it certainly should. So
21 enrollment has certainly been an issue.

22 As has been discussed, payment has been an issue,

1 payment adequacy, and really kind of getting this right,
2 with probably overaggressive estimates in terms of what is
3 possible early in the program in terms of how quickly
4 savings can be achieved through alignment of the Medicaid
5 and Medicare elements of this program.

6 The two others that I would highlight, we have
7 talked about care coordination and kind of the challenges
8 in providing access to care coordination for this
9 population, and then quality. And we've discussed this
10 previously that how do you measure quality when this is
11 such a distinct population and the traditional Stars-type
12 program probably doesn't do it justice in really adequately
13 determining quality comparisons. So when you think about
14 performance payments or selecting plans, you know, quality
15 should certainly be a component of it, but you want a fair
16 representation of quality.

17 So, again, it's early innings. There's a lot to
18 learn from the program. But one of the things that I think
19 would be helpful for me is have we thought about lining up
20 sort of how some of the other existing programs address
21 some of these challenges. So when we think about how
22 Medicaid itself deals with enrollment, payment adequacy,

1 quality, so Medicaid, MA, SNPs, D-SNPs in particular, what
2 works and what doesn't work there, or perhaps even
3 something completely new, and we line this up against the
4 problems we're facing, the enrollment, payment, quality,
5 care coordination, you know, maybe the solution here needs
6 to be taking the best of what works in these various other
7 programs and reconstructing the program in a way that kind
8 of brings to the fore what seems to be working. And so it
9 would be a blend of -- you know, the passive enrollment is
10 right from our perspective, which isn't the case in MA. So
11 passive enrollment may be right, but in terms of payment
12 adequacy or payment methodology or care coordination or
13 even marketing freedoms, perhaps that's more like MA. And
14 for quality measurement, perhaps it's something completely
15 new because Stars and MA is not adequate for the MMP
16 programs.

17 So I wonder if we can kind of map out and compare
18 and contrast the various programs as a way to educate what
19 some of the suggestions could be to improve MMP going
20 forward.

21 DR. HALL: Along those same lines, Eric, there
22 was a reference to the PACE program in the white sheets you

1 sent out. Do you think there are any parallels there that
2 would be useful? PACE has certainly had long experience.
3 Obviously, it's a social daycare program so it differs,
4 but...

5 MR. ROLLINS: PACE has been very successful
6 within sort of its bailiwick. The problem with PACE has
7 been sort of getting it to operate on a larger scale, and
8 one reason, as you know, that does make it successful is
9 it's sort of a completely integrated plan that sort of
10 directly, you know, sort of a mini-staff model HMO. And
11 that's hard to apply for the MMP model, which is much more
12 sort of a broad-scale health plan that is serving in some
13 cases, you know, 10,000 or 20,000 people over a fairly
14 broad geographic area.

15 As I think I mentioned in the paper, I think
16 that's one problem that New York ran into with its first
17 demonstration, is they were sort of thinking of sort of
18 PACE-like care coordination requirements, which were
19 difficult to implement when you moved outside of the PACE
20 model.

21 MS. BUTO: I had exactly the same question, but I
22 wanted to add about PACE, Eric, do we know whether PACE

1 over the years has saved money for both Medicare and
2 Medicaid?

3 MR. ROLLINS: I believe when we last looked at
4 it, which is now three or four years ago, we came to the
5 conclusion that PACE plans were getting paid more than it
6 would cost to treat those beneficiaries in fee-for-service,
7 and we recommended that they be paid closer to the
8 methodology for traditional MA plans. Their impact on
9 Medicaid spending I do not know.

10 MR. GRADISON: Just a couple of dots I would like
11 in my own mind to try to tie together. We know or at least
12 used to hear from ACOs that one of their big challenges was
13 people going out of network, not only incurring a lot of
14 costs out of network, but also the slowness of the ACO
15 learning about the care that was given out of network,
16 which made it pretty hard to do -- not just to save money,
17 but to do effective care coordination.

18 One of my former students is running a three-year
19 MCCI \$6 million program involving children. It's a
20 Medicare program in Massachusetts. Same problem in
21 Medicaid, and that is, the slowness of getting records back
22 in that case from the state Medicaid agency to assist.

1 I can certainly understand why in this instance
2 there's the additional complication, and that is, getting
3 the Medicare information to the Medicaid officials and back
4 and forth to try to coordinate this. It may be that
5 solutions have been -- maybe there have been solutions that
6 have occurred in both the ACO environment and in the
7 Medicaid environment to permit the exchange of information
8 on more of a real-time basis since I last had conversations
9 about those two programs. But I would like to suggest
10 that's terribly important. And it's difficult for me as a
11 layman to understand why there should be a delay since so
12 much of this is presumably being handled electronically.

13 DR. CHRISTIANSON: Eric, do you have any initial
14 data on the types of diagnosis and people that are dual
15 eligible? And, particularly, I'm interested in how many
16 are there because of behavioral health disability kinds of
17 diagnoses?

18 MR. ROLLINS: We do not have that information
19 yet. Once we get the enrollment data for MMPs, we should
20 be able to more easily find those people in the fee-for-
21 service claims we have to see what they looked like before
22 they went into the plans.

1 DR. CHRISTIANSON: Yeah, so I think it makes a
2 lot of difference how you think about the problems that the
3 demonstration is having, and I go back to a time when I
4 served on the board of a local agency that contracted the
5 state and local government to serve the most severely ill,
6 mentally ill people in their community. And back to what
7 Rita said, and Dave to some extent, we started -- we
8 actually were more of a housing agency than anything else.
9 And we started with housing and finding people a place to
10 live. And then the next thing we started with is -- and
11 without conditions, like you don't have to be clean to live
12 here. If you live here, maybe we can help you get clean.

13 Then dental care, because the pain involved in
14 the oral problems people were having led them to self-
15 medicate, which exacerbated their mental health problems,
16 which made it difficult to get them to medical care, and it
17 just kind of went on and on. But without a starting place
18 of, you know, where are these people and how do we give
19 them a safe place so that they can start thinking about
20 their life, and we had lots of negotiations because we're
21 in Minnesota so we have everybody in managed care. So we
22 had lots of negotiations with the health plans that

1 contracted with the state about what we do, what you do.
2 And, of course, the health plans approach things from a
3 medical point of view. People get care. They go to a
4 doctor's office. They get drugs and things like that,
5 which -- so this whole set of activities that we were
6 engaged in for this population was totally foreign to the
7 way they thought about delivering care, back to David's
8 point.

9 So this is extremely complicated for that
10 population, so I think I'd be very interested to have some
11 data as it comes out and share that with us about, when we
12 talk about dual eligibles, how many people have these kinds
13 of diagnoses.

14 DR. HOADLEY: So, yeah, I want to follow up on
15 Jon's comment. I do think, you know, that kind of analysis
16 will be really helpful. I mean, one of the challenges
17 presumably is once these people are enrolled in MMPs, you
18 know, how much you're able to look at in terms of -- but
19 you've got -- presumably any of them that came from fee-
20 for-service, you'll at least have the background
21 information on sort of the mix of diagnoses and things they
22 had when in fee-for-service. Some of these people have

1 come from MA, so, you know, I don't know how much you'll be
2 able to look at using encounter data to get at that. But
3 it does seem pretty important.

4 It also comes back to this challenge to me of
5 thinking about the potential for savings, and, you know,
6 this is a population that by definition is probably much of
7 it -- we'll be informed about that, but much of it is
8 probably underserved population. And, you know, it becomes
9 a question of whether looking for savings is really the
10 right answer, and then also the whole notion of blending
11 Medicare and Medicaid funding streams together goes to
12 these same questions. I mean, you could get savings on the
13 Medicare side because you're investing more on the Medicaid
14 side, and then, of course, once you've tried to blend
15 those, you're supposedly not going to think about it that
16 way, but we obviously still will and still do.

17 But, you know, to the extent that we empower
18 these organizations to have the flexibility to use dollars
19 in ways to deal if not all the way into housing at least
20 with other kinds of social service supports and things --
21 and I think this goes back to my point about sort of
22 whether the plans that are into these are really fully

1 ready to do that. And I heard one conversation from the
2 health plan side on the subject of personal care assistants
3 that are -- and this goes to some of Dave's comments, you
4 know, a very core part of what some of the people with
5 disabilities rely on. They said, well, our view is that we
6 can find personal care assistants that will be in our
7 network, and they'll be the one -- they'll substitute for
8 the ones that these beneficiaries are using. And, you
9 know, from the beneficiary side, that's just -- you know,
10 that's just like a non-starter. I mean, if nothing else,
11 that will have them opt out. And even if they were
12 mandatory in or locked in or whatever, that's going to
13 cause a point of tension. And it seemed to me like in this
14 case the person we were talking to just didn't even
15 understand really the role that those individuals played in
16 the lives of these beneficiaries.

17 And so, you know, putting more -- the potential
18 for thinking about are there more requirements on the plans
19 that get brought into these to make sure they're ready to
20 take on this kind of joint Medicare-Medicaid kind of, you
21 know, funding stream and all the services that implies.

22 MR. ROLLINS: One quick point just to follow up

1 on the encounter data. So we do have some encounter data
2 now, and our understanding -- we haven't probed deeply into
3 this yet -- is that the Medicare side of the encounters for
4 the MMPs is probably in there. Now, how complete it is I
5 do not know yet. But that data set, as we understand it,
6 does not have the Medicaid side of the encounters.

7 DR. HOADLEY: Is there any way to get visibility
8 into the Medicaid data as part of this -- I mean, I assume
9 that the duals office, or whatever it's called, in CMS, you
10 know, at some point will have the ability or evaluators
11 will, so --

12 MR. ROLLINS: They are definitely collecting it,
13 and that's going to play a key part in the evaluations that
14 they're planning to do. At this point I just don't have a
15 good sense of sort of how ready the data is to the point
16 where it's sort of worth it for us to get it from them and
17 sort of start analyzing it.

18 DR. HOADLEY: Can you remind us of the evaluation
19 plans and sort of timetable? Are there preliminary
20 reports? I think, what, RTI is doing the major cross-state
21 evaluation, as I recall.

22 MR. ROLLINS: RTI is leading the effort. There

1 are a number of subcontractors. As you can imagine, it's a
2 big, big lift. Their plan is to do a series of preliminary
3 reports for each of the states. I think Washington's
4 managed fee-for-service report is the first one we've seen
5 in that area. None of the other reports have been released
6 yet. And then they plan to do a final evaluation, but
7 given the timeline and with the two-year extension, we
8 probably won't see those final reports for some time yet.

9 MS. BUTO: Eric, I was wondering whether -- and I
10 know we're not thinking yet to Phase 2 of these debt
11 limits, but these demonstrations, again, are really
12 initiated by the states, so they're of their design in a
13 sense, as agreed to by CMS. I'm wondering whether we ought
14 to at least think about or put out there the possibility of
15 D-SNPs through Medicaid waivers being able to take
16 responsibility for this population -- in other words, with
17 a combined funding. So go the other way, have Medicare
18 take ownership of Medicaid funding and look for ways to
19 optimize care for the same population.

20 I think that model has to be out there, too, not
21 just the state-run or -designed approach. And I say that
22 because I just think there may be different priorities and

1 different emphases, and it would be worth looking into.
2 This is the one they've decided to take, and I understand
3 it's probably the path of least resistance. But I recall
4 some years ago, one of the states -- I think it was
5 Wisconsin -- the Medicaid director said, What if we
6 provided Medicaid funding to reward Medicare plans, MA
7 plans, that are doing a particularly good job of serving
8 the dual eligibles by some set of metrics that we agree on
9 together? In other words, let's agree on what those are,
10 and we'll provide funding to help reward those plans. So
11 it was a different model where the state was actually
12 enhancing Medicare plans, if you will, to improve the
13 quality to that population.

14 And so I think there are a number of things that
15 could be done on the Medicare side. I'd like to see us be
16 open to that or see CMS be open to that in the future.

17 DR. MILLER: Just a couple things on that, and
18 this is not the main point, but it's refreshing to hear
19 some state said that at some point in time, because it's
20 generally the other way. Yeah, I'd actually like you to
21 find that quote for me.

22 MS. BUTO: The Medicaid director later came to

1 CMS.

2 DR. MILLER: Okay, so -- all right. So a couple
3 years back -- this predates you being on the Commission --
4 we worked through the various SNP options, you know,
5 institutional, chronic condition, and dual SNPs, and what
6 we said at the time was we would -- there was sort of this
7 -- there's always this question of should the SNP model be
8 extended, and we said -- we looked at cost, quality, and
9 various components, and we said the SNP dual-eligible
10 models that were truly integrated -- the fully integrated
11 dual-eligible SNP models -- did seem to have something to
12 show in terms of the quality of care for the dual-eligible
13 population. And as a Commission, among other sets of
14 recommendations, we said that is the model where it's fully
15 integrated.

16 Now, SNP community -- and, of course, logically,
17 that makes sense. It's like if you're a dual-eligible SNP,
18 then you should be doing dual-eligible stuff, right? And
19 the SNP community, you know, is fairly frustrated about
20 this because they have D-SNPs, and they say that it is very
21 hard to get the state to coordinate and, you know, get a
22 fully integrated model and all those things.

1 And so this is really just a long way around to
2 your point, which is you're exactly right, and that's where
3 I think some of the initiative came, you know, from states
4 that said we'll do this and then you come to us and we'll
5 decide how to do this.

6 And one of the other fault lines in all of this,
7 beyond the passive enrollment and providers rejecting it
8 and wanting people to disenroll, was tension among the
9 plans where the plans would be in a state and say, well,
10 I'm offering choices to different Medicare beneficiaries,
11 but when you come into these demonstrations, the states
12 pick which plans take the entire operation over. And
13 that's yet another flash point that occurs in all of these
14 and plays into your point of what is the beneficiary status
15 here. And so that fault line just arises as well.

16 But the narrow point was we did some thinking
17 about the dual-eligible SNP thing a few years back.

18 DR. HOADLEY: To sort of link that collection of
19 issues to the question of this is a demo that has an
20 endpoint, and I was particularly concerned about this when
21 it was a three-year demo and it felt like some of these
22 plans and states even were barely going to be rolling by

1 the time it ended. With two more years, this is not quite
2 as immediate an issue, but the question of what comes next
3 is one thing from a sort of program design and a testing
4 and a demo and an evaluating point of view, but it's
5 another thing from the point of view of an enrolled
6 beneficiary who is -- if we're in a situation where those
7 plans simply end or, you know, is there a sense that those
8 could become D-SNPs or have some way to avoid once again
9 disrupting beneficiaries who've -- the ones who at least
10 stayed in it may have, we hope, settled into good patterns
11 of -- you know, whether they're getting consistently better
12 care, they're at least have some stability in their pattern
13 of how they're getting care. So those are all questions
14 you've got to ask. Do we want to keep that up? Do we want
15 to -- we at least have to worry about transitions, and one
16 of the potential transitions it does seem like could be to
17 D-SNPs, with a lot of if's coming after that.

18 DR. MILLER: And just a minor point, I think back
19 to Jon's point, which is why we're doing this, and, again,
20 I know Jack and Kathy and Herb and probably everybody gets
21 the sense of these things start, they're supposed to be
22 demonstrations, we'll look at this, and then we'll stop if

1 it doesn't succeed. But, generally, that's not how it
2 goes. They continue to stay in place for 10 and 20 years.

3 So I think, you know, understanding what's going
4 on here, because I think in some version we're going to be
5 living with this for a while, would be my guess.

6 MR. ROLLINS: And in some sense, too, I think
7 it'll be valuable that Virginia actually is ending after
8 three years, at least sort of a test case, sort of how do
9 you navigate some of these issues.

10 DR. HOADLEY: Right, and those people are going
11 to be mandatorily enrolled in Medicaid, managed long-term-
12 care plans, and I think, yeah, we'll get some good
13 examples. And then the question is: What are they doing
14 on their Medicare side?

15 DR. CROSSON: Okay. Seeing no further comments,
16 Eric, thank you very much. We'll look forward to your next
17 update.

18 We have come to the end of the agenda. This is
19 the time for the public comment period. If we have members
20 of the audience who'd like to make a public comment, I'd
21 ask you to come up to the microphone now so we can see how
22 many individuals we have, if there are any.

1 [No response.]

2 DR. CROSSON: Seeing none, we are adjourned.

3 [Whereupon, at 10:58 a.m., the Commission was

4 adjourned.]

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