MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, March 2, 2017
10:20 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[10:20 a.m.]

DR. CROSSON: Okay. If we could take our seats, we'll start the session, a bit late admittedly. Carol is here to talk about the unified payment system for post-acute care. And as we know, we are in the process of moving not just to a report on this in June but also to specific recommendations. Carol?

DR. CARTER: Good morning, everyone.

In January, we reviewed the Commission's past work on a prospective payment system to span the four post-acute care settings and discussed implementation issues that will be a chapter in this year's June report. This month's presentation will be brief, but there is more detail in the paper.

For new folks in the audience, I've laid out the timetable for developing a PAC PPS that was included in the IMPACT Act. It required the Commission to prepare a first report last June that recommended key features of a PPS and estimated impacts. The act also requires PAC providers to begin collecting uniform patient assessment information in October 2018. Then the Secretary must use two years of these data in a report recommending a PAC PPS design, likely to be submitted sometime in 2022. The following year, the Commission must propose a prototype design, and we are expecting that in 2023. On this timetable, it is unlikely that a PAC PPS would be proposed before 2024 for implementation sometime after that. And to be clear, the IMPACT Act does not require the implementation of a PAC PPS.

Again for new folks, let's review why there's interest in developing a PAC PPS. Currently, similar patients can be treated in different PAC settings, and because each setting uses its own payment system, Medicare payments can be quite different even though the patients may not be. The idea of a PAC PPS is to have one payment system to establish payments for patients treated in any of the four PAC settings. Payments would be based on patient characteristics, not where they were treated, and would eliminate the existing biases in the home health and SNF payment systems that favor treating some types of cases over others.

Last June, the Commission concluded that a PAC PPS was feasible using currently available data and, therefore, could be implemented sooner than the timetable laid out in the IMPACT Act. Functional assessment information should be included in the risk adjustment when these data become available. To create a level playing field for providers, the Secretary would need to begin to align the setting-specific regulatory requirements.

The design includes a common unit of service and risk adjustment method based on patient characteristics. Payments to home health agencies would be adjusted to reflect this setting's considerably lower costs. The design should include two outlier policies: one for unusually short stays and one for unusually high-cost stays.

In January, the Commission discussed three implementation issues. The first is whether the implementation should include a transition. The second is the level of aggregate PAC payments and whether the PPS should be implemented to be budget neutral to the current level of spending. The third issue is the need to make periodic refinements to the PPS, just like in every payment system.

The mailing materials that you were sent are very similar to the information that you saw in January, but we added some new things. Kathy, you asked to see a mix of settings, so we included that in Table 2. Jay, you asked to see other modeling scenarios, and we included that in Table 6. Jon, you asked to see a little bit more about the discussion of the pros and cons of a transition. And, Warner, you asked us to include more discussion about likely provider responses to the PAC PPS.

To evaluate the need for a transition and the level of payments, we updated our analysis of 2013 PAC stays to account for changes in costs and payments to 2017. With these updates, the average payment per stay remains well above the average cost, 14 percent higher. We confirmed our previous directional impacts. A PAC PPS would redistribute payments from stays with high amounts of therapy unrelated to patient characteristics to medical stays. With that redistribution, the equity of payments would increase and there would be smaller disparities in the relative profitability across different types of patient conditions. As a result, compared to current policy, providers would be less likely to prefer to treat certain types of patients over others.

The first implementation issue is whether to include a transition when the PPS is implemented. A transition would phase in the PAC PPS over multiple years, blending new PAC PPS rates with the current setting-specific rates.

By phasing in the PAC PPS, a transition would dampen changes to payments during the phase-in period. But it would delay the redistribution of payments and extend the current inequities in the home health and SNF payment systems. It would give providers more time to adjust their costs and their mix of patients.

The size of and variation in the changes in payments suggest the need for a transition. Estimates of the impacts on stays and providers are in the paper. We found that providers whose average payments would be lowered were more likely to have above-average profitability and vice versa. Therefore, we conclude that the transition should be relatively short.

If there is a transition, one decision is whether providers could elect to move directly to the full PAC PPS rates and bypass the transition. Providers whose payments would increase are likely to elect this option, just as they did when they were given the option to bypass their setting-specific PPSs. Therefore, a bypass option is likely to raise program spending.

In January, we heard different opinions about this option. Some of you thought it was a good idea because it would speed up the shift to payments based on patient characteristics and to more equitable payments across different types of stays. Others questioned whether the program should invite higher spending during the transition. Some of you noted that this higher cost could be mitigated by lowering the aggregate level of spending. We didn't hear a consensus about whether or not to allow providers to bypass the transition, so the chapter would lay out this issue, and it's something that you can discuss.

The second implementation issue is whether the level of payments should be lowered. We estimate that in 2017, the average payment is high relative to the average cost of a stay, 14 percent higher. Given the Commission's long-standing update recommendations, it would be consistent to lower the level of PAC spending when the PAC PPS is implemented, if the Congress has not already done so.

We modeled reductions of varying sizes, from 2 to 5 percent. Under any of these scenarios, the average payment across all stays would remain substantially above the average cost of stays, from 9 to 12 percent higher.

Looking at the impacts by different patient groups, the average payment would also remain above the average cost of the stays for the 30 different patient and severity groups that we examined. Here I show the impacts of a 2 and a 5 percent reduction for the high-volume clinical groups. Table 6 in the paper has the rest of the groups. The ratios compare the average payment to the average cost of stays in that group. You can see that even with a 5 percent reduction, the average payment would be 9 percent higher than the average cost across all stays. And for the 30 patient groups we looked at, payments clustered in the range of 7 to 9 percent higher than costs.

For groups whose payments are estimated to be below costs (such as stays with high therapy costs unrelated to the patients conditions and stays treated in IRFs and LTCHs), therapy practices and the cost structures of these high-cost settings explain these results.

The last implementation issue is the required maintenance of any payment system. As with prior payment policy changes, we expect providers to change their costs, patient mix, and practice patterns to maintain or increase their profitability. The Secretary should, therefore, periodically evaluate the need to make refinements to the PAC PPS, and these refinements fall into two broad groups. The first are the revisions to the case-mix groups and their relative weights to help maintain the equity and accuracy of payments across the different types of stays. The second group of refinements include rebasing payments if the cost of stays change. This rebasing realigns the level of payments to the cost of stays.

Both types of revisions are part of the ongoing maintenance of any PPS, and the Secretary should be given the authority to do both.

The conclusions of this chapter include:

A PAC PPS could be implemented as soon as 2021. When uniform functional assessment data becomes available, it should be incorporated into the risk adjustment method.

Given the range of impacts, the implementation should include a short transition.

Given the high level of PAC spending relative to the cost of care, the implementation should lower aggregate spending.

Concurrent with the implementation of the PAC PPS, the Secretary will need to begin the process of aligning setting-specific regulatory requirements.

And, finally, the Secretary will need the authority to revise and rebase payments to keep payments aligned with the cost of care.

This leads us to the Chairman's draft recommendation, and it reads:

The Congress should direct the Secretary to:

Implement a prospective payment system for post-acute care beginning in 2021 with a three-year transition;

Lower aggregate payments by 3 percent, absent prior reductions to the level of payments;

Concurrently, begin to align setting-specific regulatory requirements; and

Periodically revise and rebase payments, as needed, to keep payments aligned with the cost of care.

The text below the recommendation would note that if the Congress has already lowered payments to PAC providers, the Congress should compare the reduction it has already taken with this recommended amount and make an additional reduction if necessary to reach the 3 percent. We would also note that the 3 percent reduction would be taken in one transaction at the beginning of the transition and that providers could be allowed to bypass the transition. Since the level of payments would remain relatively high, there would be a transition, and providers would be allowed to bypass it. We believe that this is a reasonable course of action.

Alternatively, the Secretary could opt to phase in the reduction over the course of the transition. We would also note that MedPAC will continue to monitor provider performance and make subsequent recommendations if necessary.

In terms of implications, spending will be lower compared to current policy. We expect providers to respond to this major change in payment policy, just as they have done in the past. By rebalancing the financial incentives, the PAC PPS will correct the current inequities in the SNF and home health PPSs that favor certain types of patients and providers over others.

For beneficiaries, providers will be more willing to treat all types of patients. Therefore, patients with complex medical care needs will be easier to place at discharge from the hospital.

For providers, the PAC PPS will redistribute payments across them. The impacts will vary widely depending on a provider's costs, their mix of patients, and their current treatment practices. Payments will be more equitable as disparities in profitability will narrow across the different types of conditions.

And with that, I'll put up the draft recommendation and turn the discussion over to Jay.

DR. CROSSON: Thank you, Carol.

We'll take clarifying questions.

DR. SAMITT: So I have a question about spending impact. You talk on Slide 15 about the fact that this will lower spending versus current policy. But you also suggest in the recommendation that we allow providers to bypass the transition. How do they play off of one another? And have we modeled what the spending impact would be in the setting of expecting everyone that will benefit to bypass?

DR. CARTER: We haven't modeled that. I think we probably could do a back-of-the-envelope. As you probably know, we send our recommendations over to CBO and get the estimate from them, and so that's something, an interaction that they would surely take into effect.

Let's see. So the SNFs are, you know, a big block of dollars, and their payments are projected to increase. But the other two settings, payments would go down, and for home health there's a slight downtick. But we haven't done that modeling to sort of know how those play out. But you're right, there are those conflicting things. And it would depend a lot on what share of providers because -- you think would bypass.

DR. SAMITT: Remind me. We did the estimate of what the range would then be of kind of those that would see increases versus those that would see decreases. And so we likely could develop a pretty ready estimate of what the additional cost would be in bypassing the transition versus the --

DR. CARTER: I think we could get a ballpark, yeah.

DR. MILLER: Yeah, and the only thing I would say -- and I think you said this -- is from a policy perspective -- and, again, there wasn't entire consensus on this, but if you were to let them bypass, then you'd want to think even more about taking something off of the top during the transition, just that connection, and you can balance it off.

DR. SAMITT: It's more for me speaking to what percentage we would recommend given what we think would happen in the transition to make it budget neutral, so to speak, if that's what we want early on.

DR. CROSSON: Thank you.

MS. BUTO: Mine is a related question, Carol. As I understand the reductions that we would take in aggregate PAC PPS payments, those would be done by provider type, right? So, in other words, we'd take, I think, a larger reduction in the base payment or the baseline or whatever we're calling it, aggregate SNF payments than, say, another provider type. Is that correct? Or are we talking about an across-the-board reduction --

DR. CARTER: We're talking about across the board.

MS. BUTO: Okay, because I'm just wondering, particularly if SNFs are the beneficiaries of higher payments, is that what you said earlier to Craig?

DR. CARTER: The impacts to SNFs --

MS. BUTO: They would tend to go up, even though they are the ones that have high degree of therapy payments --

DR. CARTER: Yeah, the reason why that is is the payments are based on the average costs across all settings, and their overlap in patients is with IRFs and LTCHs, and so the --

MS. BUTO: Which are more expensive.

DR. CARTER: Which are more expensive.

MS. BUTO: Yeah.

DR. CARTER: So the average -- you know, that's something that would change over time as patients start to be more uniformly placed and payments get more uniformly distributed across settings. That's exactly the kind of recalibration that we would expect to happen.

MS. BUTO: Okay. So as I understand, the idea t some providers might choose to go directly to PPS, we might like that because it eliminates that therapy payment, sort of overpayment, if you will, even though they might benefit financially by making that change. It changes to a better payment approach that's more accurate. Is that your thinking?

DR. CARTER: Yes, and also it increases payments to medically complex patients, which I think is part of what you're saying.

MS. BUTO: Yeah, exactly.

DR. CARTER: Yes.

MS. BUTO: Thank you,

MR. PYENSON: A related question. The Chairman has recommendations for the transition to start in 2021. For that to happen, when would Congress have to act?

DR. CARTER: Well, so part of that would be kind of working back for how much time you think CMS would need to develop this. Probably next year would be my guess. I mean, CMS takes at least a year -- I mean, more than that, but to develop -- I think we've developed a good prototype, but if they were inclined to develop case-mix groups, I think that they would use this kind of -- this work would be a very good stepping stone to a classification system that they could then use, and that would take, I think, about a year.

MR. PYENSON: So if Congress acts in 2018, we could have a fully implemented system in 2024?

DR. CARTER: So we're talking about beginning the transition, and if there was a transition with blended rates, it would begin sort of the transition. So when you say full implementation, you mean having a payment system ready to then use part of the payment as a blend? Is that what you mean?

DR. MILLER: He said 2024.

MR. PYENSON: 2024 --

DR. CARTER: Oh, I'm sorry. I misheard that.

MR. PYENSON: -- the transition would end in twenty --

DR. CARTER: Yeah, right. I'm sorry. I misheard you.

DR. MILLER: And I think that's what we're -- I would have answered 2017, 2018 is when they'd have to act. A few years to construct the system and the regulations. And, yes, 2024, thereabouts. And, of course, all our recommendations are predicated on when they act, and so you just push it all back if they acted at a different time.

DR. HOADLEY: You were starting down this -- the three-year transition, you're envisioning two years with blended rates, and then the third year is fully in the new system? So in a sense, it's two transition years and then a third year --

DR. CARTER: Right, one third, two third -- right.

DR. HOADLEY: So, in fact, if you started in 2021, in 2023 we'd be at the point where it would be fully paid under the new rules, it sounds like.

DR. CARTER: Right [off microphone].

DR. MILLER: So you're saying Bruce was wrong.

[Laughter.]

MR. PYENSON: I have trouble adding.

MS. THOMPSON: Thank you, Carol. A couple of thoughts about other things going on in the environment, including the bundles. I'm wondering how does this play with those organizations and providers that are under -- are participating in orthopedic bundles, the joint replacement bundles that many times the post-acute care is a substantial piece of that expense. So I'm just curious if we've thought about that and how these new payment rules will play.

And the second piece I've thought of is the demonstration around hospital at home. We're involved in a situation where we're working -- it's a project out of Johns Hopkins where patients who actually qualify for inpatient care are sent immediately from the emergency room back home with diagnoses like COPD, congestive failure, pneumonia, where the care can actually be rendered at home. I just wanted to make sure as we think about other things going on in the environment, that over the course of two, three, four years may advance very quickly as we look to further coordinate care between providers, that we don't end up with some unintended consequences. So any thoughts about that?

DR. CARTER: Well, the bundled payments are going to and have encouraged providers to use a lower-cost setting when it's possible and to shorten stays where possible. And so over time, something like this would -- those practice patterns and changes in costs would be captured in the recalibration. So over time, those mix of patients and the costs of those patients should be folded into kind of what becomes then the new base rate.

MS. THOMPSON: So in the spirit of promoting care coordination, there would be an incentive for organizations to want to work together.

DR. CARTER: Yes.

DR. CROSSON: Okay. Further clarifying questions?

DR. DeBUSK: Just to further Susan's question, if I were an orthopedic surgeon under a BPCI, right now rationalizing those, say, SNF days or something is in my financial -- to my financial benefit. If I were under a truly prospective model, though, that cost would become fixed for the purposes of calculating how I'm performing against my benchmark. You would disincent -- well, remove the incentive for me to manage those SNF days, wouldn't you?

DR. CARTER: Well, no, your cost would -- so then your payment would be based on a discharge. But the costs you incur, let's say you're now having an average 24-day length of stay. You'd still have an incentive to lower your own costs with shorter says.

DR. DeBUSK: Okay.

DR. CARTER: Right now providers in the SNF setting have an incentive to have -- or there's no disincentive and there's a slight incentive to increase your days because that's how you're paid.

DR. DeBUSK: Right.

DR. CARTER: If you're paid on a discharge, you're going to get paid that amount whether they stay 15 days or 20 days.

DR. DeBUSK: Okay.

DR. REDBERG: Thanks again for the review of this great system, which I'm anxious to see implemented. I'm just curious. You modeled on Slide 10 a 2 percent reduction in payments and a 5 percent and showed even at 5 percent that it was about 8 or 9 percent over cost of stays. But then the draft recommendation says 3 percent, and so I was wondering how you came to that.

DR. CARTER: We didn't hear a broad consensus for a small reduction or a large reduction, so we picked something in the middle. I think that that's something, if you want to revisit, you certainly can. This is a draft recommendation.

DR. NERENZ: I was just going to follow on Brian's comment. I had the same thought, and I'm not sure we've got that settled. But I was going to make the same observation, that if right now in a bundled payment program you can save money by shifting a post-acute episode from a higher- to a lower-cost setting, this model reduces or eliminates that opportunity. Now, you can still find savings in things like, you know, how many visits and shorten the episode, but you can't achieve savings by moving from what currently is a higher- to a lower-cost setting. I was going to make the same point.

DR. DeBUSK: I was actually -- we are on the same page there, and the reason that I had backed off is because I was thinking, well, in theory, if I'm the physician that initiated the bundled episode, what I would do is I would try to code the patient characteristics down somewhat so that the prospective payment would be less, and then you'd get the same effect.

DR. NERENZ: Okay. So I guess in the spirit of Round 1 clarification, I just want to make sure that at least we're seeing this particular feature the same way. Now, in Round 2 we can debate whether it's good or bad or important or unimportant, but at least the phenomenon would exist, right?

DR. CARTER: Well, so yes. So this isn't an episode-based payment, as we know, and over time if the mix of patients and where they were treated changed, you would see that in how the average cost per stay was calculated.

DR. MILLER: Just to nail this point, I think. I had the same reaction to the exchange, and I think as a matter of principle, he's correct, that right now if you go into a bundle, there may be incentive to move from one setting to another based on the reimbursement differences as you jump from silo to silo and you're starting to flatten that out; or to put it differently, give everybody that incentive or remove the current incentive. And, two, your actual utilization controls become more what you focus on in the episode, and I think that's what David is saying. And I think in principle -- I'd have to think about it at least ten more seconds, but I think he's correct on that point.

DR. CROSSON: Well, I think Pat had a point first. No? Okay. Bruce.

MR. PYENSON: Just on that point, there is still a huge financial gain in bundles to move to home health, because that's going to be always significantly lower. And when you look at the orthopedic bundles, that's probably the current biggest potential in many parts of the country and will continue to be. So I think it's a magnitude issue, but the principle is there, I agree.

DR. MILLER: And the only thought I had when Sue was asking her question was: Do you think of that as complementary, as in, you know, get rid of thinking about the highest revenue setting? Or do you think of it as saying, well, I used to have two incentives in the bundle, now I have one? And then I think that starts to bleed over into what's the judgment.

DR. DeBUSK: I think your decision then becomes home health versus SNF utilization versus trying to, say, manage those numbers of days in the SNF from, you know, 20 days down to 13 or so, like they do in the orthopedic bundles.

MR. THOMAS: Just a quick question on the regulatory changes that would go with the payment changes as far as, you know, licensing of LTCH and SNF and rehab versus going to a bundled, you know, one kind of post-acute payment. What are the thoughts on the transition from a regulatory perspective for those different entities as we think about going to just kind of having a post-acute entity versus having, you know, an LTCH versus a SNF, et cetera?

DR. CARTER: Some of the things we've talked about are the obvious ones, like the 60 percent rule or the requirement for intensive care therapy for IRFs or the 25-day length of stay for LTCHs. Those are things that we think should be sort of at the top of the list of considering waiving. We do plan to do a deeper dive into kind of what would be reasonable things to begin with in terms of regulatory compliance and sort of making that more consistent across settings, and that's a block of work that Dana actually is planning on heading up over the next year.

CMS has already the authority to do many of these changes, but it doesn't have the authority to do others like the LTCH length of stay. So that's why the recommendation is clear to give the Secretary the authority to make those changes because that isn't possible right now.

So some of the easy things we've outlined in the paper, but I think there are other things that are definitely more complicated, and we plan on doing that work over the next year.

MS. WANG: Related to Warner's question just now, how dependent do you feel the payment changes are on achieving at least the minimum level of regulatory relief to allow more flexibility among PAC providers? So, for example, if no regulatory changes were made, if none of the items that you mentioned were addressed, do you feel that the PAC PPS would still -- should still be launched?

DR. CARTER: I think that some of those regulatory requirements do raise providers' costs, and so that would put them on unequal footing. So I think some of those things do need to -- at least the Secretary needs to begin that process of aligning the regulatory structures across the settings by the time this is beginning to be implemented.

DR. MILLER: That's exactly what I would have said as well, and I will use Kathy as my reference point here, although she may disavow this immediately. And when you get into your conversation, there's always this question of, you know, do you wait for all of this to happen, or do you set the train in motion so that people have a strong incentive to get it to happen? And Kathy has, I think, made comments like that, and that might be a point of discussion for you. But I agree with her that some of these, if they weren't removed, you know, you would have a certain inequity for providers.

DR. CROSSON: Okay. So we'll move to Round 2. Could I just see the hands of Commissioners who think they want to make comments on the recommendations? Okay. So it's about half. We'll start at this end and move this way.

Again, we have recommendations before us. What we would in general like to hear is a level of support or not for the recommendation and any specifics for improvement of the recommendation. We'll start with Craig.

DR. SAMITT: So I support the draft recommendation. The only proposed modification that I would make, given our recommendation in support of an earlier transition or a bypass option, would be to raise the reduction of aggregate payments from 3 percent to 5 percent.

DR. CROSSON: Thank you.

MS. BUTO: I agree with Craig. I would raise it to 5 percent or at least say something like "up to 5 percent," absent prior reductions. I'm conflicted on the issue of letting providers move quickly through the transition, but I think if it means they will adopt a more appropriate payment system, I think it may be worth the additional money that we'd have to spend to have that happen.

The other thing we haven't talked about but I hope can find its way into the text is I worry about some subcategories of patients who might not do equally well in every setting. We mentioned -- I think Alice at the last meeting mentioned ventilator-dependent patients, and we talked about ventilator units and so on. I think we have from time to time talked about stroke patients. So somewhere in the text, I'd like there to be a reflection of the fact that as they move through a transition, you know, CMS, the Secretary, really needs to identify any potential subcategory of patients who they'd want to watch carefully to make sure they were getting appropriate access even as we move to a more uniform system.

MR. GRADISON: I agree with the recommendation, with the 5 percent change as well. I would only comment with regard to permitting early adoption, I think there's an advantage in that once that happens, I think it's going to be much harder for the Congress or the administration to back off on the original timetable which they lay out, because there are going to be people out there who already will have committed to and support of this, and also be financially a loss if the time period were extended. So I think that the early adoption is a very good idea.

DR. CROSSON: Okay. Moving up this way, Bruce.

MR. PYENSON: Yeah, I support the Chairman's recommendation with the suggestion that Craig had of the 5 percent.

From a wording standpoint, since we're talking about implementation in Congress in 2017 or 2018, I'd suggest we change the wording from a three-year transition to a six- or seven-year transition. And that's not a transition payment, but we're giving providers three years to get ready and then another three years for changes in payment. That seems like a generous amount of time to prepare, especially in the era of IPAB.

DR. MILLER: Can I --

DR. CROSSON: Yeah, go ahead -- no. So you're saying six to seven years after the regulations are launched?

DR. CHRISTIANSON: No.

DR. CROSSON: No?

MR. PYENSON: I might have counted it wrong, but we're going to have a full implementation by 2023, and the provider community will be aware that this is coming in 2017 or 2018. So that means we are assuming that providers need that amount of advanced notice in order to get ready.

DR. CROSSON: Go ahead, Mark.

DR. MILLER: What I would do is take this suggestion and ask if what we can do is be very clear in the text that the industry will have six years to do it. I think if you write the words "six-year transition" in the recommendation, it will be interpreted as six years, you know, from 2021. And so what I would like to do -- but, you know, you guys decide in the end -- is to say it's a three-year transition from 2021 and make a big deal in the text that they will have six years to be aware of it, if you could find your way to that.

DR. CROSSON: Okay. Bill? I'm sorry. Did I miss you, David?

DR. NERENZ: No. I just put my hand up late. I do support the recommendation. I just wanted to say for the record, commend Carol for the excellent work on this and the other staff who have done this. I think this is maybe possibly the most substantively significant body of work that has been taken up during my tenure on the Commission, if not "the," at least it's in the top segment of the list. I think it's good work. I think it's been challenging. I think it takes payment in this area in the right direction, and I just want to make sure that you are commended for the excellent work you've done. Thank you.

DR. CROSSON: Thank you.

DR. HALL: I totally agree with David on this. I'm very excited about this and certainly support it. Just a couple of provisos here.

What I like about this -- there are a lot of things that I like, but a couple that I think are really going to make enormous progress is, first, that the idea of we're going to agree on common units of service. So post-acute care, PAC, isn't just one entity, but it can be lots of different things. But it's measurable in terms of how we're going to measure what it is that we're paying for.

I like the idea that we're saying this, although I wish we said it even more clearly, that one of the units of evaluation will be functional state. We're making a lot of progress on this in sort of the field of geriatrics, much more so than when I first joined the Commission six years ago when it was just kind of a word that we were looking too define. It's in here, but I hope that it isn't forgotten as we go forward.

One other thing. Okay. The other feature here that I hope does not get lost in our desire to have uniformity throughout the measurement and the payment system is that there's a huge difference trying to evaluate hospitals and evaluating this new entity of post-acute care. Let me just give you a very quick example of that.

After reading this and thinking about this, one of my routine things I do is see patients in what would be called our acute-care service in our major hospital, which is a major university hospital. And then I skedaddled in the afternoon down to within 50 miles of Rochester to parts of the world that you wouldn't recognize in terms of what hospitals look like and what the delivery of health care is. It's neither better nor worse. It's different. Hospitals are very well regulated. There's an enormous opportunity in the country to take this post-acute care concept and to try to make it much more explicit as to what we're trying to do, is to take advantage of the fact that I think that there are incredible opportunities for innovation and creative activities throughout the country.

If I think about a small community and compare it to our large place, I see opportunities in every one of these small communities to encourage innovation, incentivize innovation in terms of post-acute care. Things that you couldn't do in the big city you can sometimes do much more readily in the community. And unless the providers have the opportunity, I think, to be creative and not be tied into regulation, which is well-meaning in its application, a good example is I know places where home health care is very easy to put together if people are incentivized to use it. There are other places in rural areas where to talk about much more serious care it's going to be difficult for them, but there are different ways of adapting.

So this is one I hope that this recommendation goes very far, but it does more than kind of give a uniform post-acute care concept out there, but it doesn't become so rigid that it allows people not to innovate. I think some of the best innovations in post-acute care are going to come outside of the major cities in the United States.

That's my way of saying I really think this is a good idea.

DR. CROSSON: Thanks Bill. Alice.

DR. COOMBS: Thank you very much, Carol.

Back when this was a baby and its development, I think we talked about a couple of things. One concern that I have had was when there is a separation of state regulations versus the regulatory changes that are what we see with the difference between the LTCHs and the SNFs. So I still am concerned about some of the state regulations and state jurisdiction and how much of this is going to be impaired in terms of being able to transition into this based on state governing rules.

I know in our state we had this whole thing and it’s been -- I know it’s been a battle in many states, in terms of the ratio of nursing and each one of the different entities in terms of what is the allowable ratio. And those are regional and those are state-run kind of regulatory issues, so that it comes into play when it comes to how well -- what the margins look like in these facilities where the state has a greater footprint in the operational capacity of the PACs.

I agree with the transition of three years, but I like the idea of if you’re going to do a three year transition to have a lower aggregate percentage. And I thought 4 percent, but there was a bunch of people who thought 5 percent over there. I’m not opposed to that, at all.

I think that if you do a higher aggregate payment decrease, then the transition period becomes not much of a discussion because there will be movement that will occur as a result of that, I think, in general.

The other issue is the rebasing. I really think for home health agencies we really should include that in here because that’s going to be a big factor -- it should be aligned with the recommendations because that’s going to be a big factor going forward, especially when it comes to knees and hips and the ortho procedures because many of them, at my institution, they’re actually going home. They are going home post-op, and that’s their PAC. Their PAC is a home health agency coming in.

Just a specific line that says that. I know we’ve kind of incorporated it.

DR. MILLER: A specific line that says?

DR. COOMBS: The Secretary make a readjustment -- what we're looking for is we want a uniform PAC but including home health agencies within that. And the Secretary is going to make some kind of adjustment as to what that looks like, because the resource utilization is very different in home health agencies.

So I think that -- I mean, there is some estimate of what is the operational costs of a SNF, an LTCH. But those are not the important things here. What we're looking at is what kind of adjustment you're going to have for instead of someone going to a SNF, to make it move people toward a home health agency, the choice, the decisionmaking.

So that if the home health agency is very, very expensive relative to the other pieces of the puzzle, they may select to go that way when the difference is smaller.

DR. MILLER: The thing that I would just run you and others back through is, a couple of things. In the unified system -- this is back to the exchange over here across Brian and David.

There will be incentives to seek out the lowest cost environment that you can deliver the care in and still get a good outcome. And so I think there's some of the home health is just contemplated by the system -- the move to home health is contemplated by the system itself. It is very explicit that all four settings are in it.

And then the other thing -- and this is the most important point I want to remind you about -- deeper in the modeling, when we went through and did the analysis and structured the payment model and did the impact, we had an explicit adjustment for home health.

So even though I don't know the words need to be present here, in the models themselves I think your concern has been addressed pretty head on. And we can just make sure -- and actually, I think -- pretty present. But we can just make sure in the discussion of the methods and the construction of the model, that home health factor is in there.

And I think it goes to the point that you're talking about.

DR. CARTER: So I was thinking maybe in the text below the recommendation we come back to the design features and we could address that concern that way.

DR. MILLER: And do it right coincident --

DR. CARTER: Yeah.

DR. MILLER: That's better.

DR. CROSSON: Jack.

DR. HOADLEY: Like David, I really want to compliment the work that’s gone into this project by Carol and the others on the team. It really is top-notch work.

And I think we’ve got a recommendation here that is a really nicely well-designed package of pieces that puts things together.

I agree with the suggestion that Craig started, that we can move the payment reduction to 5 percent, and I think partly taking into account the notion of those providers that would be bypassing to the end point.

And I was initially going to be a little skeptical of whether we wanted to allow that. I really like Bill Gradison’s point about some of the advantages that bypassing might do in creating some leverage to keep the schedule of this on time. I just think we really have a package that fits together very nicely and achieves our ends and the combination of the recommendation and the text that has been indicated here that would follow it really, I think, builds the case very nicely.

DR. CROSSON: Warner.

MR. THOMAS: I support the recommendation, as well.

I would like to comment on Alice's points around the -- things like state licensure, CONs, things like that, as far as if organizations need to reconfigure or modify services, I think there just needs to be a lot of consideration around that to allow organizations to have the flexibility as they go to try to adapt their business to deal with a broader array of patients.

I know that in the text there are certain regulatory comments made. I just would like to see maybe a little bit more detail around that, that's going to allow the providers to have maximum flexibility in order to deal with a broader population of patients because ultimately that's what we want. We want to see a post-acute facility versus an LTCH, a rehab, a SNF.

And I think that's going to require probably a little bit more flexibility regulatory-wise in order to achieve that. Especially given a short-term -- I mean, three years is not a short period but in the scheme of life it’s a relatively short period of time to have such a significant change. So I just want to make sure we align the regulatory pieces, as well.

DR. CROSSON: Rita.

DR. REDBERG: I'll add my congratulations. I really think this unified payment system really incorporates the principles that we talk about as paying appropriately, the same care for the same type of patients, regardless of setting. And so -- and I think it will improve post-acute care, where we know there are a lot of issues now.

So I support the draft recommendation with the suggested change to 5 percent payments.

And I understand that it is changes, but I do feel that we have been now talking about this for several years and the transition period is still another few years. And so I feel that the industry is probably have been thinking about it already and thinking about where to go with the prospective payment system.

Thanks.

DR. CROSSON: Brian.

DR. DeBUSK: I strongly support the Chairman’s draft recommendation. I do agree with some of my colleagues here that we could do more than 3 percent -- 3, 4, or even 5 percent.

The one thing I wanted to point out here is just the contrast. To understand the nature of this problem as well as we do, and to know that it has, for example, the secondary impacts of altering MA benchmarks, of altering benchmarks in APMs, you know, the contrast between where we are now and the improvements, what an elegant solution this is.

Between the magnitude of the current problem and the power of the solution, these strike me as extremely reasonable recommendations. I mean, this is not radical when you consider where we are now and where these recommendations take us to.

So thank you and I think it’s outstanding work.

DR. CROSSON: Thank you very much and I, Carol, underscore the comments that have been made about the quality of this work. I guess my only question is what have you got left to do?

[Laughter.]

DR. CARTER: Oh, we have a lot.

DR. CROSSON: Thank you so much, and we will return in April and have a chance for further discussion and a vote on these recommendations.

[Pause.]

DR. CROSSON: Okay, so we are going to proceed now with a discussion again about the issue of hospital and SNF use by Medicare beneficiaries who are residing in nursing facilities.

Stephanie, you're on.

MS. CAMERON: Thank you.

Good morning. Today I will provide a brief overview of the context for this presentation and an overview of information that I provided during our September and October meetings on this topic. This includes a summary of the strategies that nursing facilities are using to prevent hospitalizations of their long-stay residents and a summary of the risk-adjusted rates of hospital and SNF use for this population.

In addition, I will highlight new information requested by commissioners during our fall meetings and provide considerations for future policy. Today we seek your input on the draft June chapter included in your mailing materials.

We began discussing the issue of hospital and SNF use by long-stay nursing facility residents based on the Commission's concerns about quality of care for the dual-eligible population -- that is, beneficiaries that receive both Medicare and Medicaid benefits.

Since the majority of long-stay nursing facility residents are dual-eligible beneficiaries, the nursing facility provides and easily-defined population for better care coordination. While Medicaid generally pays for the long-term services and supports provided by the nursing facility, Medicare pays for care that these beneficiaries receive in a hospital or during a subsequent post-acute SNF stay. Transferring these residents to a hospital for conditions that could have been prevented exposes beneficiaries to several health risks, unnecessarily increases Medicare program spending, and could indicate a potential program integrity issue. Existing literature has shown that a substantial portion of hospital admissions of long-stay nursing facility residents may be avoidable through better prevention or management by the nursing facility.

While the facilities that we are discussing today are typically the same facilities who provide care to beneficiaries under Medicare skilled nursing facility benefit, this presentation and our June chapter will focus on the long-stay nursing facility resident population. We defined our study population as having more than 100 days in the nursing facility. Unlike the purely SNF population, these beneficiaries are mostly dual-eligible and are not typically discharged to a community setting.

So, some background. As you will recall, the Commission conducted 10 interviews to learn about the strategies employed by facilities to reduce hospital admissions of long-stay nursing facility residents. We interviewed facilities and groups currently participating in initiatives being implemented through either the Medicare fee-for-service program or a Medicare Advantage environment. The Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents includes about 140 facilities and provides financial support for onsite training for staff, data support, and enhanced direct patient care.

Certain MA beneficiaries have access to Optum's

CarePlus model, which provides onsite nurse practitioners to manage and treat participating beneficiaries in participating nursing facilities. Some nursing facilities have also attempted to reduce hospital use by long-stay residents without participation in a formal initiative.

Interviewees reported several common strategies to reduce hospital use among long-stay nursing facility residents, which we discussed in detail in September. The strategies included improving communication between residents, facility staff, and offsite clinicians, increasing the level of clinical training, expanding the medication review process, broadening advanced-care planning efforts, and implementing telehealth programs.

Amy, in October you asked about telehealth's role in the nursing facility setting. Interviewees reported that there were several barriers to implementing telehealth broadly in a facility, including general workflow issues with requirements of additional staff time to go through any telehealth protocols, a low volume of beneficiaries making integration into everyday process is difficult, and the relatively high cost of investing in telehealth technology and its maintenance.

Next, we turn to the results from our analysis of hospital and SNF use rates. The Commission developed three measures of hospital use for the long-stay nursing facility resident population, including an all-cause hospital admission measure, a potentially avoidable hospital admission measure, and an all-cause ED visit and observation-stay measure.

Bill, as you requested in October, a detailed list of the potentially avoidable conditions is included in Appendix A of your mailing materials. And as a reminder, we risk-adjusted these measures based on age, function, and co-morbidities.

We found relatively low average rates of the three hospital-use measures. However, we found a wide variation in rates across the facilities for each measure. As we indicated in October, the variation and rates, and the level of rates above the 90th percentile, results in the Commission's focus on facilities with the highest rates.

For example, the risk-adjusted rate of hospital admissions at the 50th percentile equaled 1.6 per 1,000 long-stay nursing facility resident days. However, the variation between the 10th and the 90th percentile was more than twofold. We found a more than threefold variation between the 10th and the 90th percentiles for the rates of potentially avoidable hospital admissions and an almost fourfold difference in the all-cause ED visit and observation stay measure.

We looked at the characteristics of the facilities with hospital admission rates at or above the 90th percentile and found that these facilities were more likely to be for-profit, rural, or smaller. We also found that the frequency of visits from physicians or other health professionals was inversely related to the rates of hospital use. Facilities with access to onsite x-ray services had lower rates of potentially avoidable hospital admissions and ED visits and observation stays.

Now we move to our measure of SNF use for the long-stay resident population. We considered this measure based on Commission concerns regarding facilities using SNF services to maximize Medicare payments rather than meeting the care needs of the long-stay residents. We found that the rates of SNF days per 1,000 long-stay nursing facility days were skewed based on extremely high rates at or above the 90th percentile.

Facilities at the 90th percentile had rates of SNF use over 10 times higher than facilities at the 10th percentile. These rates indicate a potential programming integrity issue with the facilities at the highest end of the distribution. When we analyzed the facilities at or above the 90th percentile, we found that these facilities tended to be for-profit or freestanding. At the most extreme, facilities above the 99th percentile were heavily concentrated across three states and were primarily for-profit.

Before I discuss inter- and intrastate variation, please note the correction to the national average SNF days into the national average variation in SNF days compared to Tables 5 and 6 of your mailing materials.

State-level policy could influence hospital and SNF use rates. For this reason, we examine the rates for each measure across states and the variation of each rate within-state. We stratified our data by state and then compared the rates of the top five states, which is those with the highest rates, with the rates for the bottom five states, those with the lowest rates.

We found that the variation in state-level average rates for our four measures was about twofold. This degree of variation, seen in the far-right-hand column, suggests that state-level policies and geographic-specific practice patterns may help explain the variation in hospital use rates.

Amy, in October you asked about within-state variation. As you will recall, the variation of rates of hospital use was between twofold and fourfold when we compared facilities of the 90th percentile to facilities of the 10th percentile, which is represented in the first data column of the table. Then at the state level, we calculated the variation between the facilities with the highest rates to those with the lowest rates. When we compared the states with the most variation to the states with the least variation, we found that hospital-use measures largely followed the national average, which is available in the second and third data columns.

However, we found that five states had extremely high levels of variation in their facilities' SNF-use measure. For these states, the difference between facilities with the lowest rates and those with the highest rates was over 25-fold. This finding supports the Commission's concerns about the skewedness of the data and policy considerations focused on facilities at the highest end of the distribution. The intrastate variation across providers indicates that facility-specific practices also contribute to the large variation we see across the measures.

Our work suggests several options for future policy. For example, CMS could develop measures of hospital and SNF use for long-stay nursing facility residents. Once measures are developed, CMS could report the measures to providers and ultimately publicly report them for consumers through a website such as Nursing Home Compare.

Following public reporting, Congress could consider expanding Medicare's SNF value-based purchasing program to include one or more of these measures. Our findings support setting a threshold for the applicable measures in a way that captures the true outlier facilities, not necessarily those with slightly above-average rates.

Alternatively, as Kathy mentioned in October, the high variation in the rates of hospital and SNF use at the extremes of the distributions could signal a program integrity issue. CMS and its auditors could consider focusing on facilities with aberrant patterns of hospital use and SNF use for long-stay beneficiaries with further congressional action.

Today we are interested in the Commission's feedback regarding the new material we presented, including considerations for future policy. In addition, we seek your input regarding any next steps you are interested in pursuing regarding this topic.

And with that, I turn it back to Jay.

DR. CROSSON: Thank you, Stephanie.

We have clarifying questions. Let's see, Brian and Sue.

DR. DeBUSK: If you could take us back to Chart 8 where you talk about the characteristics of nursing facilities with high rates of hospital use, I noticed that you have rural hospitals as well as -- you also looked at the frequency of physician and other health care professionals and the access to x-ray equipment. Did you look for any collinear relationships between those two? I mean, could we be measuring -- could the rural hospitals, for example, have lower frequencies of physician visits just associated with rural access issues?

MS. CAMERON: We did look at those actually separately, and I do not remember why variation, but I would certainly get back with you and make sure that's highlighted in the chapter. I am just not remembering offhand if that was -- I do not remember anything jumping out but I cannot remember how close they were either.

DR. DeBUSK: I just wondered if there was a collinear relationship.

The other question I was going to ask, the gap measure that you were working with. I noticed you switched back to the SNF days per thousand. Did the gap measure just not pan out?

MS. CAMERON: That's right. So we did look at another measure when we were developing this work that considered the number of days between when a beneficiary who was a long-stay resident would be able to qualify for a new SNF benefit or a new benefit period, which starts with a hospitalization. And when we looked at that, the model had very, very low explanatory power. It was under .1, so therefore we have dropped that measure and really focused on the SNF-day measure.

And when we consider the SNF-use measure, I think thinking about kind of the extreme, those above kind of the 99th percentile, maybe even those above the 90th percentile, you know, that could be getting at some of this cycling that we have talked about in the past.

DR. CROSSON: Okay, Sue.

MS. THOMPSON: Thank you, Stephanie. Have we visited with any of the ACOs or the folks that have been working, whether it be in at-risk or MSFP ACOs in terms of their experience with what is happening with this population? And is there anything to learn from them?

MS. CAMERON: I know there is a large ACO, I believe out in California, that does have a long-stay resident population, but I do not believe that that is kind of the norm in terms of the ACO population.

MS. THOMPSON: [Off microphone.]

MS. CAMERON: So we have not been able to kind of overlap the two at this point.

MS. THOMPSON: There might be some value.

DR. CROSSON: Okay.

MS. THOMPSON: There might be some value.

Also, you know, on page 5 of the materials that you sent to us, you refer to the use of nurse practitioners and perhaps there is some benefit to the nurse practitioners who either make visits to see these patients on a regular basis in the nursing facility, but yet we do not call it out as a strategy on the list of strategies that are identified, so I am just curious about that. Was there just not enough evidence there, or what was your thought?

MS. CAMERON: So the two strategies that I do mention, the Optum CarePlus model as well as many of the seven demonstrations and the CMMI project -- I believe it is either four out of seven or five out of seven of those do, in fact, use nurse practitioners or other health professionals in the facilities.

I am happy to be more explicit that that was, you know, a piece of it. In some situations they provide direct patient care. In others they provide other levels of support. But I am happy to add that in because I think you are right; we did see that. In the kind of two tiers of initiatives we looked at, nurse practitioners did play an integral role in working with the beneficiaries.

MS. THOMPSON: And last but not least, in the spirit of continuing to support the need to get after the opportunity to use telehealth, I think there is an opportunity to connect the nurse practitioner and the access to nurse practitioner into these facilities. And I would suspect there is some incentive then to the nursing facilities to get into investing in telehealth if there is enough disincentive to not be performing. So I think all those pieces start to connect pretty nicely, which is probably a round-two comment --

[Laughter.]

MS. THOMPSON: -- but I am just including it now since the mic is on.

DR. CROSSON: But you snuck it in very, very skillfully. We will let it go this time.

MS. CAMERON: And I do want to say, keep in mind, in terms of telehealth, that at this point it is really primarily a rural benefit. So, you know, I want to keep in mind that even with the expansion of telehealth in nursing facilities, right now that would really only be targeting the rural population.

MS. THOMPSON: And to add one more comment --

DR. CROSSON: Yeah, go ahead.

MS. THOMPSON: -- back to Brian's question about the x-ray and kind of what was going on there with the rural facilities, I am curious about how many of rural hospitals also have nursing home beds either on their property or adjacent, actually contiguous in the physical setting, which makes x-ray available. It is just down the hall, happened to be in a different designated bed. So I think there is a piece there that is at play.

DR. MILLER: Yes, swing beds, that's a good point.

[Pause.]

DR. CROSSON: Stephanie, are you looking to prepare an answer? Or what are you doing?

[Laughter.]

MS. CAMERON: I was skimming a document because I do have it, but I need a moment. So I will look at the --

DR. CROSSON: Go ahead. Take your time. I was not sure.

[Pause.]

MS. CAMERON: We did find that there were -- so in terms of the access to X-ray anyway for rural versus urban, a larger percentage of urban facilities do have access to X-ray services compared to the rurals.

DR. CROSSON: Okay. Clarifying questions?

MR. GRADISON: Is there any relationship that you know of between the five states that are the outliers at the 90 percent level or higher and states in which CMS has found a concentration of program integrity issues?

MS. CAMERON: I do not, but that's a great thing to look into, and I think that's worth doing. Thank you.

MR. GRADISON: Thank you.

DR. CROSSON: Okay, Jon.

DR. CHRISTIANSON: I think this might be the same thing, but are the three states you referred to in the risk-adjusted NSF, are they also a subset of states that are aberrant or really high on other measures as well?

MS. CAMERON: When I looked at the analysis, we did look to see if there were correlations with other measures that exist. So, for example, we do have a measure of SNF readmissions, and their correlation was positive but not high. I want to say depending on which measure you looked at, from what we worked on for the long-stay population and whether or not you were looking at the potentially avoidable SNF readmission or the all-cause SNF readmission measure, the correlations I believe were between about 0.2 and 0.3.

DR. CHRISTIANSON: I guess I was probably asking a simpler question. If you were to name the three states in the one area, would you be naming the same three states in some of these other measures as well?

MS. CAMERON: In terms of like a SNF readmission rate? That I would need to double-check on, and I'll do it in the same spirit as what Bill Gradison asked.

DR. CHRISTIANSON: Yeah.

MS. BUTO: I think this is a really interesting area. To my mind, anyway, the question I have for you about the topic is whether it's possible for us to look at all at kind of the outcomes. So I think intuitively we think this is not a good thing to have a lot of readmissions to SNFs and hospitals. But I wonder -- it's a lot more compelling if we have a sense of what the actual harm is to beneficiaries. And I know it's even harder to figure out what the additional cost is to the program. But down the road, as we continue the analysis -- I'm assuming that we wouldn't want to do this right now -- is that something that you think we could look at, or are the reasons for readmissions so scattered that it's hard to make -- draw any conclusions?

MS. CAMERON: I think we would need to put some more thought into kind of outcomes measures. As you're aware, with this long-stay population, mortality rates are pretty high generally. I mean, when most beneficiaries go into a nursing home and become a long-stay nursing facility resident, they aren't discharged to the community. You know, there's a variation in how long they stay in the nursing facility before they pass. But, you know, one year, a little more than one year is kind of the average, and the outcome is mortality, is death.

So I think we would need to think about what those measures would be, and, you know, at this point I'm not sure they necessarily exist.

MS. BUTO: Okay. So in a sense, we're interested in this almost more from the standpoint of quality of care maybe, or even quality of life, toward the end of life. The readmissions complicate that and make it more hazardous, is what I'm getting from your analysis. If it's hard to figure out what the outcome is other than death, then that tells me that it's either that or the expenditure that really worries us.

MS. CAMERON: And I think it's -- you know, the Commission looked at this I think as a quality issue, and there is research showing that sending these beneficiaries to a hospital further detriments their health with exposure to, you know, infections, more falls, a lot of confusion. This is a very frail population, and removing them from the everyday environment becomes a very confusing and frankly very stressful situation for them. And when it occurs, you know -- I think the Commission's concern was, well, if that exposure is occurring for something that could have otherwise been preventable, then that's a problem.

DR. MILLER: And I think you guys have come to a comfortable place in your exchange. The only thing I would add -- and I'm doing this carefully, Stephanie. You know, in a sense you were saying but what do we know about the outcome, and then you got to your mortality conversation pretty quickly. I think upstream from that a little bit -- and it's a little different take, but I feel it's something of the same question or same point, although Stephanie's going to correct this if not -- is that's why we're looking at a little bit of the potentially avoidable in the sense of like, you know, maybe there's readmissions that should have occurred, but could you construct a measure where we have some clinical input of like this shouldn't have happened, and then the whole cascade of your comments begins to, well, then that's lower quality of life for the bene and then there's detriment, that type of thing, and very imperfectly, and that's it.

DR. CROSSON: Okay. I've got Bruce and then Pat and then Amy.

MR. PYENSON: Stephanie, I noticed on what looks like page 10 of the report, there is a reference to medication therapy management as one of the strategies people you interviewed to avoid hospitalization with medication errors and things of that sort. I think it's safe to say that virtually everybody in this population, if they have prescription drugs, are getting it through a Part D plan. And Part D plans -- probably with the LIS, low-income subsidy. And Part D plans are supposed to have medication therapy management as part of their services.

So to the extent -- my question is whether we can evaluate whether the Part D plans are doing an adequate job with this population through the data. So, for example, whether there's particular admissions that we might recognize as medication errors or things of that sort.

MS. CAMERON: So I think you're absolutely right, and the Commission has done other work kind of on this topic more generally, not necessarily for this long-stay population. But, in general, the Commission has done prior work on medication therapy management through Part D.

I think what we heard from our interviewees was that having someone in the facility also really managing the medications, especially as beneficiaries kind of went from a hospital back to the facility, you know, if there was an intervening hospitalization, there was often, you know, the immediate need for a review of the medications because there -- what we were told was there were often inconsistencies with dosing amounts of the drugs that were provided, and there really wasn't any coordination between the hospital and the facility.

And so I think when we talk about medication therapy management in kind of this setting, it's more the immediate following, you know, another -- following the beneficiary's either hospitalization or visit to an ED that they have talked about as being really important.

DR. CROSSON: Okay.

MS. WANG: The discussion before about quality I think is a really important one because there's tremendous variation in SNFs across the country. They play different roles in different communities and sort of the concept of who goes to long-term care for this, that, or the other I think is different from place to place. So, you know, the measure of avoidable hospital admissions is one measure of quality, but, you know, sort of prioritizing quality might also -- you know, we might also agree that for some of the smaller facilities, for example, we want those people to go to the hospital because there's no way that that SNF can actually take care of that person adequately inside. And so, you know, it raises questions about like if the expectation is that folks don't go to the hospital anymore, what are the eyes on the SNF to make sure that care is really -- you can avoid a hospital admission in a lot of ways, but if death is the only measurement of quality in a setting where people die a lot -- you know, what I'm trying to say is what is the -- part of this is -- this is very interesting information. I think it's really important. But what is the end-state vision of what we think a SNF should look like? Okay? If I look at Table 3 on page 19 -- and this may be a bridge too far -- it seems to me that when you look at -- when you rate the characteristics of SNFs with highest hospital admissions, 90th percentile, certain things popped out and that, in general, the facilities that did a better job were larger, not-for-profit, and hospital-based. Is that fair to say? Not so much urban-rural, but those other characteristics, if we think that those are sort of leading edge and sort of best practice, it might suggest future work in the direction of connecting those sort of smaller, more poorer performer facilities with SNFs with these characteristics. It's inherent in some of the comments about access to physicians, access to telehealth, access to nurse practitioners. Maybe there's a more direct correlation there. I'm just suggesting.

The other observation I would make, just looking at this table, going back to the earlier discussion about the PAC PPS, is that my recollection is that hospital-based SNFs would benefit from the uniform PPS, so maybe looking at this table, which is an indication of quality, further suggests that that's the right direction to go in. But I'm trying to grasp the conversation that we had about quality. Like what is the end state here that we're all looking for?

DR. CROSSON: Okay. Just a reminder, we're on clarifying questions. Do you have a comment on --

DR. NERENZ: A clarifying question just on Pat. These are not necessarily SNFs, right? In fact, for the most part they are not SNFs?

MS. CAMERON: So this is -- and, again, I think stepping back to an earlier slide, this is where it does get confusing in that, you know, we use the term "nursing facility" and "SNF" very interchangeably, I think, in our everyday lexicon, and really SNF is a Medicare concept, it's a post-acute Medicare concept. And so many facilities do provide SNF services and long-stay nursing facility services. Most, in fact, do. There are some that only provide -- truly do only provide post-acute care, and there are some facilities that really want to focus on long-stay nursing facility residents. So there is a wide variation of what nursing facilities as kind of an umbrella term serve in terms of post-acute and long stay. But we are focused on a population of long-stay residents in this work.

DR. NERENZ: Okay. Well, that's why I wanted to clarify, because one of the measures that you talked about was actually the transition from non-SNF to SNF, which implies that the main denominator is not SNF. I just wanted to clarify that.

MS. CAMERON: That's right. All of our denominators are only beneficiaries that exceed 100 days in a facility.

DR. NERENZ: Got it. Okay.

MS. BRICKER: At the risk of being oversimplistic, I thought it was fascinating, the observation around on-site X-ray. In your opinion, based on what you know, is this something that could actually be solved for? Would it make, you know, enough of a difference either having incentives or penalties for not or trying to solve for they should all have access to on-site X-ray?

MS. CAMERON: You know, I think there's an association there. It makes me nervous to think on my feet and give a policy about whether or not all nursing facilities should provide a service. We know there's an association with lower risk of hospitalizations, and the access to X-ray services, which are mostly contracted services, nursing facilities typically don't own their own X-ray equipment. This is a service that is provided where, you know, an X-ray service will come to the facility when necessary. But that is something -- you know, and Medicare obviously pays for those X-rays, so that is something, you know, that was associated with lower rates of hospitalization and would avoid -- you know, if a beneficiary is going to the hospital for purposes of an X-ray, they are exposed to the things that we talked about a little bit earlier, and this having on-site prevents that exposure.

DR. REDBERG: Just on that point, Jay?

DR. CROSSON: Okay.

DR. REDBERG: It just doesn't seem -- you know, looking at the list in Appendix A of the potentially avoidable hospital admissions, I mean, in X-ray I think we're mostly talking about a fall and you're looking for a broken bone. Very few of those. I just don't think it will make a big difference.

DR. MILLER: And the other thing I would add -- and, you know, again, this then will spillover into discussion as opposed to clarification. You know, a question for you guys always to be thinking about in all of these conversations is: Do you see something and say, "I want each provider to do this," and be directive? Or do you want to say, "I want to measure an outcome I'm looking for, avoided hospitalizations, you guys figure out the way to do it"? And so that always becomes a question, which gets us into Round 2, which gets me into trouble with him.

DR. CROSSON: Paul, keep us out of trouble.

DR. GINSBURG: I'll try. Earlier we were having this discussion about the particular geographic areas of states that had particularly high rates of events like SNF admissions, and I started thinking about the Commission's prior work on overall -- this was actually by county rather than by state, but Medicare spending per beneficiary and the variation. And if I recall properly, the key factor behind variation was post-acute care. I was wondering if there is some correlation between the areas that came out in your screens and the ones that came out in that prior work. It could be all part of the same story.

MS. CAMERON: Yep.

DR. CROSSON: Okay. So we have really a two-part discussion period here. Stephanie has asked for comments, having received some since the last presentation, to improve the June chapter, which she will now proceed to draft -- write, actually. So that's one.

And the second one, which you can find on Slide 12 -- and we've heard some already in the question period -- priorities for future work in this area. We've already heard a few. So those are the two things.

So can I see roughly who would like to make comments at this point? Okay. I see more over here, so we'll start with Alice.

DR. COOMBS: I just wanted to speak to something that Amy had talked about, and having a chest X-ray at a facility may be a proxy for having robust access to resources. So that same facility may have more nurse practitioners.

One of the things I was concerned about is that there was a tool that -- I think it was CMMI was conducting on communications on transfer from acute-care facilities to nursing homes or to PACs. And I'm wondering if that ever was able to lend itself to any information that may be something we could apply in this entity. So it was a data system whereby information was collected from one health care resource facility or entity to transfer that information to a long-term-care nursing home or a short-term facility. And I looked at the tool just briefly because it was proposed by an entity in Massachusetts, and I saw that it had some really neat things about not just med reconciliation, because I think everyone is on board with med reconciliation, but the whole thing from having the discussion for end-of-life care, whether or not a patient was no resuscitation. It was very comprehensive, and I think that piece is really important to have the family engagement, you know, the bracelets and the whole works.

And so I'd be interested to know if some of the facilities you've looked at have been engaged in that kind of work.

MS. CAMERON: So I can speak to this a bit. There are suites of resources that provide facilities, and many of the facilities in, for example, the CMMI demo that we've been talking about use that provides all sorts of kind of communication forms, and that might be, you know, what the facility needs to communicate with the on-call physician prior to -- you know, and what information needs to be gathered by the nurse's aides, the nurses on site, before initiating a call. There are also forms that do talk about, you know, end-of-life preferences and, you know, making sure that those forms get transferred if the beneficiary is going to the hospital, that all of that goes with the beneficiary.

So we have seen definitely -- or I should say we have heard about steps and suites of communication kind of forms that have been carried forward that the facilities are really trying to implement to help communication and get at, I think, exactly your point.

DR. COOMBS: And the literature about states with most forms and what that looks like in terms of inappropriate admissions to acute-care hospitals, and I think that we have most forms within our state, but I would look at that as well, because that may be another clue as to inappropriate admissions and ED visits.

MS. CAMERON: I actually did touch on this a little bit in my analysis. What I did was I looked at the states that either had some level of pulsed or most or -- you know, every state I think has a little bit of a different name for these. And when you kind of do a very, very high level analysis looking at the states that actually have implemented these programs, those states do tend to have -- there's a correlation between the lower readmission rates and the use of those programs. But it's a very high level, and, you know, every state is at a different developmental standpoint from that perspective.

DR. COOMBS: So I was just saying a negative predictive value of states that don't have any initiatives, then that might be very valuable going forward.

DR. CROSSON: Okay.

MS. THOMPSON: Well, my comments really echo yours, and that just gets back to, Stephanie, my suggestion that we visit with some of the folks who have been in the ACO work because my prediction would be we will find a lot of pretty mature palliative care programs where good time is spent, you know, talking with patients and families about what do you want and what do we want these last days to look like. You know, I think we had some conversation in our discussion about outcomes in terms of what's the end-stage vision for what does this facility look like and what are the characteristics. Maybe if we put our focus on what is our work around helping patients and families to find their end-stage vision, because I think this is the most vulnerable population in terms -- do they even want to go back to the emergency room? Do they even want to go into the hospital and go through ICU and antibiotics and all the things that on the financial side of this equation we're very concerned about?

So I think upstream here we could get ahead of this and be very, very appropriate and dignified to the Medicare beneficiary. So I just think there's an incredible opportunity here. So I do, I love this work, so thanks.

MR. THOMAS: Just a real brief comment. I think that just putting a focus and daylight on this will impact it in a positive way, and I think you'll see that in ACOs or integrated organizations that are more active and engaged with these organizations, you'll see improved reductions in readmissions or admissions to hospitals. There is such wide variation there. You know, we find that our experience is organizations that are focused on it do a much better job and have programs that are in place to reduce this type utilization.

I would agree with Sue that, you know, palliative care has a big focus on it as well, but I think this is great work just to put daylight on it and to make it a priority. And the more we do that, I think you'll see improvement in this area.

DR. DeBUSK: I would second that. I do think there's some great work in this area. My question is: Would we want to weigh in on bed-hold policies at some point or maybe even tie some of that back to utilization rates?

MS. CAMERON: Well, I think bed-hold policies, you know, have been shown to influence hospital use in other research. Bed-hold policies are decisions that are made at the state level. It's truly a Medicaid payment issue, so, you know, there are right now 51 different policies, and it really affects the Medicaid payment piece, although, yes, I mean, it then blends into Medicare because Medicare is obviously paying for the hospitalization. But a bed-hold policy is a state-level policy.

DR. DeBUSK: Agreed, but it does impact program spending on the SNF side, which, I mean, just simple, hit-it-over-the-head solution, what if you deducted bed-hold payments from SNF reimbursement?

DR. MILLER: So since we are putting Stephanie on the spot, maybe I'll --

DR. DeBUSK: Sorry.

[Laughter.]

DR. MILLER: That's all right. It's an interesting thought. It's not one that I had, and so what I would say at this particular point is I think as a Commission you'd have to be careful and even by law not be making recommendations about Medicaid. That I think would be out of our lane. The notion of, however, pointing out the relationship, which I think is somewhat contemplated in the chapter -- or is it not in there?

MS. CAMERON: It's briefly contemplated because of the issue that every state has a different policy with varying degrees of --

DR. MILLER: Right. And so what I would say is we can certainly make it clear that there is this relationship, because this relationship is established in the literature. People know it, you know, and that type of thing. And if there was appetite for it, revisit it on the Medicare metric and payment side. But I wouldn't want to do that on the fly. I'd want to take your thought and, you know, kind of parse through it. But I think it would be out of our lane to say Medicaid law or policy should be changed. That, we would be out of our lane.

DR. CROSSON: Okay. Can I see hands on this side again? David and Bruce.

DR. NERENZ: Yeah, just a couple things, and these I think involve possible expansions as this moves forward. One is I'd like to learn a little more about the financing pieces of the CMMI models or other similar initiatives. I think the text makes some sort of brief, passing mention that, you know, project funding was used for X, which implied to me that there's some kind of special or supplemental funding streams that's sort of characteristic of CMMI projects. And then the sobering part, though, is that there's not a clear net savings benefit, so even though you can do some extra things, presumably pay for them, it's kind of this classic offset problem that looks good, and then you don't see it in practice, where you can reduce admissions but then you net it all out, it's not necessarily better.

I guess I'd like to see more of that, and the reason -- to the extent it's there to be had. The reason I think that that takes us in the direction of possible Medicare payment initiatives that squarely are in our lane that we might consider. So, for example, if one of the reasons that patients get admitted too much is that there's not enough physician time in the facility, is there some sort of tweak to Medicare payment that would solve that problem, that would pay physicians to be in the facility?

I think the CMMI project sounds like there may be examples of that. There may be other examples. But I guess I'd appreciate seeing sort of in front of us are there very specific Medicare payment changes that might be considered that would speak to the issue of too many admissions or too many ED visits in this setting.

And the second thing is I'd like to know a little more about the physician or possible nurse practitioner models that are present in these facilities. We've used the term "on-call," and that has certain meaning. It's implemented in certain ways. It implies to me just by its terminology that possibly it's a little late in the game, meaning the patient's already in trouble and then somebody gets called, and by that time the patient is on his or her way to the hospital anyway. It's not necessarily so. But I'm thinking also that there are relationships in which a nursing facility has some standing relationship with a physician or with a nurse practitioner or perhaps with a group and that's paid in some way, and that suggests that all the residents in the facility come under sooner or later the auspices or the care of that physician.

Now, that's a different model from saying that every single resident in that facility has his or her own physician that he or she has had for 20, 30, or 50 years, and that it's multiple physicians who deal with individual patients, but not necessarily responsibility for the whole place.

I'd just like to know more. How did that work? And is there any evidence that one model works better than another or that as a matter of payment policy, we should be shifting things preferentially in one direction or another?

DR. CROSSON: Bruce.

DR. COOMBS: I’m sorry, can I comment on this?

DR. CROSSON: I’m sorry. Alice, go ahead.

DR. COOMBS: I just want to say what you’re looking at is closed systems versus open systems. And it varies across the country but what he's saying may make a difference because when you have closed systems where there is one team of internists or primary care doctors who are working in a group they more likely -- and this is my own bias -- may have protocolized care, where something happens and there’s like a way to do something in a predictable fashion.

Whereas the other, it may be more of a division of what this practitioner is used to who’s covering the nursing home for a month, 24 hour call. So that may make a difference with the utilization of ED services and services outside of the institution.

DR. CROSSON: Bruce.

MR. PYENSON: Stephanie, terrific report. Thank you very much.

I am wondering if in the future iterations we could look at the role of end-of-life care for these patients. In particular, it strikes me that when a patient in a nursing home receives hospice care, that’s in effect a transfer of liability for the daily rate from the Medicaid program to the Medicare program. And to see, to look at how that works, some of the statistics on that and the variability in that.

And another issue that I am curious about is the variation in the use of nursing home in the context of long-term supports and services, in particular home and community-based waivers. There is a big variation by state in the use of long-term care site, whether it's nursing home or community, and whether that plays a role in some of the variations that we've seen.

DR. CROSSON: Okay, Craig and then Jack. Last comments.

DR. SAMITT: So I want to tag on to Sue's comments actually about digging deeper into some of the benchmarking. And I'm not so sure I would suggest looking at ACOs, per se. And I certainly let a session go by without referencing encounter data. Sorry.

[Laughter.]

DR. SAMITT: But I do wonder, I mean the benchmarking that's been done really is analyzed, I would say, more from the provider prospective, what is unique about these facilities. I am interested in more from a plan perspective.

So if we were to look at some of the MA plans, in particular, I would be curious to know which have encounter data that suggests that they have achieved good results and favorable results in admission rates for hospital for the long-term residents. I would be interested to know which MA plans are doing that very well. And what specific payer-driven interventions they've put in place that can drive to those great results. And I don't know whether there are policy recommendations that can be learned for CMS from what some of those private plans are doing.

DR. CROSSON: Okay, Rita, do you have a point on what Craig said?

DR. REDBERG: Yeah.

DR. CROSSON: Go ahead.

DR. REDBERG: And I think that would be valuable. I think there is some data thought currently that suggests that when MA plan patients start getting expensive in those -- they move to fee-for-service Medicare. And so it would be hard to account for that.

DR. CROSSON: Jack and then you.

DR. HOADLEY: So this last set of comments makes me think -- and I don't think this was mentioned anywhere in the chapter -- whether the financial alignment demonstrations, the dual demos, give us any insights, whether -- I mean, it's almost a special case of what Craig's talking about. Here are the managed care plans where both streams of dollars are put together and where some of the issues we're talking about are supposed to not be a problem.

But I don't know if we know enough yet from any of those, and whether any has specifically looked at that. But that might be something to bring into the discussion down the road.

DR. CROSSON: Okay, so I think, Stephanie, we have good support for the chapter. Go for it.

But then, with respect to future work, I think Mark would like to make some closing comments.

DR. MILLER: Yeah, I want to manage expectations here a little bit. Stephanie will work through the weekend and we'll take care of all of this.

I want to manage expectations in a couple of ways. I do want to just deal with your comment. You know, we have done site visits on the dual integration demonstrations. At that time, there wasn’t -- beyond process issues and that type of stuff -- there weren’t results. But we’re going to be -- we’re going to keep looking. We’re going to keep going at it. And I think that issue will continue to be -- even rise, given some of the directions other policy areas are going.

The second thing I want to say is you made a lot of suggestions for future ideas. For example, the payment stuff that you guys were saying other ways to -- Brian and David, other ways to incent payment. And Bruce, you were asking about the end-of-life, and there were other comments that we could look at.

So what I would like to do in the chapter is to end up with a list of possible directions. I’m not going to be able to deal these out in time for the June report.

And then, as we go forward, we’ll have to figure out the priorities here because you guys also ask for other things. And so we will get Stephanie to flesh out the things that we said in the chapter, put a list of ideas at the end of that chapter, and then going forward we will figure out which one of those we want to chase down.

That’s what you should expect to see in the chapter. That’s all workable? Stephanie, you’re okay?

DR. CROSSON: Okay, seeing no further comments, Stephanie, thank you again on behalf of the Commission for this work. We look forward to future work, as well as naming rights.

[Laughter.]

DR. CROSSON: So now we have time for the public comment period. If there are any members of the public who wish to make a comment, now is the time to come up to the microphone.

[No response.]

DR. CROSSON: Seeing none, then we are adjourned until 1:30.

[Whereupon, at 12:11 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION

[1:29 p.m.]

DR. CROSSON: Okay. Good afternoon, everyone. We have a busy afternoon. The first agenda item is our return to the issue of Part B drug payment, and we will have a presentation by Kim Neuman, Nancy Ray, and Brian O'Donnell. And we will proceed to our first examination of the draft recommendations, which will be revisited again in April for a final vote.

So, Brian, you looked poised to begin. Please go ahead.

MR. O'DONNELL: Good afternoon. In this session, we are continuing to examine ways to address the rapid growth in Part B drug spending. In particular, we will be discussing a package of policy reforms that the Commission has been developing over the last two years and that was most recently refined based on the Commission's feedback from the January meeting.

The goal for our discussion today is to solicit feedback on the Chairman's draft recommendation, with the intent of having final a recommendation ready for a vote during the April meeting.

In terms of background, I know this information is not new to the Commission, but it's worth reviewing a couple basic facts regarding Part B drugs as they help motivate our discussion today.

First, Medicare spent $26 billion on Part B drugs in 2015, with the program paying $21 billion and beneficiaries being responsible for $5 billion.

Beyond the magnitude of expenditures, the Commission's interest in reforming the payment structure of Part B drugs over the last several years has been driven by a couple of concerns, including potential incentives under the ASP+6 system for providers to choose higher-priced products and the rapid growth in the prices of and expenditures for Part B drugs.

In fact, Part B drug expenditures grew 13 percent from 2014 to 2015, the most recent year for which we have complete data. This growth rate is part of a longer-term trend as well. From 2009 to 2015, growth in Part B drug expenditures averaged 9 percent per year, which far outstrips the growth in the economy and many other health care sectors over the same time period.

Part of that growth has been driven by price increases. For example, from 2009 to 2013, half of the growth in expenditures was driven by price growth, which includes price increases for existing drugs and a shift in the mix of drugs to higher-priced products.

This next slide gives some broader context for how our package of reforms could fit together and the potential timing of the reforms. As the figure shows, our first set of reforms is aimed at improving the current ASP system and can be implemented almost immediately.

The Commission has also expressed substantial interest in a longer-term reform, which is the creation of an alternative, voluntary program that providers could choose to enroll in instead of remaining in the traditional buy-and-bill system. The design of this new market-based program, which we refer to as the Drug Value Program or DVP, is informed by Medicare's experience with the competitive acquisition program for Part B drugs, with several key improvements. Kim will discuss the details of the DVP later in the presentation.

Also, as part of the transition to the DVP, the current ASP add-on of 6 percent could be reduced to give providers an incentive to enroll in the DVP.

Now I will start walking through the specific policy reforms, beginning with improving ASP data reporting.

As we discussed in January, only manufacturers with Medicaid rebate agreements are required to report their ASP data. Some entities, such as repackagers and manufacturers of drugs that are considered devices by Medicaid, do not have Medicaid rebate agreements and are, therefore, not required to submit ASP data. Also, some manufacturers who are required to report ASP data fail to do so in a timely manner.

A policy reform for the Commission to consider is requiring manufacturers to report ASP data for all Part B drugs and increase the civil monetary penalties for failing to report the data in a timely manner.

As part of this policy, the Commission could consider giving the Secretary the authority to exempt special cases from reporting. For example, repackagers, entities that buy and then repackage drugs into smaller doses, could be excluded from reporting to ensure drugs are not double counted (as repackagers' drugs would already be included in another manufacturer's ASP submission).

Our next issue is drugs that are paid based solely on manufacturers' list prices, which is referred to as the wholesale acquisition cost or WAC. Importantly, WAC-based prices do not incorporate discounts that manufacturers commonly provide.

New single-source drugs and the first biosimilar to a reference biologic can be paid at WAC+6 for nearly three quarters because ASP is based on the first full quarter of data and there is a two-quarter lag due to data reporting.

Our analysis found that for a subset of new, high-expenditure drugs, small discounts were common while the drugs were WAC-priced. Consequently, Medicare currently pays more for the same drug when it is WAC-priced compared to when it is ASP-priced.

To bring WAC-based prices and ASP-based prices for the same drug closer together, the Commission discussed the possibility of reducing the WAC add-on by three percentage points, roughly the high end of the discounts we observed.

In addition, to maintain parity to ASP-priced drugs in the future, the WAC add-on could be further reduced if the ASP add-on is reduced to encourage enrollment in the DVP. For example, if the ASP add-on is reduced by one percentage point -- going from 6 percent to 5 percent -- then the WAC add-on could be reduced by the same amount -- going from 3 percent to 2 percent.

Now Nancy will now take over with a discussion of the ASP inflation rebate.

MS. RAY: Thank you, Brian.

Growth in the ASP payment rates are driven by manufacturer pricing decisions. There is no statutory limit on how much Medicare's ASP payment for a product can increase over time. For example, between 2010 and 2017, about half of the top 20 highest expenditure Part B drugs had annual price growth of 5 percent or more.

During the October and January meetings, we discussed improving the Part B ASP system by implementing an ASP inflation rebate. This policy would require manufacturers to pay Medicare a rebate when ASP growth exceeds an inflation benchmark. Under this policy, the savings from rebates would be shared with the beneficiary by basing cost sharing on the lower inflation-adjusted ASP. The provider add-on payment would also be based on the inflation-adjusted ASP.

To address the concern about CMS administrative resources to implement a rebate, lower-cost drugs could be excluded from the policy. Also, duplicate discounts could be avoided meaning that the ASP inflation rebate could exempt Medicare utilization already subject to a 340B discount or Medicaid rebate.

An inflation benchmark would need to be chosen. It could be CPI-U like the Medicaid inflation rebate, or an alternative could be considered. If an alternative is chosen, a principle that could be considered is that the inflation benchmark be in a similar range to the annual payment updates received by Medicare providers.

Next, under the current ASP system, to promote maximum competition the brand drug and its generics are in one billing code, and all biosimilars associated with the same reference biologic are paid in one billing code. By contrast, we do not have maximum competition for most single-source drugs and for reference biologics because they are each paid under their own billing codes.

It is widely recognized that separate billing codes do not maximize price competition, and your briefing paper provides examples.

In more than one policy area, the Commission has held that Medicare should pay similar rates for similar care recognizing clinical differences. For example, the Commission has recommended site-neutral payments for certain services across the physician fee schedule and the hospital outpatient department, as well as for select patients across long-term-care hospitals and acute-care hospitals.

During the October and January meetings, we discussed improving the Part B ASP system by implementing a consolidated billing code policy for the reference biologic and its biosimilars.

This policy would require the Secretary to group the reference biologic and its biosimilars in the same billing code and pay them the same rate based on the volume-weighted ASP for the products in the code. To group the reference biologic and its biosimilars, the Secretary would rely on the FDA approval process for biosimilars established by the Biologics Price Competition and Innovation Act of 2010 to determine what products to group together.

Under a combined billing code policy, the clinician would continue to have the choice to prescribe the most appropriate product for the patient, with Medicare's payment based on the volume-weighted ASP of all the products assigned to the code. The Secretary could be given the flexibility to implement a limited payment exception process under which Medicare would reimburse the provider based on the ASP of the higher-priced product. A limited payment exception process addresses the concern that beneficiary access could be harmed if some providers are unwilling to supply the higher-cost product to a beneficiary who needs a particular product due to clinical reasons.

While there was most consensus for using a common billing code to pay for a reference biologic and its biosimilars, there was also some consensus for using consolidated billing codes more broadly beyond the reference product and its biosimilars. The text in the draft chapter will include language encouraging the Secretary to examine the potential of using the consolidated billing code policy for groups of drugs with similar health effects and for groups of biologics with similar health effects.

And now Kim will take you through the Drug Value Program.

MS. NEUMAN: The policies Nancy and Brian just discussed would seek to improve the current ASP payment system. Next we will talk about developing a second system, which would be a voluntary market-based alternative to the ASP buy-and-bill system.

This policy would give the Secretary the authority to create a Part B Drug Value Program that would use private vendors to negotiate prices and offer providers shared savings opportunities.

The Drug Value Program, or DVP, would be informed by lessons learned from the former competitive acquisition program for Part B drugs, but structured differently to increase vendors' negotiating leverage and encourage provider enrollment.

The DVP would be voluntary for physicians and outpatient hospitals. Each year these providers would decide whether to enroll in the DVP or remain in the ASP buy-and-bill system.

To encourage providers to enroll in the DVP, the

ASP add-on would be reduced gradually in the buy-and-bill system. The reduction to the ASP add-on could be timed to coincide with the target date for operationalizing the DVP. The add-on reduction could begin by that target date regardless of whether the DVP has been operationalized to create pressure for implementation of the DVP.

The DVP program would involve a small number of private DVP vendors. This would give providers a choice of which DVP they wanted to work with while consolidating volume among a small number of vendors in order to facilitate negotiating leverage.

The DVP vendors would negotiate Part B drug prices. DVP prices would be kept confidential. DVP vendors would not directly ship product to beneficiaries; rather, providers would buy drugs in the marketplace from distributors, wholesalers, or directly from manufacturers at the DVP-negotiated rate.

In terms of Medicare payment rates, providers would be paid for drugs at the DVP price and would continue to be paid for drug administration services under the physician fee schedule or the outpatient prospective payment system.

An important feature of the DVP program would be shared savings opportunities for providers. If the DVP program resulted in lower total cost of Part B drugs, enrolled providers would share in those savings. Beneficiaries would also share in savings because they would pay lower cost sharing.

Vendors would be compensated through an administrative fee, which might be a fixed dollar fee or a fee per enrolled provider, or a combination of approaches. Vendors would also be eligible for shared savings if the DVP resulted in lower total cost of Part B drugs and they met standards for promoting quality or met other performance benchmarks.

We've talked about this model as being similar to a GPO. But one key difference is that Medicare would share in the savings under the DVP; whereas, it does not share in the savings under existing GPOs. With the DVP model, Medicare shares in savings because the Medicare payment rate for the drugs under the DVP would be set at the DVP-negotiated rate.

One of the challenges that the prior CAP program faced was that vendors had little leverage to negotiate discounts. With that in mind, the DVP would be structured to include several tools to increase negotiating leverage.

First, private vendors would be permitted to develop a formulary. We would expect that a formulary would spur price competition among products with therapeutic alternatives -- for example, when there are multiple brand products in the same therapeutics class -- and this would result in lower prices for these products. Recall that a problem with the CAP program was that CAP vendors had to offer all drugs, giving them little negotiating leverage. Permitting the DVP vendors to operate a formulary would address this.

Second, prices under the DVP would be limited to no more than 100 percent of ASP. This would ensure that vendors can get at least typical market prices for all drugs.

Third, vendors could be permitted to use additional tools like step therapy and prior authorization.

Fourth, binding arbitration could be used in the DVP for expensive drugs without close substitutes.

A couple other key elements of the DVP structure:

DVP prices would not be included in the

calculation of ASP in order to give vendors more negotiating leverage with manufacturers.

Finally, it will take time to develop the DVP so it could be phased in beginning with a subset of drugs where the savings potential appears to be greatest and which are most straightforward to implement.

In the description of the DVP program we just went through, we talked about reducing the ASP add-on in the buy-and-bill system to encourage DVP enrollment.

At the January meeting, there was some conversation about the sequester, which reduces the provider's payment from 106 percent of ASP to 104.3 percent of ASP and the implications of this for reducing the ASP add-on.

In our June 2016 report, we had some work that was relevant to that discussion.

In that report, to get a sense of how the prices providers pay for Part B drugs compare to Medicare payment rates, we analyzed proprietary invoice price data from IMS Health Incorporated. These data break out prices for the clinic channel of purchasers, which includes physician offices, hospital outpatient departments, and certain other purchasers. The IMS invoice prices reflect all on-invoice discounts but do not reflect off-invoice rebates.

Our analysis found that for two-thirds of the 34 Part B drugs we examined, at least 75 percent of the volume was sold to clinics at an invoice price less than 102 percent of ASP.

In addition, we looked at pricing data for the quarters before and after the sequester went into effect and found that manufacturers appeared to alter their pricing patterns in ways that mitigated the effect of the sequester on some providers.

To make the DVP program more concrete, here is a hypothetical example of how it would work. In this example, we have a drug with an ASP of $500. The DVP vendor in this example negotiates a price with the manufacturer of $400.

Providers enrolled in that DVP would buy the drug in the marketplace from wholesalers or distributors and would pay $400 per dose for the volume they estimate will go to Medicare beneficiaries.

Once the provider administers the drug to a beneficiary, the provider will submit a claim to Medicare for the drug and for drug administration services.

The provider payment rate for the drug would be $400, the same amount as they purchased the drug for.

The provider would also continue to be paid for drug administration services through the physician fee schedule or outpatient prospective payment system.

In addition, the provider would have an opportunity to share in that $100 savings that comes from the drug costing $400 instead of $500. Also, beneficiaries would save in this example through lower cost sharing.

From a technical perspective, one thing to note is that there'd be a retroactive true-up that would occur between the provider and the distributor or wholesaler after the drugs are administered to identify the quantity supplied to Medicare fee-for-service patients and ensure that the price paid for that quantity was $400.

So next we'll move to the Chairman's draft recommendation, and as you see, we've put up the overview slide one more time. This gives you sort of a visual picture of the potential policy and how all the pieces work together.

So this brings us to the Chairman's draft recommendation, and that reads:

The Congress should change Medicare's payments for Part B drugs and biologicals as follows:

(1) Modify the average sales price system in 2018 to:

Require all manufacturers of products paid under Part B to submit ASP data and impose penalties for failure to report.

Reduce wholesale acquisition cost-based payment to WAC plus 3 percent.

Require manufacturers to pay Medicare a rebate when the ASP for their product exceeds an inflation benchmark, and tie beneficiary cost sharing and the ASP add-on to the inflation-adjusted ASP.

Require the Secretary to use a common billing code to pay for a reference biologic and its biosimilars.

(2) No later than 2022, create and phase in a voluntary Drug Value Program that must have the following elements:

Medicare contracts with a small number of private vendors to negotiate prices for Part B products.

Providers purchase all DVP products at the price negotiated by their selected DVP vendor.

Medicare pays providers the DVP-negotiated price and pays vendors an administrative fee, with opportunities for shared savings.

Beneficiaries pay lower cost sharing.

Medicare payments under the DVP cannot exceed 100 percent of ASP.

Vendors use tools including a formulary and, for products meeting selected criteria, binding arbitration.

(3) Upon implementation of the DVP or no later than 2022, reduce the ASP add-on under the ASP system.

In terms of implications, the draft recommendation would be expected to result in lower payment rates for Part B drugs and decrease program spending relative to current law.

In terms of implications for beneficiaries and providers, the draft recommendation would: generate savings for beneficiaries through lower cost sharing and would not be expected to affect beneficiaries' access to needed medicines.

In terms of the effect on providers' revenues, for providers choosing to remain in the ASP system, the ASP add-on payments would be reduced but the effect on providers' net revenues would depend on how manufacturers respond to the policy.

For providers that choose to enroll in the DVP program, they would be paid the DVP price for the drug and would have shared savings opportunities.

Beyond the specific text of the Chairman's draft recommendation, we would intend to add in the June report additional text to reflect more detail about certain issues or to reflect conversations that occurred among Commissioners about alternative approaches or ideas that could be explored further.

For example, on the ASP inflation limit, the Commission discussed two approaches: a manufacturer rebate and a provider payment limit. Although both approaches have merit, there has been broader Commissioner support for the manufacturer assuming financial risk for price increases rather than the provider. So the Chairman's draft recommendation specifies a manufacturer rebate, but the text of the report would mention there is another way to structure the policy and discuss the pros and cons.

On consolidated billing, as Nancy mentioned, the text would encourage the Secretary to examine the potential for consolidated billing codes more broadly beyond biosimilars and reference biologics.

The text would also discuss the timing of gradually reducing the ASP add-on from 6 percent to 3 percent and would make the clear that the WAC add-on would be reduced further as the ASP add-on is reduced.

Finally, the text would discuss in more detail design options for binding arbitration under the DVP.

So that concludes our presentation. We'd be happy to answer questions and look forward to your discussion.

DR. CROSSON: Thank you, Kim, Nancy, Brian. We now have the opportunity for clarifying questions.

DR. SAMITT: So starting on Slide 13, you talk about the fact that DVP prices would be excluded from ASP. Can you play back a little bit more of the implications of that? As the DVP utilization grows, what implication will that have on ASP pricing? And does that lead to any dynamics that we would need to be cognizant of?

MS. NEUMAN: So ASP reflects the price paid to all purchasers with certain exceptions, and one of the exceptions would be DVP prices. So as the DVP became larger and got greater volume, that would mean that the Medicare volume that is effectively in the ASP would be there no longer. And so you might wonder, is there enough volume in there to calculate an accurate ASP?

Since there are other payers besides Medicare in the marketplace and other types of purchasers, you would think that you would generally still have a solid ASP. But, you know, we'd have to think about on a product-specific basis if maybe -- you know, you could imagine there could be situations where there could be an issue, but, by and large, because there's other purchasers and other insurers, we should still have data to be able to calculate the ASP.

DR. SAMITT: Okay, thanks. And my second question is on Slide 15 on your example. You talk about provider opportunity for shared savings, and I assume the implication here is that the shared savings percentage would be sufficient enough to incent the use of DVP against the alternative of the buy-and-bill. So, in essence, I think what we would be looking at is, you know, you could do the math, that 6 percent of 500 is $30, that the shared savings would need to represent at least 30 percent to -- you know, as a provider is thinking of alternatives A or B, that we would need to compare and contrast the two.

MS. NEUMAN: And with the ASP add-on effectively being ramped down, that 30 would go down a bit to sort of help with that calculus.

DR. SAMITT: Got it. Thank you.

DR. CROSSON: Clarifying questions, coming up this way.

MR. PYENSON: A question for Nancy on the inflation index. On the bottom of page 26 to the top of page 27, you suggest a principle that could be considered for the inflation index benchmark is similar in range to the typical payment updates received by other providers in the Medicare program, particularly physicians and hospitals that purchase these drugs. And my question is whether there's other principles that you've thought of that could be applied here. And what prompts my question is that for sure in the Medicare payments for many kinds of services, some services have -- the payment rates have gone down, including dramatically. So the Medicare system has a way of identifying fees that should be decreasing over time, and whether that's a -- if there's a principle that you could -- other principles that you've thought of other than this one.

DR. MILLER: What do you want to do, Nancy? Do you want to take it, or do you want me to?

MS. RAY: Why don't you take it [off microphone].

[Laughter.]

DR. MILLER: Okay. No, I could see the -- but jump in, okay, because I see you were hesitating a little bit.

I would say one of the reasons that this principle is expressed and written very directly is it came out of a comment that Warner made in one of our conversations, well, wait a second, you know, if the drugs are allowed to grow at this rate and my rates only grow -- you know, shouldn't there be some symmetry there? And we were trying to capture that as probably the strongest and clearest statement on this front that, you know, folks said. We're still open to discussion, and, also, we're not taking a very hard line on what the index is. We're using one for illustrative purposes.

Other principles here, you could think about what index, you know, reflects affordability and, of course, how you define that and what that would be I think is, you know, hours of conversation. You could try and capture an index that talked about, you know, the cost of production, but at that point in time, you know, the production of a drug or a biologic is very different than the development. And, again, thinking through all of that I think could be hard. But there's other principles you could try and pursue. I think what we're trying to do is some reasonable proxy for inflation and also being mindful of what Warner said in a different meeting.

Nancy, am I close?

MS. RAY: Yeah, I guess the other item you could throw out there perhaps is, just like we do for other providers in fee-for-service, some sort of principle to promote efficiency.

DR. MILLER: Yeah.

DR. CROSSON: Paul, on this?

DR. GINSBERG: I was going to raise this in our next go-round, but one of my thoughts is that it would be very useful in the chapter to have some conceptual thing on why there is a need to constrain price increases for existing drugs. And, you know, the framework that I am thinking in terms of is that the market out there for prescription drugs has changed a great deal in the past 15 years, mostly because of better coverage. We have Part D in Medicare. We have out-of-pocket maximums in commercial insurance and in the ACA insurance that apply to drug spending as well as hospital physician services.

So, in a sense, a lot of the demand restraints in the market has been removed. And what would you expect? You would expect that, you know, the equilibrium price, which we may not think is wise, is likely to go up. And that is why we are seeing some of these substantial increases which cannot be driven by production costs, because in many cases -- because, you know, the fixed cost of developments were already reflected in the introductory price and we are just talking about increases.

So I think just some reasoning in the report about why the rates of increase are just not consistent with our notion of an efficient market. This is really an adjustment to a market that has very little demand constraint, and that is the reason we are getting into this.

DR. CROSSON: And what I am hearing also -- what you are saying is that the dynamics of this market are further deteriorating as a function of demand change.

DR. GINSBERG: Right.

DR. CROSSON: Okay, so now a new one on this.

MS. WANG: On this.

DR. CROSSON: Oh.

DR. MILLER: No. Bruce, I think, was still --

DR. CROSSON: Oh, Bruce, you were still -- yeah.

MR. PYENSON: Just as a follow up, what is different about Part B drugs in particular? I am wondering if this was part of the considerations that Part B drugs are not a consumer-facing service, not nearly in the same way that a physician's service is or even a hospital service. So, I think some of the analogy is perhaps more like producer price or wholesale price as it is sold to the physician.

So, as we think about it, I think Paul's suggestion would be very helpful, but to have -- I am curious about this thinking about consumer versus producer or wholesale.

DR. CROSSON: Okay, clarifying questions. Pat.

MS. WANG: Kim, can you talk about how Medicare Advantage participants are not in the DPP in your --

MS. NEUMAN: So the model, as we have constructed it thus far, is a fee-for-service model to this point.

DR. MILLER: Yeah, the presumption here is that, you know, the MA plans right now may have their own ways of kind of purchasing, negotiating drugs. They are getting a capitated rate that encompasses all A and B, and they may have their own, you know, strategies for purchasing drugs and we do not have to cross into that area.

MS. WANG: Can I request --

DR. CROSSON: Let me just say there is one element in our set of recommendations that is a tool that is not available to MA plans right now, and that is binding arbitration. But otherwise, for the most part, the MA plans right now are capable of negotiating and, for the most part, using the tools that we envision in the fee-for-service model.

MS. WANG: Can I ask for a little bit more thinking or research into this? I mean, part of what you are describing is the dynamic that occurs with Part D. But Part B, being a provider-driven acquisition process, is --

I am not sure that most MA plans have any participation in the purchase of Part D --

DR. CROSSON: Yeah. And I apologize because I am thinking of a certain model, or I am used to --

MS. WANG: Yeah.

DR. CROSSON: -- being as a physician.

DR. SAMITT: Well, and to tag on to that, I think the question is could we consider suggesting that prescribers in MA plans could acquire drugs through the DVP program as well? If the infrastructure is being created, wouldn't we want to encourage the same prescribers to acquire drugs through the same vehicle as DVP?

DR. CROSSON: Yeah. I mean, it would seem to me to be reasonable, yes. I am sorry for the confusion. I made a mistake, yeah.

Amy?

MS. BRICKER: My question was similar to what I thought Craig was asking. But further, if I am a physician or a buyer today and I am contemplating joining the DVP or not, I would assume that the majority of the people that would raise their hand are the ones on the wrong side of ASP, bringing the average up.

And so, is that the right way to think about it, that if I am a buyer that is doing well, if I -- you know, with ASP I am actually making money when I am reimbursed to ASP because I am a sophisticated buyer, I am less likely to probably join the DVP until such time that ASP reimbursement is no longer attractive to me. And so if am thinking about that right, then the largest buyers that have the most share and the most clout would hold back, not enroll as quickly in the DVP. Is that the right theory, or no?

MS. NEUMAN: I think that, in general, that is sort of the incentive on the margin, right, that the smaller purchases who might not be getting as favorable a price might find the DVP more attractive relative to fee-for-service than the larger purchaser. And so, that might happen as you are sort of laying it out.

I think that the unknown is, you know, to what extent can formularies and other management tools for some of these very expensive products lead to large savings? And if that is the case, then the DVP could be attractive as well to some of these bigger purchasers because they might be purchasing a bit below, but if you could get substantial savings for the DVP there might be sharing opportunities that are attractive to them in the DVP program.

DR. MILLER: Can I get you to continue one more round on this, just like -- in the middle of what you said, you said something about it being more expensive as a result of it. So just for the moment, stipulating to it is the small practice who is on the wrong side of ASP who jumps, where is the additional -- when you said -- what do you think happens when that happens? Could you add a few words on that?

MS. BRICKER: So in order for the DVP to be successful, you need the lives, you need the participation. You need to be able to go to the manufacturer and say, I am representing a large population of --

DR. MILLER: Ten-thousand lives.

MS. BRICKER: -- buyers, right, or large health systems, right?

And so, presumably -- I am just thinking, if I am a very large, sophisticated entity, and ASP reimbursement I am absolutely fine with -- even if you cut it by a couple percent I am going to wait and see; this is still profitable to me -- I am making an assumption -- then I am not going to be as interested in moving into DVP. So the ASP, how does ASP change over time if the bad buyers come out of the ASP calculation and they go sit in DVP? Does DVP -- is it able to be successful with just the small fish?

And so, how do we think about the structure of kind of in the in-between and what we think the tipping point would be so that it would actually be beneficial?

DR. MILLER: I will answer what I think needs some close attention here. I will answer what I think are the easier parts of your question. And then the tipping point, I do not know.

So out of the distribution, if this is the distribution around ASP, and this is the middle here with the mean, you would expect people who are not doing well as ASP to move over to DVP, let's say. That would lower the average on this side. Over here it is the big fish, little fish concept: Well, as a little fish I could not get this price, but as 10,000 of us little fish, now can I get a lower price on the DVP? The tipping point? We are making a market here. I do not know.

And I think you are right, like, the big purchaser that you are talking about, at first blush -- you know, if I am extracting -- I am at this end of the distribution, I may not have a lot of reason. And I think in some ways Warner has been saying things like: I am in a GPO. I am getting -- well, whatever. You know, I may be already getting my discounts.

And then, I think what Kim was saying is it depends. If you really thought you could bring some clout, there may be some, you know, shared savings there. But I think our initial response would be people on this side of the distribution would have the first incentive to jump and not be little fish anymore.

MS. BRICKER: Because the way it is structured -- and if I understand it, you are saying in the DVP you would never pay more than ASP. And if ASP is actually not a reflection of the big fish buyer, are we in fact just setting pricing at the big fish average?

DR. CROSSON: Setting the ceiling, not the actual price?

MS. BRICKER: Right.

MS. BUTO: Yeah, but the big fish get the biggest discount.

MS. BRICKER: Right.

MS. BUTO: So ASP should probably go down in that calculation.

MS. BRICKER: Right. Yeah.

MS. NEUMAN: We would expect it to go down a bit.

DR. CROSSON: You know, and I think, Amy, the other implication of your point -- and we will get to this a little bit later -- has to do with the other side of the dynamic, and that is when, on a calendar basis, and how quickly the ASP is taken down, because arguably the earlier and the more rapid production in the ASP add-on, the more that balance begins to tilt. And we have a choice to be made there as well.

MS. BRICKER: Okay.

DR. CROSSON: Clarifying questions?

DR. DeBUSK: I had a -- on a related --

DR. CROSSON: On this point, Brian?

DR. DeBUSK: On this point.

Amy, to your earlier observation, let's say we did take down that top 20 or 25 percent of the least sophisticated, highest-priced buyers. Well, they would disappear from the radar screen because, you know, their new price is not used in the ASP calculation anymore. So you would get immediate ASP reductions.

Well, then I would think -- back to your comment about the institutional buyer, they are used to operating on a margin. They are used to being able to buy X points better than ASP. Well, when ASP slips, my guess is that the sophisticated buyer comes back now and says: Make me whole. I want that margin back.

Well, that creates a second wave that would push ASP ever further, which would actually bounce back into the DVP. You have actually created a positive feedback there as the institutional buyers want to maintain that spread. So I think there is actually a virtuous cycle here that would continue to help pricing.

DR. CROSSON: Another question?

MS. BRICKER: I was just thinking about it in terms of if I am a manufacturer and I have mapped all this out -- and we have just outlined exactly, for them, what we think will happen anyway, so they do not really have to map it out -- how likely am I to provide some great discount to this DVP when exactly what you just said is going to happen with the ones that are actually my largest buyers?

DR. DeBUSK: Well, I think the plan was they had to sell into the DVP at ASP. So you are going to lose that top 20 or 25 or 15 percent of your premium customers the day DVP is available, presumably because they would want to access the better pricing.

DR. MILLER: I think the other thing I would say is that -- and, you know, we are making something here, so, right, with all those caveats, is you could say, you know, I am not going to provide this discount because I am worried about this cycle. But if there are four or five, you know, drugs or bios that could be used there and they say, okay, I will go on to the manufacturer -- I mean, I will go on to the formulary, then you are frozen out of that percentage of the market that has actually jumped.

So part of this, as we see, is, you know, if there is a set of name brands or bios that could be used here and the DVP comes along and says, you know, I will take one or two of you, then that is -- you have got to be looking over your shoulder to see if everybody is going to go, no, we are not doing this, or somebody decides, I am going to jump and take the market share.

The other thing I will just say, with all respect to Bruce, is Bruce has also said, yeah, and do not forget there may be some generic competition here. I described everything as name brand and I know Bruce has some other views on that, but just out of respect.

DR. CROSSON: Okay, clarifying questions, coming down this way. Alice and Jack, and we will proceed down.

DR. COOMBS: I will be quick.

On page 25, last paragraph, you allude to the issue regarding manufacturers' exemption from multiple rebates, and I just wanted you to talk a little bit about when there is Medicaid -- there is a Medicaid stipulation for rebates as well as the overlap between Medicaid and Medicare. You make a statement and I was just wondering if you could kind of map that out.

MS. NEUMAN: So right now how it works is that if you have got a dual-eligible who is getting a drug in a 340B hospital, there is not two discounts. There is either they get it at the 340B price or the manufacturer pays a Medicaid rebate, but not both. And usually it is the provider who decides how they want to handle it.

And so this policy here, which is for using the same principle to say that, you know, with the Medicare inflation rebate we would not be subjecting the Medicare utilization to two or three rebates. It only would get -- the manufacturer would only need to provide one.

DR. COOMBS: I am curious as to does Medicare know whether that is a 340B versus a Medicaid rebate? Does that matter at all?

MS. NEUMAN: So HRSA has a list of the 340B hospitals, so Medicare can know if it is a 340B hospital or not. And then there is information as well on who are duals and not. So there would be ways to structure this to be able to effectively exempt utilization that is getting those discounts.

DR. CROSSON: Alice, are you still unclear?

DR. COOMBS: Well, I can ask in Round 2 the significance of that, why --

DR. CROSSON: You mean in a later round? Okay.

Jack?

DR. HOADLEY: So, I am just trying to make sure I understand exactly what the chairman's draft recommendation includes. So, on Slide 17 on the inflation -- I think this was clear in the earlier conversation, but the recommendation is not picking a particular inflation benchmark; it is just saying use one. And then we will have text that talks about there being these various alternatives, right?

DR. CROSSON: Correct.

DR. HOADLEY: And then, secondly, in the discussion we talked about potential exclusion of lower-priced drugs and I do not see any of that language here. So that is another thing that is --

DR. CROSSON: In the text?

DR. HOADLEY: Text.

DR. CROSSON: As you can imagine, there is a fair amount of supportive text --

DR. HOADLEY: Yep. Okay, thank you.

DR. CROSSON: -- including, you know, on the slide --

DR. HOADLEY: The other alternatives.

DR. CROSSON: Slide 20, you know, other alternative directions.

DR. HOADLEY: And I will come back to that in Round 2.

DR. CROSSON: Yeah. Okay.

Clarifying questions? Sue.

MS. THOMPSON: I want to go back to Amy's point that she was thinking and asking the question about the tipping point, and just calling out the change management strategy of making DVP a voluntary alternative.

I am wondering if, just for purposes of discussion, taking the discussion to the extreme of it not being voluntary but rather this is how it -- this is how we will operationalize payment for Part B in DVP so we get the full benefit of the Medicare numbers and not this sort of incremental -- I am just wondering, have we thought about that, and thinking a little bit more about the why voluntary and what is the thinking behind that change management strategy and the potential that it could fail because there will not be enough buy-in quickly enough.

DR. MILLER: I think you --

DR. CROSSON: Do you want me to take it?

DR. MILLER: Well, I think you and I are taking it.

DR. CROSSON: Yeah.

DR. MILLER: And I will do it, or you -- whichever way you want.

DR. CROSSON: Well, I will start and then you can do it right.

[Laughter.]

DR. MILLER: I do not know that there is a right answer.

DR. CROSSON: So we did consider this. From the earliest time when Kathy first suggested let's take a look at the CAP program, you know, we looked at the elements of it and what we thought were the strengths and weaknesses of that. And the fact that it was voluntary was potentially a weakness of it, compared with making it mandatory, very much for the reasons you say.

Then you have to consider, you know, kind of the feasibility -- and I mean this both from a modeling perspective and the ability to, you know, have this policy, you know, enacted. You know, one, mandatory is potentially viewed one way by actors in the industry and other policymakers and people who are determinative in this process. And, you know, doing it on a voluntary basis and constructing it in such a way -- and some of the elements that we have here I believe are constructing what is a new market-driven mechanism that, you know, over time shifts power to the DVP -- you know, power or influence or acceptability, or all of those things -- versus the old buy-and-bill system.

So it is a design element and a design choice that you are absolutely correct to raise, because we could have gone in the other direction. And there are, as you say, strong arguments for doing that. In the end, I think we felt that the arguments for doing it in this way, particularly if we constructed the DVP in such a way that it had, you know, significantly more impactful tools than certainly the CAP model -- so, for example, you know, a formulary, other tools such as are used more broadly with respect to managing drug costs.

And then the added issue to try to deal with the launch price problem because, you know, one of the difficulties we had in putting this all together was that if, in fact, we put in an annual cap, the first objection -- we have not gotten to that yet, but the first objection we heard to that was, well, that will simply blow back into higher launch prices. But if we also have, on the DVP side, the ability in certain circumstances with certain drugs at certain price levels to implement mandatory binding arbitration, then that further strengthens that model.

So it was a judgment call as well, and I perfectly understand the argument that you are making. Does that --

DR. MILLER: I do not think I would add anything. We were trying to leave choice for the provider, you know, but that is implied in everything that he said.

DR. CROSSON: Clarifying questions? Warner?

MR. THOMAS: On Slide 15 you give an example of the DVP negotiating a price -- $400 versus ASP at $500. Have you thought about, or has there been any estimation on what you think the discount might be from ASP, because that shows a pretty material differential. And I just want to know, is that illustrative? Is that where you think this could go directionally? Have we thought about what that might look like?

DR. CROSSON: Personally, I think it would be unfair to try, because, you know, we are setting up a different marketplace.

MR. THOMAS: Right.

DR. CROSSON: We do not know the questions about what the volume of this would be, how fast that volume would come up, what the mix of incentives between buy-and-build and the DVP would be. And I think to hazard a guess -- even for me to say what I actually think is that over time it would grow to be pretty significant has no basis in fact.

[Laughter.]

DR. MILLER: And just in case, you know, it is not clear to anyone else, yeah, the $500 and $400 are not real numbers. We are trying to do simple math just to sort of give people a sense. And I know you know that, but now that you mentioned it I want to make sure everyone else knows that.

MR. THOMAS: And then just -- I should know this, but just to clarify, so on -- for Part B and D, or the ASP+6 is used in this pricing. How does that compare to, you know, Part D and then Part A as far as -- is that consistent across all of those, or how -- what are the differentials there between Part A, B, and D?

MS. NEUMAN: Are you asking the differentials in the payment rates across those?

MR. THOMAS: Yeah, so the ASP+6, is that -- you know, how does that compare across the different components of Medicare, roughly?

MS. NEUMAN: So, I do not know that we have a direct comparison of the Part D and Part B prices, in part because we do not have rebate information on the Part D side to be able to say that. And then on the Part A side, I think that the payments are generally bundled, so there is not a sort of separate payment rate to compare to.

DR. CROSSON: Let me try it conceptually. And sure I am going to make some conceptual errors here. Please point them out immediately.

MR. THOMAS: It is probably a bad question anyway, so --

DR. CROSSON: But fundamentally, at least in my mind -- and I think this applies, for example, to hospital payments better than some others, Warner, but the notion is that Medicare tries to pay on the basis of what it costs to deliver the services and then with some reasonable margin, right? In this particular case, the payment is based upon the putative cost, which is ASP, but in fact we know that purchasers -- physicians, hospital purchasers -- are purchasing a drug for less.

In addition, there is the administrative fee. And as I think we have mentioned in the presentation, we are not suggesting the administration fee, or whatever is the proper term, should be changed. But in Part B we ended up with this additional idea, and that was that there was going to be -- of course, as there are -- a mix of purchasers purchasing at different prices.

And we wanted to avoid the situation where some physicians in this case, particularly smaller physicians, were put in the position of having to purchase the drug at a loss, and so 6 percent was added onto the ASP to kind of cover that distribution curve with the notion that even the least-able negotiators among the physicians would at least not have to purchase that drug and administer it at a loss.

The problem for the Medicare program with that model is that you can imagine that, as a consequence of trying to deal with the physicians and prevent them from providing the drug at a loss, Medicare is expending huge amounts of money for that 6 percent coverage. And that is money that, from my perspective anyway, even though I understand well it is built into the income expectations at the moment, the revenue expectations, that money is, in fact -- a large portion of it is simply wasted and could be used more effectively and more efficiently for Medicare beneficiaries in other ways.

Yes, Amy, on this point?

MS. BRICKER: Yes.

So, yes, you do not have that rebate information, but Part D is reimbursed off of AWP, which is a derivative of WAC. So you could compare -- every drug has a WAC. You could compare the difference, on average, of what ASP on a given drug is, and then also reimburse it or reprocess it as a discount off of AWP. I am happy to give you some, you know, range of, on average, what those contracts look like.

Yes, you are right, it would not have the plan cost in total, but what the provider is paid in Part D would be known as a comparator to B. Does that make sense?

MR. THOMAS: I guess the actual answer is we really don't know.

DR. MILLER: No, but wait, because I was surprised that your first answer wasn't this, okay? At least on Part B -- and I'll come to D late, but on the Part B side, the ASP+6 is the same in the physician's office and the same in the outpatient department of the hospital.

Right? Okay. And so I thought you were asking do you pay the same across sectors. Is that what you're asking?

MR. THOMAS: Yes, and.

DR. MILLER: And?

MR. THOMAS: How does that compare to Part A and Part B?

DR. MILLER: Part A?

MR. THOMAS: Yeah.

DR. MILLER: Okay. Then that gets to the bundled part. But I misunderstood A. I thought you were saying hospital -- right, okay.

DR. CROSSON: I thought you were asking a broader philosophical question, which is why are we paying this way for Part B drugs when we pay another way in Part A, another way for the rest of Part B, another way in Part D.

MR. THOMAS: That's the question. That's the question.

DR. CROSSON: What I was simply trying to do was to sell, well, they're different, and it was constructed this way, and I think at the moment, in terms of our policy, we're questioning whether or not that's the right way to do it.

MR. THOMAS: I guess my first question that I didn't know was are they paid -- you know, are they at different rates across the three components of Medicare? And the answer sounds like it's yes.

DR. CROSSON: Yes.

MR. THOMAS: So that was really -- that's the fundamental question.

DR. CROSSON: Different philosophies driving payment mechanisms.

MR. THOMAS: Okay. All right. Thank you.

DR. REDBERG: So the question on -- actually, a footnote on the mailing materials. On page 4, where you're referring to home infusion drugs that were paid 95 percent of AWP, but that's changing this year to now be paid ASP plus percent, I'm just wondering if you could give some examples of -- because I was trying to picture what those were. And if you could then also say how big like a financial market is that and will that change to be paid ASP+6, meaning Medicare is now paying more for those drugs?

MS. NEUMAN: So examples of the drugs are like subcutaneous immunoglobulin, insulin, a few heart products, and there are differential effects up and down across drugs, but in aggregate, the switch to ASP+6 saves money. And I don't have the total dollars, but that's something we could give you, about what the pool was last year.

MR. O'DONNELL: Yeah, and also I'd say the OIG did some good work looking at the top kind of infusion drugs and how the switch from that previous payment policy to ASP+6 affects them.

DR. REDBERG: Great.

MR. O'DONNELL: So it's good it's out there.

DR. REDBERG: Thank you. And two more small -- on page 11 of the mailing materials, in the discussion about WAC, it says WAC is the manufacturer's list price and does not incorporate prompt pay or other discounts. Do you know about how much prompt pay discount usually is? And what are the other discounts that you're referring to?

MR. O'DONNELL: Right. So I think Kim and Nancy have heard that prompt pay can be 1 to 2 percent, so that's what's been kind of refuted. The other discounts are really anything that the manufacturer offers. So, for instance, just as an example, for Zarxio, the discount that we observed was much larger than 1 to 2 percent and is a discount given by the manufacturer. I don't know what you want to call it, but it was a bigger discount than what the 1 to 2 percent kind of prompt pay discounts are.

DR. REDBERG: Thanks. And then the last Round 1, again, from the mailing materials on page 14 -- and you mentioned it also in your presentation -- that some manufacturers of Part B drugs don't have Medicaid rebate agreements, so they're not required to submit ASP data. Do you know about what percentage part of the market that is that's not required as opposed to the ones that are required but just don't?

MR. O'DONNELL: No, I don't.

DR. REDBERG: Thank you.

DR. CROSSON: Brian, do you have a clarifying question? No. Warner.

MR. THOMAS: Just another question. I'm sorry. For the companies that do not report ASP data, how are they reimbursed? How are they paid?

DR. GINSBURG: The physician pays them. This is just a report to CMS.

MR. THOMAS: How is the fee set? I mean, if they don't report ASP data, then how is the fee set that they get paid?

MR. O'DONNELL: Right, so if there's no -- if no one reports the data, which happens in a couple instances -- the OIG has a report on this -- then it's paid at WAC. It can be paid on WAC. Right? And if only, let's say, one out of three manufacturers don't report, then it's just based on those kind of manufacturers who do report the data.

MR. GRADISON: Is there anything preventing a PBM from starting a DVP right now without a change in the law?

MS. NEUMAN: Yes, given how we've structured it with this DVP price lowering the Medicare payment amount, that could not be done without a statutory change.

MS. BUTO: Also, prior authorization and some of the other things couldn't be done without a statutory --

DR. MILLER: The formulary.

DR. CROSSON: Binding arbitration. Are people going for more questions, or are we going to the next round? Pat.

MS. WANG: In sort of examining lessons learned from the voluntary CAP pilot demo, was there any issue with manufacturer participation?

MS. NEUMAN: I am not aware of issues of

manufacturer participation. What I do recall is the vendor reporting issues with manufacturers offering them good prices. That's what I recall.

DR. CROSSON: All right. And, Pat, I read the RTI report as well, and my memory is the same as Kim's.

MS. WANG: So this proposal address that by putting a ceiling price on at ASP. Is that right?

DR. CROSSON: Addresses the question of the --

MS. WANG: Poor pricing by basically saying --

DR. CROSSON: Well, I think it addresses it in a number of ways. It addresses it through the formulary mechanism, which wasn't present in the CAP model. It potentially addresses it as well through the binding arbitration as well.

MS. WANG: I just wonder whether -- and, Sue, you triggered this thought in my mind -- there is any concern about getting robust manufacturer participation. In order to get robust provider participation, there has to be full manufacturer participation.

DR. CROSSON: So you're absolutely correct, this is -- as Mark said earlier, we're suggesting something new, a new business, a new market mechanism, a new Medicare payment mechanism. In anything that is new, there's always the chicken-and-egg problem. You know, now I'm going to go off on this because, you know, for example, Tesla, right? Do you build a battery plant to make 10 million little batteries? Or do you sell the car first and see how many people want the car? And in my mind, these are sort of unknowable market dynamics. Our hope is that the elements, particularly a lot of the detail elements, of how this is constructed and ultimately gets implement will tip the balance in the right direction. But it is by its nature unknowable, I think.

DR. MILLER: In a sense, it does go back to Sue's point, which, you know, do you set this up in such a way that you do your best job of saying, okay, there was this -- and I'm sorry, Alice, but, you know, to try and correct what went wrong on CAP and maybe it will succeed. But if it fails, you still have all of your changes on the buy-and-bill side, so you're not left empty-handed.

I think Sue's point is why aren't you going full force on the other side, and I guess I don't have, you know, an opinion in this group. But, I mean, it's also the fear of like have you designed this in a way that there's actually a there there. And that's, I think, the walk we're trying to walk at this point.

DR. CROSSON: Alice, on this point?

DR. COOMBS: Yeah, I just want to say there was a key factor with the clinicians with CAP, and that was, instead of the logistics of negotiating for price and the doc would go directly to the drug companies, CAP was responsible for acquiring the chemotherapeutic agents and making sure it got to the doctor's office. So patients would show up, and they would not have their chemotherapy or whatever medication they were going to be administered. So that was a key reason why there was a disconnect between the clinician saying, "I don't want to be a part of this CAP program," and so this actually circumvents that in the sense that they can still go to the manufacturers and still maintain that relationship, but now they have a negotiated price for it.

DR. CROSSON: That's correct. And that was another early decision model choice that we made as well.

MR. PYENSON: I think this is a question for Kim. On the section, improving ASP data reporting -- or was that Brian? My question is: How is that audited? This seems to be self-reported data, and even in audited situations, there's lots of choices and decisions to be made, timing and other things like that. So I'm curious if there have been descriptions of the audit process for that from OIG or elsewhere.

MR. O'DONNELL: Yeah, and I think what you just said there is exactly right, and I think I gave a bad answer to -- I think someone asked is there anything known about how often this non-reporting happens, and I think OIG has put out studies, and they've looked at, using multiple data sources, kind of what are the types of entities that don't report, how many NDCs are not reporting on a given drug and things like that. So the OIG does kind of look into the reporting process.

MR. PYENSON: That's on the specific issues of non-reporting and so forth. I guess I'm asking more of a fundamental financial accounting basis and whether there has been financial accounting standards on how this should be reported and whether those are -- because without that, there's lots of different things that could go on.

MR. O'DONNELL: I'll say something, and then I'll let Kim say things. I mean, there are standards for what should be included into the ASP, so it's not just kind of free-wheeling, so certain discounts like prompt pay discounts have to be included in there. But I don't know if you have anything else to add to that.

MS. NEUMAN: So CMS has guidance, as Brian is saying, on, you know, sort of what kinds of discount have to be included and what kinds of service fees can be excluded. You know, there's some broadness to some of those definitions, and the OIG does have authority to audit the actually ASP submissions. And I do know that they have done that from time to time, but we don't have a good window on that process. That's more in their sort of ballpark.

MR. PYENSON: Would that -- and forgive me if this is in here, but is improving that audit process part of the improving ASP data reporting?

MR. O'DONNELL: That's not part of our recommendation.

MR. PYENSON: Thank you.

DR. CROSSON: Okay. I see no further hands for clarifying questions, so we're going to move on to the commentary portion here. Could I just roughly see the number of hands of people who want to comment? So it's most of the Commission.

So let's put up that summary slide of the recommendations -- no, further on, the one that's -- so this is a summary. You can go to the details in the prior slides.

So as we do when we have recommendations on the table, I'm going to ask for comments from the Commissioners, the degree of support for the recommendations that you have in front of you, as well as any thoughts that you may have as to try to improve what we have done, starting with Brian.

DR. DeBUSK: Well, I support the Chairman's draft recommendation both on the changes to the average sales price as well as the DVP. What I'd like to comment on for a moment is the DVP. Obviously, I've been a big advocate for that program.

I think it is a very cleverly designed ratchet to bring pricing down. I think some of the agency issues that you guys addressed in the text where you gave yourself the leeway to do, say, value-based pricing or indication-specific pricing and some of the different permutations on shared savings, I know, you know, that didn't come out in the presentation, but just in the pages around 48 and 49, I felt that was very well done and very well thought out.

My one thought is to show -- we may have to do just one example and show how an ASP would be affected if, say, that top 15 or 20 or 25 percent of the customers did participate in the DVP, just to simply show how that shifts the mean and triggers this downward spiral. Now, it will bottom out, but I think it wouldn't be hard to illustrate how the mean iteratively shifts. And I think a lot of light bulbs would go off because people would realize that you're losing what would be your premium customers day one. And I think that would be very helpful in clarifying what you're doing there.

DR. CROSSON: Thank you. Comments?

MR. THOMAS: So, generally, I'm in favor of the recommendation with some caveats that I think it could go further to do more on the pricing side.

I guess, first of all, on the inflation cap, I come back to that if you look at all the other fees that we are involved in setting, the rate increases have been negative to maybe 1 to 1.5 percent. And if you look at drug pricing, it's been many multiples of that for multiple years. So I would just encourage us to be very disciplined about setting an inflation cap going forward.

On consolidated billing codes, I think it's a very good idea. I think it's something that should be put in place as well.

I would like us to think about this idea of drug pricing across Medicare, and, you know, whether it's considered as part of this recommendation or just considered in general, the idea that we pay different prices for drugs across A, B, and D to me just doesn't make a lot of sense given that we've had a policy we've put in place around site neutral. To me, this is like site neutral for drugs. Why wouldn't we pay the same for a drug across A, B, and D? It sounds like we could probably get the pricing if we wanted to, and I think that's something that should be considered.

On the concept of companies that don't report ASP, I think if they don't report ASP, we shouldn't pay for the drug, period. I just think we ought to force them to provide that information, and if they don't want to, it's hard to understand why they wouldn't be willing to do that.

And then, finally -- and I know this is controversial, but I would come back to -- I think I would be remiss if I didn't say, you know, drug pricing is such a huge issue for the industry. The idea that we do not set pricing for drugs versus going through a DVP or another model versus just setting a price, a Medicare price for a drug, I still think is something that should be considered. It's the fastest growing area from a cost perspective, and it's really the only area that we're purchasing goods or services where we're not setting pricing. And I just think it's a major issue that -- hopefully the DVPs work. You know, we're sitting here debating whether they will work or not. If we were to set a price, we know that would work, and we know it would have a significant benefit to the program and a significant benefit to the beneficiary. So thank you.

DR. CROSSON: Thank you.

DR. REDBERG: I wanted to let Warner speak first so I could just agree with him and then add on. So thank you, Warner.

[Laughter.]

DR. REDBERG: You know, I always -- first, it was a great chapter and a lot of really important ideas. And, clearly, you know, $26 billion, $5 billion in beneficiary costs, is a lot of money, and I do agree that it doesn't seem particularly well spent in terms of the view from the Medicare program. So the first thing I always like to look at is, you know, what are we spending this on and, you know, how many of these drugs are even appropriate -- by "appropriate," I mean improving beneficiary health, which is kind of out of your purview. But I will say that certainly my oncology colleagues have said to me that a lot of chemotherapy given these days is not appropriate, not necessary, not improving health.

Certainly taking that kind of incentive out of the system, which clearly there is a lot of -- you know, I'm sure some is, but some is not appropriate. So the restructuring that is part of the Drug Value Program I think is really important for program and for beneficiaries.

And then, you know, the numerous examples in here and our discussion, clearly, you know, the market doesn't operate in drug pricing and the fact that, you know, biosimilars and even now generics for the small-molecule drugs, you know, there are numerous examples of multiple generics or biosimilars on the market and the prices haven't come down and in some cases are going up. But where a biosimilar could launch at a higher price than the reference price drug is just astounding to me, and clearly, there's not a market that is operating for these drugs. And I agree again that the launch price is another big issue that we haven't dealt with, and it gets back to the sort of lack of competition. And I don't think the launch price is particularly related to production cost, as one would hope or expect.

And so I do support the Chairman's draft recommendations and again would just reiterate I think consolidated billing codes are really important and make a lot of sense. You know, it's consistent with our principles of paying similar prices for similar drugs or treatments.

Thanks.

DR. CROSSON: Thank you.

MS. THOMPSON: I'll be quick, and I'm really happy I sat next to Warner and then Rita, because I want to say I agree with both of them. And I agree with the

Chairman's draft recommendations. You heard my concerns in my question about the voluntary versus mandatory change management strategy, so I won't further comment. But on consolidated billing codes, I'm quite supportive.

DR. HOADLEY: So, first of all, I want to just again thank the staff. This has been kind of like a two-year journey in getting to this point, and it's been a lot of hard work that's gone into this, and I think we --

DR. MILLER: Don't say that.

[Laughter.]

DR. HOADLEY: We should recognize it.

I do support the draft recommendation. I think like all of us, there are items I like better than others. But I think we're all there, and I think it comes together as a package that gives a good set of things to try. I remain -- and I've said this in numerous other conversations -- skeptical about the ability of the DVP to accomplish some of the things that we hope it will, but having said that, I think it's well designed. We've done a lot of smart things in putting this together, and we should go ahead and see what happens, assuming Congress wants to follow our fine advice.

Where I want to spend a minute or two is on the list of text items that are sort of some of the alternatives that you identified on one of the previous slides. I think there are a couple of things that I might add to that list.

One is in talking about consolidated billing is to maybe raise the issue of other ways to define a price. You know, we talked a long time ago, I guess, in a chapter a year ago about the least costly alternative, and maybe it's worth sort of referencing that again. There's a January policy brief by Pew Charitable Trust that sort of puts that in the context of exactly the situation we're looking at, which is the biosimilars, and pointing out that if you go to the lowest price, you can potentially get different dynamics of pricing and just some reference to that and some discussion of that as a different alternative, even though I think we're -- you know, I like the one we have in the recommendation, but I think it's worth identifying that.

Secondly, I think you implicitly, if not explicitly, would be doing this, the potential exclusion of low-priced drugs, although I think in saying that, we should also acknowledge the issue that some of those low-priced drugs sometimes see some very large price increases, and maybe in talking about excluding low-priced drugs, we would suggest there's the possibility of still applying an inflation rebate in any case where they go up dramatically, say by 50 percent or 100 percent or some kind of much more substantial threshold and then apply the policy that we would otherwise apply. It's just other things to put in that mix, I think.

And, third, the potential of talking about the ASP add-on reduction, you talk about delaying and sort of doing it on a more gradual basis. We could also raise the possibility it could be done more immediately in the shorter term as another piece of the short-term reforms, and I think those are things that we could add.

The other thing I would suggest -- and this is not in that same section in the text, but somewhere in the text -- is to maybe put this in the context of acknowledging that, you know, we're limited to tools that we can use within the purview of Medicare, and that a lot of the things that would have a larger impact on drug pricing are outside of our purview, but at least to put that -- I don't think that's in the chapter now, but put that in explicitly and talk about the fact that patent law, patent term, Hatch-Waxman, FDA approval processes are all parts of the dynamics that will really potentially have a much larger influence on pricing than the things we're doing, but, of course, they're not in our purview, so we're not in a position to comment on those, but at least acknowledge that those are other factors out there. And I think it addresses maybe some of the frustration that we've all had at times that, you know, we're doing a bunch of things which are good recommendations, but they may in the end not have a big effect, I mean, the kind of comments that various of us have made around the table that some of these steps are only going to be relatively small impact changes. Some of them could turn out to be bigger, and that would be great if they do. But some of the biggest potential changes are clearly outside of our purview. So I think just some acknowledgment of that somewhere in the chapter would be helpful.

DR. CROSSON: Yeah, just on a couple of points you made, I do believe the third bullet point here about discussing the timing of the ASP add-on reduction, we'll cover that. That's the intention, anyway.

And with respect to the issue of those elements that are outside of our purview or even outside of Medicare, did we not do that in a previous report last --

DR. MILLER: I can't remember if it made its way into -- was it in the D?

DR. CROSSON: In the D. In the D.

DR. MILLER: Yeah.

DR. CROSSON: So I think --

DR. MILLER: Well, I was going to say I don't mind stealing that text and, you know, reiterating it here, because we did sort of say it when we were making our D reforms and saying, remember, we have to work inside Medicare. And we're doing this -- it's the same phenomenon here.

Now if you don't want it repeated again, I think we can just --

DR. CROSSON: No, I was trying to agree with you.

DR. MILLER: Okay. All right. I think we can steal it, rework it, and put it right in there.

DR. HOADLEY: Thank you.

DR. COOMBS: So I agree with the Chairman's recommendation, and there are several issues that I would like for us to address, either in the reading materials -- one is specifically regarding the development of the DVP and not increasing the amount of administrative cost to the providers, because we've actually assessed what that looks like. In terms of whether or not there will be an additional requirement for the provider with the DVP in terms of paperwork, there's going to be the prior authorization, which may be somewhat labor intensive under some categories, but things outside of the usual tool sets that are going to be necessary for the DVP to function. So I would include that.

I like what was mentioned on page 26. Kudos to you for considering that.

I think we ought to think about this whole notion of moving oncologists to hospital-based practices, and that changes the paradigm for costs in general. It is cheaper cost for patients to be cared for at physician offices, and I would like for us to consider the whole notion of what consolidation does to escalating costs. So that's really important.

The other piece on page 26 which I'm trying to reconcile is if you exempt manufacturers because they participate in 340B as well as the Medicaid rebate, what happens to the non-duals in terms of the beneficiaries getting some of that feedback? Is that a concern of Russia? Because, you know, in the reading, it talks about 68 percent or something like that of DSH hospitals having 340B programs, but then there's this large group of hospitals that are 340B that are not necessarily disproportionate share hospitals. So is there a significant amount of patients who have, I guess, hospital-based systems that are exempt such that the beneficiaries don't get the benefit of decreasing their co-pays?

DR. MILLER: Okay. I'm going to need some help here. Right now in a -- I'm going to need some help here. Everybody ready?

Right now in a 340B hospital, you know, the discount is deeper on the acquisition of the drug, but Medicare's payment continues to be 106. So all of the changes that you make on the buy-and-bill side would affect what Medicare pays, but leave the hospital free to, you know, get their 340B discount. Is that -- those are all true statements.

So to the extent that that brought the ASP down and the beneficiary's paying 20 percent off of that, then the beneficiary would get the benefit of it.

DR. COOMBS: We had said in the other session --

DR. MILLER: So the only thing I wanted to say really clearly just before you go on is we're not exempting whole hospitals from the policy. We're just not counting the price and discounts in the 340B in the calculations of the ASPs or the DVPs.

MS. NEUMAN: I was wondering, is it the -- are you worried about the duplicate discount issue? Is that what's driving the question?

DR. COOMBS: I was more concerned that one of the goals was the beneficiary having access to a reduced co-pay, and do we do that with this system?

MS. NEUMAN: So are you talking about the DVP versus the ASP? Or are you talking about --

DR. CROSSON: 340B.

MS. NEUMAN: Oh. So when we -- what would happen is that anybody in the DVP or any beneficiary who went to a provider who participated in the DVP would be eligible for reduced cost sharing, so they would all -- anyone who went to one of those providers would benefit. So I think that in general you can stay in the ASP and you would have the same thing you do today, or you could go to a provider who chooses to participate in the DVP, and as a beneficiary, you'll save more than you would have if you had stayed in the old system.

DR. MILLER: But all I was saying, Kim, is if they stay on the buy-and-bill side, there will be some reduction even relative to steady state because we're walking the ASP add-on down.

MS. NEUMAN: That's true.

DR. MILLER: So my only point was that I thought you were worried about the bene's co-payment, let's say in a 340B hospital, and in this example let's say the 340B hospital sticks on the buy-and-bill side, even relative to current law the bene will get some benefit out of that, and then what she said about DVP is also true.

DR. COOMBS: And I know it's probably a small number because many of these patients are LIS patients, but I was wondering, one of the discussion points, was it not the discussion point that we voted on the 10 percent with the 340B program -- and maybe that was the D part. That was the whole discussion.

MS. BUTO: We had a separate recommendation on that, Mark, on 340B and how to split the discount reduction between the beneficiary and the program, and that's already out there.

DR. MILLER: Right, but I thought she was talking about this proposal and how the beneficiary -- whether the beneficiary gets some benefit from it.

DR. COOMBS: So since we don't know what the 340B program -- what kind of discounts they get -- remember we talked it could be as much as 50 percent?

DR. MILLER: We were thinking about 29 or 30.

DR. COOMBS: Yeah, 29 or 30. Is that translated to the patient's co-pay?

DR. MILLER: No. And under current law, it isn't either, and so one more time --

COURT REPORTER: Can you keep your mic on?

DR. MILLER: Yeah, except I don't want anybody to hear it.

[Laughter.]

DR. MILLER: Other than that, I'm fine.

So right now you're in a hospital, the hospital takes a 30 percent discount on acquiring the drug. Medicare pays 106, and the beneficiary pays 20 percent of that. And so in that sense, the beneficiary doesn't get the benefit of that discount. And I know we have that small thing that we did, but if I could just hold that aside for a second. In this world, if buy-and-bill drives the ASP add-on down, which is part of our proposal, then the beneficiary would get the benefit of that change, even though we haven't messed with the physician -- or, sorry, the hospital's discount that they took the drug at. So the hospital gets its discount. Medicare's payment comes down. There's a bit less revenue, and the beneficiary benefits from that on the buy-and-bill side. On the DVP side, it's her story. If the DVP negotiates underneath it.

So that's how this proposal works. You're correct, we did talk about a small adjustment to the 340B a year back or whenever it was. We could talk about that again. But in this context, the beneficiary should get some benefit on both sides of this proposal, whether it's a little bit or a lot, and that's unclear.

DR. COOMBS: So my question was: Is it going to be comparable if you just happen to be in a 340B program versus -- okay.

DR. MILLER: My reaction is it should be comparable.

DR. CROSSON: And just to note, Alice, on your earlier comment about consolidation, to the extent that smaller practices -- and I think your use of oncology was the correct analogy. To the extent that the inability to purchase pharmaceuticals without a loss by those small practices is one of the elements that drives practices into hospital employment -- certainly not the only one, but we have had some comments that it is one -- then the DVP process should provide an escape from that for practices.

DR. COOMBS: And one last thing. Is it possible that we could put in a footnote, the impact of the sequester on the ASP as well?

DR. MILLER: Yeah.

DR. CROSSON: Yeah.

DR. NERENZ: Thanks. I'm generally supportive of the recommendation. I just wanted to make one point about the shared savings component of the DVP program. I think it would be nice if in the evolution of this in the next month, if we could either illustrate an example of a shared savings model that we think might be useful, or at least identify some desirable features. We currently don't really say anything about it, and as I'm reading the proposal, at least from the perspective of incentives to physicians, the only attraction to DVP is the shared savings, because right now you've got your plus 6 percent. Even if we drop it down to WAC+3 percent, there's a positive margin there that is predictable, it is certain, and it is immediate.

Now, if you move to DVP, it is uncertain, it might be weak, it might be two years delayed. You never know. I think our examples currently of shared savings model are not that positive, they're not that strong. So we could just --

DR. CROSSON: Are you talking about ACO models?

DR. NERENZ: ACO, bundled payment, what-not. You can call it shared savings, but there's good, powerful shared savings features that will draw people into this model, and you could have a shared savings model that is utterly unattractive. And I think we could say something about what would be of the one type and the other. And I presume we'd want to recommend shared savings features that would be positively attractive for physicians in the program.

I was thinking of this one, Sue made the comment about mandatory. You make it mandatory -- except one reason you don't is that everybody's going to be up in arms and they're going to revolt about it if it is not attractive. They won't do it. And they certainly won't be forced to do it.

DR. CROSSON: I agree with that, and I think this is predicated on the notion that if you're looking at population-based pharmaceutical costs and the DVPs have these tools, that given what we know about the escalation of pharmaceutical costs, there ought to be opportunities there to produce shared savings which are materially different from, for example, MSSP ACOs.

DR. NERENZ: I agree. I just would like to see it explicitly stated, and just noting there probably are some nuances in there. So, for example, on the example you showed about 500 versus 400, well, that $100 difference could feed a shared savings model. But let's say there's a second drug in that class that's $1,000, and the negotiated price is $800. Now, there's a bigger savings. That could even drive shared savings. But wait a minute. In order to get that savings, you have to do the $1,000 drug.

So there's all kinds of details about how you build the shared savings. You know, do you build it on the savings at each individual drug regardless of the overall package and pattern of use? Do you build it on pattern of use? You know, if there are 10,000 docs in the system, each one sort of goes along with what happens with 9,999 of his or her colleagues and their prescribing patterns, which makes it look a whole lot like SGR. So there's a lot of detail about the shared savings.

DR. CROSSON: Right, and for that reason, I think we've stopped short of trying to, you know, suggest, well, it has to be this method. I certainly think the point that you're making, which is that the success of this will be predicated on both the reality and the early perception of the shared savings opportunity.

DR. MILLER: And I also agree with you that it's largely the shared savings on, you know, the positive incentive. And as you were talking, you know, maybe what we can do is take a section and sort of -- you know, what is the incentive here for the physician to do this? And I think what you've gone through is part of that. And then the other side of it is the push side, so, you know, Amy's comments were there's a group of people up in this part of the distribution who aren't doing that, while you were saying six, it's clear, everything's good, unless you're on the far right tail of that distribution, in which case life isn't potentially all good. And so that would be a push. And then the notion that if the add-on is going to come down, that begins to push. And so the incentive would include this is what's drawing you, this might be what's pushing you, to try and speak to Sue's point, which is, you know, there's mandatory but there's also pushing. And we can put that in a section and make it all try and make some sense.

MS. BRICKER: Okay. So I am in support of the Chairman's recommendations on improved ASP and WAC+3 revisions. Consolidated billing codes, I'm supportive of all except for inclusion of biosimilars. I think this is still in its embryonic state. There are only two on the market. And I feel like we're trying to regulate a market that doesn't yet exist and is not mature. So I'm not in favor of that aspect from consolidated billing codes, the rest yes.

Inflation rebate. So this isn't a new concept. This exists today in the drug space, but they are, in fact, rebates, and they're negotiated by PBMs and health plans. So if we were to do this, I wouldn't be in favor of CMS or Congress setting some, you know, global inflation rate, but instead maybe you give it to the DVP to negotiate with those manufacturers so that it's confidential and it doesn't have the effect that I think this would have on the entire pharmaceutical market, if, in fact, that were to take hold. And I think it would -- you're actually more likely, I think, to get success or get manufacturers to engage in a dialogue around this versus essentially the government setting drug pricing, which this sort of is.

Lots more comments. So back then to DVP. So I've given this a ton of thought since we've been talking about since the summer, and you're right, this is a new model. It's not a GPO, and it's not a PBM. It's something else. For me, prior authorization and step therapy is utilization management, and I don't know that -- is that what we're trying to create? We're trying to create almost like a health plan that also acquires drugs. And if not, maybe instead it's not -- it's not an infrastructure around appropriate utilization. I think what we're trying to solve for is formulary compliance. And so is it instead a bonus to those participants of the DVP a formulary compliance, which would then be their incentive to use the drugs on formulary? Because this isn't about coverage. When I think about prior auth and step, this is about what our health plans, our sponsors are willing to pay for. And ultimately we're not saying we're not going to pay for anything. It's just, you know, acquisition cost.

Back to your comment, Warner, about D and B. So I want to make sure, just to clarify. Drugs are either covered under B or covered under D. They're not typically covered under both, so it's not a site-of-care issue. There are some exceptions. Like test strips typically are B, but they can be under D. So, yes, I think we could look at a few of those exceptions where they bleed over. But drugs are just typically covered under B or covered under D, but the methodology for reimbursement is different.

There's an exception in the paper around inflation rebate and if it's a single-source brand, and I want to make sure I understood the comment that you would exempt them from the inflation rebate. And if that is, in fact, our recommendation, I'm not in support of that. You're looking at me funny. Maybe I misunderstood it.

MR. PYENSON: Where is that?

MS. BRICKER: It's page 26, talk about if there's a high-cost drug, that there's a shortage. So to me, that's EpiPen, and we could name other ones that are our favorites, but I wouldn't incent -- I wouldn't say because there's a shortage or what have you that we're not going to hold you to some sort of inflation cap.

I'm not in favor of arbitration. Again, I think it's a bridge too far. If I'm a DVP operator, I just go to arbitration for everything because ASP is the worst I can do, so I'm just not sure that -- it's a bridge too far for me.

One last thing. If you don't have the DVP negotiating inflation cap, ASP is on a two-quarter lag. So inflation, though, I would assume we would measure that at a calendar year, but the ASP was from six months ago, so you'd have to also solve for that. Are you looking at the inflation over which period of time? So it goes back to my recommendation if you're going to do inflation cap, give it to the DVP, and they would, you know, measure inflation based on, you know, the same periods of time, their ability to buy for that calendar year and then the inflation associated with that.

And I would just generally try not for us to create any loopholes. I would not exclude repackagers. I would not exclude low-cost drugs. You know, we regulate the heck out of this, and we create loopholes that we think are sort of harmless, and then people exploit. So to the extent that we can not have exceptions or loopholes I think is a positive.

DR. CROSSON: Thank you. Those are all good comments, Amy. I'll just talk about one, and that's the binding arbitration. So it was not our idea, because I agree with you, to just say, for example, DVP, anytime we want to do binding arbitration, you have the right to enforce it. It would be -- the model would be that the Congress in constructing this would set the guardrails for that and would say essentially -- and this would be across all DVPs, not one at a time. But if a manufacturer comes in with a launch price, for example, or is a single-source provider by some other mechanism, that exceeds some benchmark in terms of cost -- and we have not tried to say what that would be, whether it would be an annual cost for a patient or whatever -- then that would open the gate for binding arbitration, but only in those circumstances.

MS. BRICKER: So then the output of that binding arbitration would be then all DVPs could acquire that drug at the same price?

DR. CROSSON: Or no more than that, yeah.

MS. BRICKER: Okay. I'm still not in favor.

[Laughter.]

DR. CROSSON: Well, I did my best. Okay.

MR. PYENSON: I support the Chairman's recommendations, and I have a concern over the quality of ASP reporting, not so much from the completeness of who's reporting and who isn't, but I have not seen in these discussions the kind of rigorous definitions that apply, for example, to medical loss ratio by insurance companies. It could be they're there and we just haven't gotten there, but it could also be the case that there is a fair amount of flexibility in what could be considered in and out of ASP. And I think -- I'm not sure how to incorporate that into a recommendation or if that's Round 3 of Part B drugs.

DR. CROSSON: There ain't no Round 3.

[Laughter.]

MR. PYENSON: So I want to express that concern.

DR. MILLER: Let me commit to only this: that I will talk it out with the crew and see if there is some adjustment, either in text or in a recommendation, that can be brought to this, because I don't get the sense that a lot of other people would object to the notion if there was some more oversight and how rigorously the data was defined. Assuming there's not a bunch of objections here, we'll talk about it.

MR. PYENSON: Ask Amy [off microphone].

DR. MILLER: No. Amy--we're clear where she is.

[Laughter.]

DR. MILLER: But we'll at least talk through this and see if there's some there there. So we'd make that much commitment to you.

MS. WANG: I'm generally with the direction of the draft recommendations, although I think that some of the questions and comments that the Commissioners have raised are really worth -- I'd like to understand more. I'd like to understand Amy's comments about consolidated billing for biosimilars. It's a very important comment.

On DVP, which we are kind of talking about, it is like it's a new thing completely, something in between organizations and models that exist today, worth a try. I think it's worth a try. I think, you know, some of the -- to David's comments and, Mark, your response about what's the pull, attraction from providers, is really quite important to try to tease out a little bit. And so I agree with it as a voluntary for providers for sure, so it has to have a strong pull. I wonder whether it should be voluntary for manufacturers, because I think that if it is well designed, it will be for some people and not for other people, and it will be a new market alternative. I would hate for it to be -- I think that it's something to consider, the danger of a pocket veto, if there's not participation by manufacturers. And I think it's something that we should think about. If you're going to have your drugs, your Part B drugs reimbursed under the buy-and-bill system, you also participate in the DVP.

DR. MILLER: And that is precisely the construct. If you're not willing to negotiate with the DVP, then you can't play in buy-and-bill. But, of course, we're not saying that each manufacturer has to come to a negotiated agreement with DVP. And so, you know, we're just saying you want to play, you have to sit down at the table. They could decide not to offer a discount. I've got all that correct, Kim? Again, an enthusiastic -- right, okay.

MS. NEUMAN: [off microphone] the DVP.

DR. MILLER: Right. And so the mechanism that, you know, you're frozen out of a $26 billion market in general if you're not willing to come and have conversations with the DVP is assumed here. Okay.

DR. GINSBURG: Yeah, I support the recommendation. On the shorter-term things, I think the consolidated billing codes for biosimilars is one of the most important things, and because I'm concerned, given what the staff drafted in the chapter, that we're in a situation where we're -- you know, current rules are actually undermining the potential of the entire biosimilar market by not having a mechanism to drive volume towards the biosimilars when they have a price that's lower than the reference drug. So even though we don't have much experience, I don't think we're going to get a lot of experience unless we do this right. So that just, you know, the reason generics succeeded is because there was a mechanism through formularies to drive large amounts of volume to the generics. And biosimilars take a lot more investment on the part of fair manufacturers, so I really want to make sure that there's an incentive there for them to do it.

On the DVP, I want to make sure that when we write this up that we focus on the fact that, yes, it is a hybrid of functions that different parts of the health care system play, and the GPO part I think is the least important. And I think David's comment is important that just the GPO part, just buying at a lower price may not be enough to coax the physicians into this. To me, the functions that are provided by Part D plans with a formulary, step therapy, prior utilization, and the like, that to me is where the big upside is. That is what can produce substantial savings and really attract the physicians to volunteer for the DVP.

So I'd like to make sure that we're always emphasizing this is not just, you know, a purchasing thing like a GPO. This is really recognizing that a lot of the health plan functions that have been really critical to the success of Part D don't exist in Part B. And we need to create some entity that can take on these health plan functions for Part B drugs; otherwise, we're not going to be able to get significant savings.

DR. CROSSON: Thank you.

MR. GRADISON: I hope you all will bear with me a little. I'm going to take a little more time than usual. I haven't voted no on anything in six years, and I'd like not to have to vote no on anything here. There are parts of this I like and parts of this I strongly dislike. And it would certainly be my hope that rather than having a single vote on the whole package we could vote on it in pieces. Whatever the Chairman decides, that's fine with me. It makes it an easier choice at my end because there are parts I would like to be able to support, and let me go down this one at a time.

Data reporting, yes.

With regard to the WAC+3 percent, I think there's a better way than what's been discussed. The problem is there's a lag in the data, a six- to nine-month lag in the data. But after six months, after nine months, let's say, the average sales price is known for that previous period of time. And it seems to me a very simple matter. We have WAC+3 say during the first nine months, and then you go back and there's a clawback of the excess between WAC+3 and what the actual sales price was. I don't think it's that big a deal because it isn't going to happen that often with that many products. I've suggested that before and it hasn't sold, but I want to mention it again because I personally think it's not a bad idea, or I wouldn't mention it.

With regard to the inflation rebate, you could just put this down to prejudice on my part. I have not seen a price support system for anything that has worked successfully over a long period of time, period. And there are people -- you can go back way -- this has nothing to do with any current politics. It started, I think, with St. Thomas Aquinas trying to figure out the just price. And he was not very successful in doing so and giving much guidance to us today.

There will be, I think, unintended consequences of doing that. Leaving out the low-priced drugs is okay with me, but that's not where the problem could be. It would be in the low-margin drugs where the problem could arise, where increases in costs, new regulatory burdens that might be imposed by the Food and Drug Administration, quite legitimately, where the use of the facility might more profitably be directed to some new product rather than being a new plant. And I just think that it's an invitation to shortages. That's my opinion. And I can't prove it, but that's why I would not support that.

Consolidated billing codes, I happen to agree with that.

I don't have any particular problem with the DVP with regard -- that sounds weak. It's fine. It's fine. Worth a try.

The arbitration, here's how I think the arbitration is going to work out. I acknowledge that with high volume like oncology drugs, manufacturers have got to find a way to get into the Medicare market. I got that. But they don't have to start there. If I were introducing a new drug, let's say setting the launch price or dealing with something else that was sole source for some other reason, what I would do first is offer it in the private market through employer plans, through health plans, through MA, I guess, and try to establish a price through that mechanism. And it may be sky high. I don't know what it would be. Certainly it's not going to be a bargain. But I would establish a price that I could go into arbitration and say we are selling such-and-such at quantities that people are paying these prices, that is what the market shows. And then I would say in coming up with my proposal, if I were a manufacturer in arbitration, but in order to close this deal, I'll offer it for 20 percent off, I'll go -- my price in the arbitration will be 20 percent off what people are already paying.

Now I grant the arbitrator could say go with some lower price, but I think that there would be a lot to overcome and going about it, and I just think that's sort of what it would end up being. That's my opinion.

With regard to -- well, we've already in the past suggested a reduction in the 6 percent add-on. In a sense, that's nothing new. Here it's being used as an incentive for something else. Bear with me just a second because I want to make -- this is my chance. I don't want to leave anything out.

Yes, I'm dis -- this is not a reason that I'm raising questions about this package at all. I am disappointed that we have just focused on B. Warner has already brought this up. It's been on my mind, too. I think what we're trying to do here legitimately is say we don't like these rapidly rising costs, prices, for pharmaceuticals. Okay. I think we're also saying, since our scope is Medicare, Medicare is going to set an example and demonstrate what can be done to do something about this. I think our position would be stronger if we didn't say, well, just for Part B, because even if the spillovers, Amy, are just very limited between B and D, they are significant between A and B because some of these same drugs might be purchased for hospital use for, you know, non-340B hospitals. And so I just think if it were up to me, I'd say let's broaden our recommendation and spend a little more time on it. But I won't be around here after April, so this is my chance to -- and thank you for patience -- explain why for the first time in six years I'm losing sleep over this. I'd like to get to yes. I can't on every item. And I only use this opportunity to extend in public a deep sense of appreciation to Jay for his patience. He's patient with all of us, but he's certainly been patient with me, not just on this issue but on others when we've talked these things out. We must have spent 45 minutes just on this item before, and I deeply appreciate that courtesy.

DR. CROSSON: Thank you.

MS. BUTO: So I generally support the Chairman's draft recommendations and, like others, want to comment on some of the specifics. So I would pick up the suggestion that the text talk about the alternative ways of setting an inflation limit on price increases. Again, my preference would be do it through the payment rate. It's simpler, and there are a lot of reasons to do it that way, in my opinion. I'd rather do it that way.

On consolidated billing, you know, I guess I'm 180 degrees from where Amy is because I think probably the best case for consolidated billing is with biosimilars and the originator biologic. And the main reason I feel that way is it's an externally scientifically derived analysis by the FDA. I'm very concerned about extending consolidated billing to "therapeutically similar" products." I'm very comfortable extending the idea of bundling to include drugs that are similar and even going with some kind of a weighted average rate for the drug inside a bundle for an episode treatment, but give the clinician the right and the ability to make those tradeoffs rather than say we're setting the price for your drug regardless of what you have to pay for it, this is what it is, and driving -- letting price drive or at least highly influence clinical decisionmaking. I just think that's wrong.

I want to get back to the A, B, D question with drugs. You know, I would hate to see A pulled apart, the DRG system, and for us to say we think we ought to be setting a payment rate for drugs inside the DRG bundle, because I am generally more favorable to larger bundles to allow greater flexibility clinically than for us to set every component of payment. I think we cannot possibly get it right.

Between B and D -- I think Amy makes a good point -- there is some overlap, not a lot of overlap. I just started thinking, how would you operationalize that because we have got all these D contractors negotiating their own rates and then you potentially have a B contractor using competitive methods to come up with a rate. I do not even know how you come up with a rate that is the same across the board, so it is just very hard to operationalize, in my mind.

Binding arbitration, I will be honest, I had not thought deeply about it until I started listening to the other commissioners. I think, first of all, this is going to be hard to pull off. I do not mean politically; I mean operationally. It is very tough to do. The benchmarks are tough to come up with. I think we may want to look at this whole issue of high launch prices and look more broadly. Are there other mechanisms? Are there other things we should be considering? I know we are trying to give all the tools to the DVP, but I worry that this one sounds very appealing but I fear cannot be done. So that is something I have sort of developed a greater appreciation for.

I want to go back to something Rita said about appropriateness. I do not think -- we have talked a lot about payment rates. We rarely talk about appropriateness, and that is at least, in my mind, more than half of the consideration of what treatment people get, whether they are appropriately getting drugs at all, whether they are getting the right drugs, et cetera. And somewhere we ought to at least address this and say we are going to come back to it, because otherwise I just feel like we sound like we are only interested in paying the lowest rate for drugs in a category.

Oh, and then the issue of participation by manufacturers in the DVP. I feel as if they are going to come because that -- you know, Medicare lives are pretty hard to resist. You know, CBO looked at what would happen if Part D plans -- I am looking at Rachel -- did not participate in Part D. And of course we know what happened.

Manufacturers are going to want to get that part of the market and participate in whatever options there are. I think they are just going to tie themselves in knots about, you know, what the strategy is around buy-and-build versus DVP, but they will look both at the long game and the short game and try to figure out how to make it work. But I do not have any doubt they are going to participate.

DR. CROSSON: Thank you, Kathy.

Craig.

DR. SAMITT: So the danger of going last, everything has been said, but I would say that my thinking is most in line with Warner's. I fully support these recommendations. In fact, I do not think they are bold enough. And I worry as I hear the discussion that we are talking about watering down this recommendation when, thinking back to why we are here, you know, the unsustainable increase in drug costs are unmanageable and we need some strategies to really help assure that, you know, the majority of everything we pay for in health care is not all about drugs.

And so, I think these levers are all very important, and so I would not be in favor of removing anything. I mean, there have been some good suggestions about alternatives, whether it is the clawback alternative for WAC. So I would say are there improvements to continue to use the strategy as opposed to remove it, because I think we need all of these things.

And, you know, we recall that there were other things also that we considered on the list that I also do not want to lose, whether it is the use of clinical pathways -- suggestion of clinical pathways or other potential approaches -- the one we talked about earlier, the inclusion of MA Part B purchasing as part of this strategy as well through the DVP. There are probably even more that we should and could be doing to help bend the curve here. So I fully endorse this and, frankly, think that we should continue the discussions and go even bolder.

DR. CROSSON: Thank you, Craig. And to make you not be last we will go back to Bill, because we jumped over Bill.

DR. HALL: I just want to save you from going last.

[Laughter.]

DR. HALL: In case it goes off, I am in favor of the Chairman's recommendations.

[Laughter.]

DR. HALL: Well, I am in the minority in terms of expertise in this area, for sure, but one thing I do know is that there is not a week in my professional life that goes by that I do not see a drug misadventure in a real-live person. Sometimes it just means a few more days in the hospital. Sometimes it means they die.

And the whole issue of the use of drugs -- and I guess "appropriateness" is probably a pretty good word -- is that it seems to me a shame that we have come so far and yet we have not really reached the real benefits of some of that expertise. We introduced Medicare. Let me put it another way: When we introduced Medicare there were only about two drugs or three drugs that were in use. They did not cost anything. They were derivations of plants.

Many, many decades later we got coverage of drugs for Medicare recipients. In the meantime, the science got incredibly good. We got drugs for the first time that worked. We have made great progress in the science of pharmacology, we got better at expertise, and yet here we are in this sort of nirvana era. And the people that we are representing here are still dying, sometimes because they do not get the right drug because they cannot afford it, other times because they get the wrong drug. This is not just rhetoric. This is the really -- this is really what is happening out there in the world.

And you cannot separate one part of this puzzle from the other. So even though I may not get entirely what we are talking about on some of these issues, I do know that this whole business of constantly trying to rectify how we distribute the right drug at the right time to the right patient is one of the most important things that we do. So I think this particular topic is well worth the struggle and the expertise and you simply cannot separate that from other types of medical misadventure or negligence, or just not getting the right drug to the right person.

I know that does not help our dialogues so much, but I sort of put this at a very, very high level of what is really important in what we are doing here. And this is something we can do something about. This is not magic. This is just very careful, hard thinking. So, thank you.

DR. CROSSON: Amy, last word.

MS. BRICKER: I forgot to mention we are going to go back and look at the Part D chapter around the policy, you know, conversation and maybe bring that forward. If we could -- if it is not included, the pay-for-delay that exists today where brand manufacturers, in some cases, will pay generic manufacturers to delay coming to market, so we should highlight that. And currently, I believe FDA has a backlog of 4,000 generic drug applications as we speak. So competition is what is going to drive costs down. And I agree that this is not a B issue.

So, you know, bringing those policy issues to light and making recommendations around, you know, more global issues I think will be quite relevant and timely. Thanks.

DR. CROSSON: Thank you, Amy.

DR. MILLER: Can I just --

DR. CROSSON: Mark, on that?

DR. MILLER: One quick thing. And this links comments Amy made, Bill made, and Kathy made, and to some extent Warner as well.

So there was some angst expressed by a few people of, like, you know, C, D -- or, sorry, B and D -- B and D. You know, we were not completely unconscious on this point. I mean, remember Amy's point was, you know, the drugs in B and D kind of look like this. They do not fully overlap.

I appreciated Kathy's comments because, you know, it was like operationally they came from two very different worlds. They are on two very different platforms -- rightly or wrongly, but that is where they are -- and how you would meld those.

Remember -- and I am saying this mostly for the public -- we just made a set of recommendations on Part D, and at the end of the June report in '16 and at the end of the June report in '15 -- or '17, or whatever -- Bruce, I am going to need help with numbers, but at the end of, you know, the June report in 2016 and the end of the June report in 2017, this commission will have tried to address the issues on the D side and on the B side.

And to your last round of comments, yeah, we have all discovered things we need to come back to in both of these areas, including bundling in oncology, which we had talked about in different points in time, and some follow-up issues in the D world. So another way to look at it is in a one-year period you will have spoken on D and B, even if you did not put them all in one policy and make one, you know, issue around them. So I just want to remind particularly the public that there has been action taken on D.

Sorry.

DR. CROSSON: Last word, Warner, and then we have to move on.

MR. THOMAS: I will just take 30 seconds.

I appreciate Kathy's comment on Part A and the difficulty with the bundle and the fact that -- I think we could create a situation where you do not have to unpackage the DRG but still look at a drug price that is paid for drugs within Part A. And I would not bring it up because I know that it is a complicated situation if the cost escalation was not so significant and so material in an area where we are seeing, you know, 1 to 1.5 percent cost inflation.

The last comment I will make, because I know that these recommendations will probably be -- will face a lot of opposition, is that one of the things we do in other areas when we talk about price increases or looking at pricing is we give kind of an overview of the industry. And we do this in inpatient, we do this in home health, we do it in other areas. I would encourage us to do the same type of thing in drugs to provide kind of an overview of what is going on in the industry, what the margins look like the ability to reinvest, because I think it puts it in the context of what we are trying to do.

So, thank you.

DR. CROSSON: Thank you, Warner. And thank you, Brian, Kim, and Nancy, particularly Kim. You all have been working on this. Kim has been laboring in this vineyard for a number of years. She has purple feet, as a matter of fact, from this work.

[Laughter.]

DR. CROSSON: That is a California reference. Sorry about that.

[Laughter.]

DR. CROSSON: But really, I mean, this is just -- you know, from the earliest stages of trying to figure out what we could do here to the point we have come today has been herculean. So thank all of you.

[Pause.]

DR. CROSSON: We'll go ahead and proceed. Now we're going to move to the relatively uncomplicated --

[Laughter.]

DR. CROSSON: -- area of MACRA physician payment reform combined with our long-term issue of trying to encourage the growth of flagging interest in primary care among young physicians. So we've got Kate, David, and Ariel, and it looks like -- who's starting? Kate? Take it away.

MS. BLONIARZ: So the last session today builds off your discussion in January on two topics in clinician payment: refining MACRA and supporting primary care. And so a special thanks to Sydney McClendon, Ledia Tabor, Jennifer Podulka, and Kevin Hayes.

So the topics are fairly complex on their own, and we are merging them. So the next two slides will lay out what we heard from your January discussions and some potential policies, and also where we see linkages between the two policy areas. So starting with MACRA and then moving to primary care.

First, the MIPS system is a very overbuilt system that's unlikely to be successful at identifying high-value clinicians. And ideas for fixing it include eliminating all measure reporting by clinicians and replacing it with a set of CMS-calculated outcome and patient experience measures. Assessing performance and adjusting payment would happen at an aggregate level.

Second, we heard some interest in designing the policies so they help move clinicians from MIPS to A-APMs. Ways we've talked about addressing that are limiting the potential upside in MIPS and moving the $500 million MIPS exceptional performance bonus to A-APMs, and David will talk about a way to do so.

Third, there was interest in also making A-APMs relatively more attractive, and the interest here seemed to be in two areas. One is to address the ability of practices who receive a small share of total AB spending as their own revenue to take full population risk. The idea that we've come up with is a model that would allow small clinician-only or primary care-focused entities to limit their risk to a share of practice revenue.

The second idea is to create an additional upside for two-sided ACOs. This could use some of the $500 million MIPS exceptional performance bonus money to fund an asymmetric risk corridor in two-sided ACOs. And I've moved into talking specifically about two-sided ACOs here because two-sided ACOs and models like them are the A-APMs currently in existence that are most consistent with Commission principles.

The fourth area is better supporting primary care, and the first idea is an upfront payment for primary care providers in two-sided ACOs. And the linkage to two-sided ACOs also brings it back to MACRA.

The second idea is a per beneficiary payment for all primary care providers, and this would go to the bigger issue of mispricing of primary care services in the fee schedule and would redistribute spending from non-primary care to primary care.

On the next few slides, I'll go through the MIPS piece in detail. To reiterate some of the issues with MIPS, first, MIPS uses hundreds of clinician-reported quality measures. Second, two of the other components of MIPS, meaningful use and clinical practice improvement activities, only require attestation by a clinician and haven't been proven to correspond to high-value care. Third, for any given clinician, there are a relatively small number of Medicare cases, which can contribute to noisy performance. Fourth, under MIPS each clinician is judged based on their own set of measures that they reported, and so the results aren't comparable across clinicians. In total, we don't expect that MIPS will be able to identify high- and low-value clinicians and will not be useful for beneficiaries, clinicians, or the program.

So what could the Medicare program do instead? And I'll lay out one idea that we'd like your feedback on.

In this new framework, all clinicians would contribute to a quality pool, let's say a 1 percent withhold. Clinicians would receive this withhold back if they joined an A-APM.

Then clinicians could be eligible for a positive or negative quality adjustment if they elect to be part of a clinician-defined virtual group or elect to be measured at a CMS-defined referral area. These virtual groups or referral areas must be big enough to detect performance of the group as a whole on certain population quality measures. Clinicians who do none of these three things -- join an A-APM, join a virtual group, or elect to be measured at a referral area -- would lose the withhold.

As I said on the previous slide, clinicians would elect to be measured at either a clinician-defined virtual group or CMS-defined referral area. And the performance of each group or area would be based on a set of population-based outcome measures, and it could build off the set of measures contemplated in the Commission's premium support work for comparing performance across different payment models. Each virtual group or referral area would receive a single performance score and would result in a uniform payment adjustment that would be applied to all clinicians in the virtual group or referral area.

This would be a real pivot from the current MIPS program. As a reminder, the MIPS program is a redistributive budget-neutral payment adjustment, aside from the $500 million. Our illustrative proposal is also a redistributive payment adjustment, but the downside could be limited to the amount of the withhold, and you could also limit the upside. The proposal would also remove all clinician quality, practice improvement, and EHR reporting from the current system. Third, it would use a uniform set of claims-calculated and patient-reported measures to assess all clinicians. Fourth, probably one of the biggest changes is that clinicians are no longer measured on an individual basis There is only the option for group or area measurement. Fifth, the resulting payment adjustments are for the entire group or referral area and wouldn't vary among clinicians within that group or area.

So I'll stop here on MIPS and turn it to David to talk about A-APMs.

MR. GLASS: Thank you, Kate.

So we now turn to rebalancing the program from MIPS to A-APMs. As Kate just discussed, under the illustrative MIPS proposal, there would be a tilt toward A-APMs because clinicians would automatically get their withhold back if they joined one, so they would have an incentive to do so.

A second way to rebalance the program would be to move the MIPS "exceptional performance" fund to A-APMs and use it to fund asymmetric risk corridors. That fund is $500 million each year from 2019 to 2024. So this would lower rewards in MIPS and increase the attractiveness of A-APMs. So I will discuss this proposal in the next few slides.

As background, last month we discussed several issues. First, removing the 5 percent incentive payment cliff by making payment proportional to a practice's revenue coming though an A-APM rather than the current approach that establishes an arbitrary threshold. For example, if 25 percent of revenue was through an A-APM, you get the 5 percent bonus; if 24.9 percent of revenue is through the A-APM, you don't get anything.

Second, you asked for a design to make it more attractive for small practices to take on two-sided risk. The law requires that an A-APM have more than nominal risk, and CMS has to establish that standard. The design discussed has a revenue-based standard instead of a benchmark-based standard and defines the risk corridor, that is, the limit for savings and losses in revenue terms. It would define revenue as a practice's fee-for-service revenue coming through the A-APM. Savings and losses would still be based on total Part A and Part B performance consistent with the Commission's principles. This model is also consistent with the Commission's other principles, and two are shown on the slide.

The idea was to create an incentive that is large enough to motivate improvement but limit the loss to something a practice might take on. And the design could be incorporated into the Track 1+ ACO model as that is defined.

The concept addressed the underlying fact that there is a disproportion between a clinician group's revenue and the entity's benchmark because a primary care group, for example, has only about 5 percent of the benchmark as its own revenue. The other spending goes to other providers. That is a lot of leverage, which works fine if you are in a one-sided risk model, but can be too much to venture if you are at two-sided risk.

So with that model in mind, we now turn to moving the $500 million exceptional performance money in MIPS to the A-APM side of the ledger to encourage clinicians to join two-sided ACOs.

This builds on the new model by making the risk corridors that we just discussed asymmetric, that is, they would have a higher upside than downside.

This would rebalance from MIPS to A-APMs because it would encourages practices to accept risk by increasing the expected value of that choice.

Asymmetric risk corridors require funding because if you look at it from the Medicare program prospective, given random variation, the program will pay out more on the upside than it collects on the downside, and we can get into this point in more detail on question.

In addition, this is an indirect approach to promoting primary care. It works to the extent that attribution favors primary care, practices that emphasize primary care case management are successful, and that those successful ACOs then reward the PCPs in them.

ACOs have to be successful to benefit from the higher upside so it meets that requirement which Craig proposed last meeting to limit rewards to successful entities.

So here is just a quick numerical example of how this might look. So we'll assume this entity is attributed 1,000 beneficiaries under some A-APM model. And we'll further assume the benchmark spending per capita is $10,000. Then the total A and B benchmark for the entity will be $10 million. Finally, let us assume that the clinicians in the entity receive $500,000 in Medicare fee-for-service revenue through the A-APM. That is 5 percent of the benchmark A and B spending which is about what primary care accounts for.

We then compare two possible designs. In the first column, we have a symmetric risk corridor of 20 percent up and down, which would translate to $100,000 of up- or downside risk. The next column has upside of 100 percent of revenue and downside of 20 percent as before. Thus, the limits are $500,000 up which is an increase and $100,000 down as it was before.

By the way, in addition, the practice would get the 5 percent incentive on its revenue, which would be

$25,000, so the total upside would really be $525,000.

Remember this is the practice's revenue through the A-APM, and, in fact, the practice's total revenue would likely be much higher, so the risk would be much less than 20 percent of practice's total revenue. That said, the 20 percent and 100 percent are just for illustration, not policy proposals.

Ariel will now take us through ways to better support primary care.

MR. WINTER: Continuing with the theme of two-sided ACOs, the first approach to supporting primary care would allow primary care practitioners in two-sided ACOs to receive an upfront, lump sum payment. This upfront payment would be voluntary, and it would be financed by reducing the fee-for-service payment for each primary care visit provided by a PCP during the year.

So PCPs in ACOs would not receive new money for this upfront payment; instead, they would be shifting some of their own revenue from fee-for-service payments to the upfront payment.

The advantage of this upfront payment is that it would give providers more flexibility to invest in infrastructure and staff for care coordination activities, and there would be no change in beneficiary cost sharing.

Before discussing the next approach, I want to take a step back and remind you of the issues that we have identified with primary care in the fee schedule.

First, primary care services are underpriced in the fee schedule relative to procedures and tests.

Second, the fee schedule is not well designed to support care coordination and primary care because it is oriented towards payment for discrete services.

Third, mispricing in the fee schedule contributes to an income disparity between primary care and specialty physicians. This disparity may encourage medical students to choose careers as specialists instead of primary care physicians, which raises concerns about the primary care workforce.

In light of all these concerns, the Congress created a bonus for primary care practitioners called the Primary Care Incentive Payment program, or PCIP, which expired at the end of 2015.

In 2015, we recommended that the Congress establish a per beneficiary payment for primary care to replace the expiring PCIP program. The Commission was concerned that if the PCIP expired without a replacement, Medicare would be sending a negative signal to primary care clinicians. However, the PCIP has not yet been replaced.

This slide goes into more detail about a per beneficiary payment for PCPs and has a couple of ideas for how much to spend on this payment.

The first idea is that the funding level would be based on the amount of money in the PCIP program when it expired -- about $700 million -- and this was the recommended funding level in our 2015 recommendation. At this level, the per beneficiary payment would equal $28 per year, or almost $3,600 per clinician, on average. It would be funded by reducing fees by 1.3 percent for all services other than primary care visits.

There would be no reduction in fees for primary care visits provided by primary care clinicians or specialists. This funding method is budget neutral and would help rebalance fee schedule between primary care and specialty care.

Alternatively, you could roughly double the funding level to $1.5 billion per year. At this level, the per beneficiary payment would equal about $60 per year, or $7,800 per clinician, on average. It would be funded by reducing fees by 2.8 percent for all services other than primary care visits. And there would be no beneficiary cost sharing under either funding level.

At future meetings, we plan to discuss broader fee schedule issues. These issues include: the need for a greater focus on overpriced services; the importance of improving the process for pricing services; and the inadequacy of the data used to maintain the fee schedule.

We also plan to revisit prior Commission recommendations for CMS to establish an expert panel to help them set payment rates and to collect data from a cohort of selected practices. We will also explore combining CPT codes into larger families of codes.

So for your discussion, we are seeking your comments on redesigning MIPS, rebalancing from MIPS to advanced APMs, creating a two-sided ACO risk model with an asymmetric risk corridor, and how to better support primary care.

With regard to primary care, we'd like to get your comments on the two approaches we discussed: an upfront payment for PCPs and two-sided ACOs, and the level of funding for a per beneficiary payment for PCPs.

We look forward to your discussion.

DR. CROSSON: Okay. Thank you very much. We are open for clarifying questions. Can I see hands for clarifying questions? Okay. Mostly over here, so let's start with Bill Hall this time.

DR. HALL: When you look at the low end of participation, some of these models, what would you say would be the smallest group that would be able to participate?

MR. GLASS: Well, you could probably start with a fairly small group, but they'd have to aggregate with others so that the numbers coming out of it all would be meaningful. So on the MSSP, the minimum size is 5,000 beneficiaries, and I think when we analyzed that, that still left a fairly substantial amount of variation. But we could start with that.

DR. HALL: Thank you.

DR. COOMBS: So under the 1 percent withhold, if I am in a small practice and say I can't graduate and go over to the APM side and I'm stuck where I am for a number of reasons, logistic reasons, maybe not having the infrastructure, what happens at the end of the year to my small, onesie-twosie practice?

MS. BLONIARZ: Yeah, so the 1 percent is just illustrative. You know, you could set it wherever you wanted. But the idea would be that, you know, if they did not want to join an A-APM to get it back, you know, they could either join a virtual group of clinicians -- there is a provision in MACRA for that -- or they could elect to be measured at a local area. So, you know, and CMS could set what that local area is, but it would have to be big enough to detect performance on the measures. If they don't do any of those things, they would not be eligible to receive it back.

DR. COOMBS: Do we have the capacity to go outside of the geographic region?

MS. BLONIARZ: Yeah, I mean, I think that's definitely a policy you could talk about, is how would you want to let these virtual groups form. I think the one contemplated in the law, which CMS hasn't implemented yet, I don't think it's limited to geography. But, yeah, those are policy questions that we could talk through.

DR. HOADLEY: So I'm kind of building on Alice's question and trying to think through this MIPS kind of thing. The 1 percent withhold that you used for illustration, that would be 1 percent of what? Of Medicare revenues?

MS. BLONIARZ: Yeah, a 1 percent reduction in the Medicare payment rates.

DR. HOADLEY: And I guess it would be useful at some point to sort of play that out a little bit in illustrations, you know, sort of what amount of revenue does that amount to, what kind of dollar for a typical physician are we talking about. And then I guess I'm also trying to get some sense of, you know, this is tied now to these performance measures, these population-based outcome measures that CMS would calculate, and sort of what that might look like in terms of what it might take to get your full withhold back or, you know, to get the maximum increase and the maximum decrease, and just, you know, trying to understand what this looks like.

I know one of the concerns I've always had on some of these programs is, okay, you build up all this mechanism, and we're talking about a few hundred dollars in revenue at the end of a year, and it's sort of like, you know, somewhere it shows up in your accounting, but it's not something you're ever going to really notice, so it doesn't end up having any behavioral incentive. And, you know, that either calls for doing a bigger number, but that may have other downsides. But at least as a starting point, sort of what do these numbers potentially look like and what kind of a change in behavior would be required to be at the top or the bottom.

MS. BLONIARZ: So just a couple things. So the 1 percent, you know, you could think of that as being a little less than $1,000 if the average clinician is getting somewhere between $60,000 and $100,000 in Medicare revenue.

I think the other questions that you've raised at completely relevant. There is, you know, a belief that for value-based purchasing to work well, it has to be a substantial, you know, amount of money that is at stake and very transparent on that.

I think, you know, when we were kind of thinking through the policy, one of the things we were thinking about is would you want to create a minimum reduction that is no worse than whatever the withhold is. So if you elect to be measured, you can't do much worse than if you made no election at all.

I think on the other side, you know, we were thinking about keeping it somewhere so that it would not be particularly attractive, so with the idea that, you know, you're not going to do great by staying in MIPS, and that helps move people to A-APMs. But these are all kind of different policy tradeoffs that we can work through.

DR. HOADLEY: The other thing I would also -- you know, when you look at these kind of population-based measures with a virtual group or a geographically based group, it certainly doesn't feel like it has any potential for anything I do as a clinician to make those measures go up or down. So it's sort of like, okay, if I'm lucky enough to be in an area that performed well or improved its performance, you know, whether it measured this improvement or absolute -- or I happen to align myself with this virtual group that, because it's virtual, doesn't have a whole lot of meaning to it, so, again, trying to think -- you know, if that's part of the strategy to make these less attractive, I get that.

DR. CROSSON: Let's -- I think we need to --

MR. GLASS: The virtual group could be something that you recognize, such as your hospital and its associated physicians. It doesn't have to be some ephemeral --

DR. CROSSON: Right, I wouldn't take that term "virtual" too far, because one model for that --

MS. BLONIARZ: Yeah.

DR. CROSSON: Maybe the most common model we had in mind was a hospital medical staff, and so there would be at least putatively mechanisms to do what you say.

DR. MILLER: Right, and we're drifting out of --

DR. COOMBS: Round 1.

DR. MILLER: Round 1? Is that what we call it? You know, and some of it was driven by comments that, you know, we went back and forth with David on, the notion of, like, well, maybe the hospital, because they would know; it wouldn't just be virtual. It would be, you know, the people that work in the hospital. So I want to reinforce that.

In your exchange of, like, well, could this be small and meaningless, I mean -- and I know you get this. Obviously, the first toggle would be 1 percent, 2 percent, you know, how much do you want to put into the game? But the other thing I'd do is keep in mind the reference point right now. The reference point right now is that you're reporting lots of information. We're very concerned that the detectability is approaching zero, and you're being compared to people on completely different bases. So, you know, you're right, but also keep in mind -- you know, you're also right about the current system, like how much signal is the person getting out of the current system?

MS. BLONIARZ: Can I just make one other point? You can also think about having these broad measures that, you know, an individual clinician may say I have very little control over that. But one thing it could do is align the clinician's incentives with, you know, the incentives of other parts of the sector, so with hospitals and other sectors. And to the extent that these measures are used to compare across MA and fee-for-service and ACOs, again, it's just trying to make sure everybody is facing the same set of kind of global incentives.

DR. CROSSON: Brian, you have a point on this question?

DR. DeBUSK: I had a related question. Have you explored ways to prevent negative feedback loops where, for example, in a geography, let's say one of these broad population measures, let's say they're doing poorly, could you find yourself in an underserved area that now has a significant negative adjustment? Because to Mark's point, we've cranked it up from 1 to 2 to 3 percent, and now we have trouble actually bringing physicians and providers into that area because they know they're coming into a negative adjustment.

MR. GLASS: Well, they could join a group. You know, they could join either one of these virtual groups, which could be real things --

DR. DeBUSK: So could I gerrymander my group perhaps? And even though I practice in Georgia, pick a group in New York?

[Laughter.]

MR. GLASS: Well, I don't know. That might be a possibility.

DR. CROSSON: I think -- and correct me if I'm wrong, because I don't know if we've gotten this far. But at least the way I've been thinking about it is when we're talking about a group here, we're talking about a collection of physicians who have an economic connection with each other in some way, not necessarily a formal medical group. It could be an IPA, for example, a certain sort of IPA anyway. Whereas, a virtual group would be physicians who either by dint of the way their practice is organized -- for example, they're part of an organized medical staff -- or they choose to create some sort of a looser coalition for this purpose, but they're not economically linked in the way that physicians are who are employed, for example, or owners of a medical group. Is that fair enough?

DR. MILLER: It is true, and this might be the shakeout for is this a group of physicians or other providers that I might want to think about going into an APM model with. And I get in this group, and I think, you know, Jay's a good guy, I'm going to work with him, or not. You know, so you could use it both to get your MIPS reward, but also you could sort of align loosely and see if these are people that then you want to go in with on a model.

DR. DeBUSK: I was just thinking like let's say you're in a rural underserved area, and let's say you're having trouble getting -- recruiting physicians to begin with. You had terrible health outcomes. Would you create a situation where you say, sure, come to Cookeville, Tennessee, come to Crossville, Tennessee, and, oh, by the way, here's your minus 5 percent payment adjustment in our system? I mean, there's still merit in the idea. I just wonder if there's a way to safeguard against that negative feedback loop.

DR. MILLER: And I guess there's a few things. You know, there's also other adjusters when people go to underserved areas, so you have numbers and dollars that move in the other direction. And I guess the other question I would ask -- and, unfortunately, that means we have to answer it, too -- is, you know, you're sort of positing, well, it's this geographic area and I'm going to get that negative adjustment. But under the current system, collecting information, some of it is outcomes based, and, you know, are you going to be any better off? I mean, if the health of the people in that area is bad and you're being measured either as an individual physician with a lot of noise -- and maybe you're better off, but you're better off because basically you can't measure it. And that's the problem.

We can think about the mechanics, but it will get to something of a philosophical question. At what level do you want to --

DR. SAMITT: And I think the ultimate punchline here is there's always the option of joining an APM and, in fact, is this what we're encouraging, the adoption of more APMs as opposed to the potential risk of uncertainty as to who is going to be in your virtual panel.

DR. CROSSON: All good points.

Now I'm going to make the argument that we're now in substance as opposed to questions. So let's try to get through the questions, and then we'll come back to this set of points, if we can.

DR. COOMBS: Round 3.

DR. CROSSON: Round 3, right.

Sue.

MS. THOMPSON: Kate, I think you answered this, but I just want to make sure. In terms of reconciling the quality measures between APMs and ACOs and across the board here, just talk to me about the attention being paid to not creating another whole set of --

MS. BLONIARZ: So what we were kind of thinking is, so the Commission has done work on comparing across various models, payment models, and this linked to the premium support discussion. But the idea is you would assess a local area based on basically the top four measures on the slide, so potentially preventable admissions, ED visits, mortality and readmission, patient experience, some measure of healthy days at home, and you could think of those as kind of the broader systemic measures that you have. And then one thing we were thinking about is maybe you could supplement it with a few things that are important for the clinician sector, and so what we were thinking there are rates of low-value care and relative resource use.

So it's not the same, but it's consistent. It's largely the same set of measures, but it doesn't have to be done that way. But the benefit is you get kind of all the signals going in the same direction.

DR. CROSSON: Clarifying questions? Moving down that way, Craig and then Pat.

DR. SAMITT: Let me put on glasses here. Slide 12, please.

In terms of the redistributed PCP payment, would this be within a distinct two-sided ACO, or is it so it would be a singular ACO's redistribution of a per-visit payment to an up-front payment, not more broadly for all PCPs?

MR. WINTER: Correct. Yeah. And one reason to do that is -- the way we think of it is the PCPs and the ACO would have an option to determine the percent of their payments for primary care visits they want to take as the up-front payment. They could say 20 percent, 40 percent, 60 percent. So you would have to do an adjustment within the ACO to take that money -- to recoup that money, in a sense, and offset the up-front payment.

DR. SAMITT: Got it. Thank you.

MR. GLASS: And this is being done in the Next Gen model already.

MR. WINTER: Right.

DR. CROSSON: Pat.

MS. WANG: You said it's being done in Next Gen with a partial up-front payment?

MR. GLASS: Yeah. The Next Gen model has a -- one of the options, payment options, is they can choose to have basically a partial capitation payment, and they can actually agree with different providers on different percentage of up-front payments versus --

MS. WANG: I guess that I -- maybe I lack imagination, but I was wondering if you could talk more about -- this seems like partial-partial capitation because the doctors electing to get a portion up front, which seems like a nice cash flow advance, but they still have to bill a recognizable billable service of the same number of visits in order to break even, whereas if it's -- think of PCP capitation. It's a little more flexible than that because the capitation is for the whole amount. So I guess I was just trying to figure out like --

MR. GLASS: Well, it's the kind of classic partial capitation theory of you pay the -- well, Paul can explain it. You pay the up-front amount -- that's your fixed cost -- and then the amount you get per visit is your variable cost, so you have on reason to over-provision or under-provision care. So it's that kind of idea. So I want the PCPs to get 60 percent of their payment up front, and then each time they do a visit, they get 40 percent, so they don't have a reason to do more or fewer.

MS. WANG: Okay, I understand.

MR. GLASS: Yeah.

MS. WANG: But that is an approach that covers fixed cost as opposed to provides funding to may be switch the composition of services. I don't know. So I was wondering about that.

DR. MILLER: Can I just try one thing, though? So are you saying -- and I'm driven by your words where you say, well, this really just sounds like a cash flow type of thing, and I think you're right. This is getting a portion of what we assume you would have gotten anyway or this particular provider up front.

Next question or next point, the second thing that Ariel was talking about was to actually shift dollars and make the reimbursement for the primary care more than it currently is. So I think the thinking process -- and you guys back this up or not -- is you get the cash up front. That gives you some white space that you don't have to do everything visit by visit, a little more coordination, a little more flexibility, hire help in order to run the office, and then the primary care shift in the fee schedule is to actually put more resources in the hands of the primary care physician. And then if the ACO works out, maybe you get some bonus out of that, but that's obviously behavioral.

MS. WANG: Okay.

DR. GINSBURG: On this thing, I think it's a combination of a lot of things that the partial capitation, meaning that, say, half of what you get is going to be capitated and half per visit, is an attempt both to reflect more the nature of primary care, the fact that there are a lot of important primary care services that don't occur during face-to-face visits.

But also, as David was getting into, this is a classic thing of any time you pay fee-for-service, you get too much use, and in a sense, if you can blend part of it, which is covering your fixed costs and then the other part, which is covering your marginal or variable cost, you actually get ideal incentives for the physician in the context of traditional Medicare.

MR. WINTER: If I could just point out one difference between this approach here on Slide 12 and what's allowed in Next Gen ACO is that the up-front payment in Next Gen ACO could include the entire payment for all the services -- across clinician services, hospital services, post-acute care -- whereas what we're talking about here is much more limited.

MS. WANG: Yeah, yeah. I mean, I would have -- so thank you for the explanation. I think of the ideal in terms of clinical flexibility to be capitation for everything, so that you can mix the services. It's just doing it part way, you still have to have medically billable services, and maybe that doesn't give as much flexibility.

The only other question I had was there was a statement that -- so this is a good idea to limit it to ACOs because it solves the attribution problem. Can you talk about why it solves the risk adjustment problem?

MR. WINTER: So the concern with having a partial capitation approach is that there is variation in the disease burden, comorbidities of patients, and so you might want to increase that per-beneficiary payment for PCPs that treat sicker patients and decrease it for those that treat healthier patients.

The way we think that it addresses that concern in a two-sided -- in an ACO is that the up-front payment would be set based on the ACO's historical level of spending for primary care visits. So if the ACO has historically treated sicker beneficiaries who require more visits, their up-front payment would be higher than another ACO.

The other way to address it is if you wanted to expand this to general fee-for-services to base it on the risk score or the HCC risk score of beneficiaries, for example, which is how CMS is doing it in CPC+.

DR. CROSSON: Clarifying questions. Bruce.

MR. PYENSON: A question for Kate. In the original MIPs, there were some really impressive double-digit reductions in the outer years. Is the intent here to create a road, glide path towards something like that?

MS. BLONIARZ: I mean, I think that's a policy question. By 2022, they're up to 9 percent up and down, and it can be even higher on the up side in MIPs.

I think it kind of just goes back, again, to what would be the point of building a different MIPS system. Would it be that you would want clinicians to see a very large payment reduction and make changes around that, or would it have another set of goals?

I don't think we've really figured all that out, and I think that would probably play into do you want -- you could also think of something like making it less comfortable over time if you want to move everyone from MIPS to A-APMs, but those are just kind of policy choices.

DR. MILLER: And it might be worth just saying it again. What we're trying to do here is we've had a few conversations with you, and we've gotten lots of comments. And we're trying to pull these into a framework and figure out, in a sense, "Bruce, is this" -- you know, this is one of the rare instances where we can put the question back on your guys.

In the MIPS world, very burdensome. We're worried about signal to noise. Are we actually getting -- are we encouraging concern that people might stay?

A second signal was, Can you make APMs more attractive? Many of you said that. Craig was leading that charge pretty hard, and other people have said, "But what about primary care?" And so we're trying to thread this needle here. The numbers, the specifics, 1 percent, we're just trying to get the concept in your head to see if we're even in the ball park, and then if you want to -- like, "I want this to be 9 percent in 2022," then we can have those kinds of conversations.

DR. CROSSON: Okay. It looks like we're questioned out. So now we'll have a discussion. Have we got the discussion slide up? Can you throw that slide up there?

Again, comments on the proposed models here, including MIPS, A-APMs, and the primary care incentives. So could I see hands for people that want to make comments?

[Show of hands.]

DR. CROSSON: Okay. I think this time, we'll start at this side. Craig.

What? Did I miss something? What?

DR. SAMITT: Alice is going to kick it off.

DR. CROSSON: Oh, I'm sorry.

DR. COOMBS: I was just going to say --

DR. CROSSON: I did it again. I did it again.

Alice, go ahead.

DR. COOMBS: Thank you, Craig.

[Laughter.]

DR. COOMBS: So a couple of things. I think this is such a hard job to get to the marrying or finding a home for the primary care physician and the MIPS and MACRA, and

I think what we're trying to do is a very difficult thing, which is move a primary care doctor from one entity to the other.

It's easier if you start with a robust health care delivery system like Partners or Ochsner or anyplace like that, but I think this is a varying heterogeneous group across the country, and so I'm a primary care doctor, and I'm looking for a home. And you tell me I can actually go and join a group. Virtual, geographic, or somewhere, I'm going to go join a home, and so I'm working on Benning Road in Washington, D.C. So where do you think I'm going to try and find a home? I would probably marry someone who is rich and famous.

[Laughter.]

DR. COOMBS: Or I'm trying to make my stats look a little better.

That being said, we actually showed -- at the Mass Medical Society, we had a RAND study that looked a reliability of quality measures, and this study was very good because when you have multiple specialties caring for one patient, you have to have enough of a numbers threshold to be able to differentiate who is responsible for what good outcomes or what bad outcomes.

My greatest concern is that even under a primary care umbrella, I may take care of X number of diabetics, but I may have decided that I want to be an addiction specialist or a weight management person, and so that even for the given diagnosis and the risk adjustors to apply to my heterogeneous practice -- and I fall as an outlier for internal medicine -- it's going to be a very difficult thing to do. The whole notion of attribution within a geographic region, it's sealed with a lot of problems.

Solutions to the problems? I think if you can have a little mercy one the onesie-twosie groups, I think that's where we could probably do focus groups and find out from local and regional internists and family practice docs what kind of things they're doing on an innovative scale because they're trying to adjust to this changing landscape just like anyone else, and we have to remember that primary care doctors are roughly 25 to 30 percent in a given area. So we're taking -- and each of the proposals that we have, we have one proposal that says take from the 75 percent, 2.8 versus whatever the 1-plus percentage, and pour that into primary care. Something needs to be done with primary care.

And I absolutely agree, that first option seems like it's probably the less threatening option. The 1 percent option, I only fear that people will have a different type of compensatory mechanism to adjust to the change. So it's going to take something much more creative, especially when the attribution is imperfect.

The population measures that are being applied to me in the trenches, I may have a hard time becoming a part of that in terms of my participation and what did I lend myself to in that whole process.

I think there's a great example in the anesthesia and surgery literature, and it's called ERAS, and it's early recovery after anesthesia, where they've actually been able to combine care. So if you can combine care and you can kind of say, okay, you're responsible for this kind of outcome, that's an easier type of -- but in the landscape of primary care, unless you're from the Dean Clinic or someplace that has a robust integrated system, integrated IT that can actually pinpoint, okay, this is where we have a deficit -- I mean, there are people who do hemoglobin A1c, and that's still up for discussion. Jeff

Drazen will tell you that measure changes daily. So if you're going to use things like that, those process measures, it's very hard to tell.

I think the population measures is where we should be, but how to get the internal medicine doctor, the family practice doctor being inculcated in, that's your part over there. That's what you all -- I think that's where the problem is going forward.

DR. CROSSON: So, Alice, help me because it's been a while for me, but let's just think about the organized medical staff model for a moment. As you well know, as I do, it's kind of a group but not really a group because you've got -- it's a mulling-alone model. Essentially, everybody is in practice, but they're nominally working in the same institution yet. Historically, the organized medical staff has had a role.

DR. COOMBS: They have a --

DR. CROSSON: And I'm thinking more functionally. They have had a role in trying to oversee and manage quality within that institution, right?

Now, some are effective, and many have not been, and in fact, the enthusiasm for the value of the organized medical staff model has kind of waned over the last couple of decades.

So at least one of the ways I've been thinking about this -- and correct me if I'm wrong -- is that -- and remember this is just an option. So joining an A-APM would be an option, but then you would have the other option, which is to organize your organized medical staff to be the unit of measurement on these population-based measurements.

DR. COOMBS: So there's an underlying assumption that you just made.

DR. CROSSON: Yeah.

DR. COOMBS: In our community, 80 percent of docs don't even come to the hospital. The hospital's program has superseded on every single service. Pediatrics has an inpatient hospitalist. It's hospitalist internal medicine. So that question of where does care happen, believe it or not, the majority of care happens outside the hospital, and so what we're trying to do is coordinate the outside of the hospital to say let's have it on the premise of what the hospital looks like.

In the olden days, you're right --

DR. CROSSON: Yeah.

DR. COOMBS: -- it would be a physician hospital organization, and we would work from that premise, but this is a very different practice now because some doctors, they don't even come to medical staff meetings. So just that information flow about what's happening --

DR. CROSSON: No, I think that's fair enough, and you're right. Hospital care has been reduce as a proportion of care, both through technology and through use of hospitalists. So that's an imperfect -- I'll grant you that's an imperfect model, but the notion here still applies, which is that either using the hospital as a base or the county medical society, for example, or some other -- and this could be specialty based, potentially, as well, you would have the option here, as defined, to choose, as Mark said earlier, the physicians that you want to be associated with. And the whole point of that is to achieve a volume of care of Medicare beneficiaries that is actually measureable, measureable against relatively simple, simple in terms of collection and simple in terms of concept, measures of quality, so --

DR. MILLER: In listening to you guys, you are absolutely right. Tons of physicians do not set foot in a hospital, but you could almost have the hospital-based physicians be a nucleus and begin to say, okay, let's reach out and get these sets of physicians so that we can all be measured together.

And then I will just say this again: Keep in your mind, what is the alternative? You know, if you are sort of saying, well, it is really hard to kind of coordinate and know your place in the system and what your effect is, then you are also saying that under the current system where we are trying to -- where we are, in fact, imposing a bunch of burden and collecting a bunch of information, we are still talking about a physician who is completely disconnected and not coordinated. And what we are actually measuring there and getting out of that is kind of the question.

And so I am going to -- each time you guys say this I am going to, you know, kind of force you back to the status quo of, like, you are right, this has a bunch of problems; so does the status quo. And so if there is another idea, that is what we are searching for.

DR. CROSSON: The status quo being a lot of work on the part of physicians, a lot of reporting requirements, and down at the bottom of the end of it virtually nothing in terms of this will work for nothing.

So I admit, you know, if this is the choice -- creating or reenergizing a virtual group -- that is work. But in the end, the argument would be it is work with some reasonable expectation of gain at the end as well as actually improving quality.

Okay, you still do not believe me. I know. I know.

DR. COOMBS: Well, I am just saying that -- Mark, you bring up a very good point because you are thinking what the counter-factual might be, what if this -- but the situation is, I think, a lot of physicians are in the place where they are looking at, well, it will not be so bad if I continue to do what I am doing right now. And so that is the other piece of it is that --

DR. MILLER: But do not be so bad -- or will not be so bad, sorry, I think is, at least in the current state of place -- given the lack of reporting and the inability to distinguish, they are just saying, okay, we are going to just sort of do this nominal thing for everybody.

So you have this reporting requirement, you have, you know, nothing that really says, oh, you are really good and you are not. So that is not really happening. And you are not sort of pushing, you know, physicians together to say, okay, is there a coordination effort there?

And at least, you know, early on, remember -- another way to make the point that I am making -- I am just making the same point -- is -- she did not know my microphone was off.

[Laughter.]

COURT REPORTER: I do.

DR. CROSSON: She just copied and pasted your earlier remarks.

[Laughter.]

DR. CROSSON: This is so great.

[Laughter.]

DR. MILLER: Sorry, man.

Remember, you know, your first reaction when we started taking you through MIPS. I mean, your reaction was: I do not understand any of this. How is a physician and other provider going to see what the signals are? And that is what -- that and subsequent conversations are what we are trying to rebuild from. And you are right; there are problems with these things.

Sorry, Kate.

MS. BLONIARZ: And I just wanted to make another point.

I mean, one question you could go directly at is, if MIPS as it currently exists is not appealing and, you know, other ways are dealing with it, do you want to go directly at the question of should there be value-based purchasing for clinicians in Medicare? I think you could go right at that.

DR. CROSSON: Okay, and now we have got Alice -- now Alice's head is going this way, so --

[Simultaneous discussion.] [Laughter.]

DR. CROSSON: All right, so let's go back --

MR. GRADISON: Jay?

DR. CROSSON: We will start at that end with Craig and then come up.

DR. MILLER: You know, Kate's question actually is the right place to start. You know, should we -- do we want value-based incentives? For clinicians in Medicare I would say absolutely yes.

The discussions that we have been having now for years -- you know, I think what we are trying to accomplish is we want to reward PCPs and other physicians who deliver high-quality, affordable care. And, in fact, we want to encourage the development and movement toward more of those types of clinicians.

And so, I think the -- when I looked at your proposal, which I think is really good work, what I kept thinking about is, does it do that? And I very much think it does. I like a lot of what you have suggested. You know, starting on the APM side, part of it is I think I need a tally of all the parts because I got lost in all of the bonuses and the, you know, imbalanced upside.

And I think it would be good to sort of recognize what is it that you are offering to APMs, but when I glanced at the total package, it is very much lucrative for high-performing APMs, that organizations that are truly demonstrably best in quality and affordability will do well. So I think you have done well on the APM side. In fact, perhaps you have gone a bit farther than you need to. On the MIPS side I am not so sure. I think, for all the reasons that you described, MIPS does not distinguish between high performance and low performance, and it is very complex.

I also do not -- I wonder whether 1 percent -- and I know you said the number can be anything, but is 1 percent a significant disincentive? So now, regardless of the upside for APMs, if what you are telling me is you are no longer going to measure my performance, it is a 1 percent withhold, I could get 1 percent back if I become part of a virtual panel, I am wondering if I am just inclined to stay exactly where I am, no change.

So, I am not an expert in behavioral economics, but I think the intent here is to say, if we want to encourage movement to APM, how significantly do these recommendations do that? And maybe it is not a 1 percent; it may need to be higher than 1 percent to continue to encourage movement toward APMs. Let me end there.

DR. CROSSON: Comments? Kathy.

MS. BUTO: Mine will be brief.

I keep looking at the primary care portion and feeling like it is not enough. I do not know what it is but it does not feel like it is enough. And it would be really helpful as we flesh this out more if we could say, what is it we want primary care to be doing that it is not doing now? And then, what do we think it is going to take to make that possible, whether it is more money -- and it may be more authority, so it is not just more money -- I think that would be helpful, or more information.

But I do not know what we are trying to do with primary care, except we keep trying to give them a little more money but we also talk about how great the disparity is. So I feel like we are not really -- we are not really getting underneath all we need to do there.

DR. CROSSON: Bill.

MR. GRADISON: With regard to MIPS, it sounds like we would be moving from the current system, which really does not distinguish high quality from low quality, to a system which does not distinguish high quality from low quality at the provider level.

A question in my mind -- and I know there are a lot of people thinking about this, but it might be something you want to do for another -- at another time -- how much progress, if any, could be accomplished through the use of data that is already available in terms of the risk assessment of the individual patients in terms of the claims, data, and so forth? I am very aware of the limitations, but I just wonder about that because the current system where you -- gosh, I wish we had that in college, where you could take a course in European history and you could decide which country you were going to be examined on ahead of time. That would be marvelous.

[Laughter.]

MR. GRADISON: You know, that is what we have here. You are going to pick something where you look good, obviously, and that is easy to fill out. And it does not mean a thing.

DR. CROSSON: So, moving from Lichtenstein, we will go to Paul.

[Laughter.]

DR. GINSBURG: Yeah, I liked the paper a lot and the presentation a lot too. It has a ton of good ideas that really reflect the work that we have been doing over the months I have been here.

The way I see it is that, you know, MIPS came out really as a misfire. I just do not think you can do very much in measuring the value of -- you know, of small practices, especially, you know, just with readily available data. And I think the big mistake on MIPS was making MIPS way too large and, you know, offering some big gains for large practices to stay out of APMs because they could do so well with MIPS in driving the small practices into the hospitals because it looked like it was going to be a disaster for them -- so, in a sense, just getting rid of the worst features of MIPS even if you do not believe much in the way of incentives to improve your value because you really cannot do that effectively.

And I am very comfortable with that because I think that -- I believe in value-based payments, but I believe that getting physicians into organized -- you know, organizations which have the numbers to measure it is really the way to go. And I cannot say whether you have the best ways of drawing people into APMs, but I really think that we need to give up on pushing people out of -- pushing people -- repelling people from unorganized care and drawing them into organized care. There is a lot of work to be done.

I will stop now. You know, I also agree with Kathy that the things we are doing for primary care are very small. I think they are positive things, and maybe when we -- so I certainly support them, but keep looking for bigger things we can do. And maybe we just need to think bigger.

DR. CROSSON: Comments, coming up this way?

Bill.

DR. HALL: It seems to me that with MIPS and a number of other things that we are doing now, besides maybe some very poor planning that maybe could be corrected somewhat, is that we are asking a group of physicians who call themselves primary care providers -- which means they are sort of the generalists of medicine -- and we are saying: You are responsible for some kind of a catchment area or some kind of a group. And as we look at your area where you are, you have some problems -- like maybe diabetes is not being cared for in general very well, or there seems to be too much alcoholism in your community. And we are saying: Why don't you fix that? And they do not have anything to do with that. They are out in the `burbs somewhere.

And so, I think we have very muddy expectations what modern primary care should do. Maybe the burden of proof of this quality should not be put so much on the individual physician -- some should be -- but maybe it should be put on the people who gain from having a cadre of physicians and health care providers who are really trained and paid for what they are supposed to do. I mean, one could say maybe it is the hospital system that should be responsible for recruiting, organizing people to do the job correctly.

So I do not know that we are targeting -- getting the right target. When many of these things came out, including MIPS, it was almost as if somebody was at an art institute and looking at pictures of the -- you know, the famous --

DR. CROSSON: You are not going to say Roy Lichtenstein, are you?

[Laughter.]

DR. HALL: No, I have never been to Liechtenstein.

DR. COOMBS: It is a Rorschach test.

[Laughter.]

DR. HALL: And they say: Well, here is primary care. What is that on the wall? That is a picture of a primary care physician.

[Laughter.]

DR. HALL: So anyway -- what did I do?

[Laughter.]

DR. HALL: What did I do this time, besides pulling an all-nighter and not sleeping -- not staying awake?

[Laughter.]

DR. HALL: So anyway, I think it is well worth our while discussing these issues but I do not know that we have the right target yet for measuring quality circa 2017.

That is not very helpful. I am sorry.

DR. CROSSON: Okay, Bill.

Alice on redirect?

DR. COOMBS: Well, I think our heart is in the right place. And Kate, her recommendation about value-based purchasing might be something we would look at.

But I think it is a complex -- it is a complex issue. I do support the first tier of what we said in the box in terms of the traditional PCIP approach. As for the 1 percent, I think it is fraught with problems right now in the current climate.

DR. CROSSON: Okay.

Comments? Sue.

MS. THOMPSON: Well, at the risk of stating the obvious I just want to say, in general I am quite supportive of the direction that we are going. And I feel a little bit like we get into all the detail and lost in the weeds a little bit, of wondering about quality metrics and individual physicians and how do they fit into the big picture, and have to remind ourselves, in the beginning, what were we trying to accomplish when we left SGR and moved to this business called MACRA?

And I think it had something to do with a sense that there was value in coordinating care for our Medicare beneficiaries, and that to do this required a new set of incentives for our provider communities. And I agree with you; I think there is some accountability more appropriately placed on whether it is an accountable care organization, as we see in the Next Gen structure, or if it is in some organized medical staff -- however we chose, or individuals chose, to be organized.

I think we have got to get out of some of those weeds and remind ourselves, what is it we -- what is the problem we were trying to solve? And I believe the recommendations you have here, where we think very, very carefully about what makes becoming part of an APM much more advantageous than being in MIPS? And I think if we keep our eye on that question, we will continue to drive the detail in an appropriate way. And I believe you are doing that as you get this work put together, so thank you.

DR. CROSSON: Okay, I think you have got the executive summary for the next version of the chapter.

Warner?

MR. THOMAS: Just briefly, I think that -- you know, with this it looks to me like you are trying to create incentives for primary care physicians going to APMs, which I think makes a lot of sense. I do think that there needs to be a downside if folks do not gravitate in that direction, because I still think there is a lot of people that just say, I am just going to kind of maintain as I am today. And I think there has to be incentives and also a downside if you are going to be able to create the type of change that we need going forward.

DR. CROSSON: Okay.

Rita?

DR. REDBERG: As long as we are waxing philosophical, I thought I would share my concept of primary care , not that -- I know we will get back to it.

But, going back, when I was a medical student at the University of Pennsylvania and I was thinking about family practice, we did not have a department there. So I spent a month in North Carolina working with a GP, Jane Carswell, who I think is my idea of what primary care I wish was like now, because she had a huge panel of patients; she took care of them.

You know, she did forceps deliveries, which OBs do not even do now, all the way through. And, you know, she did very few referrals because she went into medicine because she wanted to take care of these patients. And she knew them and she was -- she bought -- I saw her buy medicines for people that could not afford to buy their own and she knew they would not buy them. You know, she started practicing before Medicare even existed.

And so when I think, you know, how do we get back to that kind of model, you know, it was kind of when we had this newer concept of a patient-centered medical home. I mean, that really -- and a lot of primary care physicians said this -- that was what the primary care doctor used to do but, you know, now we kind of created another entity.

And now we have shifted -- and obviously I am a specialist but, you know, when I look even now, I think primary care doctors have given up a lot of what they used to take care of. You know, chest pain, it is coming to cardiology, and things -- and it leads to a lot more care than is probably in patients' interests when you have so much specialty care.

So, you know, I think this is -- and I think this is a good start to rebalancing -- I am saying it is a big problem. You know, we have workforce issues here. We have, you know, geographic issues here, training issues. I think the idea of shrinking the measures is a great idea because that is very burdensome, you know. And looking at population-based outcome measures and trying to take these much broader ones rather than, you know, the European history analogy is a good -- really good idea.

I am not sure, you know, how much money is the right amount of money because it is more than, I think, just money. It is sort of the autonomy and what physicians went into medicine for that I think we need to try to capture again. So I think this is a really good start.

DR. CROSSON: Okay, thank you.

Brian.

DR. DeBUSK: I am really excited to see us take on MIPS redesign. You know, we have talked about the shortcomings of the model here earlier. I think the more illustrative we can be -- and you have been fantastic so far on just showing how it is just not going to work, between pick your own measures and PQRS.

I also hope that we can steal a page from the PAC PPS, where not only do we show what is broken but we say, here is what we can do; maybe here is what we can get from administrative data or from claims data, realizing it is not going to be perfect.

And Mark made the point earlier, you know, as we do virtual groups or look at geographies, that is not going to be perfect either. But I do wonder if we could double down on our fair criticism of the shortcomings of the current MIPS, PQRS design, but also paint a picture -- and it is not a perfect picture. It may not be a Picasso, but it will be a lot better than the picture that is out there now. And I think that would -- number one, that may facilitate change.

The other thing, I love the idea of the

asymmetric risk corridor in the ACO. I mean, I think it is time to put our thumb on the scale for ACOs. We need them to be successful, and it is going to require some money. I would support an asymmetric risk corridor. I would also support tinkering with their benchmarks a little bit so that it is a little easier for them to hit those goals.

You know, I have made this comment before. When we launched Medicare Choice, what would become Medicare Advantage, I mean, what kind of -- what kind of subsidies did that program have coming out of the gate? I mean, it has taken us seven years to walk those subsidies down, and we are still, what, 3 or 4 percent -- 3 or 4 percent high. You know, I am not advocating crazy subsidies, but maybe it is time to put our thumb on the ACO scale and make sure these things work.

And then my final comment -- you know, obviously primary care, we have to do something about primary care. And I think a number of people mentioned this. I do not think we -- we need to do something dramatic, we need to do something big.

My one thought is, if we are going to double down on ACOs and ensure their success, maybe we do not want to be quite as prescriptive with primary care because -- and again, need to go back and reread, but I could have sworn reading something about this first round of ACOs, a disproportionate amount of the settlement payments I think did go to primary care.

So I do wonder, if we were a little less prescriptive on exactly how primary care is to be paid but doubled down on helping ACOs to be more successful, if they could solve some of these issues around how do you align the primary care physician themselves? And I would rather have 400, 500 test tubes around the country looking at different ways to pay primary care than maybe us sitting in a room saying this is the way to do it.

So those are my thoughts.

DR. CROSSON: Okay. Thank you, Brian.

Seeing no further comments, Kate, Ariel, David, thank you very much. We will be returning to this issue probably early in the next MedPAC term. So thank you for the work. We are going in the right direction.

So it is now time for the public comment session. Could I see the people who want to make public comments please come to the microphone and line up?

[Pause.]

DR. CROSSON: I'm just waiting to see how many people are moving where. It looks like everybody is heading for the hills. So we have a couple.

Let me make a couple of preliminary remarks. This is an opportunity to address the Commission on issues that we have had before us this afternoon. It is not the only opportunity, you may know that. There are opportunities to contact the MedPAC staff before we have our meetings, both in person and online through the website.

I would recommend those opportunities to you.

However, we do have this opportunity. I would ask you to identify who you are by name, any association or organization you are affiliated with. And please keep your remarks to two minutes. When this light returns to red, then that’s two minutes.

Go right ahead.

MS. O'CONNOR: Thank you.

My name is Mallory O'Connor and I’m with the Biotechnology Innovation Organization.

The Biotechnology Innovation Organization appreciates the opportunity to provide comments during this public meeting of the Medicare Payment Advisory Commission.

BIO is the world’s largest trade association representing biotechnology companies, academic institutions, state biotechnology centers and related organizations across the United States and in more than 30 nations.

BIO’s members develop medical products and technologies to treat patients afflicted with serious diseases, to delay onset of these diseases, or to prevent them in the first place.

BIO would like to take this time to express our continued interest in engaging directly with the MedPAC staff to identify and consider policy solutions that balance our common goal of improving Medicare’s beneficiaries’ access to high quality care, decreasing overall program spending, and incentivizing future innovation in medical technologies.

BIO is concerned that some of the proposals currently under consideration may fall short of these goals. Specifically, consolidated billing codes as we are concerned these practices may preclude patient access to the most appropriate therapies for them individually, undermine market-based reimbursement, and provide a disincentive to innovation.

The Drug Value Program, as we ask MedPAC to provide additional details with regard to the structure of the program and prioritization of beneficiary protections and cost savings.

And an ASP inflation rebate, as we are concerned that this policy will effectively create a price control that will negatively impact the market-based reimbursement system that works to foster patient access to critical Part B medicines.

Thank you for the opportunity to comment today and we look forward to the opportunity to discuss these perspectives in more detail with the MedPAC staff in the coming weeks.

Thank you.

DR. CROSSON: Thank you.

DR. BENNETT: My name is Susan Bennett and I am here by happenstance, no prepared statement.

I am a cardiologist. I have been in practice for 20 years. I have obviously had a lot of interface with primary care physicians.

I also resigned my position in October and since then I have been reading a lot of Health Affairs, so I am familiar with some of these acronyms.

With that as an introduction, I would say there's several -- listening to all of the comments and all of the proposals, which is a lot of work that's been done and I can really see, from all of your perspectives, you have really been able to combine a lot.

One of the things I can tell you, though, about primary care and emphasize is that I think they are absolutely the linchpin to how we solve fee-for-service to value-based care. I do not think there is any other important group that we can identify, other than the primary care physician.

In the models that I've looked at, and some of them I've had a chance to actually see on the ground, I think the most effective have been when you really put a lot of risk in those people's hands.

To coordinate care requires a group. It may not require a large group. I am sure you can get better examples than I could give here of medium-sized groups and small groups, but I think it's possible to do. I think combining the fact that primary care physicians really have to be able to see patients as frequently as they need to, that's relatively low cost.

The upside would, of course, be that they are able to identify these patients that are ready for admission or readmission.

The use of subspecialties, I think, is very, very crucial to this. A good primary care physician will know when to refer and not to refer. I think the concept of a curbside is very important. In other words, having primary care physicians be able to readily access a subspecialist to say, for instance, I get a lot of consults for abnormal EKGs. 80 percent of the time I could look at those EKGs and ask them one or two questions and say you know what, they really don't need to have a consult. So we will avoid all of that extra testing.

So in summary, thank you very much for all of your work. It is an extraordinarily difficult, incredible thing that you're going and I hope that you can maybe, for future meetings, get more input on the ground from primary care physicians who have made it work in various ways.

DR. CROSSON: Thank you.

MS. BRENNAN: Good afternoon. My name is Allison Brennan with the National Association of ACOs.

I obviously really appreciate the discussion today and support the work that you're doing to encourage providers to move into advanced APMs.

One thing that wasn't discussed today, which I'd kind of like to raise and encourage you to consider is as we're looking at payment models, value-based payment models geared towards primary care, we also have to look at the overlap of other payment models, particularly those related to episodic payments and bundled payments.

We're seeing a lot of new things come out and the overlap of all of these things on top of each other really can have a negative effect and kind of take the wind out of the sails on some of these original models that I think sometimes we're viewing as kind of the linchpin to this.

So I would just encourage you, as you're considering your work on primary care at the same time to consider the overlap of those other payment models so that we're not unintentionally undermining the primary care models.

Thank you.

DR. CROSSON: Thank you.

UNIDENTIFIED SPEAKER: I'm Zach. I'm an intern with the National Association of Community Health Centers. I am also a future medical student.

I wholeheartedly agree that primary care is struggling. I am a medical scribe back home in Minneapolis and my doctors are consistently telling me don't enter primary care, this isn't a job for you, we don't like this, our jobs suck. I am doing a study right now on burnout for the community health centers. It has increased 9 percent in the last three years to now up to 54 percent is the average physician burnout, and then 63 percent of family medicine physicians have burnout.

And so how do you get that comparative to others when it's so high in that field? And what are we doing to incentivize people to go in it when people like me, who want to be in primary care, are being told not to enter that field?

And so what are we doing to help? And how are we going to make that better?

And then if you do groups, you're incentivizing that you want to do groups where doctors are highly trained and that you want to be with people who have already proven that they're worth -- if I'm a new medical student and I know I'm going to make mistakes, are people going to take me into that group and want me to be part of that if I may hurt whatever projections you're trying to meet?

So those are just my comments on what I see from being a young student.

DR. CROSSON: Thank you.

Okay, seeing no one else at the microphone, we are adjourned until 8:30 tomorrow morning. Thank you very much to the Commissioners and staff.

[Whereupon, at 5:07 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, March 3, 2017.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, March 3, 2017
8:31 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
ALICE COOMBS, MD
BRIAN DeBUSK, PhD
PAUL GINSBURG, PhD
WILLIS D. GRADISON, JR., MBA, DCS
WILLIAM J. HALL, MD, MACP
JACK HOADLEY, PhD
DAVID NERENZ, PhD
BRUCE PYENSON, FSA, MAAA
RITA REDBERG, MD, MSc
CRAIG SAMITT, MD, MBA
WARNER THOMAS, MBA
SUSAN THOMPSON, MS, RN
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AGENDA PAGE

P R O C E E D I N G S

[8:31 a.m.]

DR. CROSSON: Okay. Let's take our seats and we can begin. For this morning's session, we are going to expand our discussion and thinking about the issue of premium support. As the Commissioners know and some of our guests may want to know, for about the last year or so, we have been looking into a range of aspects with respect to the concept that is roughly called premium support.

The purpose of this is not to -- and the Commission has not and does not intend to -- take a position on whether this direction is the appropriate direction for the future of Medicare. However, we are aware that policymakers have been working on this, thinking about this for some period of time, and our belief is that the Commission could be helpful to that thought process, to provide information about essentially if the policymakers were to proceed in this direction in the future, what are the most appropriate considerations and modeling aspects that ought to be taken into consideration with respect to the premium support?

It is our intention, assuming the discussion goes forward properly today, that we will be putting together a report for the June report according to those parameters that I just described.

So we have two presentations today to further expand and actually begin to complete our work on premium support. The first one has to do with a set of issues with respect to standardization across the various models that would be part of premium support. And Carlos Zarabozo is going to take us through that. It is quite a piece of -- what a master work that you have put together, Carlos. It's taking an extremely complex set of concepts and putting them into a form that I think we'll be able to analyze and have a robust discussion about. So you have the microphone.

MR. ZARABOZO: Thank you, and you pretty much did my first slide, so I will try to salvage something from the text here.

DR. CROSSON: You may notice I have a tendency to do that.

MR. ZARABOZO: So, in conclusion --

[Laughter.]

MR. ZARABOZO: So far the Commission has

discussed options for setting the government contribution in a premium support system and the effect that different approaches might have on the costs beneficiaries would face in such a system in a given geographic area, including a discussion of how to mitigate any large changes in beneficiary costs in moving to such a system.

Most recently, in October 2016, the Commission discussed the issue of reforming quality measurement and implications for premium support, and in November, the Commission reviewed issues in determining the government contribution and beneficiary premiums. This morning, I will be discussing issues related to standardization, and then Amy, Scott, and Eric will talk about the impact a premium support system might have on beneficiaries and plans.

Here is the road map for this first presentation, which consists of some discussion of the terminology used, the rationale for standardization, a look at the extent of standardization in current programs (that is, in Medigap, Medicare Advantage, and Part D); how standardization might apply in a premium support system and what the rationale would be; and, finally, I'll discuss some additional related issues.

First, to define standardization. For purposes of today's discussion, what is meant by complete standardization in health insurance is that there are no differences among the products that different insurers offer in the marketplace, a definition that will become clearer in looking at the Medigap model. Aside from complete standardization, there can be standardization of components of health insurance offerings.

We will talk about three components today: benefits, cost sharing, and plan offerings. An example of the standardization of benefits is the skilled nursing facility benefit in Medicare fee-for-service and Medicare Advantage plans. Medicare fee-for-service covers 100 SNF days, and MA plans are required to cover 100 SNF days. Medicare fee-for-service has a fixed cost-sharing amount for SNF days beyond the 20th day. If one wanted to strictly standardize cost sharing in Medicare Advantage for the SNF benefit, the requirement would be that MA plans would also charge the same daily co-payment as fee-for-service.

By the last term listed here, offerings, what is meant is the products that are sold to Medicare beneficiaries. With SNF coverage, for example, the Medicare program could tell MA plans that they must cover 100 days, but CMS could permit plans could offer another option that has expanded SNF coverage, but it could only be coverage of exactly 150 days by an MA plan. No other variants would be permitted if you were standardizing plan offerings.

What might be viewed as an alternative type of standardization is to use an actuarial equivalence standard, which is relevant in our discussion of cost sharing. In cost sharing, one insurance product is actuarially equivalent to another if average overall cost sharing is equal. For example, Medicare Advantage has a requirement that a plan's bid to cover the Medicare Part A and Part B services must have cost sharing that is equal to that of Medicare fee-for-service. This requirement can be met by using the exact same cost-sharing structure as Medicare fee-for-service, or it is met if the total average of all the expected amounts that enrollees pay in cost sharing for Medicare-covered services is the same as the average total that the enrollees would have incurred in fee-for-service Medicare, regardless of how a plan might apply the cost sharing to individual items and services. So, for example, if fee-for-service cost-sharing averages $100 per person per month, then plan cost sharing must equal, on average, $100 per enrollee per month in the basic bid.

Benefit standardization has a number of advantages, not the least of which is that it helps beneficiaries choose among various options because there is clear pricing information and the beneficiary knows that benefits are the same across all plans. Benefit standardization also makes for a level playing field among plans, with price differences that reflect relative efficiency rather than a reduced level of coverage.

Standardizing benefits also helps to avoid selection strategies, where plans use the benefit design as a way of avoiding sicker beneficiaries, and the uniformity helps with program administration and the evaluation of bids. The benefit design can also be used to specify an adequate benefit level that all plans would be providing. The drawbacks are that standardization can limit plans' flexibility and innovation, and it consequently may limit beneficiary choices.

Looking now at specific programs and their degree of standardization, the most well-known example relevant to Medicare is the standardization in Medigap, where (in the majority of states), for the three elements we are looking at, there is standardization for all three: benefits, cost sharing, and plan offerings. The way standardization works is that, in the case of benefits, standard plan F from any insurer covers the same benefits as the standard plan F of any other insurer, and similarly for cost sharing. In Medigap offerings, an insurer cannot deviate from the design and features that characterize the ten packages that can be offered to Medicare beneficiaries. An insurance company can offer up to the ten Medigap packages identified by a letter designation. They are not required to offer all ten, but any offerings that the insurer chooses to sell have to be chosen from one of the ten standard packages.

Now let's look at Medicare Advantage, or Part C, which is the coverage of Medicare's Part A and Part B benefits through Medicare Advantage plans. There are two broad categories of plans in Part C. There has to be a basic bid, which is used to determine whether a plan has a basic premium and whether it will have rebate dollars for bids below the benchmark. Coverage in the basic bid is standardized -- that is, plans are bidding on benefits that are exactly those of fee-for-service Medicare, and the cost sharing is standardized in such a bid -- as I mentioned, either by mirroring fee-for-service cost sharing or using an actuarially equivalent level of cost sharing.

However, there is no requirement that a basic package has to be one of the offerings. The offerings of MA plans, apart from the Medicare component of the benefit, are not standardized across plans except in the case of a basic plan. There can be additional non-covered benefits and optional riders, for example. Cost sharing is not standardized as it would be in a basic plan for Medicare-covered services, though there are limits applied to cost sharing. So in MA, given that there are very few basic plans being offered, there is a broad array of varying plan designs in the current market.

Turning now to Part D, the basic benefit is standardized to the extent that specific classes of drugs must be covered; cost sharing is standardized as specified in the statute for the standard benefit, but an actuarially equivalent cost sharing is also permitted, as in Part C. However, what is different from Part C is that all Part D sponsors are required to offer -- that is, market to the public -- a standard benefit plan or an actuarially equivalent plan. Enhanced plans offered under Part D are not standardized with respect to benefits, once the basic requirement is met, or with respect to cost sharing, though there are certain rules regarding cost sharing in the Part D program that apply to enhanced offerings.

So here is a summary of the current landscape in standardization, with Medigap, shown in the first column, standardized in all three elements. In Part C and Part D, the basic or standard plans have benefits that are standardized and cost sharing that is standardized or actuarially equivalent to the standard. But looking at the columns labeled for Part C "other offerings" and for Part D also "other offerings" -- where you see all the "NOTs" -- you can make the generalization that they are not standardized beyond meeting some basic requirements of coverage and rules about cost sharing. What you see in the green box is a difference between Part C and Part D. What is different in Part C is that a sponsor does not have to offer or market a basic benefit package, even though for bidding purposes, Part C plans must prepare bids for the basic package to determine whether there will be a plan premium or rebate dollars. Unlike in Part D, a Part C sponsor's offerings can consist solely of what you could call enhanced benefits, meaning that beneficiaries could be required to pay for benefits beyond what Medicare covers as a condition of enrolling with the organization, or they have rebate finance benefits that are not standardized.

So here is a schematic of what a premium support system might look like with respect to the features we are talking about that is modeled on Part C and Part D features. It would have a standardized benefit package, with cost sharing that is standardized or actuarially equivalent across plans, and a standard option would be available for beneficiaries to buy. There could be supplemental plans and optional additional coverage. In the next few slides, we will review what the rationale might be for this kind of design.

In the current system in Part C, plans bid on the equivalent of the fee-for-service benefit package -- that is, a standardized benefit package -- for purposes of determining the government payments to the plan and member premiums. That is why you have a standard bid. This structure would be an appropriate structure for a premium support system that has bidding as such an important component. However, although the Medicare Advantage program is referred to as a bidding system, what plans are doing is bidding in relation to an administratively determined benchmark that establishes the maximum Medicare program payment available.

In the type of premium support system the Commission has been examining, plan bids determine the government contribution towards a beneficiary's choice, and fee-for-service Medicare is treated as a bidding plan. The competition among plans determines the benchmark. In order to have competition on a level playing field, there needs to be comparability across plans and between plans and fee-for-service. Note also that when we talk about a standardized benefit, we should keep in mind that the Commission has recommended modifications to the basic Medicare benefit to incorporate various features, some of which are found in MA -- for example, an out-of-pocket maximum and a preference for copayments over coinsurance for some services. Such a standard benefit would be the benefit plans bid on, and offer, in the premium support illustrative examples the Commission has been examining.

The same arguments made for standardization of the benefit package apply with regard to the standardization of cost sharing, as is currently done in Part C, using Medicare fee-for-service levels of cost sharing or the actuarial equivalent of fee-for-service cost sharing. Such standardization enables comparisons across plans on a level playing field when fee-for-service is a bidding plan that defines the standard benefit.

In Part C currently, cost sharing that is equivalent to fee-for-service can be cost sharing that exactly matches fee-for-service on a service-by-service basis or, as I mentioned, an actuarially equivalent level -- the example that I used of the $100 per member per month average. By allowing actuarial equivalence, plans can design cost sharing in a way that seeks to avoid the sickest patients or the highest-risk patients. Until a statutory change was made, for example, some MA plans were charging 30 percent coinsurance on Part B drugs -- which in fee-for-service Medicare have a 20 percent coinsurance. To avoid the use of cost sharing as a selection strategy, the statute and CMS rules impose service-by-service limits on cost sharing for certain services. There is also a general rule that CMS will reject bids that have a benefit design that is discriminatory. This type of program management and oversight should likely continue in a premium support environment.

If you remember the green boxes showing what is different between Part C and Part D with regard to basic or standard bids, it was that in Part C, unlike Part D, a sponsor does not have to offer or market a basic benefit package, even though for bidding purposes, Part C plans must prepare bids for the basic package to determine whether there will be a plan premium or rebate dollars. As I previously mentioned, unlike in Part D, a Part C sponsor's offerings can consist solely of what would be enhanced benefits, meaning that beneficiaries again would be required to pay for benefits beyond what Medicare covers as a condition of enrolling in the organization.

There are advantages to having all plans market a basic benefit package, as is true of Part D. This approach is consistent with key concepts in premium support, where beneficiary decisionmaking is a key factor. By having basic benefit offerings, beneficiaries can directly compare the cost of those offerings with the cost of fee-for-service Medicare in the market area. In addition, the offering of basic benefit packages gives beneficiaries greater choice. Some beneficiaries may not wish to pay for extra benefits that they may not anticipate using.

Having standardized basic offerings also ensures that in the bidding process, there are plan bids that are directly comparable across sponsors and comparable with fee-for-service, and that the bids that plans submit for the basic package are good-faith bids and that they are likely to be an actual best price bid.

Moving on to some additional related issues, Amy will have something to say about research on the number of offerings and how beneficiary decision making is affected -- that is, at what point is information overload an issue. The current policy in MA and in Part D is that when a sponsor has multiple offerings in a market, those offerings must have meaningful differences in order to be approved. In the Congressional Budget Office's options paper on premium support, the illustrative option had a very limited set of offerings, consisting of at most two basic options, each of which could have one enhanced option.

We have not suggested that in premium support we would eliminate enhanced benefits or optional supplemental benefits like those that are currently offered in Medicare Advantage. However, given the history with Medigap, where standardization was introduced in part because of the proliferation of benefit designs, and given how much variation we see in extra benefits in MA today, policymakers could consider having some level of standardization in enhanced benefits and optional supplemental benefits to facilitate beneficiary decisionmaking and to streamline program administration. The disadvantage of such a policy is that plans have less flexibility to innovate and beneficiaries may have fewer choices.

The last issue is the matter or induced utilization, which is handled differently in Part C and Part D. In Part D, only standard bids or actuarially equivalent standard bids are used to determine the government contribution or subsidy level. In the case of enhanced benefits in Part D, any costs from additional utilization arising from reduced cost sharing are to be borne by the beneficiaries who purchase the enhanced products. This is not the case in Part C currently, but such an approach is consistent with the recommendation made as part of the set of the recommendations for redesigning the Medicare benefit package. That set of recommendations from the Commission included the recommendations to impose an additional charge on holders of supplemental coverage to offset the additional program costs from induced demand when reduced cost sharing generated that additional demand.

So for your further discussion, we would appreciate comments on the structure and the content of the material as we have presented it here and in the mailing material and any changes or additions you would like to see on the topic of standardization in the June chapter. I look forward to your questions because I will be forwarding them on to the next group. Thank you.

[Laughter.]

DR. CROSSON: That sounds like a lateral to me. Okay. Thank you, Carlos.

Can I see hands for clarifying questions? Maybe more this way, so we'll start with David and go down.

DR. NERENZ: Thanks. If we could go to Slide 15, I think this would be a good anchor point. I just want to make sure I understand. In this model as we're thinking about it, if there's a beneficiary, I want a plan that has less than the compliance A and B package of benefits. Can I do that. The implication to me here is that I cannot.

MR. ZARABOZO: That is the implication.

DR. NERENZ: Okay.

MR. ZARABOZO: Yeah, because it's -- again, the fee-for-service benefit defines the standard benefit. If you're going to set government contributions and so on, you want the plans to have a basic bid. Now, we didn't -- I mean, you could argue about whether actually they -- I mean, that is a point to talk about, whether there could be a lesser offering. But we --

DR. NERENZ: That's Round 2. I just want to clarify here that is what this all implies.

MR. ZARABOZO: Right.

DR. NERENZ: Okay.

DR. MILLER: I hadn't thought about it quite this way, and I think one way to think about this is that there is a basic benefit in an area that a beneficiary can get if they want; two, that there is a bid that's actually tied to a real plan as opposed to a bid that's theoretical in nature, which I think was some of the thinking in Part D. But when you do enhanced plans, I think general -- or variations of that, which you can offer alongside of it, I think we generally think of things like extra benefits and you pay an extra premium. But there's also things like HSAs and that type of thing, which could be actuarially equivalent, but I wonder if there's a conversation we should have at some point about offering those types of things alongside the basic --

MR. ZARABOZO: That's one issue, but I think that David's question is, for example, if I as a company said, well, I don't want to offer the SNF package, so I'm going to drop it from the benefit, can I have such an offering? Is that what you're saying?

DR. NERENZ: Well, I'm actually thinking of it from the beneficiary point of view, that if part of what we're trying to do here is enhance beneficiary choice, it's an asymmetrical range of choices. You can have the basic Part A/B benefit, and you can go up from there, but you can't go down from there. And, first of all, I just want to clarify that that is indeed what you're talking about.

MR. ZARABOZO: And as you say, that is a Round 2 issue of what --

DR. MILLER: Yeah, I just wanted to build it out for when we got to Round 2 [off microphone].

DR. CHRISTIANSON: Amy, did you -- Bruce.

MR. PYENSON: Yeah, thank you very much. I liked the structure of standardization and the different types of standardization. One of the implications of that is how do we deal with supplemental benefits in fee-for-service. Today, as we know, many beneficiaries buy Medicare supplement insurance, and that's not allowed for Medicare Advantage. This may be going too far into the practicalities, but would you envision that if health plans had to, MA plans had to offer the standard Medicare benefit, that the beneficiary would be able to buy a separate Medicare supplement policy the way they can on the fee-for-service side?

DR. MILLER: There is some work that we did a few years -- this is the direction you were going to go, right? Fee-for-service standardization? Or the fee-for-service reform. So a few years ago, what we worked through as a

Commission was the notion of taking the fee-for-service benefit and beginning to kind of update that and bring it into more alignment with what you find in the standard MA plan. And so in 30 seconds or less, you know, we said there would be a catastrophic cap, you restructure the deductibles, and then we had co-payments as opposed to co-insurance, through the range, and we kept the actuarial value of the benefit constant to the beneficiary.

MR. PYENSON: I think I'm talking about something a little --

DR. MILLER: Well, I'm going to get you there.

MR. PYENSON: Oh, okay.

DR. MILLER: And part of that process, once you had a reformed benefit, you would say you can have and purchase supplemental insurance, but you have to pay for the full value of that, which is one of the issues Carlos has raised here, which is, yeah, I'm buying a supplemental benefit, and here's the pricing of those benefits. But it also imposes cost, you know, because that can have an induction effect. And we're saying you have to pay something closer to that true cost.

I think what's happening here is we would answer

-- I'm sorry -- your question as follows: This is sort of discussed in the presence of a reformed fee-for-service system. You could purchase supplemental, but your premium would track more precisely to the cost of it. And then here I think what Carlos is spelling out is if you go to enhanced benefit off of the basic, your premium also has to track the true cost of that benefit. And if it's, you know, relieving you of cost sharing and so forth, it has to track that benefit and the induction effect. So that on both the fee-for-service and the MA side there's a certain at least conceptual continuity. Is that about right?

MR. ZARABOZO: Yes. And from a practical point of view, what you're proposing -- if you said, for example, in premium support, yes, we will allow supplemental coverage, and if we're saying -- and, by the way, induction is always paid for in that premium, so you would have one company offering supplemental coverage for 20 different plans, let's say, in the United States, so all 20 of those plans would have to say, well, this is the induction resulting from this external, you know, supplemental coverage, and they're going to have to pay that. So it would be very complicated to include induction and allow that kind of additional external coverage of supplemental coverage, just from a practical point of view.

MR. PYENSON: So just to clarify my question, the supplemental coverage that's offered, you know, A through Z or M through Z for the changed fee-for-service side, those same supplements you would envision being offered by the Medicare Advantage plan.

MR. ZARABOZO: No. No. We're -- okay.

MR. PYENSON: Then --

MR. ZARABOZO: Yeah, fee-for-service. So in the redesigned Medicare, where we have the recommendation about redesign and we have the recommendation about there will be additional charge on Medigap holders for the induction, that's one side. We didn't touch the issue of Medicare Advantage where, currently, as you said, there are no -- you don't have supplemental, except as offered by the plan. The plan itself can say we have a benefit package that essentially fills in all the cost sharing.

MR. PYENSON: So that aspect would not be standardized?

MR. ZARABOZO: Yes, a plan could have -- I mean, what we're talking about here, a plan could have an enhance benefit. To the extent there was induced utilization, the induction would be part of the member premium.

MR. PYENSON: Right, I get the utilization side. But from a fee-for-service side, we would have a new Medigap plan, say Plan M --

DR. MILLER: So I think we're getting close, okay? So, you know, be positive. We're going to get there. So actually what the Commission talked about on the fee-for-service side -- and then we'll go back over to the MA side, but for the moment, we're still on the fee-for-service side. The Commission talked about this, and in the Medigap -- you know, how Medigap bumps up against the newly reformed fee-for-service system, there were a couple of conversations, and they were fairly -- we went through this a couple of times.

You're absolutely correct -- and a lot of people come to a starting place where they say actually what I'm going to do in the list of Medigap plans is I'm going to start saying your offerings have to change. They can't cover the full deductible, half the -- I know you're very familiar with this stuff. Or you have to have at least $20 of co-payment before it starts indemnifying you against additional co-payment, that type of thing. And the Commission -- that's all discussed in the report, but the Commission sort of moved away from that and said allow offerings to occur, but just make sure that what the beneficiary pays in premium fully reflects the cost that it imposes.

So if I take a plan that covers half a deductible, that has less induction effect, and the premium might be less; whereas, if Jay takes one that covers the full deductible, he has to pay a higher premium. And the Commission settled on sending the signal through the price. That's on the fee-for-service side.

On the MA side, what Carlos just said to you in his sentence is the plan can enter the market, and we've got this basic concept in play, and say here's your basic benefit. But if you want to indemnify yourself against cost sharing, here's an enhanced benefit and here's how the premium changes in order to cover that enhancement, and it has to track the induction effect as well.

So on both sides, you can offer ways to indemnify the beneficiary out of their cost sharing, and for the most part, it's through the price that they pay that the signal of do you want to buy this or not buy this is expressed -- either the premium on the Medigap or the premium on the enhanced plan. That was what you were asking?

MR. PYENSON: Yes. Thank you.

DR. MILLER: Okay. I have to go home now.

[Laughter.]

DR. MILLER: I'm going to go lay down.

DR. CROSSON: Clarifying questions.

MS. WANG: So I think maybe my question is related, but I'm going to ask it in sort of a different way. Sort of bottom line, I'm interested in whether you think that the kind of construct that you've conceptualized here, which is very, you know, extensive, would reduce and lower levels of Medicare spending compared to what exists today. So, in particular, standardization of sort of everybody has to offer the A/B benefit, because today it's -- as you say, the distinction is you bid against it, but plans flex around that. And, second, whether the sort of peeling out induced utilization and converting it into like an extra premium to the beneficiary, you know, my -- and I guess maybe if you wanted to talk about duals and LIS members separately, that might be -- because there is a different bidding process for them now, as you know, and a lot of what is in here I sort of see as a step back from what's available to them. So just overall, Carlos, would this reduce program spending?

MR. ZARABOZO: Are you still there? Well, okay. Taking a couple -- first of all, there is going to be a presentation on the situation with low-income people in the premium support model. I think. Is that right?

DR. MILLER: Yeah, and I mean, what I would say about the LIS and low-income folks is we're working through a set of issues here on premium support, how you set the benchmark, you know, how fee-for-service is treated. We've been doing that over October, November, or whatever Carlos said a few minutes ago. Now we're up to this issue of thinking of standardizing benefits. We need to come and build and have a session on how to deal with low-income folks, and that is planned for going forward. There will be some discussion of it, but these plans often come out, and there's not a lot of detail on how to deal with the low-income folks. And I think we've got to grind through that and think through it. We haven't done it for today and aren't ready to talk about it, unless Carlos wants to free-form it.

Then the other thing you were saying is how does this affect, you know, overall cost and expenditures, and my take on this, Carlos -- and you should, you know, jump right in -- there are many other things that we've talked about in terms of the role of fee-for-service, how the benchmarks get set, how the bidding process works, that probably have, you know, a very clear and large impact on whether your total level is, you know, high, low, medium, whatever the case may be.

What I would say about this is this can have an effect in the sense that if you, you know, had a wide-open-ended -- like you can set the benefit how you like, you know, lots of -- or very little standardization, to the extent that you could play selection games, that could have an impact on what your expenditures are, and also my guess is how costs would fall across plans as they try and compete with each other, as I try and grab healthy patients relative to you, that type of thing. But I think there are some other factors we have talked about that probably have first-line effect on what your total expenditures are. That's my first take.

MR. ZARABOZO: And on this specific induced demand point, if you said, for example, today induced demand is a government expenditure, tomorrow it will not be, then presumably you'll have savings, you know, all other things being equal.

DR. CROSSON: Clarifying questions?

MS. BUTO: So just to follow on Pat's point, I think the issue of whether money is saved or not really falls to whether you think a competitive system is going to save money over a regulated price in MA and fee-for-service. And how standardization serves that strikes me as it makes competition easier. So to me, the issue of saving goes to whether the system itself will eventually generate saving. So I just throw that out as a Round 2 answer to a Round 1 question.

My two questions on Round 1 are -- and sorry not to know this, but is it fairly common for MA plans not to offer a basic benefit package? In other words, is that the common practice?

MR. ZARABOZO: Yes, because, and it's because most everybody is bidding under the benchmark. So you don't have the standard benefit because within the basic package you are required to have additional benefits.

MS. BUTO: Got it.

MR. ZARABOZO: So there are some plans that are bidding over the benchmark, so, yes, they do have --

MS. BUTO: Okay, because of the current structure.

MR. ZARABOZO: Today, current structure, everybody has extra benefits.

MS. BUTO: And the other question I have -- and this goes to the issue of how much standardization we might want in premium support for supplemental packages -- is: Are we confident that without some degree of standardization, which I like the flexibility, but what worries me about lack of standardization is selection. So what's the relationship between -- or has there been enough research on the ability to vary supplemental packages and selection? Do we have any sense of that? Because to me that would inform which direction we might want to go in this regard down the road with premium support. How much standardization?

MR. ZARABOZO: I don't -- I know there's been work on standardization. I know within the exchanges, for example, there was a recent Health Affairs blog about this, that some states actually had more standardization than others. Some states require standards -- so the point of that particular study was looking at HIV/AIDS drugs and what kind of cost sharing was involved. There were clear indicators of, well, this is disadvantageous for this kind of population. So presumably what they're trying to do is avoid this kind of population.

I mean, it is an issue, what you do -- as we mentioned, what you do with the extra benefits does create selection -- possible selection issues, yeah.

DR. MILLER: And, Kathy, for myself -- and we can go back and sort of see if there's formal studies. As I think about it, I don't feel like I've run across a lot of these. I feel more of it's than things like -- and I suspect you've sat through some of these meetings, where a plan comes in and complains about what another plan is doing, and some of the stuff that Carlos hit really briefly, where there was a period where people started to look at the bidding, and the bids were coming in with high cost sharing on cancer patients, and that's almost what informs my thinking here, is where you've sort of seen almost by exception behaviors that might be militating against, you know, one-to-one competition.

DR. CROSSON: Clarifying questions? Alice.

DR. COOMBS: So on Slide 8, I'm trying to conceptualize how things are currently with some of the plans, with the highly deductible plans that are out there. Does Slide 8 say that this wouldn't be a possibility under the premium if we had these as our baseline? In other words, if we standardize for each one of these and someone has a premium, as you outline in the chapter, for X number of dollars, what's to say that that given patient who enters into a plan wouldn't have an evolution of a highly deductible arrangement where they go into a plan expecting basic benefits and wind up with cost sharing that is similar to what happens in the commercial world right now?

MR. ZARABOZO: And that's a different slide. That's the one about cost sharing and what you do with cost sharing, whether or not there should be restrictions on cost sharing. Now, of course, high-deductible plans is sort of like a different issue, as Mark mentioned. You have MSAs currently within Medicare as the one question, and premium support is would those kinds of plans be available in a premium support system, which is kind of like a Round 2 policy issue.

DR. HOADLEY: So my question actually builds off of Bruce's question, and it seems like implicitly -- but we haven't said explicitly -- part of the answer to Bruce's questions would be that if you want to have an enhancement or a supplement to a Medicare Advantage plan, you have to essentially get it from the same Medicare Advantage plan. And I don't think you actually said that, but is that implicitly part of how we're envisioning this?

MR. ZARABOZO: Yeah, I think I implied that in the response to Bruce. I think the original question was: Will there be a Medigap market, a Medigap kind of market for Medicare Advantage plans? Which doesn't exist today.

DR. HOADLEY: For different vendors --

MR. ZARABOZO: Right. There's no Medigap coverage for Medicare Advantage beneficiaries, I think, so --

DR. MILLER: Yeah, I mean, I hadn't thought about it the way Bruce asked and you're asking. I think, you know, the way I've been thinking about is the way it seems to have shaken out in C and D where, you know, the plan says here's my offering, indeed here's the basic, here's the enhanced, and you kind of purchase from that, I hadn't thought about this notion of some new entity coming in and trying to ensure across all of the plans. And I'd have to pause and think about what do you do with the bidding structure to make --

DR. HOADLEY: Right.

DR. MILLER: I mean, you're working off the basic bid. Maybe -- I'd have to think about it. And it's not hostile. It's just I hadn't thought about it that way.

DR. HOADLEY: I mean, my gut says that you would not want to go that way. You would want to keep the sale. So if I'm going to Humana to get my Medicare Advantage, you know, they can offer whatever level of enhancement and supplementation in multiple offerings with whatever rules and restrictions we want to impose on that, whether it's --

DR. MILLER: And I'll tell you another reason you might want to think about it that way, but, again, you know, if there's other thoughts on this, I definitely don't want to close them off. But the other reason people often talk about -- think about the drug market, you know, having a PDP separate from the medical care, people talk about concern and coordination. And I know we're not necessarily talking about drugs here, but the notion of if I'm going to offer a suite of benefits, are they hooked to the entire, you know, continuum of care for that patient, for that plan, you know, in that plan's network of providers. You'd have to think about whether you're creating fractures in the --

DR. HOADLEY: Yeah, and the basic MA plan that was offering it is potentially going to say, you know, this other company's coming in and is messing up the design, the cost containment strategies, the care management strategies.

DR. MILLER: We've crossed the line here.

DR. CROSSON: Paul, do you have a comment here?

DR. GINSBURG: Yeah, on this point. To me, the notion in insurance markets about having a separate insurer supplementing an insurer's plan is really a scourge, because it's really in a sense underpricing your product, imposing costs on the other one. For the most part, you know, it's avoided in commercial insurance by rules. I think there's -- you know, in traditional Medicare, there was a motivation to do it because a lot of people wanted richer benefits than the Medicare package, so that was the motivation. But in Medicare Advantage, they're offering the richer benefits, and I really see no reason to get involved in this layering of insurance.

DR. CROSSON: Okay.

MR. THOMAS: So my question is -- and I just want to make sure I understand exactly what we're trying to accomplish. So the idea is that because we may want to move to a premium support model, that in each market -- I assume this is by market -- we want to make sure we -- or we're thinking about the idea of having a product that is in MA that is essentially equivalent to traditional Medicare so that we can do a true comparison? Is that the rationale behind what we're trying to accomplish? I'm just trying to understand the goal.

DR. MILLER: I mean, I would say yes, and true comparison can mean a few things from different points of view, that the beneficiary can view a product and say, "I know I'm getting the basic benefit," or, "I know I'm getting an enhanced benefit." But, yes, a basic benefit. And I think the reason -- I think the reason in D that they called for in law the notion that you had to offer a basic benefit is because in that instance the benchmark is based on the bids, where, as you know, in MA, as we've gone through here, it's an administrative benchmark, and that, you know, the rigor of the bid will be stronger if it actually represents a plan that somebody could walk in the door and get services.

And so I think, yes, there's some ability from the beneficiary's perspective to know how the landscape works, from the bidding process to know what bids are coming in at and being able to compare them.

MR. ZARABOZO: And when you say equivalent, of course, an MA plan, a managed care plan, can do many, many things to fashion whatever -- for example, network design, the way they impose cost sharing. We're using an actuarial equivalent so they can have different levels of cost sharing for different -- we mentioned, for example, VBID, value-based insurance design, is permissible in an actuarial equivalent kind of situation. So it's not, you know, very strict, it has to exactly look like fee-for-service. But for bidding purposes, it is your -- you are bidding on a particular product. It's the fee-for-service product. So what is your bid for that particular product?

MR. THOMAS: But going back to the MA bid -- maybe I've got this wrong -- I thought the administrative benchmark that you bid against I thought was always a traditional Medicare product or cost, what you guys reference as the administrative benchmark.

MR. ZARABOZO: Right, a benchmark set by law, in other words, so an administered -- it is specified by law that it's X percent of fee-for-service in a given geographic area. So it's not -- competition does not determine the benchmark. In premium support, competition would determine the benchmark. Right now it is determined externally, if you want to --

MR. THOMAS: But to me -- and once again I'm trying to -- this is a clarifying question. I'm trying to understand. So when you are competing -- or when you're bidding against the administrative benchmark, that is essential a Medicare fee-for-service equivalent. Is that correct? And you have to be at or better than that as an MA plan?

MR. ZARABOZO: Yes. I mean, you can be at that, and what that means, if you bid at the benchmark, that means you are offering the Medicare package.

MR. THOMAS: Right.

MR. ZARABOZO: That's it.

MR. THOMAS: And/or you can be better, i.e., you can have more benefits than the --

MR. ZARABOZO: Right, you come in below the benchmark, yes.

MR. THOMAS: And then you essentially have to add more benefits --

MR. ZARABOZO: Right.

MR. THOMAS: -- in order to meet the equivalent, correct?

MR. ZARABOZO: Well, that's the requirement, yes. If you come in below the benchmark -- now, it used to be that you could return money to the government if you so desired. That was not all that popular, but --

MR. THOMAS: So in this model that we're talking about, if we talk about a Medicare -- let's say we have a standard product that's a Medicare fee-for-service set of benefits. If that bid is lower than fee-for-service Medicare, then the question is: What do we do with the extra dollars? Is that a policy question?

MR. ZARABOZO: Well, in a premium support environment, for example, let's say you just have in a given market fee-for-service and one plan. If you say, as mentioned in the mailing material, well, the benchmark now will be the weighted average -- let's say each gets half of the enrollment. Essentially, the average of the two bids is the benchmark now. There's no -- unrelated to fee-for-service, in a sense, except that fee-for-service is the bidding plan in that context. So you have a new benchmark, and either a beneficiary has to pay more to be in the one that was above the benchmark or they gain by choosing the one that was below the benchmark.

DR. MILLER: I also want to zero in, because I think what you said is correct. So the other conceptual shift that's occurring here is not just how the benchmark is structured. It's saying -- because I know -- I know I'm doing some violence to this. I mean, in some ways, yeah, you're bidding on an average fee-for-service person with, you know, a 1.0 health risk. And in a sense, I know, Carlos, you know, you'll still be bidding on an average fee-for-service person with a 1.0 health risk, but what it will conceptually change -- and you are picking up on this, which is what if I go below that, what do I do with those dollars? And I want to be really clear. The fundamental -- one of the fundamental shifts here is you're saying your premium's less, and you're saying to the beneficiary, you come with me, you don't pay a $100 premium, you pay an $80 premium. And then you could say, by the way, if you would like to purchase some, you know, additional cost-sharing protection or some dental or something like that, you know, you could use some of those dollars to pay for that benefit. So you could get them to use those premium dollars that you've just saved them to purchase additional coverage if you wanted to offer that. And the difference is we're saying you have to -- or in premium support, if you follow the Part D model, you do have to offer the basic benefit and then you go with your enhancements next to that.

MR. THOMAS: So basically, if you're an MA plan, I guess what -- I guess I'm just trying to understand this. If you're an MA plan, let's say you've got whatever product you got in the market today that has a richer benefit structure than traditional fee-for-service Medicare. You're saying you'd have another product in the market that is just exactly like traditional fee-for-service Medicare and that would be -- you know, and that becomes a level playing field of which to bid off from.

DR. MILLER: You got it, and I just want to take on the word "exactly" a little bit in the sense that that "exactly" could be literally your cost sharing has to be this, or it could be actuarial equivalent where you say, you know, across all of this, within some rules, you're not really distorting your cancer coverage or whatever the case may be, it is actuarially equivalent. So you could think of the concept actually as either literally I have to do these things, which I don't know that we're really -- that's not what really goes on in C and D, or there's an actuarial equivalence concept. But everything else, yes.

MR. THOMAS: Okay. And then how do you contemplate in that, in the standardization, the network? Does the network have to be the same as fee-for-service Medicare as well? Or is the network -- I mean, and what's being contemplated here?

DR. MILLER: I would say no, and the easiest thing to get through the rest of this day -- which is turning out to be really complicated, Warner.

[Laughter.]

MR. THOMAS: You put it on the agenda.

[Laughter.]

DR. MILLER: I know. I am not making this mistake again.

So, anyway, no, the easiest thing to do, and particularly for the MA folks in the room, is think about it like it is today, which is you have certain network requirements, but, no, you don't have to replicate the --

MR. THOMAS: Okay. Thanks.

DR. CROSSON: Okay. Brian.

DR. DeBUSK: Surprise, surprise, I too am hung up on Chart 17, the extra benefits issue around MA. And my question was: On the MA side, there are clearly certain things that are going to induce utilization. But how do you tease that apart from hybrids that maybe are a combination of utilization enhancement or inducement but also value-based insurance design?

A good example: Let's say I want to do a flat $5 co-pay for all foot exams because I think that's going to reduce my diabetic foot ulcer treatment rate. Well, I'm clearly inducing utilization there, right, by going to a flat $5 co-pay. But what I may be doing is reducing my overall cost. How do you tease apart VBID and utilization inducement in those hybrid situations?

MR. ZARABOZO: You hire Bruce to figure that out.

[Laughter.]

DR. DeBUSK: That was a bank shot off you to Bruce, so good call.

DR. GINSBURG: [off microphone] Brian, is that this is a good example of why you want to have the same plan providing the supplements, because then it's all internal to them. You don't want to get into a situation where there's another carrier that's supplementing where, as in your example, it's a really good one about how do you actually calculate the induced utilization. You don't want to use the general rule because this is a very specific reduction in cost sharing that you're hoping is actually going to save you money in the long term. So I think it's just an argument for leaving this internal within the companies, within the carriers.

DR. DeBUSK: That's what I was just trying to tease apart, because the idea of building on -- you bid low, which would be a reduced premium. I love the example. And then there would be the additional benefit that you would stack on as additional premium. I could see where they would offset. I just don't understand in a true VBID situation where all this is in MA and happening sort of underneath the hood, I don't quite understand yet how you would get back to that base number.

MR. ZARABOZO: The reason I mentioned Bruce is I think you would say that if you have overall costs that are lower because of your cost structure, then you did not have induced demand on net. So, again, this is like an actuarial determination. Is there or is there not induced demand in this particular design?

DR. MILLER: Or to put it differently, we've been using the inducement effect, but inducement could be a plus or a minus. But you have to estimate it and make sure that whatever premium you're calculating takes into account. So if someone like Bruce -- and, you know, he's sitting right here -- says, yeah, it's $5, I get more office visits, but I avoided these hospitalizations, so on net, the inducement effect is X.

DR. DeBUSK: So in theory, I could have a negative inducement score when you try to adjust my plan. I could actually induce utilization that would result in a negative adjustment.

MR. ZARABOZO: Which would be reflected in your premium, right. So it's there, yeah.

DR. MILLER: And you will have solved the health care spending crisis.

DR. DeBUSK: I was going to say, once we start having that problem, I think it will be greener pastures.

[Laughter.]

MR. ZARABOZO: I'm disappointed that you have no more questions.

DR. DeBUSK: Oh, actually, I do have one more.

[Laughter.]

DR. DeBUSK: I'm really glad you brought that up. You know, we talked about altering the basic fee-for-service package, you know, the fundamental fee-for-service package with things like out-of-pocket limits. I forget which chart you mention that in. Why couldn't we just package that up as one of the Medigap plans and make that available and see how many people are interested?

MR. ZARABOZO: Well, there are Medigap plans that do not fully fill in the cost sharing. The new Medigap plans have partial cost-sharing fill-ins, if that's -- are you talking about a government --

DR. DeBUSK: No, MedPAC, you know, we have --

MR. ZARABOZO: Oh, the MedPAC --

DR. DeBUSK: I mean, could there be -- well, I'm just asking.

MR. ZARABOZO: A government supplemental --

DR. DeBUSK: Why wouldn't you just do a MedPAC Medigap Plan L, or whatever the latest letter is? If we really want those changes, why not do that?

DR. MILLER: All right. Move to strike.

[Laughter.]

DR. CROSSON: We have moved a little bit outside of our bubble here.

DR. MILLER: The public will disregard all the --

DR. DeBUSK: Question withdrawn.

DR. MILLER: I actually kind of know what you're getting at, and, seriously, maybe we should talk offline a little bit about that. I do think that kind of takes us -- for today's exercise. But I do think I understand what you're asking, so if you just give me a little leeway, maybe Carlos and I will talk to you about that and see where it goes.

DR. CROSSON: Are we talking about a MedPAC IPO?

DR. MILLER: Yeah, but actually what I think he's -- what I took out of it is what if there was sort of a government-offered Medigap plan, is what I took out of that. Certainly not MedPAC. And, you know, that concept has arisen, and people have raised that.

DR. DeBUSK: In the reading, though, you had some of the previous Commission's ideas about things like of out-of-pocket limits and restructuring the benefit, and it was scary to think, oh, my gosh, we're going to completely redefine fee-for-service. Could you just leave fee-for-service alone and express it as a supplemental -- just the delta as a supplemental policy and tee it up as a Medigap --

DR. MILLER: But I think another -- and now I see what your question is more directed to, and my first reaction to that would be I don't think you want to do that because what you want is on the MA side and the fee-for-service side, for the benefit structures to be relatively comparable so when you get those bids, you have a common basis. And so if all the managed care plans at this point, just to do a simple example, are all offering catastrophic coverage, then, you know, you have something that isn't catastrophic, and then you have this wrap-around and you have Paul's issues where he seems to be very clear about how the outside insurance butts up against the basic insurance.

And so I think what you're trying to do is create a situation where the benefit structures on fee-for-service and MA, which are going to be competing against each other and setting the benchmark on a relatively common platform.

DR. DeBUSK: I accidentally became the scourge that Paul was referring to earlier. My apologies.

[Laughter.]

DR. MILLER: Paul was clear on that point.

DR. CROSSON: Okay. We're ready -- I hesitate to say it, but we're ready for Round 2, and Paul has volunteered, or at least he did yesterday, to lead off.

DR. GINSBURG: Before I lead off, actually I thought of a clarifying question for you, Jay.

DR. CROSSON: Yes?

DR. GINSBURG: On some of the slides, it's clear that a particular design is good for beneficiaries, good for the program. And on slides like the one here, there are pros and cons, arguments for and arguments against. So the question is: Is our goal to resolve what we'd prefer on standardizing offerings beyond the benefits plan, or just leave it as, well, you can go either way here, the pros and cons?

DR. MILLER: What I would say is this: I think what we are doing in this chapter -- and this is not going to be, you know, a surprise to you. Think of some of the other issues we've already talked about in this meeting, where in certain circumstances we've reached a place where we're saying this is what has gone into the recommendation. Well, we had some very robust conversations about different ways of doing things, which we're not going to lose, we're going to keep in the conversation.

And so here's what I would say: If you'll go to Slide 10 -- I think it's 10, yeah -- this is in a sense what I could imagine, you know, kind of working towards in the chapter and saying there are some arguments of using this as your straw man point, and the arguments would be the beneficiary's clear about what benefits, there's flexibility in the cost sharing so you can structure incentives for beneficiaries, stuff Warner and Brian were saying, how do I get, you know, signals to go to the beneficiary, and you got that flexibility there. And then because you've really gone to a premium support system, which the bids are going to drive the benchmark, you might embrace the Part D structure and say there's a basic benefit so that everybody is clear, the beneficiary, the bid, et cetera, and then enhancements beyond that are allowed, and then you just have to tie the premium to it.

And you might say here is a straw man to think through, but then let's talk through the pros and cons. You know, some people might argue they want -- and, you know, I think even David started to open this. Well, what about flexibility on the benefits? And you could talk about in a sense almost in those three boxes what's the pros and cons here.

And so if I had to answer Paul's question, that's what I would say. You know, here's a working framework. What's the toggles off of these points that might help inform somebody's thinking on designing a system?

DR. CROSSON: That's my answer.

[Laughter.]

DR. GINSBURG: Good. Let me go into Round 2 now.

This was a really incisive, very clear presentation of this material, and I really enjoyed reading it. I don't have anything I really disagree with.

I think some of the edges that we might want to push it on is one that David brought up about, you know, accommodating a plan with a larger deductible, perhaps with a savings account. Watching the Medicare population over the years, I doubt there's a lot of interest in it, but there's clearly a lot of political interest in it. So to serve Congress, we should probably be exploring some of those issues.

I'm intrigued at pushing more on the number of offerings and even the number of carriers, that I'm impressed at what has happened in Covered California, in their marketplace plans, by being an active exchange and basically having a two-stage thing of carriers compete to offer, and then those chosen to offer are the competitors. The exchange has a notion for, you know, both large urban areas and for smaller areas how many competitors would be optimal. I think based on its reading of behavioral economics research about where consumers make better choices. Everyone knows that when the consumer has 25 health insurance plans to choose between, that's not the optimal situation.

And the other point I want to make is that this material has a lot of applicability outside of premium support, and we might want to try to find a way -- in a sense, a lot of this could be done just the way we do Medicare Advantage today short of premium support. I don't think premium support is about to be enacted in the near term, although I'm sure it will be discussed for a while. But it may be that there are some things that we can do to facilitate beneficiary choice of plan with the goal of making the Medicare Advantage market more competitive, and this will clearly benefit the beneficiaries. It won't benefit the program because the benchmarks are the benchmarks and they're based on the fee-for-service experience. But it might be just a topic the Commission wants to take up about how to take the current Medicare Advantage program and make it better, make it more competitive, so that it serves the beneficiaries more effectively.

DR. CROSSON: Okay. Thank you, Paul.

So now we're going to go to further discussion, and could I see hands for further discussants? Okay. So we'll go with David and then this way and then over here.

DR. NERENZ: Thank you. Just a couple points. One will be a question, but I think it's more than a clarifying question.

I would like to understand a little better how this whole thing we're talking about is fundamentally different from what we have now with MA. You know, right now as a beneficiary I can have fee-for-service, and I pay a Part B premium, or I can go into the private market in MA. In a premium support model, I can have fee-for-service, or I can go into a private plan. So what about this new thing we're talking about is fundamentally different from what we currently have?

MR. ZARABOZO: Well, for one thing, for example, if -- today you can go into fee-for-service; you do not have an extra premium for going into fee-for-service. In a premium support model, you might have an extra premium for choosing fee-for-service, for example.

DR. NERENZ: Okay.

DR. MILLER: Or either fee-for-service or the [off microphone].

MR. ZARABOZO: Or the plan, yeah, depending on the geographic area.

DR. NERENZ: Okay. And that may speak then to my next point. I was thinking, if there's going -- if we want to have it be fundamentally different in some way, one of the ways I could imagine it being different is in a premium support environment, let's imagine that one can calculate the cost of me receiving care in the fee-for-service environment. And me, I mean as a beneficiary, age, sex, HCC mix, where I live, that kind of thing. That turns into a number.

At that point -- and I'll now personalize it to Pat -- if I happen to live where Pat's plan exists, I could take that amount of money, and I shop with Pat, and I work with Pat for whatever Pat wants to sell me for coverage. And in that model, CMS is out of the picture. CMS is not a party to the transaction that Pat and I get into for my coverage.

Now, that would seem to be a way of bringing premium support to life. It would eliminate some of what strike me as cumbersome features here. You don't have bids, for example, because Pat and I just work out a price for her covering me for any kind of plan I want. If I want a very rich, expensive plan, you offer me a price; I take what I get from CMS. I have to add to it. But also I could go the other way, to my earlier point. If I want a plan that has relatively tightly defined benefits, very narrow networks, something, we do that, and I pocket the difference.

So in that kind of model, once I've been given a dollar amount that I can take into a market, I do that and CMS is not party to that. Now, that's not what we're talking about here, but could it be? And are there fundamental reasons why this could not be done that way?

MS. BRICKER: It would a voucher [off microphone].

DR. NERENZ: It would be a voucher. Maybe that's a forbidden word in this topic, but that's kind of -- yeah, that's what it would be.

DR. CROSSON: So how then would the Medicare contribution be determined?

DR. NERENZ: By my projected cost in fee-for-service, for example, my age, sex, HCC mix, where I live.

DR. CROSSON: You mean not based on competitive bidding.

DR. NERENZ: No, not at all. Don't bother with it.

DR. GINSBURG: [off microphone].

DR. NERENZ: Well, it is as I experienced as a beneficiary. I'm given essentially a voucher -- let's call it that -- with which I can go shop with Pat. Is that not--

DR. CROSSON: I'm not sure how that's different from the current situation.

DR. NERENZ: Well, that was my first question. Well, it would be different in the sense that my interaction from the time I hold the voucher is entirely with Pat. CMS is not a party to that. CMS does not determine what the benefits look like. CMS does not determine anything about our interaction. That's a private interaction between two of us. And I'm either happy or I'm unhappy.

DR. GINSBURG: You're talking about deregulating the administered system.

DR. NERENZ: Yes.

DR. GINSBURG: As opposed to having a competitive system that regulation shapes.

DR. NERENZ: I guess that would be a fair characterization. I'm just asking: Why -- there must be some fundamental problem with that.

MR. ZARABOZO: As Jay asked, how do you determine the dollars attached to you? Because you said it would be fee-for-service. Now, if in premium support your goal is to say, well, let's find the most efficient plan, if you want to put it that way, it might not be fee-for-service. It might be Pat's plan. And the dollars would be adjusted to say, well, here are the dollars for you if you go to Pat's plan. If you go elsewhere, we're not going to contribute at a similar level.

DR. NERENZ: Well, I guess I'm just thinking of a simpler model. Once that dollar amount is established, saying here's what it would cost to cover you in fee-for-service, that's what the government owes you or you're entitled to --

MR. ZARABOZO: Again, that's a question here. Is that what the government owes you or not under premium support?

DR. NERENZ: I'm just raising it as a question.

I think it's just a much simpler model, and it must have some flaw; otherwise, we'd be talking about it. But --

DR. MILLER: Well, the first thing -- I think there's a couple of things. So in that model, you're abandoning the search for a more efficient delivery of care. You're saying --

DR. NERENZ: Oh, no, no, no. I'm personally searching for that. That's exactly what I'm looking for.

DR. MILLER: Yeah, but you're the --

DR. NERENZ: With intensity.

DR. MILLER: But you're not -- unless -- and I don't understand exactly how all this would work, but you're not necessarily allowing the taxpayer or the beneficiaries in general to benefit from that. You are the only benefactor from that.

Let's just say, you know, fee-for-service is inefficient in some way. You're saying I'm going to maintain that inefficiency, give everybody a dollar amount, and you can spend that. The fundamental difference in the stuff that we're talking about -- which you may be throwing over, which you're entitled to do -- is well, no, actually the bid is inside Miami -- let's take that -- where fee-for-service is, you know, $12,000, $14,000 per person, and there are plans that are offering it at, you know, $10,000, $9,000 per person. You're walking away from that and saying now the government could tie its payment to that $9,000. You're saying that block of dollars you're leaving on the table from a taxpayer point of view.

DR. NERENZ: No, that would be a fair criticism, but then you could amend it and just say over time if these truly innovative, less expensive models come up -- and, again, in that example -- you know, you can eventually separate that number in part or whole from fee-for-service.

DR. MILLER: That's what the bidding process does.

DR. NERENZ: Well, it is, but it just -- I mean, currently it doesn't lead us in that direction.

MS. BUTO: Dave?

DR. NERENZ: -- because it's an administrative baseline.

DR. CROSSON: Go ahead, Kathy.

MS. BUTO: Dave, I think this is like one of those fundamentals in discussing premium support, which is, you know, is it a defined benefit-based program, or is it a defined contribution? And you say why aren't more people talking about that. Well, people were talking about defined contribution, but think of it as a block grant in Medicaid. Okay? So you define the contribution at a certain point in time, but budget pressures and other things, especially if it's not a competitively set amount, could mean that it's not updated to the extent it should be to keep up with medical care costs, or there are other things that intrude. And so what it becomes is a dollar amount that may or may not buy you a package of benefits.

So that's the reason why I think most people, when they talk about premium support now in Medicare, are looking at more of a defined benefit model. You've got to have a basic package of benefits, and you go from there and figure out what that's going to cost, rather than here's a block of money and let's hope it keeps up with the cost of medical care inflation.

DR. NERENZ: I appreciate that point.

MS. BUTO: It's sort of the block grant idea.

DR. NERENZ: But I also would want to emphasize -- and it was on the slides -- that going that direction that you just described really cuts away from innovation, true innovation and benefit design in the way services are structured and what-not. If you build around standard benefits, to a great extent you lock in standard benefits.

MS. BUTO: You know, the flexibility around that I think could be debated, though.

DR. CROSSON: This is interesting, and perhaps we could have more offline discussion about this, but we've got about 15 minutes left, and I need to proceed so we can get to the rest of the discussion.

MR. PYENSON: I just want to echo Paul's comment that I think there's a lot here that could be helpfully applied to other programs for Medicare Advantage, but perhaps also the ACO program. So I haven't thought it through, but the idea of different ways of creating benchmarks might have applicability there in the relatively short term. So I just wanted to note that.

DR. CROSSON: Thank you. Pat.

MS. WANG: So I really think that the chapter was great, Carlos, and it's very, very thoughtful. You know, I haven't thought nearly as deeply as you have about this, but I would just suggest that in the chapter, and as something gets really written to be published about this, my preference would be to try to be clearer about what the concept of premium support is. Creating a competitive system to me is different from out of the box through the standardization of benefits expecting that program spending will decrease from where it is today with implications for beneficiary spending. And, you know, you could go one way, you could go the other. I just think that we need to be clear about it. And I don't know enough about -- that's why I asked the question before, but my instinct is standardizing to fee-for-service benefits compared to the way that the MA program works today would lower some sort of benchmark, and that certainly kind of trying to peel out induced utilization would do the same thing.

You know, this was Brian's point. What we're calling induced utilization I call sort of flexibility to meet the needs of members. We want to induce utilization, particularly in certain types of beneficiaries -- duals, near-duals, you know, middle-income, low-income. You know, we want to induce certain kinds of utilization for primary preventive services, for example. If that somehow turns into like the program doesn't pay for that anymore and it turns into something that has to be sort of purchased up, I think we just need to kind of be clear about that, because that is the way that the chapter is kind of written right now.

I also am a bit concerned about the point that others have raised about sort of however we -- standardization is important to the extent of being able to compare. I definitely get that. You have to have something out there that consumers can shop for and know that this is an apple, this is an apple, that's an orange, that's a pear. And there are lessons from the ACA out there in that regard about standardization.

But the reason that MA is popular today is that people don't want to buy -- they don't want Medicare fee-for-service. They've been in innovative insurance designs for their entire working life, and they don't really -- you know, they want the same thing when they get into Medicare. So, you know, there are a lot of choices available to people, to go to traditional Medicare or to pick a plan whose features are kind of more suited to where they are in life and how they want to utilize health care. So I think we need to be kind of careful about that.

The last two things are I think that the analogy to Part D is helpful, but I would just be a little cautious about that. You know, Part D is easy to standardize on a national basis. It's just a drug benefit package. A/B/C are far more complex, far more services, and mixture of services that beneficiaries need to, you know, maintain their health. And, you know, I appreciate sort of maybe a separate focus on duals and low-income because it is -- they are treated differently right now in the bidding process for MA, and I would want to make sure that we don't somehow, you know, damage the ability to do more for that population.

And the final thing I would say is as we talk about this -- and I don't know whether there's more utility in looking at the experience of the ACA, but you do have -- as you kind of tiptoe into this thing and you talk about people buying up or, you know, if they want extra, there is an example in the exchanges of market-driven subsidies according to income level, you know, set by the market to the second lowest silver. I don't think we're going to have enough time to really know whether that could ultimately work because it's in turmoil right now, which is unfortunate. But it is interesting that that is another source of kind of information or experience.

DR. CROSSON: Thank you.

MR. ZARABOZO: Could I add one point about in the exchanges, if I understand correctly, the induced utilization for low-income people because they have subsidies is recognized as sort of valid utilization at this point.

MS. WANG: Exactly [off microphone].

DR. SAMITT: So three quick things. I think there's a lot of good here. Again, the chapter is beautifully done. You've made a complex topic understandable. But I want to tag on to Pat's comments that, you know, it's going to be important here to achieve a level of balance. There's an importance here of standardization for comparative purposes, but I'm very worried about suppressing innovation and that it's going to be essential for us to assure that members, beneficiaries can effectively compare for purposes of shopping. But if we start to very significantly restrict the various options that get created, I think we go backwards. And for that exact reason, I think it is important to compare against the exchanges in the ACA, both for good and bad, because that level of restriction of benefits has had a negative effect on the exchanges also. So I think the question is: What lessons can be learned from that experience regarding standardization that would apply to what we're doing with premium support?

The other comment that I would make is I just wonder whether we're trying to do too much all at once. We also have to remember that while this is complex for us to understand, how complex will it be for the beneficiary to understand? And are we changing and modifying too much? So now I have to purchase a basic MA benefit package, and then as opposed to it being bundled, I have to have a supplemental menu that I pick from to decide MA -- it's hard enough to shop as it is for MA. And then we also talk about changing fee-for-service. And to Brian's point, I just wonder whether we leave fee-for-service alone and we focus on sort of the core elements of why premium support is important right now, without trying to modify everything at once. I just think it's going to lead to significant confusion. And perhaps the way we want to enter this is in a series of phases. You know, there are certain things we want to change to start, and maybe there are additional modifications that come later. But to try to change everything all at once, it feels like there will be chaos in the eyes of the beneficiary.

DR. MILLER: And the only thing I would say here is, you know, there is some flexibility around the cost sharing, which is also the current circumstance that MA plans are working with. And then, you know, particularly on the plan offerings, at least we are not envisioning this as necessarily restricting, you know, the offerings.

And then the way you described the choice set is not quite -- it was pretty close but just to make sure, the beneficiary would see, for a given organization, here is my basic plan, here is my enhancement one, here is my enhancement two. And you send the information out and the beneficiaries use it. They do not have to choose the basic plan. They can choose this plan. It is just that the plan has to offer it and so that there is a benchmark.

And the other point I wanted to make was when the benefit structure -- which we should talk about flexibility there, but you also have to think about going in the other direction. So if a plan enters the market and says, I am not offering -- and let's do something crazy -- any post-acute care, who bears that cost when the person needs post-acute care? You are basically just shifting that cost to an uninsured status for that provider.

And so I think there is some sense of why these conversations end up starting with a basic package. And then saying how do you go across that is some understanding that this is -- it should be available for 65 and a disabled person. And if it were not available, who exactly in society -- if you want to get all philosophical about it -- is actually going to pay when that happens? And that is why those conversations around the benefit tend to start there and work --

DR. SAMITT: Yeah, and I am very comfortable with the notion of standardization with the basic package. It is beyond that, sort of as we begin to think about innovations that modify that or supplement that, you know, for the good, that there aren't constraints, because that is the type of innovative model we want to encourage.

DR. CROSSON: Paul, on this?

DR. GINSBERG: Yeah, just want to clarify that we were talking about, in MA, offering an enhanced plan. It is not a supplement; it is just a bigger plan so that we are not going to get into this of beneficiaries having to choose two products --

DR. MILLER: Yeah.

DR. GINSBERG: -- to get more benefits. It would be one.

You know, I think we can go back and forth about, say, how many options -- how many plans in an area a single carrier can offer. Then I think we would want to get away -- I know we want innovation but we do not want each carrier offering 10, 15 plans.

DR. CROSSON: Okay, can I see hands for comments on this side? We will start with Bill and then Jack.

DR. HALL: It seems to me that this has been a very intense discussion, I think, as well as a tremendous presentation. And I agree that this approach about standardization and then applying to a lot of different things.

In the situation that we are dealing with here, now, it seems to me that if we go back a little bit when we started this whole discussion, what we now call premium support -- which I think was a MedPAC-defined term. Am I right on that? What was the long discussion we had when

Glenn was here about --

[Simultaneous discussion.]

DR. MILLER: -- using different terms than "premium support," because "premium support" was kind of a fluid term.

DR. HALL: Yeah. Okay.

DR. CROSSON: We adopted that term in place of more complicated terminology.

DR. HALL: Yes, I know. That is what I am -- right.

DR. CROSSON: But we did not --

DR. HALL: The word that shall not be used, yeah. Right.

Okay, and we need clarification and this is a wonderful start to get some of that clarification. As I see it, we are talking about standardization. At some point, though, we will be talking about and trying to clarify what is the difference between a defined contribution and a defined benefit, the pros and cons of each of those, but this can get -- whoever mentioned that this can get very complex very, very quickly -- I guess that was you, probably, wasn't it?

So, recently I had to take a little trip to Japan, and I was told that I could buy a voucher, or maybe premium support on railroad tickets, and that this would allow me to travel much less expensively and without much complexity through a very sophisticated train system.

So I started doing that and I found out that I had to apply for -- I had to apply for this, if you will, insurance plan on travel. And all I had to do was to get a piece of paper that would then allow me, when I got to Japan, to get a voucher or a premium support.

So I did that, and I found out in order to do that I had to find somebody who could buy this piece of paper outside of the United States, preferably in Japan, somehow serendipitously -- or surreptitiously get it to me, and then I could then take it with me to my trip. I had to have it before I got to Japan, so I had to have this before I got sick, so to speak -- still sounds pretty simple, except it is hard to find an agent that will provide this service for you unless you are willing, in some other way, to provide them with something, namely business.

So I figured that out, but I really could not figure it out completely until I got here before this meeting. And I finally went and looked up Japan travel agencies in Washington, D.C., of which there are four or five. I went there Wednesday and filled out all the forms and applications -- it is a good thing it was not chest pain that I was dealing with -- and got it. I got the piece of paper and reserved a hotel room as part of the requirement.

So now I find out that when I make this trip, I get my passport stamped for another agency. Then I said, you will have to go into line at Narita Airport, which averages three to four hours depending on when your plane lands. And then I will get a piece of paper that says I can buy a ticket, or I could get a ticket for free. So the balance there between -- the economic advantage I suppose is still there, but these things can get very complicated. It is kind of a silly example.

And so I think to start -- we have here more than a start, obviously -- is that we are starting to help people have the tools to understand these kinds of things. So, Carlos, I think that is what -- well, you have done the standardization. It is really very valuable.

But the other thing that was mentioned was how complex do people want this to be? And I think we are kind of going to be one of the sort of honest brokers to allow us to see how we can provide people what they can understand and without using the terms, necessarily, even of the difference between a defined contribution and a defined benefit. This is the best I think we have done so far on this whole topic.

But it is the old Chinese curse: May your dreams come true. I think this whole process here is going to get very, very complex as we try to allow our consumers to really figure out what kind of decisions that they want to make here. But, anyway, it is a long-winded way of saying I think we have some interesting challenges ahead of us and this is a good start, more than a start.

DR. CROSSON: Well, Bill, I think the point you make is a good one. And it is helpful to remind us all the time, particularly as we deal with more abstruse policy thinking processes such as this one that, in the end -- and you and Jack and others on the Commission continually remind us that not only are we here to serve the Congress but we are here to serve beneficiaries as well. And to the extent that we keep the beneficiary in mind as we are thinking through our policy determinations, we are likely to have a better product.

Jack?

DR. HOADLEY: So, thank you, and thank you for doing this chapter. I mean, I think this is, as others have said, going to be a helpful component of this discussion.

You know, I am an advocate of standardization. I think it is critical for a variety of reasons, and you have mentioned most of these. One is mitigating some of the gaming and the risk selection. Another critical one is making beneficiary choices clearer, simpler, easier, and also to help make some of the bidding rules work better. And as Paul said, some of these principles really could be translated into some of the current system in some ways, and I have written about that in the past.

I think one thing that I would like to see a little more discussion of -- you have the basics of this in the chapter -- is some of the dimensions on which we are not so much talking about standardization, so networks and formularies and other aspects of how the benefits are delivered.

You have made this point a little bit, but I think, you know, it sort of goes to some of the discussion that we have had. A number of the elements in which innovation occurs is in how you design networks, is how you design prior authorization or requirements to go from one type of benefit to another.

And that has generally not been part of any of the kinds of standardization discussions. I mean, you could make an argument for some of those, but I think here we are not generally talking about that. So I think, just to be clearer in the discussion, you almost -- in this grid to have -- it is a little bit implied and sort of the plan offering sort of thing, but maybe even another row that says other kinds of aspects of how you deliver the benefit such as networks and formularies and other sets of rules are not something that this pattern, or any of the other sort of models we look at -- the ACA, MediGap, you know, none of those kind of standardized -- that aspect. So I think that would be a helpful enhancement for this conversation.

The other thing where I think there is some discussion potential -- and a lot of this does go farther than we are trying to do at this moment, but it sort of is this notion of the basic benefit offering. And I think when we were talking about the supplemental benefits and what is in the current MA program, the challenge is that, generally, current MA tries to match what exists in traditional Medicare with some kind of MediGap supplemental coverage.

So it brings the cost sharing down, maybe not getting rid of it completely, sort of some of the more modernized versions of -- but what a typical MA offering does is have flat copays, out-of-pocket maximums and things. And so the reason that pretty much every MA plan is enhanced is because it is enhanced relative to the un-supplemented traditional Medicare.

You talked about how we might, in thinking through this kind of system, build off of the kind of reform to the basic benefit that we talked -- that the Commission talked about some years ago. And I think that is important, and it may even be a matter of going beyond that.

And one of the ways to think about that could be, as is done in the ACA, some kind of metal-level version.

And Brian kind of started on this path in thinking about, should the government try to supplement? And there have been discussions about how there could be government-offered supplemental levels.

And so it would be the equivalent of, say -- you know, if what we think of current Medicare is sort of bronze-level or silver-level benefits, maybe the government also produces a gold-level benefit that adds -- that reduces some of the cost sharing or adds some extra benefits or things like that. That could be a way to get past some of the issues with MediGap but goes to that principle of one issue or offering both the basic and the supplement instead of having what we have now, which is this hybrid.

Now, I realize this is jumping well beyond sort of where we are in this current debate, but it might be to sort of at least touch on that as a potential way to address some of the kinds of things. I think, you know, this notion that going forward without sort of an out-of-pocket limit in traditional Medicare into this kind of premium support world is something that will, I think, cause some real problems with how this would work.

So, at least at some of those levels that we have addressed in the previous discussion of benefit reform, but maybe potentially going beyond that, which could then also raise the possibility that a standardization model could think about standardizing the enhanced offerings at least to the level of some kind of a metal-level kind of standard.

So you have some tiers that would not restrict what a plan wants to do within that tier, allows sort of all the flexibilities of types of designs the networks and things that I already suggested were not part of what we standardized, but again to help beneficiaries understand that, I can get gold-level benefits and compare, you know, what issuer A, issuer B, and issuer C offer in that, and know that I am getting something like the same level of benefits.

At least, again, we are not making recommendations in this, but at least putting some of that kind of notion out on the table. And we do see some of these issues in Part D, where we have got companies that offer enhanced benefits that are actually less expensive than basic, which suggests that something is not quite working about some of the things.

So I think there are some of those issues. And I will not spend more time. I have talked about those in other meetings. But that is where things like risk selection probably have not been fully addressed. But I think those are some thoughts about how to build from this base. At least, again, I recognize we are not going to have long discussions of these other issues, but at least we can touch on some of these things within the current context.

DR. SAMITT: You know, Jay, can I weigh in on that?

DR. CROSSON: You want to counterpoint?

DR. SAMITT: Yeah.

Just one of the things that I would love for us to reconcile is beyond making the benefits comparable and standardized and having a level purchasing playing field is whether we want to make MA and fee-for-service equally attractive, so to speak.

We talked yesterday about the importance of moving toward models that are more coordinated, more value-based, driven off of the -- with the progress that has been made in MA plans. And I think while I appreciate what you are saying, what I am worried about is it starts making fee-for-service look more attractive and more like MA without all the coordination and value-based improvements that we want to see.

DR. HOADLEY: I mean, presumably under the premium support model, that is what is supposed to come out in the competitive price.

So if what you do to add that kind of coordination and -- first of all, if we can do more of that in the fee-for-service world, then obviously that is a plus. But if that is not the case and it takes the kind of management that an MA plan provides to do that, presumably that is then reflected in more efficiency and thus offering the lower premium. You know, that carries with it its own set of issues, but that is presumably where that should be playing out.

DR. CROSSON: Okay, further comments?

Warner?

MR. THOMAS: I will be brief.

It just seems to me that we are making this really complicated. And if what we want to do is try to understand what a fee-for-service product would look like, I guess, in the private or in the MA world, then why don't we just have MA plans bid at a fee-for-service level product design as well as bid with one that has increased benefits?

And it would be interesting -- from my perspective, it would actually be interesting to see how MA plans would look if they had a standard fee-for-service product that they bid on, because I think you would find that it is a -- you know, getting back to Craig's point around innovation with MA, I think we would find it is a better offering for that standard set of benefits.

Now, I know this ties into a broader issue of premium support, but the standardization, you know, I actually -- I guess I thought that is what MA plans did is they bid off of a flat kind of fee-for-service equivalent. It sounds like you are saying now it is really an administrative benchmark that they are bidding on. But, I mean, let's give them specifics, say, you know, bid this set of benefits, which is what fee-for-service Medicare is. It would be interesting to see what that would look like as they go through that process.

DR. CROSSON: Paul, you wanted to comment on that?

DR. GINSBERG: I think the last thing I would want to do is lock in the current Medicare benefit structure, which was cutting-edge in 1965 --

[Laughter.]

DR. GINSBERG: -- and has been very difficult to change.

So, you know, the fact that basically we are talking about bidding across an actuarial equivalence, I think that is the more -- you really would not want to take this standard -- you know, this existing benefit package, which is not at all up to the times, and make it even more important -- unless I am misunderstanding you.

MR. THOMAS: No, I would not disagree with that, but then we ought to be having that discussion, not this -- if that is really the key issue, that we do not like the benefit design because it is the same as it was, you know, 50 years ago, or whatever, then let's have that discussion.

But I am saying if we are looking at a standardization and a comparison, then let's have innovative organizations like Pat and Craig's and others bid that and see how they do against the fee-for-service market, which I think is not innovative. And let's put -- let's let MA plans that are more innovative use their capabilities with a fee-for-service benefit structure. And it would be interesting to see how that compares to what we see from traditional fee-for-service.

As an aside, I also would just -- and I have talked to Mark about this as well. I just think it is interesting in markets where fee-for-service is a more expensive option that we ought to enroll everybody into the most expensive option in the marketplace, which to me does not make a whole heck of a lot of sense.

And I know that is another topic, but I do think that is something that should be put on the agenda as well for us to be thinking about: How do we auto-enroll people, and should they be auto-enrolled into a more cost-effective option, certainly having the option to opt out of it. But in areas that MA is a more cost-effective option with broader benefits, to me that is what we ought to be trying to steer people to, to give them a better option.

DR. CROSSON: Okay, now we have run over time, so let's -- thank you.

DR. REDBERG: I will be brief and just say in the broad sense I support the ideas -- the details which were discussed by many of my fellow commissioners of standardizing the benefits package and revamping -- you know, looking at value-based design both in fee-for-service and in Medicare, and that I am sure we will -- this is a great start -- and work this out in the future.

I actually could see -- and this is out of our purview, but then the same idea I would love to see in the pre-Medicare, the private insurance system of having standard offerings for our less-than-65 and then enhancements and innovations, because I think that is, again, not our problem but a morass and could be much improved. And I think what we are doing here could be a basis for it.

DR. CROSSON: I like the term "pre-Medicare." I think that we are going to use that more.

[Laughter.]

DR. CROSSON: I seem to remember being pre-Medicare.

[Laughter.]

DR. MILLER: It is post-Medicare you want to --

[Laughter.]

DR. CROSSON: Right. As Mark points out, that is better than post-Medicare.

[Laughter.]

DR. CROSSON: Okay. All right, good conversation. Carlos, excellent work.

So let's move on to our final presentation.

Okay. So to continue filling in our thoughts about ideas and recommendations with respect to premium support, we're now going to take on some potential impacts of the premium support idea, including on beneficiaries. Amy, Scott, and Eric, and I think we have who beginning? Scott? Amy.

MS. PHILLIPS: In this presentation, a continuation of the discussion we've been having since the fall on premium support, you will be hearing about the possible impacts of premium support on beneficiaries and plans.

The rationale behind the concept of premium support is to engage beneficiaries to make efficient insurance plan choices. Will beneficiaries be willing and able to make rational choices under a premium support system? How will these choices impact plan behavior? Today we will be discussing these questions through lessons learned from Medicare Advantage and Part D, hypothesized plan behavior, and a study CBO did on premium support in 2013.

We will begin by taking a look at the switching which occurs in the Medicare Advantage program.

Looking at the pie chart, you will see that the Kaiser Family Foundation found that between 2013 and 2014, 78 percent of MA enrollees stayed in their same plans; 11 percent voluntarily switched to another MA plan; 2 percent switched into traditional Medicare from MA; 5 percent were switched involuntarily - of that, 4 percent were switched to another MA plan and 1 percent were switched into traditional Medicare; and lastly, 3 percent died before they could make a choice.

To contextualize this beneficiary switching, I will now go over some general characteristics and patterns in the Medicare Advantage plan switching population so that we can understand who switches and some of the motivating factors.

Beneficiaries in MA plans switch at rates similar to those in Part D prescription drug plans, but at lower rates than those in the PPACA Marketplace. Among those beneficiaries who switched plans, voluntary switching rates do not vary by gender, number of plans available across counties, or MA payment quartiles for the county. Beneficiaries switching at higher rates tend to be younger as well as higher need, higher cost.

When deciding if they want to switch plans, it was found that beneficiaries strongly consider many factors including: premiums and out-of-pocket costs, if their doctors participate, if they will have access to certain hospitals and treatment centers, if they will have access to pharmacies and physicians closest to their homes, and they also take into consideration their familiarity with the plan sponsor.

Now that we know which beneficiaries are switching plans and what they take into consideration, we will discuss a major reason why some switch.

The cost of premiums is frequently stated as a top concern for beneficiaries and a main reason for deciding to switch plans. This observation is confirmed through data analysis conducted by the Kaiser Family

Foundation where MA enrollees were found to switch plans at differing rates when confronted with particular dollar increases in premiums.

As you can see on the chart, beneficiaries faced with an increase of less than $20 switched at a rate of 11 percent. Those who faced a bump of $20 or more switched at increasingly higher rates.

MA enrollees switched at a rate of 9 percent even when confronted with a premium decrease.

The average line is in reference to the previously mentioned annual voluntary switching rate.

Keeping in mind the "who" and "why" of beneficiary switching, we will now look at what lessons we are able to glean from Medicare Advantage.

We can think about MA switching in two different ways: beneficiaries switching between MA and fee-for-service and then beneficiaries switching within MA.

Roughly the same percentage (2 to 3 percent) of beneficiaries switch between MA and traditional Medicare each year. Many beneficiaries enrolling in MA are not new to Medicare and are switching from fee-for-service. We previously found that these beneficiaries tended to be in their late 60s, early 70s, and have experienced one or more open enrollment periods.

The share of beneficiaries switching plans within MA has been about the same every year, averaging 9 percent annually. Among MA beneficiaries who switched plans, they saved an average of $210 per year.

The high retention we see in MA encourages sponsors to strengthen their incentives to keep their enrollees healthy with low medical costs since they will be there for years. However, this stickiness can also signal that as long as sponsors do not drastically increase prices or disrupt care, they have a low risk of losing enrollees which could lead to decreases in quality or the addition of program benefits.

I will now shift to discussing experiences and lessons learned from the Part D program.

During the first few years of the Part D program, the majority of beneficiaries remained with the plan they selected in the program's first year. Research suggests that the complexity of the Medicare Part D drug benefit might have discouraged enrollees from signing up and switching plans. This initial reaction could be mimicked in a premium support model without proper beneficiary education.

After that initial hesitation, beneficiaries are now found to be switching PDPs and MA-PDs at a rate of about 13 percent annually. Beneficiaries who are shopping and switching PDPs are, on average, saving $32 per year. The decrease in costs for PDP switchers indicates that those beneficiaries choosing to switch are making rational decisions taking into account their anticipated prescription needs and who cover more of their medication.

While research has shown that beneficiaries do not always maximize savings when they switch or choose to remain in a plan, this does not mean that beneficiaries are always making irrational decisions. As I previously mentioned, beneficiaries are sensitive to non-monetary switching costs, such as risk of losing a familiar physician and the value of their time spent when selecting a new plan.

With the two considerations of price and non-monetary switching costs sometimes at odds with each other, improving consumer choice and creating tools that allow for this comparison would be important considerations in a premium support model.

How we improve consumer choice comes down to how well beneficiaries are able to receive and use information for plan selection. When beneficiaries find plan selection difficult, it may lead them to stay with the same plan rather than search for a new one.

Beneficiaries would have active participation in plan selection in a premium support model which many current beneficiaries enrolled in traditional fee-for-service Medicare have not had to do. Additionally, many beneficiaries are unaware of consumer tools that can assist them in selecting a plan.

Taking this into consideration, a similar online comparison tool as Medicare Compare and Medicare Plan Finder would be essential for selection of a premium support system.

As Carlos mentioned, the number of plans offered is an important consideration in premium support. Research suggests that consumer ability to make rational decisions when confronted with numerous choices is compromised, and elderly beneficiaries have an even more difficult time when comparing plans, meaning Medicare beneficiaries may struggle to sort through the volume of plan options and may find themselves overwhelmed with choice.

Within Medicare Compare and Medicare Plan Finder, beneficiaries have spoken to difficulties with the language used on these sites saying it is too technical and that they lack standardized information between plans. These comparison tools should use a common vocabulary to display standardized information including provider networks, cost sharing, and meaningful differences for comparison.

The use of State Health Insurance Assistance Programs (or SHIPs) could also be helpful in guiding the elderly or their caregiver through the plan selection process by helping to clarify terminology and assist with computer-based tasks. Please remember that in 2008 MedPAC made a formal recommendation to increase the financial support of SHIPs for outreach to low-income Medicare beneficiaries.

Ultimately, beneficiary decisions eventually lead to impacts on plan sponsors and how they structure their premiums and coverage decisions. I will now pass things off to Scott who will discuss in more detail possible impacts on plans.

DR. HARRISON: Of course, beneficiaries must have available plans to choose. The existing MA program provides a good base of plans for a premium support model. Currently, 99 percent of all Medicare beneficiaries have at least one MA plan available. The average beneficiary has 18, and some places have more than 40 plans available.

However, plan participation could be affected by new rules under premium support. Currently, plans often submit one bid that covers multiple payment areas. Under premium support, each plan's bid will affect the area's benchmark and thus the plan's payment in that area. Therefore, plans would want to pay more attention to their bids in each area.

The Commission has suggested using new payment areas, even within MA, that would result in fewer, often larger payment areas than the currently used counties. Plans could decide to enter or leave some areas based on their perception of competition in the new payment areas.

Both in Amy and Carlos's presentations, there were suggestions that the beneficiary ability to choose might be improved if plan choices were clearer and fewer in number. Therefore, plan sponsor offerings might be limited to one basic plan and one enhanced plan. At the same time, policymakers may not want to limit the number of insurers, or sponsors, offering plans in each market. Studies have found that a greater number of competitors reduced the bids in the MA markets and in the Part D markets.

While the new rules might lead to little growth in plan participation, we expect that the size of the potential market under premium support would be much larger than the current MA market and the new markets that have opened over the past decade, namely the Part D and ACA markets. Thus, we expect widespread plan interest in participation. The question becomes how would we expect the level of the bids to be affected.

Commission work, as well as the academic literature, has found that the current MA market structure does not focus competition on price. Studies have concluded that bids are more closely related to the administratively set benchmarks than they are to plan costs. Plans compete more on providing extra benefits.

Other MedPAC work shows that fiscal pressure on benchmarks can lead to lower bids. In 2011, the benchmarks for MA plans averaged 113 percent of local fee-for-service spending, and the bids for those plans averaged 99 percent of fee-for-service spending. Legislation lowered the benchmarks over the 2011 to 2017 period to an average of 106 percent of fee-for-service. At the same time, bids came down to an average of 90 percent of fee-for-service. So while there may not be perfect price competition, MA plans have become more competitive with fee-for-service Medicare.

Premium support could focus competition between plans on price and thus encourage lower plan bid amounts, and let me show you an example.

This table uses the bids from an illustrative market that we have used before in our premium support work. In this market, fee-for-service costs or bids $800 per month, and the five MA plans submit bids ranging from $680 to $800 per month. Assume that the benchmark is also $800. Further assume that the plans offer only extra benefits that can be funded by the rebates they receive by bidding below the benchmark, what we call zero premium plans. In this example, we set the national Part B premium at $125, which is close to its current level.

If beneficiaries were to compare the five MA plans on Medicare Compare, they would see the premiums displayed in the third gray row there, which they're all zero, despite the fact that Plan E bid $120 more than Plan A. Actually, all beneficiaries would pay the $125 base premium. But the premium will not be a factor in the beneficiaries' decisions. Instead they will decide based on their analysis of the benefit differences between the plans.

The same plan bids under premium support are shown on the following three rows. We assume that the benchmark in this example was set at the median plan bid. The beneficiaries would see and pay the premiums displayed on the bottom line, which range from $65 per month to $185 per month. No doubt beneficiaries would be motivated to move to lower bidding plans in order to save money on premiums. And plans would expect this beneficiary behavior and try to lower bids to attract enrollment.

In 2013, CBO issued the findings of their premium support analysis and estimated that the plan bids in a premium support system were likely to be somewhat lower than under the MA program. The transparency of the bidding process and the price-based competition I just showed an example of would lower bids by a few percent. The greater competition and lower bids would then likely lead to lower plan margins.

As a result, CBO estimated that there would be a significant decline in fee-for-service enrollment and that decline would be greater in some geographic areas than in others.

CBO was concerned about keeping fee-for-service as a viable option and was concerned that, as the fee-for-service market waned, plans might have trouble obtaining provider prices that approximate fee-for-service prices instead of being forced to accept higher commercial sector prices.

Now I am turning it over to Eric who will show you another way of looking at the possible impacts of premium support.

MR. ROLLINS: Turning now to slide 13, some Commissioners have expressed interest in better understanding the potential distributional impacts of using premium support. We can provide some impressions using the illustrative framework for setting benchmarks and beneficiary premiums that we discussed during the

Commission's November 2016 meeting. I'd like to start by briefly reviewing five key elements of that framework.

First, the fee-for-service program would remain available throughout the country, but it would be treated like a competing plan for the purposes of determining beneficiary premiums. Second, CMS would use a system of competitive bidding between fee-for-service and managed care plans to set a benchmark that would determine how much the government contributes towards the cost of buying Medicare coverage. Third, that bidding process would be conducted using geographic areas that reflect local health care markets. Fourth, the benchmark would equal the lower of the fee-for-service bid or the median plan bid, although the Commission also discussed using the weighted average of all bids as the benchmark. Finally, beneficiary premiums would equal a base amount, which would be determined nationally like the Part B premium, plus the difference between the plan's bid and the benchmark.

Under this framework, the impact of premium support would depend heavily on the relationship between the fee-for-service bid and the median plan bid in each market area.

This next slide reproduces the table that appears in your mailing materials. Here we have grouped market areas based on the relationship between fee-for-service costs and the median MA plan bid in 2016. As you can see in the top line of the table, there are about 1,200 market areas in our analysis, given the method that we used to define them. The differences between fee-for-service costs and the median plan bid are shown here as monthly amounts. The table also provides total enrollment, fee-for-service enrollment, and MA enrollment in each type of market area. All enrollment figures are shown in millions.

Here I've highlighted the two groups of market areas where we'd expect to see the largest shifts in fee-for-service and plan enrollment under our illustrative framework. The first group, highlighted on the right side of the table, are market areas where the median bid exceeds fee-for-service costs by more than $50. Under our illustrative framework, the benchmarks in these areas would be based on fee-for-service bids, and premiums for many plans would increase by $50 or more. You'll recall from earlier in the presentation that MA enrollees switch plans at much higher rates when premiums increase by more than

$20. We would, therefore, expect a significant portion of the 1.8 million MA enrollees in these areas to switch to fee-for-service coverage or a less expensive plan.

The second group, highlighted at the bottom of the table, are market areas where fee-for-service costs exceed the median bid by more than $50. Under our illustrative framework, fee-for-service premiums would increase by at least $50 in these areas, and you can see that about two-thirds of the fee-for-service enrollees in these areas would see their premiums increase by at least $100. The MA program has not seen premium increases of this magnitude, so its experience is of limited value in assessing how many fee-for-service beneficiaries in these areas might switch to plans. Nevertheless, it seems plausible that a majority -- and possibly a sizable majority -- of the 15.7 million fee-for-service beneficiaries in these areas could switch to plans. In market areas where fee-for-service premiums increase by particularly large amounts, the share of beneficiaries who are enrolled in fee-for-service once premium support has been in effect for a few years would likely be minimal.

Moving now to Slide 16, looking across all market areas, this rough analysis suggests that approximately 15 million fee-for-service enrollees might ultimately switch to a managed care plan and 2 million MA enrollees might switch to fee-for-service coverage. If these shifts occurred, more than half of Medicare beneficiaries (roughly 55 percent) would be enrolled in managed care plans, but a significant number of beneficiaries would remain in the fee-for-service program.

However, those figures are very rough approximations at best, and they have little predictive value. Even within the illustrative framework that we have used here, there are simply too many other elements to premium support that would still need to be specified, and those details could have a significant impact on the behavioral responses by beneficiaries, plans, and providers.

Turning now to the last slide, during your upcoming discussion we'd like to get your input on whether the chapter on premium support that we plan to include in the Commission's June 2017 report should address other potential impacts beyond the ones that we have discussed here today. Please keep in mind that the amount of time that we would have to conduct any additional analysis at this point in the annual meeting cycle is fairly limited.

That concludes our presentation. We will now be happy to take your questions.

DR. CROSSON: Okay. Clarifying questions. Can I see hands, roughly? So let's start here with Amy.

MS. BRICKER: How do we think about quality with respect to this discussion? I realize this is mainly a financial one, but any thoughts there, on how to weave quality in?

MR. ROLLINS: So Ledia and Carlos had a presentation, to sort of talk about some of these quality issues. It now seems very long ago. And I think sort of what we have taken away from those discussions was, you know, some of this earlier discussion, of there are areas where we have, based on sort of your conversations, a clear sense of where you'd like to go in premium support. And then there are other areas where we might kind of just talk about, there's a couple of ways you could do it. So think there were sort of two schools of thought voice in sort of some of the discussions on quality.

The first would be sort of that you would have minimum standards for plans, provider network adequacy, and things like that, and that you would sort of publicly disclose this data, which could be something maybe akin to like the star ratings that we have now, but you wouldn't necessarily tie any sort of payment adjustment to it. Then there was another school of thought that said, you know, yes, you could do all that stuff, but you would actually sort of want to have a financial incentive to enroll in a high-quality plan. And so you can envision a system where the government's contribution for a high-quality plan is higher than it would be for other plans, and as a result, a beneficiary's premium would be lower, and they would have an incentive to enroll in those plans.

DR. MILLER: And very simplistically, in these kinds of numbers we are just assuming quality is constant, and it really is a financial exercise, as you said.

DR. CROSSON: Questions? Bruce.

MR. PYENSON: Thank you very much. This is a question for Amy. I think the -- I was struck by what seemed to be relatively low turnover rates in the program, and I'm wondering if you could guess at the impact of a longer lock-in, rather than an annual cycle, a two-year cycle, given those numbers.

MS. PHILLIPS: So a longer lock-in in terms of instead of each year they decide, saying, maybe in every two years, every three years? So looking at the MedPAC data, the work that was in the March 2015 report, we found that the beneficiaries that were switching into MA were deciding to do that after so many open enrollment periods, so it would make sense that even if you locked it in to two or three years, you would see maybe a bigger influx, because the beneficiaries have had longer to make the decision. How that would impact the beneficiaries who are shopping every year, unknown. So whether you locked it in or didn't, I don't know if you would necessarily see a different bump, because it seems that the beneficiary information that they're receiving, and how they're deciding to make those decisions is remaining constant.

DR. CROSSON: Pat.

MS. WANG: A follow-up on that. Do you think that it would be useful, in that switching rate, if it's possible to pull out folks with low-income subsidy who have special enrollment periods, because they switch more because they have 12-month continuous enrollment.

MS. PHILLIPS: Yeah, and there's also -- the duals are able to switch plans every month, so that impacts it. The analysis on that data isn't very available, or hasn't been widely explored.

MS. WANG: You know, you might have kind of like a higher-lower kind of [inaudible].

And this is just -- I should -- I'm sorry that I don't know the answer to this. In the comparators of fee-for-service spending, et cetera, et cetera, how are medical education payments, IME and direct, treated? Are they carved out on both sides, because they're not in the MA now, are they, in your analyses part of the fee-for-service side?

MR. ROLLINS: They're not. We took them out to make it more of an apples-to-apples comparison with what the MA plans are bidding on now.

MS. WANG: Okay.

DR. HOADLEY: [Off microphone] -- that Pat raised. The work that I've done on Part D, LIS beneficiaries switching, you do see some sort of small ray of plan choice, plan switching, outside of open season, but it stays quite low. Most of it is in the first month or two, which seems like people that are either "oh, I should have switched" or "I regret my switch decision" and maybe switch on to yet a different plan, or something like that. Once you get past sort of February it's quite minimal.

MS. WANG: I think that for Part C it's a different story, because of extra benefits that are geared towards this population. We see a lot of consumer behavior of shopping all through the year, back and forth, back and forth, which is another issue, I think, about --

DR. HOADLEY: I know there was some look, when I looked at the dual demos in Virginia there was a lot of anecdotal evidence of that kind of switching. It was hard to sort of see, from a data point of view, that there was as much as sort of the story. So I think that makes an interesting question, whether it's -- there's some very visible cases, or whether it really adds up to a true volume.

MS. WANG: Probably the Stars measures for dual SNPs for the voluntary disenrollment rate would provide information --

DR. HOADLEY: Yeah.

MS. WANG: -- although not across the year, but anecdotally I would just offer. I think Part C is very different from D, which is defined benefit, that's it, and C is very different.

DR. HOADLEY: Yeah.

DR. CHRISTIANSON: Paul did you have question? Bill?

DR. SAMITT: I have two questions. Amy, the first question is for you, on Slide 4. You talk about the beneficiary considerations and the things that they -- that matter in switching or selection. So my question is -- and I probably should know this -- on Medicare Compare and Medicare Plan Finder, how many of those priorities are available for beneficiaries to use to select a plan? So when I go to Medicare Plan Finder and Medicare Compare, how easily can I assess whether certain hospitals, cancer treatment centers, specific physicians, and so on and so forth, are there so that I can make a good plan selection?

MS. PHILLIPS: I don't have as much familiarity with the Medicare Compare, but within Medicare Plan Finder you can do pharmacies by geographic location, so you can see what's closest to you for that, and based off the prescriptions you need filled, and, of course, like the premiums and the out-of-cost. But the non-monetary thing, not so much.

DR. SAMITT: We may want to call that out in the chapter, because it's -- and also walking through family members, through some of these tools, that the things that beneficiaries need to consider are not available to use as a tool when they're actually selecting a plan, and it may be worthwhile to point that out in the chapter.

And then for Eric, on Slide 15, I'm just curious on those two key groups of beneficiaries. I would be interested in understanding purchasing behavior there, because even in a non-premium support world, you would argue that there should be incentives for those two groups to shift today, and yet we don't see it. So pre-premium support, what does that mean about shopping behavior?

MR. ROLLINS: I think the nature of the dynamic now is different, so that box on the right side, up at the top, the areas where fee-for-service costs less than the median MA plan, right now a lot of those markets are areas where the MA benchmark is higher than fee-for-service, and so that's why the plans can sort of be in that market, cost more than fee-for-service, but --

DR. SAMITT: Without consumer impact?

MR. ROLLINS: Right. That's correct.

DR. SAMITT: And how about the other group, where I can get supplemental benefits, in those particular settings, even though I would not have to pay more to be in fee-for-service, I get supplemental benefits if I choose a plan?

MR. ROLLINS: There, I think, what you are seeing is people are moving from fee-for-service to MA. It's just going on sort of fairly gradually. It's 1 to 2 percent of the Medicare population year. But we are seeing them move from fee-for-service to MA, and I think, in part, that's because of these extra benefits.

DR. SAMITT: Just not as rapidly as you would expect.

MR. ROLLINS: Right.

DR. SAMITT: Thank you.

DR. CHRISTIANSON: Brian, do you have any questions? No?

DR. REDBERG: Thank you. I just wanted to ask a question on Slide 13, and I think I understand the reason for the competitive bidding and the use of geographic areas, but doesn't that then kind of advantage areas that are high utilize -- I'm thinking like South Florida, where there's very high, you know, fee-for-service rates, and then we're setting benchmarks. I think it's kind of a bloated, overutilized area, and is there any other way to do that, or am I right in thinking about it that way?

MR. ROLLINS: I think that is the implication. This has been sort of a topic that the Commission has discussed on a couple of occasions. The tradeoff was given the geographic variation that we do see in spending, to what extent do you want to sort of hold the beneficiary responsible for that? You could have an alternate approach that isn't sort of market by market, that uses a national figure. This is what Part D does. In those cases, the areas, the South Floridas that have very high spending would see even larger increases in premiums that what we kind of sketched out here. And I think the concern that was sort of voiced in a lot of the discussions was, you know, what is sort of reasonable to expect the beneficiary to control?

And so I think there was a preference for using these local market areas, which would have benchmarks that are higher in high-cost areas and lower in low-cost areas, because it would provide some protection for the beneficiaries who live there, you know, and they're not going to easily relocate to another area.

That being said, even with the higher benchmark in like a South Florida, you would still have this dynamic of within that given market area, you would have the premiums for the plans that are available there differing based on their underlying cost. You would still have a dynamic within your area to sort of gravitate towards a lower-cost plan. But it was this sort of tradeoff between, you know, how do we deal with the geographic variation in spending that we have now and how much sort of do we want the beneficiary to be responsible for?

DR. REDBERG: Thanks and I do remember some of those discussions. Maybe in round two we can come back if there are other solutions that we could think of, that wouldn't penalize the beneficiary but try to hold costs better.

DR. CROSSON: Questions, coming up this way. Jack.

DR. HOADLEY: So on Slide 11, I'm trying to make sure I understand correctly the difference in the two gray bars that you're showing. In the first case, you're -- the zero excludes the Part B premium.

DR. HARRISON: Right.

DR. HOADLEY: And in the second case, it effectively -- I mean, the concept of the Part B premium changes --

DR. HARRISON: Yeah.

DR. HOADLEY: -- but --

[Simultaneous discussion.]

DR. HARRISON: So when you look on Medicare Compare you're going to see zeros. You're still paying the $125.

DR. HOADLEY: Right. So this is mostly a comment on how Medicare Compare displays prices as opposed to purely a point about how --

[Simultaneous discussion.]

DR. HARRISON: I think if you're a beneficiary and you look and you see a bunch of zeros, I don't care. I'm going to pick one of the zeros.

DR. HOADLEY: Right.

DR. HARRISON: It doesn't matter which one. When you drop -- you know, under premium support, you have a choice on every single plan, you're going to have a different premium, and it should enter your psyche as to what you pick.

DR. HOADLEY: And that point would still be true if the current Compare showed $125 on every --

[Simultaneous discussion.]

DR. HARRISON: Right. Still no difference, right.

DR. HOADLEY: -- they would see no difference. But it also looks -- I think the problem with this is it looks like, oh, everything has gone up.

DR. HARRISON: Oh, didn't mean to do that.

DR. HOADLEY: It's not like --

DR. HARRISON: It's just what's in the beneficiary's mindset, and I think they see it as a zero premium. They don't think about the $125 that's already gone in.

DR. HOADLEY: That's fine.

DR. HARRISON: Yeah.

DR. HOADLEY: And then on Slide 15, Eric, you talked about sort of making some assumptions that, you know, majority or more, particularly looking at the box on the bottom, of that group might switch, and I wonder if you -- if that's just a modeling assumption you're choosing, I mean, because the earlier stuff that we looked at showed that even with the premium increases, 70 percent stayed put. So I'm just wondering on your logic for sort of --

MR. ROLLINS: Well, I think, and sort of Amy touched on during the presentation, sort of the MA experience sort of kind of tops out at like a $30 or $40 premium increase. But if you're talking about an area, for example, where the premium is going to go up by $100 or more, I think you can sort of reasonably expect that the switching rate is going to be much higher than what we see in Medicare Advantage.

Another factor is I tried to convey this -- we're not trying to say that everybody would switch immediately.

DR. HOADLEY: Right.

MR. ROLLINS: I think this would take time to sort of work out, and there are people who might not switch during the first open season, and go, "Oh, I'll try and see if I can pay it," and then year two, year three might decide it's time to move to a plan. So I think given the

MA experience we would clearly be seeing higher switch rates than what we've seen in MA. Exactly what those are, we don't know.

DR. HOADLEY: Sure. Sure.

MR. ROLLINS: We've not seen that occur. But it seems like it would probably be much higher than what we've seen, and I think once you factor in, too, how this plays out after a couple of years, I think that was sort of the thinking about why -- the thinking for why, in these markets, after a while, your fee-for-service would probably be pretty low.

DR. HOADLEY: So part of this is a multi-year movement.

MR. ROLLINS: Yes.

DR. HOADLEY: Okay.

DR. CROSSON: Alice.

DR. COOMBS: Thank you so much. With the other choices why people switch, I know there was some kind of information we might have had when people age into Medicare. What about network? Is that prevailing decision-maker for beneficiaries, a now network or a network that doesn't include certain physicians or physicians' choice? What role does that play?

DR. HARRISON: We don't have solid data on that. What we do have would come from like focus groups that we've done, and yes, people pay attention to their doctor. Sometimes when their doctor moves in or out of the network they will follow the doctor. Sometimes they won't. That's sort of the extent of what we have.

DR. CROSSON: Jon

DR. CHRISTIANSON: I guess this is a question for Amy, but anybody. So in the switching decision between the MA and fee-for-service, can you talk a little bit about how the pricing policies in the Medigap market might influence switching?

DR. HARRISON: Actually, could you -- what do you mean about the Medigap?

DR. CHRISTIANSON: Well, the --

DR. HARRISON: Being able to give up your Medigap?

DR. CHRISTIANSON: Yes, and then coming back in at a price that changes in the Medigap policy, and that sort of thing.

DR. HARRISON: In other words, you've lost your

Medigap, when you've been in MA, coming back out. Okay.

MS. PHILLIPS: The literature briefly touched that that's a consideration, but they didn't give any idea as to how much that impacts the decision.

DR. CHRISTIANSON: Maybe you could describe that consideration for people so they understand that.

MS. PHILLIPS: So switching out of MA into fee-for service you would lose your Medigap coverage and that supplemental insurance, so some beneficiaries would have to weigh how much the MA coverage mattered or if that premium was a factor into going into fee-for-service, and if they actually want to lose that coverage.

DR. CHRISTIANSON: Okay. Is the Medigap premium likely to be less for the younger beneficiaries when they move out of MA after a few years --

DR. HARRISON: So there's different ways --

[Simultaneous discussion.]

DR. CHRISTIANSON: -- premium?

DR. HARRISON: Yeah. It depends on the state and whatnot. Some states are community rated. It doesn't matter. But many states are not. Most states are not. A lot of times what you have is there are two different age ratings. One is issue age, so if you bought it when you went there, you will be on a lower premium trajectory. So then if you come back in after you've been out for a while, if your issue age is like 75 instead of 65, you could expect a pretty large premium increase there.

DR. CHRISTIANSON: That would discourage switching out of the fee-for-service plus Medigap market --

DR. HARRISON: Right.

DR. CHRISTIANSON: -- once you're in it, correct?

DR. HARRISON: Now the other thing is that the Medigap companies can underwrite you, once you're coming in, if you're not 65, and again, it depends on the state. And then they may give you a very high premium if you have pre-existing conditions.

DR. CHRISTIANSON: So I think focusing just on the comparison of the Medicare Advantage plans and fee-for-service cost misses a potentially important consideration, in terms of just the monetary implications of switching at different points in the Medicare beneficiary lifecycle.

DR. HARRISON: Yeah. I think we agree with that.

DR. CROSSON: Okay. So now we're ready for discussion, and I think Jack had volunteered to begin.

DR. HOADLEY: Thank you, Jay, and thanks for this analysis and this material, that I think will go into a larger chapter.

It seems to me that there are a number of concerns that the material you brought to us raise in terms of, you know -- that will have an impact on the ability of premium support to go forward in a smooth way, and I think there are some tools and some things we could do to mitigate some of those concerns. The concerns that I sort of see out of this are, number one, the sort of -- the issue of suboptimal choices and the fact that people, because of the complexity, because of the income, the information deficits, various other factors, are not necessarily making the choice that's best for them financially or otherwise. And the second one is the potential for volatility and churning. If we see, you know, a fair amount of plan entry and exit, such as we've seen in the Affordable Care Act marketplaces, then people are forced to move around. If we see a lot of premium volatility changing from year to year, we could potentially see it, or then that goes to the -- sort of the third concern, is that there's insufficient switching, and that people don't respond to those cues, you know, continue to pay a much higher premium because of that stickiness factor. And so sort of those two things, you know, in some ways are contradictory, but they're both potential issues.

And then that factor, in turn, goes to the fourth point, which is whether there are insufficient signals to the market competitors, and you brought this up briefly a little more in the chapter, the extent to which if people don't track those premium changes that plans have less incentive to moderate premiums, and we've seen a fair amount of this in Part D, where some of the older plans have experienced very substantial increases in premiums, hold onto their beneficiary base because people are unwilling or unable to make switches.

And so it does appear that the market is sort of thrown out of whack a bit through that, and some companies seem to exploit that by keeping an old plan and collecting high premiums from an older population and then putting a second plan in that sort of attracts the newer beneficiaries at a lower premium, which is a suggestion that markets aren't working well.

And then I think the fifth concern, that Jon just highlighted, is sort of the level playing field around Medigap, and whether you have essentially sent a signal, and this could be one of the reasons why you might not see that switch in that one box that I highlighted a minute ago, of people switching from fee-for-service to Medicare Advantage. If they think they ever want to come back to fee-for-service, they understand that they may not be able to, and so that may be a deterrent. And if you really want a smoothly functioning marketplace, we may need to change the Medigap rules so that there is the ability to reacquire Medigap, or, per comments I made in the last session, redesign in such ways that we make the Medigap supplementation appear less necessary.

I think there are some things, and you've highlighted a number of these, that could help to improve the market function. One is the potential for limiting the number of choices, whether that's at a more aggressive way, like some of the states have done to actually say not all issuers necessarily get to enter the market. Maybe the ones that have the highest bids or lower-quality bids or something, you know, don't get to play. Or the simpler one that we've seen in Medicare, which is to say any given issuer can only offer a more limited array of choices with a meaningful different standard and so forth.

We talked in the last session about standardization. I think the tools -- you know, there was some mention here about Plan Finder. I think this would be an incentive that we already really need for some big improvements in the way Plan Finder operates. We've raised a few of these issues over the years here. Plan Finder really does not allow -- this goes to, I think it was, Craig's question -- to look at the provider choices. They basically send you off to the plan's website, and then there's all kinds of issues about the accuracy of those provider directories. We really need to have better ways, even under the current system, to make sure that people can understand what they're getting in a particular plan. Networks is the most obvious one, but to some extent, plan benefit variations too. What is it that makes a plan different, and CMS actually reduced some of the information that is available this year compared to previous years.

Resources, you brought up the SHIPs, other resources. It's really clear that people need -- that a lot of people need person-to-person counseling, and the

SHIP resources are inadequate, and there's actually been threats to reduce the amount of SHIP resources at a time when we really should be seeing those increase. So I think it's important to really continue to raise that issue. And then to find ways to make sure people focus on the right criteria. There's a tendency to shop on premium alone, but, you know, in the Part B world, looking at total costs of all your drugs, not just the premium, there are cases where the low premium plan has a lot higher out-of-pocket costs. The same thing is going to happen in the MA side. And it's more complex and more layered there. There may be all kinds of ways of providing that care coordination and all those advantages. In some cases, plans do it -- they need a higher premium to provide some of the resources. If it works well, as Craig was suggesting, you know, maybe that allows them to be more efficient and get the premium down. But if people are only judging on premium signals, they're not understanding both the positives and the negatives of some of the other dimensions.

And then trying to think about better ways to use nudges and others sorts of behavioral economics principles. There was, however, a recent article in the most recent

Health Affairs in the marketplace context where they did an actual randomized experiment with the Colorado marketplace, and they found that additional notices to people did increase their likelihood of shopping, but it did not increase their likelihood of switching. Now, they can't explain why. Was it that people shopped and they said, "No, I'm still good with the plan I'm in"? But even where they could save money, there was no increase in shopping with the additional kind of nudges that were provided to them. So I think that's the kind of thing that we should be exploring and trying to us what is it that both encourages people to do the shopping that they need to do to make sure they're in the right plan and to consider -- again, you don't expect everybody to end up making a switch or you never should see 100 percent switching, or anywhere near that, but to make sure that those who can benefit by switching will do so.

And then I already mentioned the Medigap potential reforms to further level the playing field.

So I think there's a bunch of things that could be done, and I think you've highlighted a number of these, and maybe, you know, there needs to be more about sort of a clear menu of steps that could be taken to make the system work better, should we move in this direction.

DR. CROSSON: Okay. So now we'll have further discussion. Can I just see roughly hands for further discussion? So I think we'll start at this end this time.

DR. DeBUSK: I just wanted to comment. I think this is a very well written chapter, and I've noticed as you guys iterate through the illustrations around premium support, they get better and better. I really appreciated the analysis around estimating the 15 million people that would switch and trying to get your hands around that, because I like seeing you link the beneficiary engagement mechanism to how many -- what that would translate to in people. So thank you. I thought that was great. And I do think this underlying effort to get away from this process of administrative benchmarks and bids and rebates and extra benefits and all that, and moving to something more market-based, I think this is great work and I hope we continue it. So thank you.

DR. CROSSON: Comments on this side? I did not see any other hands -- sorry, Rita, and then Alice.

DR. REDBERG: Just briefly, to comment on Jack's last comment on the Health Affairs blog, obviously I don't know either why they didn't, but I can imagine -- because I've gone into that to try to help people, and it's pretty overwhelming. So I can imagine you've gone on -- I assume that's what the shopping part was -- and then you thought, oh, my God, I don't know what I'm -- you know, is it better, is it worse? And you just stay with what you are. So I do think, you know, you need kind of the hands-on -- it's very hard to sort out those plans, so I can imagine why they increased shopping but not switched.

DR. MILLER: And that's why sometimes -- and I know you have been involved in some of this. I want to be really careful. Sometimes the suboptimal choice stuff, you know, I read it and I get it, but then I sort of feel like are we really taking in, you know, search time and that stuff into account. It can be completely rational behavior to say I'm going to -- you know, I thought Shinobu's work a few years back in Part D, you know, people tended to save some money, get the drugs they wanted, but you could probably argue it wasn't optimal from an economist's point of view. But I could imagine searching and saying, okay, saved some money, I got the drugs I got, and I'm out. You know, like I don't want to put hours more into this. So the suboptimal stuff has always left me a little off.

DR. CHRISTIANSON: So I don't think that would be the economist's point of view.

[Laughter.]

DR. CHRISTIANSON: Just to look at the dollar amount. I mean, there's a whole part of economics called reveal preference and attributes -- different product attributes and search cost and everything you're talking about. And I think the economist's point of view would be you wouldn't want to say something was rational or irrational just based on some projection of the dollar premium difference.

DR. MILLER: Oh no, and I recognize that, that they do take into account the search, these drugs, I need these drugs. But it still left them a little bit cold even at that point when people are saying it's suboptimal. And I think some of it is. The complexity of having to go through that process.

DR. CHRISTIANSON: [off microphone].

DR. MILLER: Yeah, right.

DR. HOADLEY: And I agree with that as well. I look at something like the point on Slide 5 where we were showing that when there's a premium increase of $40 or more -- which we're starting to get up to pretty substantial -- you've still got 70 percent of the folks staying put.

DR. MILLER: That's true [off microphone].

DR. HOADLEY: And I think that's part of what sort of reinforces the importance of having issue.

DR. MILLER: That's fair [off microphone].

DR. HOADLEY: Now, again, there are a lot of reasons why you might stay. You may be getting real value from that plan. You may like the folks. There may be network issues. That's the only plan that has your doctors. There are plenty of reasons why you could switch, but it's the magnitude of that ratio that says, you know, there are probably a whole lot of people that could save a bunch of money, and when you look at the Part D where, again, it's a little more of a straight financial kind of analysis, there's a lot of people leaving quite a bit of money on the table.

DR. MILLER: I just want you to be clear; economists don't just look at the financial [off microphone].

[Laughter.]

DR. CROSSON: Okay. I think it's time to hear from a doctor. Alice?

DR. COOMBS: I wanted to say that one of the issues is this whole notion of what happens with the decisionmaking of the beneficiary, which is huge because this whole thing on premium support is predicated on beneficiaries actually making a decision that I'm going to switch because X, Y, and Z. If you have a situation where, as Kahneman and Tversky say, men fear loss greater than they desire gain, then it might be that the beneficiary is sitting in a comfortable place with all their comorbid conditions and it's just a hard heel to change. And whether it means re-enrolling and getting someone in the ambulance to take you to a place where only you can transfer because you got the access to an ambulance to do something non-medical, but, you know, the transportation to get to the place, I remember there was a -- and I should name the company, was enrolling seniors in a Medicare Advantage program, and it was an off-beat place with no bus transportation, and you had to go up a couple flights of stairs. And so that was not conducive for people, you know, to switch.

I think there's other things that become in play other than the money, because the money is a signal, but there are other signals, i.e., this doctor who's been taking care of you understands that he's going to give a script to your nephew or, you know, you have a relationship. So I'm wondering if you were to look at -- and you probably couldn't do this, so, Mark, you don't need to worry.

[Laughter.]

DR. COOMBS: But if you could actually look at the behavior that we might deem as not typical, whether or not things like relationship with the providers became much more of a signal than the actual money. And I think that my underlying thought is that there are some non-monetary decisionmakers for which, if you were going to propose the premium support, it may be the wrench in the whole process. And so that's one area that I think this whole program, the premium support, is dependent on. And if what we call rational behavior or decisionmaking that we think is predictable should happen and it doesn't happen, then the cost savings and all the things that we think are about to happen may not happen.

DR. CROSSON: Okay. I'm sorry. I thought you said no.

DR. HALL: I probably did. I'm in a community that has very high MA penetrance, and there's a flurry of activity at enrollment time by three or four players. But my sense is that people ask their friends and neighbors. It's a huge influence maker. Next would be their trusted health care provider, which wouldn't necessarily be a physician. So, you know, it's -- the decisionmaking there may not be what we would consider from an economic or a sociologic standpoint rational. It's like buying the car edition of a Consumer Report and then talking to your friend at the garage in terms of -- I don't think this is necessarily a scientific area. I feel like we ought to be careful getting into it, I think.

DR. CROSSON: Okay. Comments on this side?

MR. PYENSON: Yeah, I think I disagree with Jack's comments in that I see the work that you've done as not identifying areas that are especially challenging. It seems that many of the areas in premium support and the issues are relatively technical and can be relatively easily addressed. And, in particular, we're starting from a standpoint with substantial standardization already in Medicare Advantage and, of course, in Medicare fee-for-service.

By contrast -- and the choice of which Medicare Advantage plan to join or to stay in fee-for-service is probably rarely a life or death issue. Hopefully there aren't a lot of Medicare Advantage plans or fee-for-service plans where there's huge differences there.

I would contrast that with the lack of support for life and death issues in treatment, such as whether an 85-year-old beneficiary should get open heart surgery or chemotherapy or whether the choice is to go to inpatient rehab or to a skilled nursing facility or home health for treatment.

So just on the scope of decisions, that is, I think, where we need the decision support because right now it's a cottage industry relative to the standardization that we already have in benefits. And I support this direction. It is just I see it as it works well down in the -- some of the issues that have been raised are also, you know, beneficiary choice, and the mystery of how people make decisions is very common as well in the commercial insurance world. That's part of the real world, and I'm not sure we need to spend that much effort addressing it.

DR. CROSSON: Bruce, can you just help me for a second understand, you know, within the context of the Medicare program, how you would see that sort of personalized clinical care advice provided in ways that it's not now?

MR. PYENSON: Well, I think today we depend on the Marcus Welby model where the physician is advising the patient on what should happen to them. I think there's certainly better ways to do it. I don't think that's the context for this discussion.

DR. CROSSON: No, no, it isn't. I was just -- maybe we can have a conversation offline. Okay.

MS. WANG: If I am forgetting something, then we can just move on. I don't remember whether or not in the writings so far on premium support there has been a specific consideration of how to treat indirect medical education, direct medical education, and DSH payments. So for purpose of this analysis, Eric helpfully clarified that at least, you know, IME and DME were removed to make things apples to apples. Is the suggestion that in order to maintain that apples to apples in a premium support system, these payments would continue to be made as a separate kind of payment stream? And then what happens to DSH, which is now embedded in the fee-for-service benchmarks that MA plans bid against? It's treated differently? I have a personal feeling that it shouldn't be, but it is included right now. How are those -- do we need to address that? Because if at the end of the day folks said let's put all those sort of special kind of payments into the fee-for-service, then nobody going to be able to afford it, right? I mean, it creates a distortion.

DR. MILLER: Okay. So what I would say is -- and this is mostly predicated on -- I don't think we've addressed this issue directly in our analysis. I think what we've dealt with our numbers is always to make sure that the numbers are comparable, which is almost like assuming that what goes on now continues to go on. But I don't recall that we've taken a deeper discussion and said how should it go on.

DR. STENSLAND: Moving the DSH payment out of fee-for-service [off microphone].

DR. MILLER: I'll just repeat it in just a second. Jeff is saying that -- but that discussion, Jeff, was in the context of this, or it was in the discussion of kind of the hospital world?

DR. STENSLAND: It was the hospital world [off microphone].

DR. MILLER: Right. So just for everyone, what Jeff is saying is there was some discussion in the hospital world about how to deal with uncompensated care and disproportionate care services and whether they're paid as a separate function or whether they're a function off of the formula, which is very much tied to the admissions and all of that. And what he is saying -- and it's a good thought -- is, you know, that thought could be imported into this discussion. But you are correct. I think in the context if you just read our premium support stuff, I don't think we've said that very directly at all. And so maybe some discussion can be exported from the stuff that Jeff did, at least as a marker. I don't know that we would work through solving it, but saying it needs to be there. So you're right that it's not in here.

MS. WANG: The other comment is just a really small one, and I'm not saying this just because Bruce is to my side here, but in trying to think about tools that beneficiaries could use, if this were a new format, is to consider adding something like the actuarial value of each plan design to the current out-of-pocket maximum calculator. You know, it's just a benchmark. You know, if fee-for-service is 70 percent, then what are you comparing it -- it goes -- it's just another piece of information for people.

DR. GINSBURG: First thing, I think Slide 11 was very useful for me, just showing how the different premiums are going to look different under premium support than under the current system, even though the differences are the same or roughly the same. So that was very valuable.

A bigger-picture comment is that this presentation was called impacts, and it was all about switching. And it was a good contribution on switching, but there are other aspects of impacts that maybe you're planning for a different paper. Basically, you know, how are the benchmarks going to change in the different markets? Because this is going to be extremely important to beneficiaries. If they live in Miami, they're going to have a much lower benchmark under premium support than they do today. So whether they stay in fee-for-service or switch to a Medicare Advantage plan, you know, things are not looking up for them; whereas, there are some areas where, you know, things will definitely be improved whether they stay in their plan or switch. So I think that's a very significant impact of premium support.

DR. CROSSON: Do you want to say something?

DR. MILLER: Yeah, and the thing I do want to say -- you know, some of the complication here is we're taking these issues, because you've got to organize them, come into a meeting, be prepared, talk about them for an hour plus, and then they're going to be booked into a single chapter, which at this point is going to be about 250 pages long, and I don't want a lot of complaining about that because you guys are making it really long.

But there will be a fair amount of discussion about the distributional impact on the beneficiary from the shift in the benchmark, Eric, which I think harkens back to some of the stuff you had presented previously, and then that got appended with a conversation -- and this is a quick bank shot to something Rita said -- of, well, could you think about mitigating some of the effects of the beneficiaries. And you may remember that we did kind of crank through that, and that will be a place in the chapter.

Then what Jack started saying, making the chapter much longer, was --

[Laughter.]

DR. HOADLEY: You're welcome [off microphone].

DR. MILLER: Thank you. Got it. But there are other considerations beyond the benchmark effect and the beneficiary might be hit with a premium. And so what we tried to do is scour the literature quickly on things like: Well, what about plan participation? What about beneficiary decisionmaking process? And you're right, this is very much a switching thing, because I think our view is that that is the stuff you can kind of find, and even that's relatively thin. But then other stuff like will plans come to this market or that market, at least from our perspective we think is very thin. So we're trying to spec that out.

But I do -- this is a long way of saying I think you'll see what you want in that long chapter that will all be put together shortly.

MR. GRADISON: Two quick thoughts. The first is sort of blasphemy, I guess, but I find it difficult to think that a premium support plan would be approved that required people to pay extra cash to stay in fee-for-service. It's such a fundamental element of the program from its very beginning.

Now, one could counter that, well, it would be phased in over time. Fair enough. It probably would have to be a very long period of time, and the only reasons I bring it up is I think that it might be interesting to recognize that uncertainty about -- and give some thought to what does that mean in terms of everything else we have here, because I'm not trying to inject the political issue in here. I just think as a practical matter, you put yourself in the position of somebody living in South Florida, and it's not a trivial sum, no matter how you measure it.

The second thing I want to mention is -- and maybe it's been mentioned and I have missed it -- is the possible role and assistance that people in making these decisions could get from agents. Most everybody who owns a car or a house has some agent, insurance agent, or access to them somewhere in their life. I appreciate people with very low income would be not in that category, and I recognize that. But most people have a car or a house, and I realize there are problems in how agents should be compensated. They may tilt towards companies or plans that pay them a higher fee. There would have to be regulation. I'm not saying it should be just "let loose," but there are objective people out there with no help on subject.

And while I haven't surveyed this with great care, my impression is that in the exchanges that pretty limited -- in fact, maybe almost hostility towards the idea of agents have any role in this thing, and I don't think that we should assume that that should be the case in what we're exploring. I'm not saying they should be, but I think you ought to give some thought to what role they might play.

Thank you.

DR. CROSSON: Thank you, Bill.

Seeing no further comments -- Jack? Sorry.

DR. HOADLEY: I am thinking about Bill's comments. I think there's a good point there, but clearly, they need to regulate. But we need to identify all possible sources of counseling and help, and it may be that brokers and agents could play a role in that.

Again, there are some issues, and there have been some abuses, but there's been some positive experience in the marketplaces.

The other point, I was reminded by Paul's comment. One of the impacts that I think falls in the category, Mark, of the things that are not easily done is sort of what is the expected variation and bidding behavior. I think I have raised this before. We're sort of assuming a static, that plans will bid kind of the way their bids are today in a system that has some pretty different dynamics. I suspect there isn't much literature to really say would we expect plans, given this environmental, given a Miami situation, given a situation in a market where fee-for-service, would some plans just decide not to participate, would they raise lower bids according -- as well as some of the dynamics that I talked about earlier in terms of their expectations of how people respond. But, unfortunately, I think it's one of those areas, there is just not a literature to work from.

DR. MILLER: Brian, I think we do -- I am also now confused of where I see things and where I don't see things.

I think we do have the distribution of the bid stuff in this chapter as well as the MA chapter.

DR. HARRISON: Yeah. It's in the chapter, not in this particular piece. Right.

DR. MILLER: Okay. So, I mean, we might either at least reference -- but this is the frustration with all of this. What we have to look at is based on the current dynamic, which is not at all like this dynamic. It's administrative benchmark competing on benefits, and we can put these numbers out, but they have to be extremely caveated because there's going to be all kinds of behavioral change here.

DR. CROSSON: Paul.

DR. GINSBURG: Yeah, it's a good point, Jack, about not knowing much about the bidding behavior.

I think we're going to start to learn more because research is starting to come out now on marketplace behavior, and there was something that just came out. And my reaction to reading it is that, wow, this is what a really competitive insurance market looks like, and I don't think Medicare Advantage will ever become as competitive as many marketplace markets. But I think at least that could be a source of information about real-world experience if we use it right.

DR. CROSSON: Okay. Amy, Scott, Eric, Thank you so much. Excellent work.

We now have the opportunity for a public comment period. If there are any of our guests in the audience who wish to make a comment at this time, please come to the microphone.

[No response.]

DR. CROSSON: Seeing none, we are adjourned until the April meeting. Thank you very much to the Commissioners and staff. Great work, everybody.

[Whereupon, at 11:22 a.m., the meeting was adjourned.]