

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Wednesday, April 8, 2009  
9:56 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair  
MITRA BEHROOZI, J.D.  
JOHN M. BERTKO, F.S.A., M.A.A.A.  
KAREN R. BORMAN, M.D.  
PETER W. BUTLER, M.H.S.A  
RONALD D. CASTELLANOS, M.D.  
MICHAEL CHERNEW, Ph.D.  
FRANCIS J. CROSSON, M.D.  
THOMAS M. DEAN, M.D.  
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N  
NANCY M. KANE, D.B.A.  
GEORGE N. MILLER, JR., M.H.S.A.  
ARNOLD MILSTEIN, M.D., M.P.H.  
ROBERT D. REISCHAUER, Ph.D.  
WILLIAM J. SCANLON, Ph.D.  
BRUCE STUART, Ph.D.

AGENDA	PAGE
Communicating with beneficiaries and shared decision-making -- Joan Sokolovsky, Hannah Neprash	3
Impact of physician self-referral on use of imaging services within an episode -- Ariel Winter, Jeff Stensland	68
Medicare payment systems and follow-on biologics -- Joan Sokolovsky, Kim Neuman, Nancy Ray, Hannah Miller	107
Public Comment	133
MIPPA MA payment report -- Scott Harrison, Carlos Zarabozo, David Glass	137
MIPPA MA/FFS Quality Report - Update -- John Richardson, Carlos Zarabozo	205
Medical education in the U.S. - Supporting long-term delivery system reforms -- Cristina Boccuti, Craig Lisk	244
Public Comment	298

## 1 P R O C E E D I N G S

2 MR. HACKBARTH: Welcome to the public audience. I  
3 apologize for the late start.

4 Our first session today is about communicating  
5 with beneficiaries and shared decision-making. Joan, are  
6 you going to lead the way?

7 DR. SOKOLOVSKY: I will.

8 MR. HACKBARTH: Okay. Thank you.

9 DR. SOKOLOVSKY: Good morning. This morning, we'd  
10 like to present some preliminary material that's part of our  
11 ongoing work on beneficiary education. As some of you may  
12 remember, we have developed a series of beneficiary --

13 MR. HACKBARTH: Could you pull the microphone a  
14 little bit closer?

15 DR. SOKOLOVSKY: Okay. As some of you may  
16 remember, we have developed a series of beneficiary-centered  
17 projects. Some of the past work includes focus groups and  
18 surveys on how Medicare beneficiaries made choices about  
19 Part D plans, how Medicare could increase participation in  
20 programs like the Medicare Savings Program, and a regular  
21 series of focus groups and beneficiary surveys to gather the  
22 beneficiary perspective on a range of issues.

1           Today's presentation is not for June chapter.  
2    It's more of a progress report on the work that we've been  
3    doing this past year and how best to communicate with  
4    Medicare beneficiaries. We hope to develop the material  
5    into a chapter for next year, and we're looking for your  
6    guidance on additional areas of research that we should be  
7    looking into.

8           Jennie, you asked us last year to look at the  
9    issue of health literacy and the elderly population, and  
10   Hannah is going to present our findings from that research  
11   this morning. And then I'm going to tell you about our site  
12   visits to Dartmouth Hitchcock and Massachusetts General  
13   Hospitals to look at models of shared decision-making  
14   between patients and providers.

15           To date, we have found that to best communicate  
16   with beneficiaries, Medicare must take into account how they  
17   learn and when information is most useful. One  
18   communication strategy is focused on shared decision-making,  
19   providing people with knowledge about their conditions and  
20   treatment options so they can participate with their  
21   physicians in making treatment decisions that reflect their  
22   values and preferences.

1           Analysts believe that shared decision-making may  
2 help reduce unwarranted variation in use of discretionary  
3 services, and we'll be looking at some of the challenges  
4 involved in implementing it. But, first, Hannah is going to  
5 talk to you about what we've learned about the elderly and  
6 health literacy.

7           MS. NEPRASH: Health literacy is defined by the  
8 IOM as "the degree to which individuals have the capacity to  
9 obtain, process, and understand basic health information and  
10 services needed to make appropriate health decisions." A  
11 survey of health literacy conducted by a division of the  
12 Department of Education found that adults aged 65 and older  
13 had lower average health literacy than younger adults, with  
14 roughly 30 percent of elderly adults falling into the worst  
15 health literacy category compared with the overall survey  
16 average of 14 percent in the worst category. Additionally,  
17 adults receiving Medicare or Medicaid also had lower average  
18 health literacy than adults with privately purchased or  
19 employer-provided insurance.

20           Researchers have found, after controlling for  
21 demographic and socioeconomic factors, including income,  
22 that low health literacy is associated with poor health

1 outcomes. Studies show that elderly adults with poor health  
2 literacy were more likely to be in poor physical and mental  
3 health, knew less about their chronic disease than adults  
4 with high health literacy, were less likely to receive  
5 preventive care, such as influenza vaccines and mammograms,  
6 and were hospitalized more. Finally, poor health literacy  
7 was found to more accurately predict all-cause mortality and  
8 cardiovascular deaths than self-reported education.

9           While many researchers have assessed levels of  
10 health literacy among the general and Medicare-specific  
11 population, fewer have studied how health literacy affects  
12 health care decision-making. The existing research suggests  
13 that adults with low health literacy are more likely to get  
14 information on health issues from radio and television as  
15 opposed to their high health literacy counterparts who get  
16 information from written sources, such as assurance peoples,  
17 magazines, brochures, and the Internet. Other researchers  
18 found that those with low health literacy may be more likely  
19 to indicate desire to delegate insurance coverage decisions.  
20 They may also be more likely to view more information and  
21 decision options as unwelcome burdens.

22           These research findings on knowledge and

1 communication emphasize the importance of taking into  
2 account individual beneficiary factors when designing a  
3 communication and information presentation strategy.  
4 Multiple modes of communication may be one way to address  
5 the demographic and cognitive issues of Medicare  
6 beneficiaries. Current research suggests that when patients  
7 discuss treatment options with their health care provider,  
8 providers tend to emphasize pros over cons of the treatment  
9 decision in question. There is additional evidence  
10 suggesting that patients' goal in making treatment decision  
11 are not always what the provider assumes them to be.

12 In one study, researchers surveys patients and  
13 providers to assess their rankings of key facts and goals  
14 for 14 treatment decisions. When providers were asked to  
15 choose the top three things patients should know about chemo  
16 and hormonal therapy for breast cancer, not on selected side  
17 effects or risks; whereas, almost one-quarter of patients  
18 surveyed expressed wanting to know about serious side  
19 effects.

20 When patients and providers were asked to choose  
21 their top three goals and concerns for the same 14 treatment  
22 decisions, none of the conditions had the same top three

1 items. Providers had a tendency to cluster around a few  
2 goals such as keeping the breast, living as long as  
3 possible, and looking natural without clothes for breast  
4 cancer decisions, while patients were much more diverse in  
5 their goals.

6 Now I will turn it back over to Joan who will tell  
7 you about our site visits to Dartmouth and Massachusetts  
8 General.

9 DR. SOKOLOVSKY: Thanks. So shared decision-  
10 making is a way to facilitate patient participation in  
11 decision-making by getting them the information about  
12 clinical alternatives and an opportunity to express their  
13 preferences. For example, breast cancer patients are  
14 informed that there is no difference in average survival  
15 rates for lumpectomy compared to mastectomy, but that there  
16 are other trade-offs with both procedures that they should  
17 consider. It includes the use of patient decision aids.  
18 These are tools that give a patient objective information on  
19 all treatment options for a given condition. They present  
20 the risks and benefits and help patients understand how  
21 likely it is that those benefits or harms would affect them.  
22 They can be written, web-based, or videos. The ones used in

1 the sites that we visited were multimedia, combining many  
2 ways of presenting information, including video clips of  
3 patients discussing how and why they made different  
4 decisions.

5 Shared decision-making clearly is not appropriate  
6 for all decisions. It wouldn't be of use in an emergency  
7 situation or when the medical evidence is unambiguous. It's  
8 used generally for preference-sensitive procedures when  
9 medical evidence is unclear about which treatment option is  
10 best. The goal is to reduce unwarranted variation by  
11 ensuring that these procedures are chosen by informed  
12 patients who value the possible benefits more than the  
13 potential harms.

14 The Cochrane Collaboration, an international,  
15 nonprofit, independent organization that produces and  
16 disseminates reviews of medical evidence on health care  
17 interventions, looked at 55 randomized, controlled studies  
18 of the use of patient decision aids as part of its shared  
19 decision-making program. Compared to usual care, patients  
20 using these aids had greater knowledge of their treatment  
21 options, fewer people were passive or undecided about their  
22 treatment, and exposure to these aids resulted in reduced

1 rates of elective invasive surgery in favor of more  
2 conservative options. Of course, the rates varied by study.

3 In addition, surveys have generally shown that  
4 physicians have a positive attitude toward shared decision-  
5 making. For example, a 2004 survey of orthopedic surgeons  
6 found that the majority thought that shared decision-making  
7 was an excellent or good idea. The most important benefit  
8 they cited was that it increased patient comprehension of  
9 their condition and the potential treatment options, but few  
10 had attempted to implement it within their practice. They  
11 reported that the most important barrier was the fear that  
12 it would take lots of time and interfere with office work  
13 flow.

14 A more recent survey of primary care physicians  
15 had similar results. Ninety-three percent said that the  
16 principles of shared decision-making sounded good. Most  
17 think it is very important for patients to be well informed,  
18 especially about their chronic conditions, but most don't  
19 think that their patients currently are well informed. And  
20 45 percent thought that the main barrier to use of shared  
21 decision-making was lack of time for detailed discussion.

22 So it seemed from our preliminary research and

1 interviews that an important reason why there has not been  
2 widespread adoption of shared decision-making is not because  
3 of opposition to the concept but, rather, difficulties in  
4 implementing it within programs without disrupting office  
5 work. So we visited two sites -- Dartmouth Hitchcock  
6 Medical Center Massachusetts General Hospital -- both of  
7 which had been in the forefront of research on how to  
8 implement shared decision-making. At Dartmouth, the main  
9 focus has been on specialty care, and at Massachusetts  
10 General, the focus has been on primary care. And both of  
11 them use the same multimedia decision aids.

12           Although the different focuses of the two sites  
13 suggested many contrasts, which I'll talk about in a little  
14 while, there was some general themes that emerged from our  
15 visit. They both stressed the importance of getting  
16 physician support before trying to implement a program. And  
17 while these programs are physician initiatives in both  
18 sites, that doesn't mean that physicians are involved in the  
19 day-to-day operation of the program. In fact, organizers at  
20 both sites emphasized that these programs could only work if  
21 they fit into the way physicians practice. If the program  
22 created more work or interrupted the work flow in the

1 office, it was unlikely to be widely adopted. Programs  
2 also, we found, have more impact when there is a feedback  
3 loop that ensures that physicians meet with patients after  
4 they've seen the decision aid.

5           Let me take you through the steps involved in one  
6 shared decision-making program. I should emphasize that  
7 this is not what we'd call a typical program. I don't know  
8 if there is a typical program. It's probably the most  
9 comprehensive program we saw, and that's the shared  
10 decision-making program at Dartmouth for breast cancer  
11 patients. It is part of a comprehensive, coordinated care  
12 system for newly diagnosed breast cancer patients. It  
13 requires no additional work for the surgeons. Patients are  
14 automatically prescribed decision aids upon diagnosis and  
15 asked to complete a survey after they viewed the aid. This  
16 first aid is basically about the choice between a lumpectomy  
17 and a mastectomy. Counselors are available to help patients  
18 with the material as well as other issues that they may  
19 face.

20           When the surgeon sees the patient, she has the  
21 survey results in hand, which indicate the patient's values  
22 and preferences, as well as measures of how well she

1 understood the material covered in the decision aid. This  
2 feedback loop where physicians meet with patients after  
3 they've seen the decision aid is very significant.

4           For example, if the patient's decision does not  
5 seem to accord with their values, for example, a patient who  
6 says that the most important thing to her is keeping her  
7 breasts and then says what she wants is a full mastectomy,  
8 the physician may ask the patient to view the video again.  
9 Following the surgery, the program has two additional  
10 decision aids -- one on follow-up treatments and one on  
11 reconstructive surgery.

12           Program organizers at both sites stress the  
13 importance of implementing shared decision-making and  
14 primary care. But the differences seem especially  
15 significant. Let me give you a few examples.

16           Specialists are more likely to have a limited  
17 number of decision aids to prescribe for their patients.  
18 Primary care physicians deal with a wider range of issues.  
19 Organizers at Massachusetts General identified 22 different  
20 decision aids that are available for use by primary care  
21 physicians. This includes decision aids on cancer  
22 screening, diabetes, heart disease, depression, advance

1 directives, and general health. Physicians are less likely  
2 to know before a patient visit which decision aids may be  
3 appropriate.

4           Program organizers at Massachusetts General told  
5 us that the most prescribed programs were those for PSA  
6 testing, colon cancer screening options, advance directives,  
7 and chronic lower back pain.

8           Another challenge in primary care is that patients  
9 may find decision aids less salient than decision aids  
10 involving subjects like cancer treatment or back surgery.  
11 Specialists prescribe decision aids at a time when the  
12 information is most useful to patients: before meeting with  
13 the physician to make a treatment decision. The patient has  
14 an incentive to study the material. The physician can then  
15 spend more time with the patient answering questions and  
16 discussing the options and less time explaining the basics  
17 of the diagnosis and the treatment options.

18           On the other hand, patients may not be willing to  
19 invest the same amount of time and energy to understand the  
20 advantages and disadvantages of, for example, different  
21 cancer screening options. Specialists are also more likely  
22 to get the results of the patient survey and have a chance

1 to discuss it with the patient.

2           Nevertheless, physicians believe implementing  
3 these programs in primary care is very important. For  
4 example, we spoke to an orthopedic surgeon who said that his  
5 eventual goal was to move the shared decision-making, as he  
6 called it, upstream. He said say, for example, for lower  
7 back pain, if the patient got the decision aid from their  
8 primary care doctor, it might eliminate some unneeded  
9 imagine and result in fewer referrals to the orthopedist;  
10 but the referrals that he did get would be for patients who  
11 were more likely to be appropriate candidates for surgery.

12           Physicians at both sites mentioned that shared  
13 decision-making programs in their institutions were  
14 implemented despite the negative incentives created by a  
15 fee-for-service payment system. For example, again,  
16 surgeons might expect to see fewer patients electing back  
17 surgery if they engaged in shared decision-making. The  
18 specialists we talked to believed a different payment  
19 structure would facilitate wider dissemination of the  
20 programs. Several suggested that shared decision-making  
21 would go very well in an accountable care organization. A  
22 number noted that primary care decision-making would fit

1 with the incentives of a medical home. One interviewee  
2 suggested that shared decision-making would also be  
3 appropriate in payment systems based on episodes of care.  
4 However, no one suggested that shared decision-making was  
5 only possible in an organized delivery system, and this is  
6 an issue that we'd like to look more into in the future.

7           In May 2007, Washington became the first state to  
8 endorsed shared decision-making. The legislature directed  
9 the health care authority to enact a demonstration project  
10 at one or more multi-specialty group practices that are  
11 providing state-purchased care. These sites must  
12 incorporate decision aids into preference-sensitive care  
13 areas and complete an evaluation of their impact.

14           Group Health of Puget Sound is going to be the  
15 site of this demonstration. They've spent more than a year  
16 getting ready for the project, primarily talking to  
17 physicians and getting their input on how the program should  
18 be implemented. In fact, this month they've started  
19 implementing the program, and much of the initial work,  
20 again, was discussions with physicians. We plan to study  
21 this demonstration and see what we can learn from their  
22 efforts. Other states, in fact, are actively considering

1 similar initiatives.

2 So we present the following questions for your  
3 discussion:

4 First, do you have any suggestions for our wider  
5 beneficiary-centered agenda?

6 Secondly, how can shared decision-making programs  
7 be used in primary care?

8 And, finally, is widespread adoption of shared  
9 decision-making possible given the incentives of a fee-for-  
10 service payment system?

11 And we would like your guidance on additional work  
12 you'd like to see in this area.

13 MR. HACKBARTH: Okay. Let's begin with round one  
14 questions, clarifying questions for Joan or Hannah.

15 MR. BUTLER: This is one of those areas where I'm  
16 not sure whether it would make a lot of difference based on  
17 the socioeconomic differences, racial differences, literacy-  
18 language differences. Could you share a little bit more  
19 about the characteristics of the two populations as you went  
20 and saw it at Dartmouth and Mass. General? Because they  
21 don't strike me as being like a federally qualified health  
22 center in an underserved area kind of population.

1 DR. SOKOLOVSKY: I think it's fair to say -- in  
2 fat, they did say at Dartmouth that it was probably one of  
3 the least diverse populations that you could find in the  
4 U.S. But Massachusetts General was very different, because  
5 these were primary care clinics that were affiliated with a  
6 hospital that were all over the area and many of them in the  
7 poorest areas of the city and were, in fact, very diverse.  
8 But we don't yet have any kind of evaluation to know what  
9 difference it made.

10 MR. GEORGE MILLER: My question is very similar to  
11 Peter's, and that is, on Slide 7, when you talked about the  
12 follow-up discussions researchers had with the patients, do  
13 you know if their responses, you could lump them into high  
14 literacy or low literacy with the responses, and if there  
15 was a difference in how they responded to the questions from  
16 the researchers? Could you break that out demographically  
17 by those who had higher literacy versus lower literacy? And  
18 did you get the same responses?

19 MS. NEPRASH: In the research that I read that I  
20 then presented, they did not break it down by health  
21 literacy, but this is by no means -- it's part of a very  
22 large survey they did, and I know that there are forthcoming

1 papers, so I'll keep an eye on that and get back to you.

2 MR. GEORGE MILLER: Thank you.

3 DR. CROSSON: Thank you, Joan, for an excellent  
4 report, as usual. I had one question. There are sort of  
5 two kinds of therapeutic choices and, therefore, decision  
6 aids. One involves the choice of among or between two  
7 procedures, for example, mastectomy and lumpectomy. But the  
8 universe is still that there is going to be a procedure  
9 performed.

10 The second kind is, for example, in prostate  
11 surgery between some intervention and watchful waiting where  
12 there would be no procedure performed. And I have a feeling  
13 that the dynamics at the provider level may be different  
14 between those two kinds of decision processes. And I  
15 wondered if in the discussion that you had in either site  
16 that distinction had arisen.

17 DR. SOKOLOVSKY: Yes, in fact, it has arisen, and  
18 let me give you two answers in how it worked.

19 There is a decision aid on colon cancer screening,  
20 and one of the options that's discussed in the video and in  
21 the material is no colon cancer screening, and the sense in  
22 there is that for some people that could be a reasonable

1 option. The gastroenterologists at Dartmouth decided that  
2 they didn't want anybody using that decision aid at  
3 Dartmouth because they didn't agree that that could be a  
4 reasonable decision; whereas, the physicians at  
5 Massachusetts General were okay with it. So that was one  
6 for them.

7           For back pain, for example, wait and see is --  
8 since I have back pain, I paid a lot of attention to that  
9 one and actually watched it, and that's definitely treated  
10 as -- wait and see is definitely an option that they discuss  
11 there.

12           On the other hand, some of the decision aids that  
13 are about, for example, diabetes, to me it seemed like a  
14 very different kind of thing, I mean in terms of decisions.  
15 And I asked -- looking at it there, things about eating  
16 healthy and, you know, lifestyle changes, and I asked what  
17 the disadvantages were of eating healthy, and all I got was  
18 laughter. So I can't take you beyond that.

19           DR. DEAN: My question is sort of a follow-on to  
20 what Jay just asked, and it strikes me, just to follow up on  
21 what you said about implementing it with a lot of primary  
22 care decisions is more difficult, because if these kinds of

1 activities around a decision that is imminent where you  
2 specifically have to make a decision, yes or no, you're  
3 going to have surgery or no surgery, you're going to have  
4 this surgery or that surgery, there certainly is a strong  
5 incentive for patients to get involved and to pay attention.

6 I wonder what the experience is in these programs  
7 in dealing with this kind of a process for conditions like  
8 diabetes where there is no urgent decision that has to be  
9 decided soon, you know, or something. It's more talking  
10 about things you were just mentioning, the lifestyle things.

11 What was their success in getting patients  
12 involved? My experience is there certainly are a few  
13 patients who will be very involved and who will really grab  
14 onto this stuff and make use of it, and there are a lot who  
15 would think that they're just not quite ready to tackle all  
16 these problems.

17 DR. SOKOLOVSKY: I haven't seen an evaluation yet  
18 of that, but I agree that that seems to be one of the key  
19 issues in terms of how will you get people to focus on those  
20 kinds of decisions. So it's something that I think we need  
21 to follow up on.

22 DR. DEAN: I'm sure that the involvement has

1 something to do with the level of literacy, but it also has  
2 something to do with the nature of the problem, too.

3 DR. SOKOLOVSKY: Yes.

4 DR. MILSTEIN: I have two questions. I'll give  
5 you the chance to answer one before I ask the second. You  
6 referenced the Cochrane summary that indicated, among other  
7 things, that when patients have an opportunity to  
8 methodically consider the risks and benefits of two  
9 different treatment alternatives, two or more different  
10 treatment alternatives, they are inclined at the margin to  
11 decline more aggressive interventions that are, you know,  
12 one of the two arms of the two treatment options.

13 In your research so far, have you uncovered any  
14 attempt to model whether or not total health care spending  
15 goes down as a result of use of these aids? On the one  
16 hand, a more conservative approach on the face of it might  
17 cost less, but, you know, some of those patients will need  
18 more aggressive treatment later down the line, and  
19 conservative therapy is not without its costs. Has anybody  
20 attempted to sort of dig into the question of whether or not  
21 these decision aids would likely be cost additive or cost  
22 reducing relative to total health care spending?

1 DR. SOKOLOVSKY: I've tried specifically to look  
2 at that. That is clearly a question that is of interest to  
3 MedPAC. I've seen a number of attempts to look at the  
4 answer. I haven't seen anything that I have found very  
5 satisfactory as yet.

6 DR. MILSTEIN: A second question, then. There are  
7 multiple facets of decision-making that a more thoughtful  
8 and neutrally presented set of information might facilitate.  
9 So far you've referenced choice of treatment option. Once  
10 one chooses a treatment option, there is then a subsequent  
11 decision that could also benefit from this kind of more  
12 neutral presentation of risks and benefits, and that would  
13 be the choice of provider that would implement the treatment  
14 option.

15 For example, there are some treatment options,  
16 like bariatric surgery, you know, where there is quite a  
17 profound difference in probability of adverse outcome,  
18 depending on the surgeon's experience or the facility's  
19 experience. And so the question is: Have any of these  
20 decision aids that you've looked at looked at this sort of  
21 second element of shared decision-making, which is  
22 thoughtful and neutral facilitation of patients'

1 consideration of the pros and cons of which provider might  
2 be a better provider, you know, in view of the risks and  
3 benefits?

4 DR. SOKOLOVSKY: I would say, not only would I say  
5 no, that they haven't -- I mean, at least nothing that I've  
6 looked at so far does, but I would think even more than that  
7 they haven't, I think maybe it's more their perspective not  
8 to go there, that the focus is meant to be on clinical  
9 evidence, and they don't want it to be -- too much focus on  
10 cost could lead to discussion on is this about rationing.

11 DR. MILSTEIN: I'm sorry. I didn't convey the  
12 question. Irrespective of costs, with something like  
13 bariatric surgery, there is a major difference -- there can  
14 be major differences in your risk of surviving depending on  
15 whether or not your surgeon has more or less experience. So  
16 that is not a choice of treatment. It is a choice of  
17 provider once a treatment decision has been arrived at, and  
18 I was asking whether any of these decision aids had  
19 addressed the question of choice of provider.

20 DR. SOKOLOVSKY: Not that I've seen to date.

21 MR. HACKBARTH: Years ago, more than 10 years ago,  
22 when I was at Harvard Vanguard Medical Associates, we looked

1 closely at doing this and for a variety of reasons decided  
2 not to at that point. But I spent some time talking to Al  
3 Mulley at Mass. General who was one of the early proponents  
4 of this, and Al made a distinction that really stuck with  
5 me. He said there are certain cases where it is a good  
6 thing to have more informed patients. An example of that  
7 would be where a better informed patient is more likely to  
8 adhere to the appropriate regimen because they have more  
9 information, they understand the importance of doing certain  
10 things. It is also good to have more informed patients to  
11 engage with the physician where there's uncertainty about  
12 what the right course of action is, and there is not a clear  
13 clinical right answer.

14           There is the case, though, where, in his view, it  
15 was essential to have informed patients, and there are some  
16 treatments where the right answer depends entirely on how  
17 the patient values certain risks and benefits and how they  
18 trade those off. There simply is not an evidence-driven  
19 right answer. It is entirely up to the patient's judgment  
20 about how to weigh risks and benefits.

21           We often hear of the category used by Dartmouth  
22 analysts of preference-sensitive care, which I'm not sure is

1 exactly the same thing, but it's sort of a close cousin.

2 Could you remind me what percentage of care falls into that  
3 sort of patient preference-sensitive category? Does anybody  
4 know that? I think it is a pretty big hunk.

5 DR. MILSTEIN: I think when folks have tried to  
6 estimate it, I think they've told me as a percentage of  
7 total spending, 3 to 5 percent.

8 MR. HACKBARTH: Okay. So the point I wanted to  
9 make is that there are a variety of reasons why you might do  
10 this, and at least some cases, it seems to me it's almost a  
11 moral imperative that we do a better job because the right  
12 answer hinges entirely on patient preferences.

13 Okay. Any other round one questions? Ron?

14 DR. CASTELLANOS: Round two.

15 MR. HACKBARTH: Round two. Any more round one's?  
16 Okay. Let's go to round two. Let me see hands, and we'll  
17 just go down this way starting with Bruce.

18 DR. STUART: This is a very interesting topic, and  
19 I look forward to what you learn over the next year. It is  
20 also nice to look at experiments that you think are going to  
21 succeed, but I think it would also be important to look at  
22 not experiments but interventions in these areas that there

1 is general consensus have not succeeded very well and to  
2 learn what doesn't work so that you can kind of build up the  
3 knowledge base that says, well, don't go into these areas,  
4 this clearly doesn't work.

5 I guess where I'm thinking of -- and I don't mean  
6 this to cast aspersions on the whole area, but disease  
7 management is an area in which virtually all of the  
8 interventions have some contact with patients, and it seems  
9 like the contacts, for the most part, have -- there's not  
10 much evidence that they're successful.

11 And so what can we learn from areas in which there  
12 is communication, but communication has not worked very  
13 well?

14 DR. SOKOLOVSKY: I guess where I saw this as quite  
15 different was the effort, which I think is different from  
16 general disease management, to get the physician on board  
17 before an intervention takes place, to make sure that it's  
18 done in a way that physicians appreciate and that physicians  
19 are comfortable with the content.

20 One of the things I used to hear on the oncology  
21 site visits was physicians used to talk about some of their  
22 patients being enrolled in disease management programs, and

1 they would tell them, as soon as they got it, to throw out  
2 any material they got because it was -- I mean, not --  
3 because it might be about the patient having diabetes or  
4 something where the information might be useful for a  
5 diabetes patient but not one who also had cancer. So I  
6 think that the role of the physician here is very crucial.

7 MR. BUTLER: You know, part of me says we have  
8 shared decision-making now; particularly if a procedure is  
9 involved, you have to sign a consent form as a patient and  
10 say, "I agree to this." And so at one end of the continuum,  
11 we do have shared decision-making, and it is in a pretty  
12 crude way for sure. And so at the other end is a fancy  
13 model that, you know, really engages.

14 So I am thinking, is there some way as you study  
15 this to look at a continuum rather than now we don't have  
16 shared decision-making, let's have it, and at other steps  
17 along the way that you could kind of appropriately insert,  
18 depending on the condition, depending on the population, so  
19 that you give a little bit, you know, broader range of  
20 options to engage the patient? Whether or not it saves  
21 money, whether it reduces utilization, I think it's a good  
22 idea. It's obviously a good idea. The more you're going to

1 do it, the more you're going to get compliance and all the  
2 rest. But I think about a model or something that could  
3 present a continuum that would help us look at it more like  
4 yes or no, but something in between that could be applied.

5 DR. SOKOLOVSKY: I think that is kind of what they  
6 want to look at in Washington State because I think their  
7 goal eventually is to change the definition of informed  
8 consent, to in the appropriate places have a model that is  
9 more like shared decision-making, and I think even going  
10 forward further, they are thinking of that in terms of  
11 liability, that if a physician has gone through this kind of  
12 program in terms of the actions for informed consent and  
13 talking about all treatment options, if the physician shows  
14 that they've done this program, then that is a high bar for  
15 liability protection.

16 DR. KANE: Yes, I think in terms of -- I think  
17 this is actually a fascinating area, engaging the  
18 beneficiaries much more actively in any kind of care process  
19 from treating themselves, which treatment to take, but also  
20 there are other areas I wondered if anybody is looking at.  
21 One is what types of educational techniques work to improve  
22 compliance. I am thinking more if you are going to into

1 diabetes or chronic disease management. Are there  
2 techniques, are there educational aids or modes that work  
3 better than others around getting patients to be more  
4 compliant when they have a chronic disease or a regimen that  
5 they have to adhere to, to ensure the best outcome?

6           And so this is focused on, you know, making a  
7 decision about a treatment, but it seems they also make  
8 daily decisions about what to do with respect to compliance,  
9 and I don't know if anybody has tested or looked at aids  
10 that affect that.

11           And then the other place I'd be interested in  
12 knowing if there's any effort to engage beneficiaries more  
13 actively is in the areas like testing, like imaging, whether  
14 there is any -- you know, in the areas where we really have  
15 a problem, and many physicians will say, "Well, I had to  
16 order that test because the beneficiary just insisted on it,  
17 even though I thought it was unnecessary or I was worried  
18 about defensive medicine." I mean, is there any effort to  
19 engage the beneficiary in those really high-volume, highly  
20 discretionary areas that everybody claims is because the  
21 beneficiary wants it and it's just they're being forced to  
22 order it, is there any tool out there that people have

1 developed to try to educate patients better on the  
2 appropriate use of imagine or, you know, the implications of  
3 getting one more MRI or that kind of thing?

4 DR. SOKOLOVSKY: We definitely heard discussion  
5 about the development of aids on that issue, but it may,  
6 again, be one of those areas where -- I mean, the patient  
7 has to really focus on this stuff, and will they be willing  
8 to focus on whether one additional MRI is relevant or not?

9 DR. KANE: Maybe it would have to be coupled with  
10 more cost-sharing, but even so, I wonder whether people  
11 really put that kind of effort in to explain to people that,  
12 no, there isn't that much value. I don't know.

13 DR. REISCHAUER: Nancy, isn't the whole issue of  
14 patient compliance really a different one? I'm not sure  
15 you'd want to muddy this analysis, that you can learn things  
16 about how patients take in information and how they react  
17 through this analysis, but somebody who has a chronic  
18 condition, how do you convince them to take the medication  
19 or receive the treatment at appropriate periods strikes me  
20 as a different and conceivably even a bigger issue.

21 DR. KANE: Well, I'm just wondering if some of the  
22 methods wouldn't be similar. For instance, some kind of

1 really well-thought-out program you take home, and then you  
2 are quizzed on it and your doctor asks you questions about  
3 it could apply to not just treatment decisions but also to  
4 compliance issues. I'm not sure. I'm actually responding  
5 to the questions for discussion about are there any  
6 beneficiary-centered agenda items that we would want to --  
7 not that -- you know.

8 MR. HACKBARTH: It might be helpful, Joan,  
9 building on Nancy's comment, if we had sort of a typology of  
10 decisions, and maybe clinicians could help develop that, you  
11 know, typology of patient engagement. Some of it has to do  
12 with making sure that they understand why something is  
13 important so that they're more likely to adhere to the  
14 regimen. In other cases, it might be that the right  
15 decision hinges on how people value different risks and  
16 benefits. In other cases, it might involve cost trade-offs.

17 DR. REISCHAUER: Choice of provider. Arnie and  
18 John --

19 MR. HACKBARTH: Choice of provider. I haven't  
20 thought through this systematically, but there might be a  
21 typology that can help us organize our thinking and say  
22 we're going to focus on these boxes in the typology and

1 really define what we're talking about.

2 DR. CASTELLANOS: Well, first of all, this is a  
3 great topic, and you did a great job. As a practicing  
4 physician, this is the world that I live in. You asked for  
5 some directions. I'm going to give it to you from a  
6 physician's viewpoint.

7 One of the things we think is extremely important  
8 on this -- and I don't mean to say it out of context -- is  
9 when you talk about patients, you need to get some kind of  
10 an advance directive, and you need to have somebody on board  
11 as a health surrogate for the downstream effects, because  
12 these people may change when they get in the hospital or  
13 with an acute disease. And it's really nice to get that  
14 information way ahead of time.

15 I think it is great that you went to Mass.  
16 General, and I think it is great that you went to Hitchcock.  
17 But these experiences are real-world experiences, and I  
18 think you need to get out where the tire hits the road, and  
19 you really need to get out, as we have talked about, to see  
20 the ethnic diversity, to see the difference in economy and  
21 the difference in patients, and to see what is really  
22 happening in the real world. I think you're going to be

1 surprised because this is something that we're doing  
2 already. I'm not saying we're doing it to the degree that  
3 we should be, but it's something that is already happening.

4           You know, Bruce, you asked about chronic disease  
5 management, why hasn't it worked. Well, it's very simple.  
6 They don't have a team approach. They don't have the  
7 physician involved. And the reason here is because I think  
8 it's a team approach. It's not just the physician and  
9 nurses. It's a whole team of us. And I think care  
10 coordination is really important.

11           The other point that I really would like to try to  
12 make is that there are a lot of barriers for this, and one  
13 of the barriers you mentioned is the lack of time,  
14 especially for the primary care person, and especially as it  
15 fits into the fee-for-service. Unfortunately, there is no  
16 compensation for that. You know, where you went, you had  
17 care coordination, you had care coordinators. In a tertiary  
18 center, they have a lot of people. In the real world, it's  
19 not that way.

20           So I think there is going to have to be some  
21 consideration, especially in the primary care field, for the  
22 lack of time where perhaps the medical home, perhaps we can

1 use the primary care physician more effective by having  
2 nurse practitioners doing the elementary stuff and having  
3 the physician elevate to a position where it's much more  
4 important to him.

5           The other point that has been snuck around, and  
6 when I talk to people about options and stuff, I always give  
7 the point of a second opinion, and I think that needs to be  
8 discussed openly with the patient, that the patient has that  
9 right to seek a second opinion.

10           Thank you.

11           DR. CROSSON: Thank you again, Joan. I have been  
12 somewhat befuddled over the years by the fact that this  
13 seemingly very logical and effective tool has been  
14 underused, even in settings where it would seem clear that  
15 it should be and could be. And I would probably include my  
16 own organization in that regard. And yet it hasn't been.

17           You know, we were talking earlier, the discussion  
18 here before the meeting, about, you know, sort of why can't  
19 people behave logically. I'm not sure I know the answer to  
20 that, but there seems to be a few things at play, and you  
21 have covered them. One, of course, is the fee-for-service  
22 incentive, which in some settings mitigates against the use

1 of this. The second clearly is the issue of time,  
2 particularly for busy practitioners and particularly for  
3 individuals who do procedures and who value more the time  
4 and actually working in that way than perhaps taking a long  
5 time to explain things.

6           There is also the sort of immeasurable thing. It  
7 has to do with sort of pride in expertise so that for some  
8 individual -- for many individual physicians, once they've  
9 developed great skill at doing something, the notion of  
10 trying to essentially talk someone out of having that  
11 procedure done seems counterintuitive. I think that's  
12 probably true for all of us in various areas of skill.

13           It would seem to me, therefore, that if we're  
14 going to find a solution, to craft a solution which would  
15 increase the use of this tool, because my intuition with  
16 data is that the proper use of this tool probably would  
17 result in less invasive procedures in situations where  
18 probably individuals don't really need them. At least  
19 that's the experience, that individuals, when they go  
20 through this, tend to make more conservative decisions.

21           There needs to be an incentive piece, that  
22 somewhere we have to deal with incentives, and it has to

1 deal with incentives both for -- or could deal with  
2 incentives both for the physician or provider to perhaps  
3 mitigate fee-for-service incentives in some way, but also  
4 perhaps provide incentives for the beneficiary or the  
5 patient to create the greater likelihood that people at  
6 least understand the availability of this tool if not  
7 receive incentives for using it.

8           The idea of having some sort of support structure  
9 that would do this to take it off of the time schedule of  
10 the physician, and yet be integral enough into the  
11 physician's practice so that it's not looked at by the  
12 physician or by the patient as being something alien and  
13 disconnected from the care relationship between the patient  
14 and the physician. And I realize that's difficult.

15           And then also I think a piece of this that for  
16 physicians who do procedures, to make it clear to those  
17 physicians that the net result of this would actually be, as  
18 Glenn was talking about earlier, the production of a flow to  
19 that physician of individuals who were much better, more  
20 selected, happier, and potentially lower-risk patients for  
21 the particular procedure that's involved.

22           Now, that's a lot, but it would seem to me that in

1 each case there simply hasn't been a collective approach  
2 that would incorporate those, and, therefore, we have what  
3 we have, which is under utilization of a very useful tool.

4 MR. HACKBARTH: I thought you were going to react  
5 to that since your light was on.

6 DR. SOKOLOVSKY: No, I just want to say that what  
7 you said, essentially that was the message that we were  
8 getting most frequently from the different specialists -- at  
9 Dartmouth, in particular, exactly the points that you made.

10 MR. HACKBARTH: Joan, did you talk about just  
11 mechanically how these programs work and how the patients  
12 are educated and, you know, sort of what the flow is?  
13 Because I think a couple of the points that have been made  
14 here is a critical issue is how this affects the physician  
15 and the physician's time, but also -- and these may work in  
16 sort of opposite directions -- whether the information is  
17 embraced by the physician and seen by the patient as  
18 consistent with and a part of their relationship with the  
19 physician. How the mechanics of this work are very  
20 important.

21 DR. SOKOLOVSKY: Again, let me go through the  
22 breast cancer one because that's where it's the most spelled

1 out one. A patient is diagnosed. They could be a regular  
2 patient at Dartmouth, or they could be a patient who's being  
3 referred in from somewhere else. As soon as they're  
4 diagnosed and the physician is not involved here at all, in  
5 the course of making an appointment, the decision aid is  
6 sent immediately to the patient.

7 MR. HACKBARTH: Right.

8 DR. SOKOLOVSKY: At that point a person working in  
9 the program -- again, not a physician -- gets in contact  
10 with the person and makes sure they've received it, asks if  
11 they need help. Sometimes a patient, particularly if there  
12 are language problems, may want to come in and watch it in  
13 the office of the decision-making where they can get more  
14 explanation of what they were watching in terms of the  
15 video. Sometimes a patient really wants -- most of the  
16 time, I think, a patient really wants it at home where their  
17 family members may also see it, and if this is a cancer  
18 decision in particular, it may help to have the whole family  
19 watch this.

20 They are also at the same time given a survey.  
21 The survey is numbered, and they need to send it back to the  
22 office. The survey is then put into the patient's medical

1 record. It's an electronic record in both of these cases.  
2 It has not only what the patient's preferences are, but  
3 through the course of watching the decision aid, there are  
4 questions that test comprehension. And so, again, this is  
5 to see when people are saying this is what I think is  
6 important and this is where I'm leaning -- they're not  
7 usually making a decision, but they're kind of leaning one  
8 way or another -- it's to see if there is concordance  
9 between what they say is important and do they actually  
10 understand what they saw.

11           So far, there has been no additional work for the  
12 physician at all. The patient comes into the physician for  
13 the appointment, and instead of the physician having to  
14 start at the beginning and say, okay, you have this  
15 condition, this is what it means, there are a bunch of  
16 different things you could do, and this is the mechanics of  
17 this option, this is the mechanics of the other option, the  
18 physician can start a little bit further on and say, "I see  
19 that you've been thinking about this," and actually address  
20 the patient's preferences, address the patient's questions.

21           One thing that was kind of interesting, the  
22 different physicians we spoke to and different of these

1 practices, sometimes referred to the appointment as being  
2 much more fun or interesting, because instead of having to  
3 worry, "Have I told them every possible side effect that is  
4 possible? Have I told them every possible option?" they  
5 know that the patient has already received this basic  
6 information, and they can talk more deeply about the  
7 patient's concerns.

8           So they say, in general, that it does not increase  
9 the time spent. It's a different kind of an appointment,  
10 but not a longer appointment.

11           MR. HACKBARTH: Well, let me just underline  
12 something that Ron said. You could have all of that, and it  
13 still leaves open to me where is the information coming  
14 from. So back in the '90s when I was looking at this, one  
15 company, a start-up company, was trying to market this to  
16 insurers, so this was going to be a product offered by the  
17 insurers, the insurers were going to pay for the nurse  
18 educators that interacted with the patients. It was all  
19 done independent of the physician. And so the patient, the  
20 "informed" patient, was going to walk into the physician's  
21 office armed with information produced by somebody else,  
22 never embraced by the physician, and you are going to get

1 one sort of result. It may be better than the status quo,  
2 where we are now, but it still may be less than optimal.

3           You know, another approach is that it's the  
4 physician's office or the physician's organization that has  
5 embraced this. The physician is intimately familiar with  
6 all the materials, and they're the ones sending that out to  
7 the patient or having it available in the next room for the  
8 patient to study. Differences in terms of the flow and  
9 those relationships I think could be the difference between  
10 success and failure. And so that is the sort of mechanics  
11 that I'd like to learn more about.

12           DR. CASTELLANOS: Can I comment? What you are  
13 describing isn't the real-world experience. That patient is  
14 coming in to see Karen with a mass in her breast. She  
15 doesn't know about cancer. She doesn't know anything about  
16 it. So what you're doing now is cherrypicking that patient  
17 who has a diagnosis, has a metastatic work-up, has  
18 everything, and that person then is going to a tertiary  
19 center where that's available. But that is not how it works  
20 in the real world.

21           I would love Karen to make some comments  
22 concerning that.

1           MR. HACKBARTH: Karen is on my list, and I can see  
2 she's got thoughtful comments.

3           DR. MARK MILLER: Can I just say one thing? When  
4 you went through the mechanics of that for Glenn in response  
5 to his question -- and I may have misunderstood when we had  
6 our conversations. But I thought in both of these  
7 instances, this material had involved the physician  
8 community up front and had buy-in from them.

9           DR. SOKOLOVSKY: Yes, well, I mean, it's both. In  
10 both of these places, and pretty much every place we have  
11 looked at recently, there is the Foundation for Informed  
12 Decision Making, and they are involved -- more than  
13 involved. They are the ones who are developing these  
14 decision aids and keeping them up to date. And they have  
15 panels of physicians for every specialty who are constantly  
16 reviewing and updating these decision aids.

17           When it is brought into a practice, it's brought  
18 in because the physicians have looked at these aids and are  
19 comfortable with them. As in the case of the  
20 gastroenterologist at Dartmouth where they weren't  
21 comfortable, that aid was not used there. So they're not  
22 developing it themselves, but they are very familiar with it

1 and have signed on for it.

2 MR. HACKBARTH: And that's one thing at Mass.  
3 General or at Dartmouth Hitchcock or Kaiser Permanente or at  
4 Harvard Vanguard Medical Associates. It's a different thing  
5 in the disaggregated delivery system that most Americans use  
6 for their health care.

7 I am not trying to pour cold water on it. I'm  
8 just saying that the logistics are very different, as Ron  
9 was saying, in an organized system versus a disorganized  
10 system or unorganized system. We need to make our way  
11 through this list now.

12 MR. BERTKO: I think your hint is be quick. I  
13 will try.

14 Joan and Hannah, first of all, great work on this  
15 thing. I strongly support it. Two questions here. One is:  
16 In my own experience with my organization, on a slightly  
17 different topic, which is benefits structure, there were  
18 different types, subsets of people, and I am curious on  
19 whether your investigations will look at different groups.  
20 One that comes to me is the young-old, for example, versus  
21 the old-old. In my own family, we've got a very senior  
22 person who at 95 is going to have a different set of

1 decisions than he would have when he had a similar procedure  
2 in his 80s.

3           The second one follows up on Ron's question, which  
4 is: Clearly, I'm aware of shared decision-making for  
5 discrete procedures. Does this also apply to end-of-life  
6 issues as well? And will you be looking into things like  
7 that?

8           DR. SOKOLOVSKY: Well, the first question let me  
9 take as something to research.

10           The second question, yes, at Mass. General,  
11 amongst primary care doctors, the advance directive is  
12 probably the most popular of all of the decision aids. In  
13 fact, one of the physicians at Dartmouth said why can't  
14 MedPAC require everybody to have an advance directive.  
15 We're not there. That seems to be a big one.

16           MR. BERTKO: The reports are that advance  
17 directives and the way physicians use it are -- I'll call it  
18 "underutilized." Anything more that you put into a final or  
19 the next version of the report I think would be of big  
20 interest.

21           MS. HANSEN: Yes, I just want to say thank you  
22 very, very much for doing this work. I appreciate your --

1 this robust discussion has evolved from this because it is  
2 always being discussed that the beneficiaries really nominee  
3 to take a more active role, and I think -- Karen, I remember  
4 a conversation where we were saying that there is  
5 beneficiary responsibility, you know, as we think about  
6 selecting procedures and choosing things. So this really  
7 does perhaps convey a dimension of this that we can look at  
8 more fully.

9           Probably the most important pieces that I just  
10 want to underscore that you found in one of the studies is  
11 the ability to perhaps see if there are other research  
12 pieces that speak to the difference in synchrony between  
13 what the provider thinks is important and what the patients  
14 may consider important. I think that part needs to just  
15 perhaps be corroborated further, because I think it makes  
16 such a big difference in terms of how people will eventually  
17 either make decisions, ask for care, or certainly the  
18 adherence afterwards as to what was prescribed. And so it's  
19 not -- I think we have a term that we call "compliance,"  
20 but, you know, I think if we really think about that word,  
21 it means you're not doing what I'm telling you to do as  
22 compared to understanding really what adherence to an

1 agreed-upon decision of what -- it's more of a contract in  
2 some ways of what it is. So I think our ability to build up  
3 that side of the information would be helpful.

4 I think that the last piece is the aspect of  
5 looking at what will come in Washington State, which is a  
6 state that is different and beginning to raise this. And I  
7 know that some earlier discussion was of some concern as to  
8 whether or not -- not concern, but a question of whether or  
9 not the whole aspect of liability insurance would be looked  
10 at somewhat differently if, in fact, patients went through  
11 this. But it's certainly far premature to really consider  
12 that, and I appreciate the study side.

13 I do want to, again, underscore one point other  
14 people have made, and that is, this population is really the  
15 best practice with a fairly literate group. But if people  
16 don't think about health care or decisions the same way,  
17 could we begin to look at other populations? Peter  
18 mentioned federally qualified health clinics. Are there  
19 other best practices with much more diverse populations  
20 linguistically or economically that show some promise in how  
21 that patient decision-making comes about?

22 Thank you.

1 DR. MILSTEIN: Three brief comments that really  
2 build on other good comments that others have previously  
3 made.

4 First, I really like -- I think I want to speak in  
5 favor of at least considering, as we think about options,  
6 Pete's idea of relooking at informed consent. All the  
7 research suggests that those are not very well understood  
8 processes by patients, and it is my personal belief, based  
9 on my personal experience, that if you randomly inserted in  
10 the middle paragraph informed consent randomly selected text  
11 from Wikipedia, very few people would notice.

12 The second comment is really a build on Glenn's  
13 notion of really thinking through a typology of how we might  
14 help Medicare -- what might be some of the high-opportunity  
15 avenues for better informing Medicare patients in shaping  
16 their treatments. One of the things I hope we would look at  
17 is the research that was well published in a very respected  
18 peer-reviewed journal I think more than 10 years ago by  
19 Kaplan and Greenfield which shows that with respect to the  
20 issue of informing patients with respect to knowing when a  
21 treatment isn't working and, therefore, they ought to be  
22 playing more of a role in encouraging a doctor to consider

1 alternative options, that Medicare patients who were exposed  
2 to that information and that particular program actually  
3 lived longer than Medicare patients that were not so  
4 exposed.

5           The third comment is to reinforce Jay's comment  
6 about incentives. I don't think it is -- I think it would  
7 be quite consistent with much of what we recommended before  
8 if we were to think about a recommendation that Medicare  
9 ought to consider paying differently for treatments that a  
10 well-informed patient actually wanted than for treatments  
11 for which it was not clear whether or not the patient was  
12 well informed and whether they actually wanted it.

13           MS. BEHROOZI: So much to say and so little time.  
14 Thank you, guys. I just want to say about Dartmouth  
15 Hitchcock Hospital, it was a little bit of an out-of-body  
16 experience to go with Joan and Hannah to visit there, and it  
17 was certainly not diverse in a lot of the ways that I am  
18 used to diversity in New York City. But I did learn a  
19 little bit about rural health care and some of the  
20 challenges of providing care there. And I think  
21 socioeconomically maybe it was less un-diverse -- I mean,  
22 people were poorer, I guess, than you might think by

1 associating the name Dartmouth with this hospital. And I  
2 didn't have the opportunity to go to Mass. General.

3           So thinking about it a lot, I have felt like I  
4 need to separate out a few of the dimensions of what we are  
5 talking about here, and I think, you know, the way that you  
6 guys separated your presentation, we're focusing all on the  
7 endpoint, the patient decision aid. We're talking about the  
8 patient decision-making, but really what Hannah started with  
9 was how people learn and get information. And patient  
10 education is never a bad thing, and we always expect that  
11 it's happening, yet we have doctors telling us, very well-  
12 respected, caring doctors telling us that they don't have  
13 time for all of it. And we also know that not only do  
14 people learn differently, but people communicate  
15 differently. All across the board, lawyers as well as  
16 doctors, some of good communicators and some aren't.

17           So I think that first, before getting to the  
18 results and what you can use this type of educational tool  
19 for, I think we should just focus on its value in patient  
20 education. It does do a good job of giving people  
21 information, these tools, because, again, as you've  
22 reflected, they are both written and visual, you know,

1 active, visual DVDs. And so you have standardization of the  
2 information, and then, of course, the validity of it is  
3 what's at issue. But, again, as Joan described, there's a  
4 great effort made to validate these tools with the physician  
5 community.

6           So it's standardization. It doesn't depend on  
7 whether the doctor remembered to say something or is a good  
8 communicator or isn't a good communicator, whether the  
9 person heard about this procedure on TV or from an ad, from  
10 a device manufacturing company or looked it up on the  
11 Internet and got the Wikipedia entry that was the B.S. one  
12 as opposed to the good one. It's standardized.

13           So I think that goes to -- I actually was calling  
14 it "informed consent on steroids" when I was describing it  
15 to some of my colleagues, or package warning labels, package  
16 inserts, the things that your pharmacy now gives you, you  
17 know, reams and reams of paper with every prescription.  
18 It's a neat way of pulling that all together and making it  
19 be one thing or a few different things if there are  
20 different entities that feel like they've got a better  
21 product. But, you know, I guess the way we think of those  
22 things, let the market sort that out.

1           But then moving to the results part of it, people  
2 have talked about what can come out of better patient  
3 education, and I think compliance, again, given that there  
4 is a spectrum of types of educational materials that are put  
5 out there, patient compliance is certainly a big one.  
6 Patient satisfaction is huge, and I think it wasn't in your  
7 paper, but one of the other things that you had given me to  
8 read, they talked about rates of liability lawsuits falling  
9 because people, in fact, are satisfied. They feel like they  
10 got what they wanted, or even if the outcome isn't what they  
11 thought it was going to be, they were informed and engaged  
12 in the decision.

13           The component of exploring the patient's values is  
14 not just important for them to be able to make the decision,  
15 but for their physician to know more about their patient,  
16 and that was really -- I think that was revealing to some of  
17 the physicians that we talked to.

18           And then, finally, on the issue of how to incent  
19 this in a payment system, I think it's really important that  
20 we do, just because of the educational component, whether it  
21 reduces costs or liability lawsuits or not, for all of those  
22 reasons, actually, for all of those outcomes. I think we

1 should think about it when we're looking at alternative  
2 payment incentives, whether it is how to set standards for  
3 what you would consider to be a medical home or an  
4 accountable care organization, who would be eligible for  
5 enhanced payments, maybe setting this as one of those  
6 criteria to judge them by. But to your point, Glenn and  
7 Ron, several have made the point that not all patients are  
8 going to be able to access their care from these organized  
9 care delivery systems. So I think that we should also  
10 consider how to get these decision aids into the hands of  
11 more people, and perhaps Medicare should simply pay for  
12 them. They could be something that doctors prescribe and  
13 patients access them or patients have an opportunity, you  
14 know, having been given a diagnosis, to access these  
15 decision aids themselves, and we should just be paying for  
16 them.

17 MR. GEORGE MILLER: Thank you. Again, so much has  
18 been said about this, I will try to be brief and crystallize  
19 a couple of issues.

20 One, I think I agree with Ron that we probably  
21 need to get a little more diversity in talking with folks.  
22 Rural folks deal with things differently, and they would not

1 have the infrastructure of a big medical center around them  
2 to deal with these issues. So I am wondering how that would  
3 work there.

4 I was struck by one thing that was said in the  
5 presentation by Joan. I think I have this correct. You  
6 said many physicians don't think that patients are well  
7 informed, and if this is a tool to help them become well  
8 informed, I think that there could be a way to tie this  
9 together with an incentive. If they make bad decisions and  
10 in the end they are better informed with appropriate  
11 education, then maybe we can incentivize them maybe like  
12 insurance premiums, you lower their premium or their  
13 deductible, their cost. And, in effect, it seems to me it  
14 will be a lower cost to the system if they are better  
15 informed on the front end. And just as John said, different  
16 places in people's lives, they will make different  
17 decisions. So if someone is in their 90s and making a  
18 decision, you inform them differently than someone in their  
19 20s with the same procedure. It may be cost-effective to  
20 pay for their education and then lower their out-of-pocket  
21 costs in some way. I'm not sure how that would work.

22 And then the final thing, in the discussion I

1 think we need to deal with cultural competencies because,  
2 again, dealing with different diverse populations all across  
3 the country, we need to make sure that we communicate to  
4 different segments in different communities, just the  
5 thought that -- I was a hospital administrator in West  
6 Texas, and we had a population that was 65 percent Hispanic,  
7 35 percent white, and then there was my daughter, my wife,  
8 and myself.

9 [Laughter.]

10 MR. GEORGE MILLER: As a result, there was a  
11 different way to communicate with the Hispanic population  
12 and the white population, and sometimes I had to do that.  
13 It made it a little bit different. But, again, the point is  
14 you have to have cultural competency in dealing with that.

15 Thank you.

16 DR. CHERNEW: First, I want to comment on  
17 something that I think it was Bruce said, and others echoed  
18 it, about disease management, and I just want to say I think  
19 the evidence is actually pretty clear that disease  
20 management programs, for all their strengths or weaknesses,  
21 have probably improved the quality of care for people  
22 enrolled in them. Where they seem to have failed is in

1 lowering the costs, and some of that might be because they  
2 haven't involved the physician, they could have done a  
3 better job. And I agree with all that, and there's a lot of  
4 move to include physicians more. I think it's at least  
5 plausible that one reason why they haven't saved money is  
6 because the services they are promoting aren't cost-saving  
7 services. There's an old article by Joe Selby and others --  
8 I don't think Joe's first author -- on that point.

9           But, anyway, with regard to the topic at hand, I'm  
10 really interested in understanding aspects of the  
11 generalizability of all this, and a lot of that has come  
12 around the table. I think in response to a question,  
13 someone mentioned 3 to 5 percent of care is preference  
14 sensitive. That strikes me as a strikingly small number  
15 compared to the number that I would have given you. I think  
16 it has to be bigger. These work for many situations where  
17 there is discrete types of decisions as opposed to adhering  
18 to medications and stuff, although you might be able to  
19 extend it. But, still, I find 3 to 5 percent of care  
20 influenced by these, potentially influenced by these, is  
21 probably a small number if I were to guess.

22           That said, it is not clear -- that doesn't mean

1 you could save 3 to 5 percent. That is just the areas where  
2 you could apply it to. What people are choosing in the  
3 beginning, how many of them would move, is a completely  
4 separate question. Not that saving money should be our  
5 goal, but if one were going to do an analysis of any policy,  
6 at least you would want to know something about the fiscal  
7 impact.

8           So it would be interesting for me to know the  
9 number of conditions that one might think these are relevant  
10 for, and knowing that is going to be hard. The number of  
11 conditions for which they are being -- you know, how many  
12 actually exist and how much spending is represented. I know  
13 the Cochrane Collaboration study, it was written in Chapter  
14 34 of these things. But my guess is you get a bunch of  
15 cancers, and you could probably begin to name on your  
16 fingers, certainly your fingers and toes, the number of  
17 conditions. And even within the conditions, you're only  
18 looking at a relatively few number of actual decisions.

19           So it would be interesting to know, if you were to  
20 look at the current universe of these aids, how much care  
21 would be in that purview and maybe think about, you know, if  
22 we doubled it or tripled it, how big would that be.

1           That's not to say a small number means we should  
2 ignore it. I am actually a big supporter of these things,  
3 and so making better in a small area is better than not  
4 making care better in a small area.

5           I am very interested also in sort of the type of  
6 providers. We mentioned that it works well in some systems  
7 but not others. But understanding how much care is in those  
8 type of providers so you would know, that would matter. It  
9 certainly would matter if we were going to talk about any  
10 policies like incenting people to know how many providers or  
11 systems it could work in. And also it came up around the  
12 table the type of patients that could respond to this. I  
13 think this is useful not only in thinking about policy, but  
14 also thinking about evaluating the studies that were done,  
15 because many of them were sort of self-selected providers  
16 with sort of self-selected patients, and so even if they're  
17 randomized, oftentimes they're randomized within a setting  
18 where the providers are sympathetic selecting patients into  
19 the trial, or the patients were sympathetic, and then they  
20 get randomized. So there's some sort of research issues in  
21 interpreting the results and some thinking about policy  
22 forward where the generalizability matters a lot.

1           I would be remiss if I didn't mention, obviously  
2 what is of great interest to me, the role that patient cost-  
3 sharing plays. I understand the topic about giving people  
4 incentives to use the decision aid versus not. That is an  
5 interesting question. But, more broadly, if people move  
6 into high-deductible health plans or medical savings  
7 accounts or whatever it is, it is somehow -- I know that all  
8 these evaluations, at least the ones I'm familiar with --  
9 many of which were done by Jay's organization. The Kaiser  
10 ones were the earliest ones, I think, in Colorado and stuff.  
11 Anyway, they explicitly avoided the issue of cost because  
12 they thought the discussion of cost would confuse the  
13 decision-making and muddy the waters -- all of which might  
14 be true, and I'm actually very sympathetic to that decision.  
15 But in moving toward an era where patients are paying for  
16 different things, having decision aids that tell them a lot  
17 about the alternatives, but tell them nothing about the  
18 fiscal consequences to them of choosing one versus the other  
19 strikes me as interesting. And even if it's not  
20 interesting, it strikes me as important just understanding  
21 how people that are in different cost-sharing environments  
22 use information differently.

1           So those are all difficult questions that I am,  
2 frankly, scared to talk about in general about what role  
3 money should play in decision-making. But that doesn't mean  
4 I'm comfortable ignoring it.

5           The last point I will make -- and, again, I want  
6 to emphasize I'm actually very supportive of these tools. I  
7 think there's reasonable evidence that they can improve  
8 quality, and in many cases I do think they can actually  
9 lower costs if you pick the right case. But I'm very wary  
10 of taking sort of small examples of success and applying  
11 them broadly given all these generalizability issues. And I  
12 think before I would be comfortable thinking about  
13 incentives to do this or paying doctors to do that, I would  
14 want to see a more complete policy analysis of what we think  
15 the clinical and fiscal ramifications of doing something  
16 like that are, because I think that it is easy to see where  
17 these things are really wonderful, but that doesn't mean it  
18 would be wonderful if we just thought up a broad policy  
19 that, you know, promoted them widely without thinking  
20 through what the policy is.

21           So I would encourage us to think about, once we  
22 get to what some specific policies might be, to do analyses

1 of those policies as opposed to just extrapolate from some  
2 other studies, as good as those studies may have been.

3 DR. BORMAN: I think part of what we're struggling  
4 with is there's not anybody in this room that would qualify  
5 as a typical patient, and yet we're trying to make an  
6 assessment and a judgment on behalf of the typical patient.  
7 I think that is hampering us to some degree, and we have to  
8 be a bit careful about that.

9 Just a couple of quick things. Number one, there  
10 is enormous variation in how people learn, and it is age  
11 dependent, it is education dependent, it is culture  
12 dependent. It is a whole host of things. And I think that  
13 the message from that is that whatever we go to has to come  
14 with a menu of choices; that is, there need to be a variety  
15 of educational and/or decision-making tools in different  
16 formats that can be readily accessed in a variety of  
17 environments by people with different skills and/or their  
18 sort of interfering daughter, for example, like me, sitting  
19 next to them wanting to look at the things with them as  
20 well.

21 So I think that, number one, John Berkto already  
22 alluded to, what do we know about, for example, the young

1 versus the old elderly? I think one of the pieces of data  
2 that we have in this regard already is the relative  
3 reluctance of people to switch among different health plans  
4 at a certain age, even though there may be cost savings,  
5 which would argue that even in charge of their lives and  
6 their dollars, there will be a certain inertia to that that  
7 is driven by more things that are cultural and age related  
8 than anything else. So I think some information about how  
9 does use of these things, how does decision-making and  
10 education change at different age groups, I think would be  
11 very helpful. And, again, the menu of choices.

12           The other thing is, as I try to think about this,  
13 because I talk a lot with patients about procedures and  
14 about not having them, in fact, as well, I think you need to  
15 think of this topic as something of a continuum. At one end  
16 are issues that relate more to compliance, adherence,  
17 education about ongoing conditions, where it's not a crisp  
18 "make this decision today, there is a consequence tomorrow."  
19 It is sort of about buying into knowledge about one's  
20 condition and how one interdigitates with it. That is sort  
21 of at one end of the conversation.

22           In the middle are perhaps the preference-sensitive

1 or less clear data decisions that have to be made where, for  
2 example, lumpectomy plus radiation therapy versus mastectomy  
3 are clinically equivalent for properly selected patients.  
4 That is pretty clean. But there may, in fact, be less clean  
5 areas and/or preference areas, for example, joint  
6 replacement, where you are talking about somebody with pain,  
7 and when pain becomes disabling to you is very different  
8 than it may be to someone else. So there is sort of that  
9 middle ground of activities.

10 Then there's sort of a high-end group that is  
11 relatively risky stuff and that does carry a finite,  
12 measurable risk of mortality -- radical cancer operations,  
13 certain brain interventions, certain cardiac things. At  
14 that end, frankly, I think patients are more interested in  
15 making a transfer of trust than about knowing details. No  
16 matter how many hours I spend with you in the office, I  
17 can't make you a medical school graduate and a graduate of a  
18 residency overnight.

19 So at some point, this is about a transfer of  
20 trust, and a certain amount of that is hearing a certain  
21 amount of information presented in a certain kind of way by  
22 the person who is going to provide it. And so maybe what we

1 need to think about is where can we have biggest impact with  
2 this kind of activity is probably in that middle group, as  
3 Glenn has already alluded to, where there is lack of clarity  
4 or there are multiple choices that are therapeutically  
5 equivalent. And so if we are going to particularly take  
6 this work forward, I think it ought to focus on that. If  
7 we're looking at the broader issue of informed consent and  
8 patient education, then I think we need to know more about  
9 learning styles, and our end goal needs to be to provide a  
10 menu of options.

11 DR. DEAN: There's so much to be said, and  
12 obviously we are going to approach this again.

13 First of all, thanks so much for doing it because  
14 it clearly has stimulated lots of responses on the  
15 commission.

16 I guess I would certainly second everything Karen  
17 just said, that in my experience there are a lot of  
18 situations where patients simply don't want to decide these  
19 things for sure. On our advance directive form that we use  
20 in our practice, we have a column on there that says leave  
21 to the physician, and we've taken some flack about that  
22 because a number of the people that have looked at it said

1 that shouldn't even be on there. But we have a lot of  
2 people that check that column, and I think it has to do with  
3 the issue if there's trust in the system and the  
4 organization, there are some of these decisions that are  
5 just too hard to make in advance, and people seem to be  
6 comfortable with that approach.

7           So I think it is very important to figure out  
8 which situations these kinds of activities really are  
9 relevant to and which ones maybe we need to find some other  
10 approaches.

11           I guess the other comment I'd make is that the  
12 question is, you know, this all seems so logical, why hasn't  
13 it happened before? And it certainly has in a lot of  
14 settings for all the barriers we've talked about. In my  
15 perspective, it is an issue of time. Probably another  
16 significant issue is the fact that in many of these  
17 situations, we don't have nice, clear data, and it ties in  
18 very much with the whole comparative effectiveness thing.  
19 Because if we have good, clear data about this, it is very  
20 easy to communicate that. But so often it is kind of a  
21 mushy situation, which in turn leads to the fact that  
22 patient preferences become terribly important, and our

1 assumptions about those frequently are wrong. There is data  
2 about even simple things like use of antibiotics in  
3 respiratory infections. I think most physicians feel that  
4 patients are expecting an antibiotic prescription, and there  
5 are a lot of studies that show that isn't necessarily true,  
6 that if you really explain to people the pros and cons of  
7 that, which, unfortunately, busy physicians tend not to want  
8 to take the time to do, that, in fact, frequently that is  
9 not what they expect.

10           So it is a complicated area, but figuring out ways  
11 that we can ascertain what patients' values and preferences  
12 really are is terribly important, and that is why this is  
13 such an important area that we need to move forward in.

14           DR. REISCHAUER: Yes, everything that I wanted to  
15 say has been said at least twice. I am a big supporter of  
16 moving ahead in this, but I am a big skeptic on the  
17 potential here and would reinforce those who have said this  
18 is probably going to be good for some conditions for some  
19 types of people. There are a lot of people who want to  
20 subcontract these decisions to experts, and that's a  
21 problem. And, you know, where we see the biggest evidence  
22 of these things working seems to be in breast and prostate

1 cancer, end-of-life, and we all know that people get engaged  
2 when we are talking about sex or death, but, you know, how  
3 far you can extend this, I think we should look at the  
4 literature on the other thing people are interested in,  
5 which is money, and what happens with 401(k) plans where  
6 employers, when they set these up, assume that all their  
7 employees are little Warren Buffetts and want to manage them  
8 and, you know, change them day to day and all of this. And  
9 the evidence shows that you can bombard people with  
10 information and decision tools and everything like that, and  
11 they never use them, most of them, no matter what the market  
12 is doing and all that. And I suspect -- you know, a lot of  
13 people have said concentrate on these few kinds of areas,  
14 and that's very good advice.

15 MR. HACKBARTH: Okay. Well, clearly you hit a  
16 topic of interest to people.

17 DR. SOKOLOVSKY: Does that mean I can skip my  
18 next one?

19 [Laughter.]

20 MR. HACKBARTH: No. That means you have to come  
21 back more often.

22 Okay. Next up is the Impact of Physician Self-

1 Referral on Use of Imaging Services Within an Episode.

2 MR. WINTER: Good morning. Jeff and I will be  
3 presenting results of our analysis on physician self-  
4 referral and the use of imaging within an episode of care.  
5 We would like to first thank Jennifer Podulka and Hannah  
6 Neprash for their help with this work.

7 So here is an outline of our discussion. We are  
8 going to first summarize prior MedPAC work on imaging. We  
9 will then review data on the growth of imaging and reasons  
10 for this growth. We will talk about the growth of imaging  
11 performed in physician offices. And then we will walk  
12 through the methodology and results from our two studies,  
13 the first of which is the impact of self-referral on the use  
14 of imaging, and second, whether episodes of more imaging  
15 have lower total costs for the episode. We plan to include  
16 this work for a chapter in our upcoming June report.

17 In prior reports, MedPAC has recommended quality  
18 standards for all imaging providers as well as changes to  
19 improve payment accuracy. Most recently, the Commission  
20 recommended an increase in the equipment use standard for  
21 expensive imaging machines, and this would reduce practice  
22 expense RVUs for services that use this equipment.

1           In the last couple of years, we have also had  
2 expert panels speak to the Commission about use of  
3 appropriateness criteria, efforts by private plans to  
4 require prior authorization, and physician self-referral.

5           This chart, which you have seen in our March  
6 report, shows that the volume of imaging per beneficiary has  
7 been growing faster than other physician services. Between  
8 2002 and 2007, cumulative volume growth of imaging was 44  
9 percent versus 23 percent for all physician services. This  
10 increase is likely driven by multiple factors, including  
11 technological innovations, incentives in Medicare's payment  
12 systems, defensive medicine, consumer demand for diagnostic  
13 tests, lack of research on the impact of imaging on clinical  
14 decision making and patient outcomes, inconsistent adherence  
15 to clinical guidelines, as well as physician ownership of  
16 imaging equipment and opportunities to earn ancillary  
17 revenue.

18           And this chart from GAO illustrates the last point  
19 I made. It shows the increase in the percent of total Part  
20 B revenue derived from imaging performed in the office for  
21 specialties other than radiology, and you can see large  
22 increases for several of the specialties between 2000 and

1 2006.

2           Supporters of in-office imaging contend that it is  
3 more convenient for patients. According to one study, for  
4 seven of the eight conditions studied, patients are more  
5 likely to receive a test on the same day as their office  
6 visit if they are seeing a self-referring physician. For  
7 example, about 12 percent of patients with cardiac or  
8 coronary disease who saw a self-referring physician received  
9 a nuclear medicine study on the same day as their office  
10 visit, compared to 5 percent of other patients. In  
11 addition, getting test results faster helps physicians  
12 develop treatment plans.

13           However, in-office imaging does raise some  
14 concerns. As Lawrence Baker discussed at our September  
15 meeting, there is evidence that adding more CT and MRI  
16 machines in a market is associated with higher overall  
17 volume. In addition, physicians who purchase machines for  
18 their office have a financial incentive to refer patients  
19 for additional tests as long as they are profitable.  
20 Indeed, several studies which are summarized in your paper  
21 have found that physicians who own imaging facilities or  
22 provide imaging services in their office refer physicians

1 for more tests than other physicians.

2 Many of these studies have limitations, which we  
3 have tried to address in our own study. Most of the prior  
4 studies are based on older data. Only two of the studies  
5 controlled for differences in patients' clinical conditions.  
6 Only one study examined whether physicians refer patients to  
7 other members of their practice. And none of them examined  
8 the impact of self-referral on standardized imaging spending  
9 during an entire episode of care.

10 So now I will switch gears to talk about the  
11 methodology for our analysis. We first identified  
12 physicians who self-referred for imaging. To do this, we  
13 used the 100 percent Medicare claims file for six markets,  
14 which are listed on the slide, and we defined self-referring  
15 physicians as those who refer more than half of the imaging  
16 services they order to their practice. This rule is applied  
17 severally to each modality. So, for example, physicians can  
18 be considered self-referring for MRI but not CT. And we  
19 assume that physicians who share the same tax number are in  
20 the same practice, which is an assumption that MedPAC has  
21 made in prior work.

22 We used Episode Treatment Groups, or ETGs, to

1 group claims into clinical episodes. MedPAC has been using  
2 ETGs to measure physician resource use for a couple of  
3 years. Within each ETG, episodes are stratified based on  
4 the presence of comorbidities and complications, the type of  
5 treatment, and patient severity. We selected 13 ETGs for  
6 this study.

7 For the ones we selected, imaging accounts for a  
8 significant share of overall resource use, and the ETGs we  
9 chose collectively represent a broad range of conditions and  
10 modalities and are treated by a variety of specialties. For  
11 each ETG, we selected one or two imaging modalities, for a  
12 total of 22 ETG modality combinations, and here are the ETGs  
13 and modalities we selected.

14 Next, we categorized episodes as being self-  
15 referral or not, as involving self-referral or not. Self-  
16 referral episodes are those in which at least one self-  
17 referring physician provided an office visit and non-self-  
18 referral episodes are those in which no self-referring  
19 physician provided an office visit. We used office visits  
20 to identify physicians who were involved in managing the  
21 patient's care during the episode.

22 We compared self-referral with non-self-referral

1 episodes in two ways. First, we calculated the percent of  
2 episodes in each category that received at least one imaging  
3 service. And second, we compared the ratios of observed to  
4 expected imaging spending for each category. We have used  
5 O/E ratios in our other work with ETGs. The observed value  
6 equals the imaging spending for that episode and the  
7 expected value equals average imaging spending for episodes  
8 within the same ETG patient severity level, geographic  
9 market, and the specialty of the physician who accounted for  
10 most of the E&M dollars. In other words, the O/E ratios  
11 tell us the costliness of an episode relative to similar  
12 types of episodes.

13 I also should mention that we did not examine the  
14 impact of imaging on patient outcomes.

15 Jeff will now present the results from our  
16 univariate analyses.

17 MR. STENSLAND: To test for self-referral's  
18 association with the odds that a patient receives imaging,  
19 we separated patients into different episode types and then  
20 compared episodes with a self-referring physician to  
21 episodes without a self-referring physician. All the  
22 episodes that I will be talking about today occurred during

1 2005.

2           The punch line is that patients are more likely to  
3 receive an imaging study if their episode includes a visit  
4 to a self-referring physician. This is true for all 13  
5 types of episodes. However, the magnitude of the effect  
6 varies by type of episode and imaging modality. Among the  
7 22 types of imaging studies we evaluated, we found between a  
8 two percentage point increase in the share of patients  
9 getting imaging and a 23 percentage point increase in the  
10 share of patients receiving imaging. The detailed data is  
11 on page 19 of your mailing materials.

12           For example, we looked at migraine headache  
13 episodes. We found that 14 percent of migraine episodes  
14 with a self-referring physician had an MRI. In contrast,  
15 only 8 percent of migraine episodes without a self-referring  
16 physician had an MRI. Therefore, self-referral was  
17 associated with a six percentage point increase in the share  
18 of patients receiving an MRI.

19           The differences are all statistically significant  
20 except for CT scans of lung patients. In that case, self-  
21 referral appears to have little effect. However, in the  
22 remaining 21 of 22 imaging modality pairs, or episode

1 modality pairs, self-referral always had a statistically  
2 significant association with the likelihood of receiving  
3 that type of imaging at least once during the episode.

4           Next, we shift to testing differences in imaging  
5 spending. This analysis differs from the first in two key  
6 aspects. First, imaging spending takes into account how  
7 many imaging studies the person received. And second, as  
8 Ariel mentioned, the spending analysis adjusts for the  
9 severity of the case, the MSA, and the specialty of the  
10 physician primarily seeing the patient. We asked the  
11 question, did self-referral episodes have more than expected  
12 imaging spending? The punch line is that self-referral  
13 episodes tend to have between 5 and 104 percent more imaging  
14 spending than similar episodes without self-referral. The  
15 table with the detailed data is on page 22 of your mailing.

16           For example, we compared spending on MRIs of the  
17 brain for similar migraine patients. We find that relative  
18 to expectations, the patients with self-referring physicians  
19 had 85 percent more spending on MRIs than episodes without  
20 any self-referring physicians.

21           We can go further into our methodologies and  
22 proposed future refinements to our methods during the

1 question period, but the message from both analyses is the  
2 same. Self-referring episodes are more likely to receive  
3 imaging.

4 Now, we are not the only ones doing these type of  
5 studies, and you may be wondering how our findings of a four  
6 to 104 percent increase in imaging spending compares to  
7 other studies. In a 2007 study by Gazelle and colleagues,  
8 they found that self-referral was associated with between a  
9 10 percent and 130 percent being more likely to receive  
10 imaging. So in general, their results are similar to our  
11 results.

12 And last fall, Loren Baker, a health economist  
13 from Stanford, came to a MedPAC meeting and presented his  
14 findings on self-referral and the odds of receiving an MRI.  
15 He showed that individual orthopedic surgeons and  
16 neurologists increased their rate of providing MRIs between  
17 22 percent and 28 percent after they started billing for the  
18 technical component. What was interesting about Loren's  
19 study is that he found that individual physicians changed  
20 their practice patterns after they gained the ability to  
21 bill for imaging services.

22 In addition, there are some older studies from the

1 1990s that also found a relationship between imaging and  
2 self-referral and these results tended to be even more  
3 dramatic.

4           The general point is that we have several studies  
5 over a period of 20 years. The studies used different data  
6 sets, some from private insurers and some from Medicare.  
7 They used different methodologies and different definitions  
8 of self-referral. But the results from these various  
9 studies are all consistent with what we are representing  
10 today. Self-referral is associated with more imaging.

11           Ariel will now discuss the relationship of imaging  
12 to total episode spending.

13           MR. WINTER: We also used ETGs to examine whether  
14 episodes with more imaging spending have lower total imaging  
15 regardless of the self-referral status of the episode.  
16 There is evidence in the literature that imaging in specific  
17 circumstances prevents surgeries and reduces hospital costs  
18 and the question is whether these examples translate into  
19 broader savings for an entire episode of care.

20           We examined whether the observed-to-expected  
21 ratios of imaging spending are correlated with ratios of  
22 total episode spending, excluding outpatient prescription

1 drug costs, which we did not have in the data. If greater-  
2 than-expected imaging spending leads to lower-than-expected  
3 total spending, we would find a negative correlation. We  
4 used the same 13 ETGs that we used for our self-referral  
5 study as well as 2005 data.

6 For each ETG, we found that imaging spending was  
7 positively correlated with total episode spending. The  
8 correlation coefficients ranged from 0.19 to 0.60 and all of  
9 them were statistically significant. These results suggest  
10 that more imaging is associated with greater use of all  
11 services during an episode, adjusting for a patient's  
12 clinical condition, their severity, and other factors. We  
13 also found that imaging spending was positively correlated  
14 with spending on procedures. The detailed results are on  
15 page 25 of your paper.

16 One might ask why our findings differ from studies  
17 in the literature which show that in certain cases, imaging  
18 is associated with lower use of other services. One  
19 explanation is that we looked at the impact of imaging on  
20 total spending within an episode whereas other studies  
21 examined the question more narrowly, for example, whether  
22 certain diagnostic tests within a limited time frame reduced

1 hospital costs or length of stay during an admission.

2 And second, we examined 13 clinical conditions.

3 The relationship between imaging and total spending may be  
4 different for other conditions, for example, use of CT scans  
5 for a suspected appendicitis.

6 So we have some suggestions for your discussion.  
7 We would like to get your feedback on our studies and our  
8 findings. We would like to get feedback on whether there  
9 are additional analyses we should consider performing and  
10 whether there are policy options we should investigate, for  
11 example, encouraging greater use of appropriateness  
12 criteria, improving payment accuracy, or bundling multiple  
13 services into a single unit of payment.

14 Thanks, and we look forward to your discussion.

15 MR. HACKBARTH: Okay. Could I see hands for first  
16 round clarifying questions? Peter and Ron and John, Mitra,  
17 George, and Bob. Peter?

18 MR. BUTLER: One comment. I will have a comment  
19 in round two, but this is like one of those fruits on the  
20 MedPAC vine that is about to ripen. We are just not sure  
21 what we are going to pick and recommend, but we have  
22 discussed it obviously a lot.

1           You make in the chapter a suggestion, you know,  
2 thinking about looking at nonprofit organizations as an area  
3 of further study and you define in the footnote that means  
4 where perhaps the health system employs the physician. I am  
5 not sure that that is an easy thing to do. You may even  
6 have joint ventures between health systems and physicians.  
7 The clean definition doesn't seem -- if you could clarify a  
8 little bit more what you are after, because I think probably  
9 whether the physician is getting some indirect or direct  
10 financial benefit out of it is the real issue, not  
11 necessarily where it is a nonprofit or for-profit system,  
12 but if you could elaborate a little bit more on your  
13 thinking on that.

14           MR. STENSLAND: All right. So we do think it is  
15 not going to be a clean situation. It is probably going to  
16 be muddy, and I will start with the example that you may  
17 have a nonprofit practice that is independent or owned by  
18 the hospital and the physicians may believe that the more  
19 profitable the practice is, the easier it is for them to ask  
20 for larger raises, even though it is nonprofit. So there  
21 might be some financial motivation to increase imaging even  
22 if you are in a nonprofit.

1           And then there is the question of what exactly we  
2 are going to use, and what we have data on is the tax ID  
3 number of the practice that is billing for those office  
4 visits. So if they are a nonprofit practice and they are  
5 billing for those office visits and they are billing for the  
6 imaging, then we will call them nonprofit, and that could be  
7 a nonprofit practice affiliated with an academic medical  
8 center or it could be an independent nonprofit practice.

9           The convoluted effect there of the academic  
10 medical center effect versus the nonprofit effect is also  
11 something we are going to have to try to tease out and that  
12 is some future work we are going to have to do, and it is  
13 going to be maybe somewhat difficult to get accurate data on  
14 who is actually working with an academic medical center  
15 because we would like to maybe distinguish this independent  
16 nonprofit practice, and you see some of these like in  
17 Minneapolis, from the academic medical center where you have  
18 the residents and the attendings seeing the physician [sic]  
19 because there could be two different effects going on there.  
20 There could be the nonprofit effect and also kind of the  
21 teaching resident effect and we are going to have to try to  
22 tease those out.

1           So maybe that is a long answer to your question,  
2     but the basic gist of it is we have a variable that  
3     identifies whether that tax ID number that is billing for  
4     the imaging or for the E&M services is nonprofit. We  
5     probably won't be able to get into all the different joint  
6     ventures and intricacies.

7           DR. CASTELLANOS: Pretty eye opening, and I think  
8     you did a good job. I really do. It is something I think  
9     we all expected.

10           Two questions. One is the data, the claims data  
11     you used in at least the material that you sent to us was up  
12     to 2005. I know we have data from 2006 and 2007. It may be  
13     important to use that data also. I think there is some  
14     change from the DRA.

15           MR. WINTER: Yes, those are very good points. We  
16     started this about a year-and-a-half ago. The latest data  
17     we had grouped into the ETGs was 2005, through 2005, and I  
18     think we have added 2006 since then and perhaps we can  
19     explore adding 2007 data and then extending the analysis and  
20     looking at more recent data could be a valuable  
21     contribution.

22           DR. CASTELLANOS: Great. And I think the second

1 question is, when you had on, I think it was slide whatever  
2 it was where you had the drivers, one of the things that you  
3 need to also look at is quality of care and outcomes. I  
4 know that is going to be pretty hard, but I think outcomes  
5 are going to be really important. Has there been any  
6 interest in that, or is there any direction on that?

7 MR. WINTER: As you were saying, identifying  
8 outcomes as being related to use of imaging, there is not  
9 much research in general on that question and so it would be  
10 difficult for us to identify outcomes in an episode that we  
11 could say are reasonably related to whether or not the  
12 patient got a specific imaging study.

13 The one thing that Ingenix, which produces ETGs,  
14 they also produce something called EBM Connect, which MedPAC  
15 has explored in previous work, which does look at some  
16 measures of appropriate use of certain services. So there  
17 are a couple of imaging tests which they consider to be  
18 recommended and appropriate and they rate the percent of  
19 time that patients got that imaging test. On the other  
20 hand, there are also tests which they -- which according to  
21 clinical guidelines are not recommended for certain  
22 circumstances and they identify when those tests are being

1 overused.

2           And in future work, we can try to relate use of  
3 recommended services or services that are not recommended  
4 against -- or that are recommended against, relate to  
5 whether the self-referring physician was involved or not.  
6 And it doesn't quite get to outcomes, but it is looking  
7 maybe at the appropriateness of the care.

8           MR. HACKBARTH: So, Ariel, you say that there  
9 haven't been many studies looking at the relationship  
10 between use of imaging and outcome. I assume that is not  
11 because of a lack of interest, it is just because it is so  
12 inherently difficult to connect?

13           MR. WINTER: Yes. I think that is what I have  
14 read in the literature, and there are a couple of studies  
15 that have talked about the lack of evidence on this question  
16 and it seems -- I mean, some folks made the argument that we  
17 just haven't invested the resources, that it is possible to  
18 get there. Other folks make the argument that it is very  
19 difficult to relate a specific outcome to a diagnostic test.

20           MR. HACKBARTH: Okay. John?

21           MR. BERTKO: A quick follow-up question. When you  
22 did the expected part of your observed to expected, did you

1 include all parts of the episodes, even including these ones  
2 that seemed to be high, or is it only the first group  
3 without the higher-cost people?

4 MR. WINTER: I'm not quite sure I understand the  
5 question, but we did include everybody who had the episode -

6 MR. BERTKO: Okay.

7 MR. WINTER: -- and we stratified them by their  
8 patient severity and whether or not there were comorbidities  
9 or complications.

10 MR. BERTKO: So if one were to surmise that  
11 perhaps there is some episodes with inappropriate levels of  
12 care, comparing it to, and I will use "efficient" in quotes  
13 here, it could actually be a larger difference and perhaps  
14 there would be even more savings when you made those  
15 comparisons?

16 MR. WINTER: Perhaps, or we might find that there  
17 is sort of the same level of inappropriate care for both  
18 high- and low-spending episodes.

19 MR. BERTKO: Okay.

20 MR. WINTER: But it is a question worth looking  
21 into.

22 MS. BEHROOZI: I am sorry. I just need to ask you

1 to go over how you determined whether a physician was a  
2 self-referring physician.

3 MR. WINTER: Back to that slide. Okay. So for  
4 each UPIN, which is how we identify a unique physician, we  
5 looked at all of the imaging studies within a modality that  
6 they ordered, and that was our denominator. And then we  
7 looked at the studies that they ordered that were performed  
8 by their practice, and that was the numerator, okay. So we  
9 made that calculation, and if they -- if 50 percent or more  
10 of the studies they ordered were performed by their  
11 practice, which was based on a tax number association, then  
12 we said, you are a self-referring physician.

13 And the next step was then to identify whether an  
14 episode involved a self-referring physician, and to do that,  
15 we looked at whether a physician who met our definition of  
16 self-referring provided an office visit during the episode,  
17 an E&M office visit, and that was to identify -- we wanted  
18 to see whether any of the physicians involved in managing  
19 the patient's care was identified as a self-referring  
20 physician.

21 MS. BEHROOZI: I think I am confused about  
22 something in the paper, because you referred also to a less-

1 restrictive definition using the one percent, and I just  
2 wondered if there was a big difference between them and if  
3 any of the results were based on that standard.

4 MR. WINTER: Okay. So the results presented today  
5 are based on the more restrictive standard of 50 percent or  
6 more, and I appreciate your mentioning that. In the paper,  
7 we did talk about a less-rigorous definition based on  
8 whether the physician -- at least one percent of their  
9 imaging cases that they ordered were performed by their  
10 practice, and we did the same kind of analysis that you saw  
11 here, but the results were not very different and they were  
12 statistically significant in the same direction. So that is  
13 why we didn't present them.

14 MR. GEORGE MILLER: I promise, Mitra and I did not  
15 talk about this, but I have the same question, particularly  
16 about how you chose the 50 percent as the definition of  
17 self-referral. If it was, say, 25 percent, would there be a  
18 material change?

19 MR. WINTER: What we did, as well -- so we did two  
20 analyses. One is 50 percent or more than 50 percent --

21 MR. GEORGE MILLER: Right.

22 MR. WINTER: -- and then we did anybody above one

1 percent. So it was a broader group.

2 MR. GEORGE MILLER: Right.

3 MR. WINTER: And the magnitudes, I think, were  
4 slightly larger when you used the more restrictive  
5 definition, the one we presented.

6 MR. GEORGE MILLER: Right.

7 MR. WINTER: But it wasn't a huge difference, like  
8 it wasn't like it went from, you know, a 5 percent  
9 difference in the ratios to a 100 percent difference. It  
10 was marginal. I'm sorry, I don't have the numbers off the  
11 top of my head, but that is something we can look into for  
12 the future.

13 MR. GEORGE MILLER: That is fine. But if this is  
14 an issue and we are concerned about the financial impact,  
15 would that difference be material -- I understand it is not  
16 material percentage-wise, but it would be material dollar-  
17 wise, just trying to save dollars for the Medicare program.

18 MR. WINTER: It is certainly a broader group of  
19 episodes that meet the self-referral -- that are in the  
20 self-referral category if you use a less-restrictive  
21 definition. So you would include a broader -- more  
22 episodes, more dollars, if that answers your question.

1           MR. GEORGE MILLER: So is that significantly more  
2 dollars?

3           MR. WINTER: There are definitely more episodes.  
4 I would have to go back and look at how many more and how  
5 many dollars they represent, so I will have to get back to  
6 you on that.

7           MR. GEORGE MILLER: Okay. Thank you.

8           DR. REISCHAUER: Just on that question, do you  
9 have a distribution of self-referral-dom? I mean, I would  
10 think it would be terribly skewed. I mean, there would be a  
11 lot at zero and a lot at 80 percent or more and not a whole  
12 lot in between, which would answer George's question, I  
13 think, but that --

14          MR. WINTER: We didn't calculate that, but we can  
15 certainly do that. We have the data to do a distribution.

16          DR. REISCHAUER: That is just sort of a question.

17                 I was going to ask Ron's question about outcome  
18 information and the lack thereof, and given your answer, I  
19 was wondering if we have longitudinal information and could  
20 take as a rough proxy for outcome spending in the two years  
21 following the episode on the same diagnoses or related ones.  
22 I don't want you to answer that, just think about it.

1 MR. WINTER: Right. We could think about that.

2 DR. REISCHAUER: I am not sure.

3 DR. CHERNEW: So I am fascinated by this, although  
4 you might be surprised that one of the things I am most  
5 interested in is Endnote 8.

6 [Laughter.]

7 DR. CHERNEW: Endnote 8 is the endnote that talks  
8 about the severity adjustment, and one of the challenges in  
9 all of this work is how balanced the people are, and so in  
10 the chapter, it says often adjusted for severity and stuff.  
11 So what I gather you did, just to clarify, is the ETG  
12 software does all of the adjustments for you, so you  
13 actually didn't do the adjustments. It just spits out based  
14 on its black box version of age and gender and things four  
15 scores of severity -- "not so bad," "oh no" levels --

16 MR. WINTER: Yes. Just to clarify, so it is  
17 actually up to four. Some ETGs only have one category. The  
18 most is four. And then in addition to that, they also  
19 stratify by whether or not there are comorbidities or  
20 complications in the episode that would be expected to  
21 increase overall resource use for the episode. So that is  
22 in addition to patient severity, even though those things go

1 into the patient severity calculation.

2 DR. CHERNEW: So one needs to rely on that, in  
3 general, particularly as you move to the spending portion of  
4 it, because any residual case mix confounders could show up.  
5 So my first question is, have you looked to see how those  
6 numbers, the comorbidity and severity numbers, differ across  
7 self-referring and non-self-referring so we can tell at  
8 least on observed factors these patients seem to be  
9 different, so we might be worried about other things.

10 The second thing is, do you know in the methods  
11 that the ETG software uses if the actual receipt of an MRI  
12 or the results that you get from an MRI could in and of  
13 itself push you into a different severity or comorbidity?

14 MR. WINTER: It doesn't, no. No. So the  
15 diagnostic tests, any claims from diagnostic tests, like  
16 imaging, had no influence on whether or not you were counted  
17 as having a comorbidity or complication. It would have to  
18 be a diagnosis on an E&M claim or a surgical claim for  
19 procedure or a facility claim. But I will double-check  
20 that, but that is my understanding.

21 DR. CHERNEW: That is fascinating.

22 MR. WINTER: You seem surprised.

1 DR. CHERNEW: Well, I would think that if you do  
2 an imaging procedure and you find something on the imaging  
3 procedure, that result might -- maybe it wouldn't in and of  
4 itself, the imaging procedure, but that might push the  
5 course or practice in a certain way that would generate some  
6 other codes that would make you seem more or less severe.  
7 In fact, I was worried before about it --

8 MR. WINTER: Correct.

9 DR. CHERNEW: -- seem like you did or didn't have  
10 the episode. So if you don't have the ETG, you don't get I  
11 don't know what degenerative knee thing. The problem is,  
12 you know, I don't understand a lot of these. But the  
13 degenerative knee one. Maybe you don't know it's  
14 degenerative or whichever the other one that began with a  
15 "D" was unless you've done the imaging and seen that it's  
16 not attached or is too attached or whatever is wrong with  
17 the knee.

18 MR. WINTER: So let me clarify --

19 DR. CHERNEW: So the imaging stuff might affect  
20 those things. I'm just not sure if that's a big deal or  
21 not.

22 MR. WINTER: Okay. So it doesn't affect whether

1 or not the episode gets started. So if you show up at the  
2 doctor and you get an MRI of the knee and the diagnosis is  
3 derangement of the knee, that wouldn't initiate the episode.  
4 But if the E&M office visit had that diagnosis on it or  
5 there was a procedure that followed that had that diagnosis,  
6 that would initiate the episode.

7 But you make a good point in that because you do  
8 the imaging, you learn about the condition and then you do  
9 either an office visit or a procedure or something. That  
10 gets incorporated into the episode and that can lead to it  
11 being coded as a more severe episode.

12 MR. HACKBARTH: Any other first round questions?  
13 Peter?

14 MR. BUTLER: Just one clarification. Our previous  
15 recommendations, we have gone after the quality issue. We  
16 have gone after the technical component recommendations. We  
17 have not yet recommended anything on, call them the  
18 arrangements that might be acceptable or incentivized or not  
19 incentivized, is that right?

20 MR. HACKBARTH: The only thing -- oh, Ariel, you  
21 go ahead.

22 MR. WINTER: So we have made two recommendations

1 on the Stark rules, which are -- I'm not sure I'd call them  
2 minor, but they don't go after the in-office ancillary  
3 exception, which is the real big one. One was to -- that  
4 CMS should include nuclear medicine procedures on their list  
5 of designated health services, which are the ones subject to  
6 the Stark laws, and CMS went ahead and did that.

7           And the second one was we recommended that CMS  
8 should prohibit physicians from leasing equipment to  
9 providers of designated health services. So a physician  
10 buying an MRI machine or investing in one and leasing it to  
11 a hospital or an imaging center and then getting profits  
12 from whenever they send a patient for those services. And  
13 CMS prohibited those arrangements subsequently if they are  
14 on a per unit basis, so if you get paid every -- like a per  
15 click basis, but not if the payment is fixed in advance, and  
16 our recommendation covered both kinds of things. So those  
17 are the recommendations we have made on the Stark rules.

18           MR. HACKBARTH: Round two questions or comments.

19           MR. GEORGE MILLER: Thank you. This may be  
20 question one-and-a-half, but in the text, you talked about  
21 episodes with more imaging, if they lower total cost, and  
22 I'm wondering if you're able to determined, based on that

1 analysis, what the financial impact to CMS would be if that  
2 were the case, and if not, and if it was changed, what would  
3 be the cost savings to CMS.

4 Let me see if I can clarify that a little better.  
5 If more imaging lowered cost, if that assumption is true,  
6 what is the savings to CMS?

7 MR. WINTER: We found it not to be true. We found  
8 that more imaging --

9 MR. GEORGE MILLER: Right.

10 MR. WINTER: -- associated with more total costs.

11 MR. GEORGE MILLER: Then since it's not, then  
12 what's the converse? What's the answer? How much is it  
13 worse?

14 MR. WINTER: I mean, so --

15 MR. GEORGE MILLER: What does it cost more because  
16 it is not lower cost? How much more is Medicare paying for  
17 these additional tests that don't lower downstream costs and  
18 hospitalizations and others?

19 MR. WINTER: Okay. So we found that --

20 MR. GEORGE MILLER: So you order more tests. That  
21 means we're spending more money and maybe on something that  
22 should not have been done.

1           MR. WINTER: Our correlations looked at an  
2 association between the two things.

3           MR. GEORGE MILLER: Right. Right.

4           MR. WINTER: We didn't look at causation, so  
5 that's a more difficult question to answer. But our  
6 correlations were between 0.19 and 0.60, so at the high end  
7 for every dollar in additional imaging spending, we found an  
8 additional 60 cents in total episode costs, or total episode  
9 spending.

10          MR. GEORGE MILLER: So can you extrapolate that to  
11 the whole --

12          DR. MARK MILLER: I think you need to be a little  
13 bit careful here on at least two fronts. Number one, his  
14 question is really more a parameter estimate question, how  
15 much change produces that, as opposed to a correlation  
16 question. And also, we looked at 22 episodes here and the  
17 generalizability across episodes more broadly.

18                 So what I would like to do is maybe take this  
19 question offline and kind of talk among ourselves about  
20 whether we can answer that. Off the cuff, I'm not sure we  
21 can.

22          MR. GEORGE MILLER: But something's wrong.

1 DR. REISCHAUER: Ariel, could you just repeat  
2 that? You said that if you spent a dollar more on imaging,  
3 the total episode cost would go up 60 cents?

4 MR. WINTER: At the high end. So there was a  
5 range based on ETG.

6 DR. REISCHAUER: The high end, meaning that you  
7 would, in a sense, spend 40 cents less on everything but  
8 imaging?

9 DR. CHERNEW: Right. That's why Mark's question  
10 is important.

11 DR. MARK MILLER: I don't want to have this  
12 conversation --

13 [Laughter.]

14 DR. MARK MILLER: I'm sorry to be this way.  
15 You've asked a very good question. Exactly whether this  
16 analysis will allow it to answer it, I really would like to  
17 talk to these guys before we just kind of talk out loud  
18 about it.

19 MR. GEORGE MILLER: So I shouldn't have asked the  
20 question?

21 [Laughter.]

22 MR. WINTER: I shouldn't have answered it.

1           MR. MATHEWS: George, we'll get back to you with a  
2 more thoughtful answer and discuss the potential plan that  
3 it would take to answer your question and evaluate whether  
4 it is worth that much work to get an answer for it.

5           DR. CROSSON: Just a couple of points. In terms  
6 of the disadvantages, I guess, of over-utilization of  
7 imaging procedures, in addition to the financial ones, which  
8 you have laid out very well, I think there is an important  
9 issue of patient safety, particularly with respect to  
10 modalities that use ionizing radiation, plain film  
11 certainly, but particularly CT scans, and I think it may not  
12 be intuitive to folks, the difference in the radiation dose  
13 that is inherent in some of these modalities and so many CT  
14 scans carry radiation doses which are orders of magnitude  
15 greater than some plain films. And there's no question  
16 about the fact that, particularly for people who receive  
17 repeated CT scans, there is an increased risk of cancer and  
18 other morbidity from that.

19           So there is more than just dollars at stake. But  
20 there are dollars at stake, and I think we have been working  
21 on this for some time, to try to figure out what we could do  
22 to change the path of the increase in imaging cost.

1           We haven't gotten yet to policy questions, and I  
2 think we're going to get there at one point. But when we  
3 do, I think my preference would be to look first at policy  
4 options that deal with removing the incentive for over-  
5 utilization as opposed to policy options that serve to  
6 remove the capability of physicians to perform these tests,  
7 because I do think that there are -- and you mentioned it --  
8 there are some legitimate issues of patient convenience as  
9 well as issues of timing and getting to a diagnosis and  
10 things that help people, particularly people with  
11 significant medical problems, come to grips with what is  
12 going on.

13           So I would like to see us take a hard look at  
14 modeling things like bundled payments, for example, and  
15 other counter-incentives that might remove or significantly  
16 mitigate the inherent incentive to over-utilization. And  
17 then failing that, if we determine that that simply can't  
18 work because of complexity or other issues as we model it,  
19 as a secondary issue, look to removing the capability,  
20 because I think there would be a loss there in terms of the  
21 quality of care.

22           DR. CASTELLANOS: Can you go to Slide 9 just for a

1 second? Just out of interest, in these six communities,  
2 have you looked at whether there is any geographic variation  
3 within these communities? I think that would be  
4 interesting, because then we get to practice patterns, we  
5 get to stuff like that, and I think that would be really  
6 interesting to see if there is any variation in practice  
7 patterns.

8 MR. WINTER: I could answer that. The spending  
9 ratios take that variation into account in the way we  
10 calculated the expected value. So it is sort of adjusted  
11 for each MSA. I think your question is more about if we --  
12 what is the level of use or the spending among or between  
13 those geographic areas.

14 DR. CASTELLANOS: That's correct. That would be  
15 interesting.

16 The second question is a question you don't want  
17 to bring up, Mark. Intuitively, I think if you do -- you  
18 don't do x-rays on somebody just to do x-rays. You do it  
19 because of a reason and you expect to find something. And  
20 by finding something, you can take care of it. So it's  
21 going to increase cost and, I would hope, increase outcomes.  
22 Today, we are finding so many more aneurysms, so many more

1 renal cell carcinomas because of CT scans. Now, is that  
2 good? I think it is. So I think the downstream effect may  
3 be much better with outcomes than we expect.

4           And the third thing, and again, this is appalling,  
5 what we see here, but why are physicians doing it? Well,  
6 they're doing it for one reason only, to increase income.  
7 And I think it's a reflection on our, unfortunately, the  
8 Physician Payment System and the incentives in the fee-for-  
9 service. Because of the unfunded mandates, because of the  
10 lack of significant updates, because of business and  
11 practice expenses, I am forced to do things that perhaps I  
12 don't really want to do. And the reason I do it is because  
13 I want to stay in business. I'm a small businessman. I  
14 have 80-some employees. So to stay in business, you know,  
15 it's unfortunate, but it's true.

16           And I would really like to -- I think the bigger  
17 problem here is working on the issue of Physician Payment  
18 System reform. I think that's the real big issue, and if  
19 you look at the Mayo Clinics or you look at the Kaiser  
20 Permanente clinics, I think you'd probably see that a lot of  
21 the imaging is significantly down in those clinics because  
22 these doctors are not being incentivized to do these

1 procedures.

2 MR. BUTLER: Three comments. First is, I may be  
3 wrong, but I'm not sure -- MedPAC staff is limited, and I'm  
4 not sure study after study of this is necessarily the  
5 highest priority for us, because so many people are looking  
6 at this from a variety of angles and we're all coming to the  
7 same conclusion, that there's a lot of utilization. So I'd  
8 almost like to spend more energy on kind of getting to some  
9 recommendations, not obviously in June, but, you know, next  
10 year.

11 Secondly, I think there's still an educational  
12 component here, that in another chapter, another -- we might  
13 think about. I'm not sure everybody kind of fully  
14 understands the dimensions. One is the specialty dimension,  
15 primary care and orthopedics and cardiology, et cetera.

16 Second is the setting. In the office itself is  
17 one setting. In the building is another setting. And  
18 freestanding is a third setting.

19 And the third dimension is the economic  
20 relationship. Do you wholly own it? Do you lease some  
21 time? Do you have a per click, which you've already  
22 commented on? Or do you have no economic relationship?

1 That is almost like a three-sided thing and each of those  
2 has different implications. But I suspect that that kind of  
3 framework would help lead us where we want to make some  
4 recommendations, and frankly, it is all about the last  
5 piece, the economic part of it, and I think it's partly  
6 reinforced by your comments here.

7           And I would say, similar to their comments, if you  
8 had, and I could point to your example, a multi-specialty  
9 group practice with as many as 60,000, 70,000 capitated  
10 lives in a freestanding facility, I guarantee you they'd sit  
11 there and have MRI and CT and a range of services because  
12 you know what? It would be cheaper and less utilized and  
13 coordinated on behalf of the patient than -- and yet, you  
14 know, here they go. They have got it owned. It is right in  
15 their office. But it is being used appropriately. Why?  
16 Because the finances are lined up to do it in an appropriate  
17 fashion. In the end, that's what's going to change it, I  
18 think, more than anything else.

19           DR. BORMAN: Just two comments. One is relative  
20 to the outcome piece. I think in the end, the answer is  
21 going to be that it is mixed and that there won't be a  
22 simple answer to this, and that's just based on thinking

1 about a number of clinical conditions.

2           For example, what was brought up about detection  
3 of abdominally aortic aneurysms at smaller sizes may, in  
4 fact, allow some people to get treated so that rupture of  
5 aneurysm is not their acute mode of demise. On the other  
6 hand, in cancer surveillance, the data are pretty limited  
7 that repeated frequent imaging prolongs survival. It may  
8 shorten time of detection of recurrence, but in terms of  
9 prolonging survival for many malignancies, that is a lot  
10 harder to demonstrate and there is a lot of -- or advanced  
11 imaging done for the purpose of monitoring disease. You  
12 know, in the end there's a societal value judgment about how  
13 much is one life worth, which is a very difficult decision,  
14 and in the end, I'm somewhat grateful that Congress is the  
15 benefits manager that will have to represent us in that  
16 societal decision.

17           I think the other part of that also is the  
18 detection of things that are unexpected and, in fact, are  
19 what we call incidentalomas. In my own particular world of  
20 endocrine surgery, that is highly common. For example, all  
21 these CT scans of people's cervical spine, lots of thyroid  
22 nodules turn up that people never knew they had, that likely

1 they would go to their grave never knowing that they had,  
2 and yet it triggers a fair amount of intervention and an  
3 adrenal nodule triggers an even higher level of intervention  
4 and a very expensive one even to do cost effective work-up  
5 of that nodule. So I think there's a lot of pieces to that  
6 and that we need to be really careful about getting caught  
7 up in that just on a whole host of reasons, some of which  
8 have already been mentioned.

9           One question that I wonder -- would be interested  
10 in answering because of what Jay brought up about safety is  
11 whether we could do any kind of quick and dirty calculation  
12 as to roughly how many beneficiaries per year are reaching  
13 an unsafe radiation dose. Can we aggregate on an individual  
14 beneficiary that is getting multiple scans? Can we sort out  
15 people who are getting multiple CT scans, for example, and  
16 just find out how close we are coming to those bad  
17 thresholds, because that may be a powerful piece of  
18 information.

19           It is kind of the -- we have an intrinsic wish  
20 about wanting to know the answer with certainty. That is  
21 what has led to a lot of use of advanced imaging. The  
22 patient wants to know. The doctor wants to know. We want

1 to know now. We have these fancy tools. Let's use them.  
2 But if there's a good counter-argument that is, this is  
3 putting me at risk for something bad, I think that's a  
4 powerful conversation to have with patients and with payers,  
5 and so if there's some way we could talk about that question  
6 and think about it -- I'm not sure I know how best to do it  
7 -- it might be one worth thinking of for the future.

8 MR. HACKBARTH: Okay. Thank you. Just a quick  
9 reaction to what Peter and Jay said. I agree that if you  
10 have the incentives right, these issues are not very  
11 important. However, as our work shows, getting to the point  
12 where you've got the incentives right is not an easy task.  
13 You can't snap your fingers. There are certainly certain  
14 forms of delivery where it's easier to do, but in general,  
15 we've not been able to climb that hill yet.

16 I would point out that the work here is very  
17 relevant to questions I've been asked multiple times in  
18 Congressional hearings about self-referral. People have  
19 claimed, well, yes, we're doing more of this, but it's  
20 reducing total episode cost and so don't worry about it.  
21 And so what we're trying to do is address through analysis  
22 questions and assertions that have been made frequently here

1 in context. So that's why the work is being done.

2 Thank you very much.

3 And the last session before lunch is on follow-on  
4 biologics.

5 DR. SOKOLOVSKY: Good morning, again. Hannah and  
6 I are going to present the section of the draft chapter that  
7 was missing last month, "The Role of Biologics in Medicare  
8 Part D," and how the payment system may affect potential  
9 savings from follow-on biologics.

10 Last month, we presented some informational  
11 material on the issues surrounding a regulatory path for  
12 follow-on biologics. We also looked at how Medicare could  
13 achieve savings from follow-ons under Part B if Congress  
14 authorized a pathway.

15 Today, we're going to talk about Part D. Unlike  
16 Part B, biologics still account for a relatively small  
17 percentage of benefit spending under Part D; however, given  
18 the drugs in the pipeline, we expect that percentage to grow  
19 in the future.

20 Compared to their negotiations for other drugs,  
21 plans have had a hard time negotiating lower prices for  
22 high-cost biologics, particularly those high-cost products

1 that are on specialty tiers.

2 Today, we're going to talk about some of the  
3 barriers to negotiations faced by plans and we'll also  
4 present some of the ways in which plan risk for these  
5 products is limited, and we'll begin a discussion on whether  
6 the Part D payment system could be modified to increase plan  
7 incentives to encourage use of follow-on biologics if the  
8 Congress authorizes the regulatory pathway.

9 But before we begin, I'd like to respond to some  
10 of your questions from last month.

11 Nancy, you wanted to know something about  
12 international price comparisons for biologics, and we've  
13 added a paragraph in the last section of the paper on this  
14 issue, but these comparisons are based on commercially  
15 available data, and they do not include any rebates or  
16 discounts that may exist.

17 We also want to address Bruce's question about how  
18 the VA pays for biologics. And to the best that we can  
19 tell, the VA has not prioritized particular biologics on  
20 their formulary. For pricing purposes, the VA treats  
21 biologics like other drugs. As with small-molecule drugs,  
22 by statute, the VA obtains substantial discounts on

1 biologics through the federal supply schedule and other  
2 special discounts. However, the VA as a purchaser has very  
3 significant advantages compared to Medicare: It represents  
4 a small share of the total market, it's an integrated  
5 delivery system where physicians generally support the  
6 formulary, and there are no retail dispensing fees or  
7 wholesaler costs in their prices.

8           This is not to suggest that these prices would  
9 remain the same if the VA discount was extended to Medicare.  
10 As many of you probably know, when the original Medicaid  
11 rebate was established, Congress tried to extend VA best  
12 price discounts to Medicaid and the result was that prices  
13 for all purchases, including the VA, went up.

14           Now, Hannah will begin by reminding you of some of  
15 the differences between biologics and small-molecule drugs.

16           MS. HANNAH MILLER: I'll start by reviewing some  
17 key facts about biologics that we discussed in March.

18           Biologics are drug products derived from living  
19 organisms. Unlike the drugs that most people are familiar  
20 with, these products are large, complex molecules that are  
21 generally injected or infused directly into the body. They  
22 include products such as vaccines, insulins, and hormones,

1 as well as products engineered through biotechnology, such  
2 as many treatments for cancer, anemia, and rheumatoid  
3 arthritis.

4           There are several key differences between  
5 biologics and small-molecule drugs. First, unlike small-  
6 molecule drugs, biologics cannot be replicated exactly. In  
7 other words, manufacturers cannot produce a follow-on  
8 product that is identical to its reference product.

9           Furthermore, biologics are more expensive to  
10 develop and to manufacture than small-molecule drugs.

11           And lastly, as we noted last month, biologics have  
12 specific safety risks. Most biologics exhibit  
13 immunogenicity. This means that they can stimulate an  
14 unforeseen immune response in any given patient. In rare  
15 cases, such reactions can be life-threatening, and problems  
16 may not be detected until a product hits the market.

17           I'll take a moment here to digress briefly from  
18 the subject of biologics to discuss post-marketing  
19 surveillance programs which are used to monitor all  
20 therapeutic products, not just biologics, once they reach  
21 the market. The existing surveillance programs rely on  
22 safety reports submitted by doctors, patients, and

1 manufacturers; however, in 2008, the FDA launched a new  
2 initiative to develop and implement an integrated electronic  
3 system for monitoring medical product safety. The new  
4 system, called the Sentinel System, will utilize Medicare  
5 claims data and will allow researchers to link multiple data  
6 sources so they can more actively and effectively track  
7 safety risks associated with therapeutic products. This  
8 system is still in planning stages and details have not yet  
9 been determined.

10           Returning to the subject of biologics, I will now  
11 describe the biologics covered under Part D and discuss  
12 spending on these products.

13           Biologics covered under Part D can be broken down  
14 into two broad categories. The first group includes older,  
15 simpler molecules, such as insulin and Human Growth Hormone,  
16 and the second group consists of newer, more complex  
17 molecules, such as epo and teriparatide. The older products  
18 tend to have lower prices than those created through  
19 biotechnology. An entire vial of the most expensive insulin  
20 analog, for example, costs less than a single dose of many  
21 newer biologic products.

22           Although there are no follow-on versions of

1 biologics, multiple branded versions of older biologics are  
2 often available. For instance, there are least 11 insulin  
3 brands. The presence of multiple branded insulin leads to  
4 competition that results in relatively low Medicare  
5 expenditures, despite the widespread use of insulin.  
6 Although insulin made up more than 76 percent of Part D  
7 biologic prescriptions dispensed in 2007, it accounted for  
8 only about 17 percent of total spending on Part D biologics.

9           As Joan mentioned, biologics account for a  
10 relatively small share of gross Part D spending. In 2007,  
11 spending on biologics totaled approximately \$3.9 billion, or  
12 about 6 percent of overall Part D spending. However,  
13 spending on Part D biologics has increased more rapidly than  
14 overall drug spending under Part D. Between 2006 and 2007,  
15 spending grew by about 36 percent, whereas total Part D  
16 spending grew by 22 percent. Part D spending on biologics  
17 is likely to increase as more biologics which are currently  
18 in develop under the market.

19           DR. SOKOLOVSKY: We see little sign of price  
20 competition among the Part D covered newer biologics, even  
21 in cases where there are several products available in the  
22 same therapeutic class.

1           We contracted with Acumen LLC to construct a price  
2 index to measure price trends in Part D since 2006. They  
3 used claims data to construct a volume-weighted price index.  
4 First, they compiled a market basket composed of all drugs  
5 with at least 25 claims each month and the drugs have to be  
6 listed on at least 60 percent of plan formularies, and this  
7 led to a use of -- close to 1.7 billion claims to construct  
8 the price index. The index doesn't reflect rebates but  
9 does reflect transaction prices. Measured by individual  
10 drug names, or NDCs, Part D drug prices rose by 7 percent  
11 from January 2006 to December 2007. However, when the index  
12 controlled for generic substitution, prices in the market  
13 basket actually declined by 6 percent.

14           On the other hand, prices for all biologics  
15 increased by 14 percent. And, of the top 20 drugs for  
16 specialty tier status, 6 were biologics, and prices for  
17 those increased by 16 percent.

18           So, as Hannah said, although there is some price  
19 competition for older biologics like insulin where there are  
20 multiple branded products available, we see little  
21 competition among Part D covered, more expensive biologics,  
22 and that's true even in cases where there are a number of

1 products available in the same therapeutic class.

2           There are a number of possible explanations for  
3 this. First, many of these new products are in the so-  
4 called protected classes, where plans must cover all or  
5 substantially all products in the class. Plan  
6 representatives have consistently told us that they're  
7 unable to negotiate lower prices when manufacturers know  
8 that they have to cover their products on the formulary.

9           If follow-ons for these products were approved,  
10 plans would likely have to offer the follow-on as another  
11 alternative, and this might not affect the dynamic. Another  
12 issue is that plans also have limited risk for high-cost  
13 biologics. A beneficiary taking one of these products will  
14 hit the coverage gap within a few short months. At this  
15 point, the plan bears none of the cost of continued coverage  
16 until the beneficiary reaches the catastrophic limit. And  
17 at that point, plan liability is limited to 15 percent of  
18 all covered drug spending for the rest of the year. New  
19 follow-on biologics, people expect, would be less expensive,  
20 but still expensive. The difference in price may not  
21 provide enough incentive to encourage plans to more tightly  
22 manage these products, a process which can lead to

1 considerable administrative expense for the plans.

2 Plans may also experience selection bias if they  
3 provide more generous coverage of new biologics, including  
4 FOBs, and other plans don't.

5 But a key factor that could limit Medicare savings  
6 from follow-on biologics is that the beneficiaries who  
7 receive the , or LIS, make up a disproportionately large  
8 share of the market for Part D biologics. These are  
9 products that treat MS, rheumatoid arthritis, and anemia, to  
10 give you some examples. In fact, LIS beneficiaries  
11 accounted for the majority of prescriptions for all but one  
12 of the 6 highest cost biologics.

13 In general, LIS beneficiaries are more likely to  
14 have spending that reaches the Part D coverage gap, 44  
15 percent for the LIS population versus 24 percent for the  
16 non-LIS population in 2007, and much more likely to reach  
17 the catastrophic limit, 18 percent versus 2.7 percent.

18 LIS beneficiaries have nominal cost-sharing and no  
19 coverage gap. As a result, cost-sharing differences among  
20 products are less likely to affect their utilization of  
21 drugs. For the same reason, these beneficiaries would have  
22 little incentive to ask their physicians to prescribe

1 follow-ons.

2           If LIS beneficiaries use of high-cost biologics  
3 resulted in losses in a give year, plans would be likely to  
4 raise their premiums the following year. Premiums could  
5 rise above the low-income threshold, and these beneficiaries  
6 would be reassigned to other plans still further lessening  
7 plans' incentive to encourage use of follow-ons.

8           For all of these reasons, Medicare savings from  
9 follow-ons might be quite limited. Policymakers might need  
10 to consider changes in Part D to increase the use of follow-  
11 ons and increase savings. We have some very, very  
12 preliminary thoughts on how this might be done, and I'm  
13 going to present them to help begin your discussion.

14           For one thing, Medicare could modify the current  
15 Part D risk adjustor in a budget-neutral way to take into  
16 account drug spending. In general, this would increase  
17 payments for low-income beneficiaries who, remember, tend to  
18 take more drugs than others. This could increase plan  
19 willingness to enroll LIS beneficiaries and manage their use  
20 of high-cost biologics. If the risk adjustor was based on  
21 therapeutic classes of the drugs rather than the specific  
22 drugs beneficiaries were taking, plans would have more

1 incentive to steer beneficiaries towards lower-cost  
2 alternatives in a therapeutic class. In this case, plans  
3 might create an incentive for beneficiaries to use follow-  
4 ons.

5           Alternatively, Medicare could increase plan risk  
6 for coverage of drugs over the catastrophic limit. For  
7 example, Medicare could pay 80 percent of the lowest-cost  
8 drug in a therapeutic class at the catastrophic limit. Like  
9 the previous strategy, this could lead plans to design  
10 incentives for use of follow-ons. Compared to the first  
11 option, it would require more significant restructuring of  
12 Part D.

13           Neither of these options, clearly, is ready for  
14 prime-time, but Commissioners, you may want to use them as a  
15 jumping-off point for discussion of how Medicare could  
16 benefit from the development of follow-ons.

17           You may also want to discuss additional strategies  
18 to improve the value of drugs covered by Medicare in Part B  
19 or more broadly, and we would also appreciate any comments  
20 you may have on the draft chapter as a whole.

21           That's it.

22           MR. HACKBARTH: Okay. Thank you.

1 DR. CHERNEW: My question is about this slide that  
2 you have here. And you mentioned the idea of bundling. So,  
3 my question is, in the existing bundling strategies we've  
4 discussed, what has been said, I just don't recall, about  
5 including prescription drugs, biologics or not, in the  
6 bundle?

7 DR. SOKOLOVSKY: I don't believe that MedPAC has  
8 discussed including drugs specifically, but there was a  
9 recent New England Journal article by Peter Bach where he  
10 proposes this as a possibility.

11 MR. HACKBARTH: It's a challenge when you've got  
12 two separate insurance pots.

13 MR. GEORGE MILLER: Thank you. In part of the  
14 chapter, you talked about market competition, but I don't  
15 think I heard, and maybe I was wrong, any talk about the  
16 FDA's approval process in this discussion. So, it seems to  
17 me that is a part of it, and I'm just wondering -- if I miss  
18 it, I apologize -- but what did you think about what we  
19 should recommend for the FDA approval process for FOBs?

20 DR. SOKOLOVSKY: It was my understanding, based on  
21 last month's discussion, that we were not going to weigh in  
22 on that.

1           MR. HACKBARTH: I thought it was a bit beyond our  
2 jurisdiction and area of expertise.

3           MS. HANSEN: Thank you. Just for clarifying,  
4 again, right now the most rapid use for the follow-on, that  
5 the biologics are the lower-income subsidy individuals. In  
6 terms of the offerings for us to think about of changes,  
7 could you explain again to me, to help me understand, how  
8 could we still achieve the result of receiving the clinical  
9 intervention of the biologic, possibly the lower-cost  
10 biologic, by changing the Part D benefit, again? That was  
11 one of the recommendations you had and I just didn't  
12 understand it fully.

13           DR. SOKOLOVSKY: Well, again, these are first  
14 thoughts that really need to be worked out more clearly, and  
15 I'm not even sure if they would work if we did them.

16           But one of the thoughts was, well, if we increase  
17 risk adjustment payment based on utilization of drugs, that  
18 would mean that plans would get -- because low-income  
19 subsidy patients use more drugs over an average than others,  
20 that would mean that plans would get more to cover them, and  
21 therefore, they might be more creative in developing  
22 incentives to get beneficiaries to use follow-ons since

1 cost-sharing is really not an option here.

2 MS. HANSEN: Right. So, there was the concern  
3 that I was hearing that -- what I hope we wouldn't do -- is  
4 basically cause the low-income subsidy person to move from  
5 plan to plan in that. So, what were the recommendations or  
6 thoughts that you had for mitigating that factor?

7 DR. SOKOLOVSKY: Well, this was, again, if plans  
8 were receiving more -- if the risk adjustors enabled plans  
9 to receive more money for those beneficiaries, they might  
10 have more incentive to manage their care instead of --

11 MS. HANSEN: Great. Thank you very much.

12 DR. SOKOLOVSKY: But again, this is not a  
13 recommendation, or even close to being a draft for you.

14 MR. BERTKO: Okay. Joan, a couple of  
15 clarifications, here.

16 The first one on what you've described as the  
17 plan's incentive to manage here. Your statement is true,  
18 but not necessarily accurate, in the sense that some of the  
19 Part D biologics, if they came in -- and I'll just use this  
20 as an example -- at \$15,000, the part of the 15 percent that  
21 is above the catastrophic limit, roughly \$1,500 in this  
22 example, is already more than or about the average cost for

1 a whole person. And I would suggest that there is plenty of  
2 incentive today on this.

3 The tools aren't there. We had a little bit of  
4 that discussion last month, but I will give you evidence of  
5 saying almost all large Part D plans contract or own a  
6 specialty insurer that are driven just for this. So, I'd be  
7 a little careful on the wording on that phrase on  
8 incentives.

9 The second is a pretty minor element, but I  
10 believe, and you can confirm this, that your representation  
11 of 2007 versus 2006 in spending does say something on  
12 enrollment. The increases in spending are quite large, and  
13 I'm assuming that is partly due to part-year in 2006 versus  
14 full-year in 2007 for everybody.

15 DR. SOKOLOVSKY: Certainly, the totals are based  
16 on change in enrollment, but what we were trying to  
17 emphasize was, comparatively speaking, there was a much  
18 larger increase in use of biologics than other drugs.

19 MR. BERTKO: Yes. Right, right. But the  
20 percentages are in the aggregate spending, I'm assuming.

21 DR. SOKOLOVSKY: Yes.

22 MR. BERTKO: But you're right, it's an apples-to-

1 apples comparison.

2           And the third part here is, on your comment on  
3 risk adjustment, I would like to just be careful in saying  
4 that risk adjustment would benefit from using information on  
5 prior-year drug use, but I would suggest, perhaps, making  
6 the phrase "use" rather than spending, because spending has  
7 some perverse incentives whereas the use of the drug can  
8 actually have almost the same predictive value without  
9 necessarily having that incentive.

10           DR. STUART: Good chapter on a very, very  
11 complicated topic. Two introductory issues here. One is a  
12 linguistic thing. I don't know whether it is just me, but  
13 follow-on biologics just doesn't do it, and I'm not even  
14 sure what that means, but then, when I get into this and  
15 you're talking about interchangeability or whether they're  
16 similar -- and the Europeans seem to have gotten this right;  
17 they call it biosimilar. Now, I don't know if that  
18 terminology is possible for us to use, but it strikes me in  
19 reading this that, when you bring up the issue of  
20 interchangeability, you just knock it down again and say  
21 this is not going to happen. So, I'm wondering whether in  
22 fact this is really a straw man that is just not going to

1    happen.

2                   DR. SOKOLOVSKY: Well, that's a really good point.  
3    There's a lot of disagreement. Our technical panel, for  
4    one, there was disagreement among them. And I guess what I  
5    was trying to say was, even if it doesn't happen now, that  
6    doesn't mean that, down the road, it might not happen as the  
7    science evolves.

8                   DR. STUART: Well, I think, from the way you  
9    describe it, it's not likely to happen soon. And so, I'd  
10   recommend that, in terms of the way you address the  
11   recommendations here, that they be made on the assumption  
12   that interchangeability isn't on the table at this moment.

13                   The second thing that I'd note, and this is not --  
14   you don't say that it isn't but you don't say that it is,  
15   but there is an implication in the writing that the  
16   biologics don't have substitutes in terms of small-  
17   molecules, and they clearly do. I mean, if you look at the  
18   treatment of rheumatoid arthritis, for example, most  
19   patients would go through what are called the old-line  
20   disease-modifying agents that are really pretty cheap, most  
21   of them, not all of them, before they get into the higher  
22   priced biologics. And this may well be the reason why the

1 LIS beneficiaries are so much more expensive and such higher  
2 users of these because they don't face -- it's not just that  
3 they don't face cost-sharing, but there are substitutes  
4 which would keep other people that face those cost-sharing  
5 amounts, perhaps, from using them.

6 DR. DEAN: I think I've asked Joan this before,  
7 but I'm still troubled by the slide five, which says that a  
8 follow-on biologic cannot be exactly identical to its  
9 reference product because of the large size and complexity  
10 of the molecule.

11 Clearly, the production of these entities is  
12 complex. I mean, nobody would argue with that, and yet,  
13 there has to be a process for producing them that is  
14 consistent and reproducible, because a company has to  
15 produce various batches. And if this statement is really  
16 true, then each batch is basically a new drug.

17 And so, it seems to me that -- I don't understand  
18 why, if there is an established process for producing them  
19 that is reproducible, why any number of manufacturers that  
20 have the technical sophistication to apply that process  
21 couldn't apply it. And then, the net effect is that the  
22 whole application of the concept of a generic biologic would

1 seem to me to be the same as it would for a small-molecule  
2 drug.

3 DR. SOKOLOVSKY: And I think you make very good  
4 points and I think I'm not the person to really address  
5 this. I guess it's the FDA that --

6 DR. DEAN: Well, I obviously am way out of my  
7 realm, too, in even asking the question, but I just want to  
8 be sure we're not being sold a bill of goods by the  
9 manufacturers.

10 DR. SOKOLOVSKY: I guess it's the FDA that I was  
11 quoting there, who says, in fact, that the same manufacturer  
12 producing two different batches can't say that it's exactly  
13 the same.

14 DR. DEAN: Then, there needs to be -- then they  
15 must have some way of determining that these are close  
16 enough that they can be sold as the same product. And if  
17 that's the case, my argument would still apply.

18 DR. MARK MILLER: No, I mean, both of your  
19 comments on interchangeability versus similar and then your  
20 control of the manufacturing process versus producing a  
21 follow-on collide with what is, if not the, one of the  
22 central arguments of this debate right now.

1           What you see here with this presentation is we're  
2 trying to walk that line and represent both sides of the  
3 arguments as fairly as we possibly can. You can put any  
4 given group of people in the room and they'll say  
5 interchangeability is within reach and the science is  
6 moving, it's moving quickly, and it will be there, I  
7 understand.

8           And then, your very point -- we've talked to many  
9 bio companies, and they say, from lot to lot, through the  
10 manufacturing process, there is some variance. But that  
11 said, all of your statements are true. Should we predicate  
12 our policy on an interchangeability standard or a similar  
13 standard, just your points, Bruce.

14           And on your point, there are processes that the  
15 FDA uses to figure out whether something is similar enough,  
16 and that's part of the debate about the patent process and  
17 the follow-on process which we may not make direct  
18 recommendations on.

19           But I think what you're hearing from these guys,  
20 and from the staff in general, is we're trying to walk that  
21 line and represent both sides of these debates. You can put  
22 people in the room who will say, wait a minute, this is a

1 lot more similar than the industry characterizes it, and  
2 other people who say there's a lot of variance from lot to  
3 lot, and there are even risks for a given manufacturer, and  
4 some of those risks have played out in some fairly  
5 unpleasant ways for some manufacturers.

6           So, I think what you're hearing is an attempt to  
7 walk that line, as difficult as it is. We do see your  
8 point.

9           DR. SCANLON: I feel the same uncertainty that  
10 Mark just expressed, and it comes through in the chapter,  
11 but I think in relations to Tom's point, and tell me if this  
12 is wrong, if I don't remember this -- and I certainly don't  
13 understand it, but I remember reading it -- and that was  
14 that we're talking about entities that end up -- some of  
15 them not being patentable, and some of the process actually  
16 being what is patented. And so, the issue is that if it is  
17 the process that's patented so that somebody else can't  
18 necessarily use the exact same process, at least during the  
19 patent period.

20           So, I guess that, to me, led to this issue of how  
21 do you get to something that could be considered comparable.  
22 And then, the big issue where there is still uncertainty is,

1 how do you test for comparability? That's where I came away  
2 from the chapter.

3 DR. DEAN: I guess I was assuming we were talking  
4 about after a patent had expired that there were things.

5 MS. KANE: I just had a question about -- I think  
6 the whole issue of a product that doesn't really have a  
7 competitive market is a big issue for the whole -- how we  
8 use competitive -- I mean, how we use the whole market-based  
9 idea of generating prices. But on this one, where it  
10 clearly doesn't -- and that's why I mentioned looking at  
11 international pricing and seeing if there's something we can  
12 do there.

13 I'm also wondering if we can talk a little bit  
14 about having Part D be part of the program versus not part  
15 of the program. Somebody asked a question earlier about why  
16 can't this be subject to the bundling types of payment  
17 constraints, and it was dismissed as, well, it's just a  
18 separate -- you didn't dismiss it, but you just said that's  
19 really hard because Part D is a separate plan.

20 So, my question is, are we then going to dismiss  
21 the idea that bundling can be the way that incentives people  
22 to try to shop for better substitutes for these types of

1 drugs or not?

2 MR. HACKBARTH: I didn't mean at all, Nancy, to be  
3 dismissive. It's a critical issue in my perspective, but  
4 it's a hotly debated issue, a conscious policy choice was  
5 made in establishing Part D to use private insurers for this  
6 particular service and not have it insured also by Medicare,  
7 and there are people who want to reopen that, or who at  
8 least want to for a Medicare Part D package in competition  
9 with the private insurers.

10 But the point I was trying to make earlier is,  
11 having made the decision to use separate insuring entities  
12 has some follow-on implications, and one of them is to  
13 complicate the task of bundling Part D drugs with other  
14 services, except through Medicare Advantage plans that are  
15 doing A, B, and D.

16 And it has some other implications, as well. You  
17 alluded to one of those in your opening statement: Going to  
18 a competitive model for Part D has implications in terms of  
19 purchasing of single-source drugs, which are very expensive  
20 and I think a growing portion of the bill. It is not as  
21 well adapted to that situation as it is where there are  
22 generics available and people can be moved to lower-cost

1 substitutes.

2           So, there are very big issues here. I don't mean  
3 to dismiss them, but they are also very hotly debated.

4           DR. CROSSON: Well, this is a little bit connected  
5 to Nancy's comment and has to do with where we should spend  
6 our energy.

7           So, as I looked at the numbers in the material, it  
8 looked like, at least at the time that it was measured, for  
9 Part B -- and analyzing just 6 drugs, the 6 top drugs, that  
10 accounted for about 7.3 billion, which was about 40 percent  
11 of Part B drugs. For Part D, it was about 3.9 billion,  
12 which was 6 percent of Part D drugs. So, just weighing  
13 them, you might say, well, maybe we'll work on both but  
14 maybe we'll work on Part B first.

15           But the question is, do you have a sense from  
16 looking at this what the dynamics of this is? Is in fact  
17 the pipeline weighted towards what would become Part D drugs  
18 versus Part B? Is a Part B armamentarium been exhausted and  
19 the direction is more towards Part D drugs?

20           DR. SOKOLOVSKY: That's a really good question and  
21 I think it's hard to say. I think the incentive for the  
22 manufacturers is a Part D incentive, but I think it's harder

1 with these large molecules. Infusion is one way, and that's  
2 always going to be a B. And then, when we move to  
3 injectable, to make it a D it has to be a self-injectable.  
4 And so, that's also hard.

5 So, I think there will be more coming on on the D  
6 side, but I definitely don't think it's exhausted on the B  
7 side.

8 DR. CHERNEW: I was just going to say, I think  
9 it's important that we separate two different topics.

10 One of them is one that I don't personally feel  
11 comfortable talking about at great length, and I'm not sure  
12 it's where I think MedPAC should spend a ton of time, which  
13 is a whole series of issues related to approval of follow-on  
14 biologics or biosimilars, or whatever you want to call them,  
15 and questions about the amount of evidence that different  
16 people can use. Those strike me as at least primarily FDA-  
17 type questions, not that they don't have ramifications for  
18 the Medicare Program, they do, but they don't strike me as  
19 an area that at least I feel comfortable talking in great  
20 detail. I'm sure you could educate me, but it seems like we  
21 have an organization to do that.

22 The second one is conditional on having a follow-

1 on biologic, and I'm not sure I know exactly what that  
2 means, but having a medication that has been approved by the  
3 FDA in whatever way and having the FDA develop a system for  
4 monitoring the safety and stuff, which again I view as  
5 fundamentally an FDA kind of issue -- that's my view of line  
6 of responsibilities. I think there are important issues  
7 about reimbursement and more importantly these formulary  
8 requirements and how we do different subsidies and such.  
9 And so, I guess my comment in reading all of this is that  
10 some of the discussion we've had seems to be a little bit  
11 more distracting, although they are important issues to lay  
12 the groundwork, and other parts seem really, as we move  
13 forward, center of what we need to think about, which is how  
14 we deal with requirements for -- the idea, for example, that  
15 all drugs in a class have to be on formulary even as  
16 something similar. That's an important thing when the drugs  
17 are this expensive, and that seems an area that requires  
18 some thought as to what that means, because I think there  
19 are good reasons for that in certain cases, but that doesn't  
20 mean there's always good reasons for that.

21 MR. HACKBARTH: Okay. Thank you very much. And  
22 we'll have a brief public comment period.

1           So, the ground rules are, please keep your  
2           comments to no more than two minutes. Begin by identifying  
3           yourself and your organization. And if you see the red  
4           light come back on, that means you're at the end of your  
5           time.

6           MR. HEAFITZ: Hello, my name is Jonathan Heafitz.  
7           I'm Director of Federal and Regulatory Affairs for the  
8           Pharmaceutical Care Management Association, PCMA.

9           PCMA is a trade association representing the  
10          Nation's Pharmacy Benefit Managers, PBMs, which improve  
11          affordability and quality of prescription drug delivery  
12          through the use of e-prescribing, increased generic  
13          alternatives, access to convenient mail service pharmacy,  
14          and other innovative tools for 200 plus million Americans.

15          I'd like to take this opportunity to thank MedPAC  
16          for your interest in the subject of biogenerics or follow-on  
17          biologics. As you've noted, Medicare spending on biologics  
18          has increased rapidly in recent years, totaling more than  
19          \$12 billion in spending in 2007. With national spending on  
20          biologics expected to grow to \$99 billion by 2010, we  
21          encourage MedPAC to weigh in with Congress, given that the  
22          growth rate is unsustainable for both Medicare and private

1 payers.

2           As you've noted, without a regulatory pathway for  
3 approval for generic biologics, Medicare cannot achieve  
4 significant savings in this the largest growing segment of  
5 prescription medication spending under both Parts B and D.

6           PCMA has long advocated for the establishment of  
7 an FDA approval pathway for biogenerics. In 2007, PCMA  
8 commissioned Engel and Novitt to study the savings potential  
9 from the Medicare Program from enactment of a new approval  
10 pathway for generic biologic medications.

11           Using CBO's projections for Medicare spending for  
12 just subset of Public Health Service Act licensed biologics  
13 in the top 200 Medicare Part B reimbursed categories, the  
14 report concluded that, should FDA be authorized to approve  
15 comparable and overtime interchangeable products, the  
16 Medicare Program could save more than \$14 billion over the  
17 10-year period from 2007 to 2016. We're happy to provide  
18 you with a copy of this study for your reference.

19           PCMA feels strongly that a approval pathway must  
20 be established that's free of administrative barriers that  
21 impede the FDA's ability to approve safe and effective  
22 biogenerics and that empowers the Agency to use its

1 expertise to determine on a case-by-case basis what  
2 scientific data is needed to approve comparable and  
3 interchangeable products.

4 We continue to work with a broad and diverse  
5 coalition of employers, consumers, manufacturers, and payers  
6 for meaningful biogenerics legislation that will increase  
7 access while lowering cost of biologics.

8 PCMA looks forward to working with MedPAC staff in  
9 serving as a resource as you move forward with this  
10 endeavor. Thank you.

11 MS. TODD: My name is Laurel Todd and I'm Director  
12 of Reimbursement and Economic Policy at the BIO, the  
13 Biotechnology Industry Organization. I promise to be quick  
14 so you can go and eat.

15 We appreciate the opportunity to speak before the  
16 staff and the MedPAC Commissioners today. We also  
17 appreciate MedPAC staff's willingness to meet with us and  
18 thoughtfully consider our comments regarding the need to  
19 balance patient safety with incentives for future medical  
20 advancements and breakthroughs.

21 As you are aware, BIO strongly supports the  
22 creation of a regulatory approval pathway for biosimilars.

1 Since the last MedPAC meeting in March, representatives,  
2 Eschew, Insley, and Barton introduced new legislation, H.R.  
3 1548, to establish an abbreviated regulatory approval  
4 pathway for biosimilars that BIO supports because it  
5 provides an effective, reasonable, and safe pathway for  
6 biosimilars.

7           As we have articulated in the past and reiterate  
8 here, due to the fact that a biosimilar product will be  
9 similar but not the same as the innovator product, and  
10 there are a number of complex, scientific, regulatory, and  
11 safety issues that Congress is still debating as part of its  
12 efforts to pass legislation that creates an approval pathway  
13 for biosimilars. For these reasons, BIO believes that it is  
14 most appropriate for MedPAC to consider implications for the  
15 Medicare payment systems after an approval pathway has been  
16 established by Congress.

17           Again, BIO looks forward to working with MedPAC  
18 and appreciates the opportunity to comment today.

19           MR. HACKBARTH: Okay. Thank you.

20           We will reconvene at 1:45.

21           [Whereupon, at 12:50 p.m., the meeting was  
22 recessed, to reconvene at 1:45 p.m., this same day.]



1 suggested last month.

2           The MIPPA mandate asked us to examine the accuracy  
3 of CMS's calculation of county-level fee-for-service  
4 expenditures. This is the information that CMS uses to  
5 determine Medicare Advantage benchmarks in each county.  
6 Based on our discussions with the actuaries at CMS and  
7 reviewing their methodology, we find their calculation  
8 methodology to be accurate for the purpose of producing fee-  
9 for-service expenditure estimates.

10           However, there are a couple of issues that were  
11 specifically mentioned in the MIPPA mandate that merit  
12 attention. These are very technical issues that we will  
13 only talk about briefly in the interest of time, but we'll  
14 be happy to answer any questions you may have during the  
15 discussion period.

16           One issue is the case of Puerto Rico and the  
17 estimation problem that CMS faces in the Commonwealth.  
18 Because over 60 percent of Puerto Rico's Medicare  
19 beneficiaries are in MA plans, and because among the  
20 remaining fee-for-service beneficiaries only a small portion  
21 elect Part B coverage, projecting fee-for-service  
22 expenditures presents a particular estimation problem in

1 Puerto Rico. Although we do not suggest a specific approach  
2 for CMS to use, the estimation of fee-for-service could be  
3 facilitated if MA plans in Puerto Rico provided encounter  
4 data and cost data to CMS to help with the estimation  
5 process.

6 The other fee-for-service estimation issue is the  
7 effect of Medicare beneficiaries using Department of  
8 Veterans Affairs facilities. If Medicare beneficiaries use  
9 VA facilities to obtain care that could have been paid by  
10 Medicare, the associated utilization and expenditure  
11 information would not show up in the claims data used to  
12 calculate average fee-for-service costs, nor does CMS  
13 necessarily have full diagnosis information for these  
14 individuals.

15 CMS has looked at VA data and is now looking at  
16 data on beneficiaries who use Department of Defense  
17 facilities. We believe that if CMS finds that the use of  
18 military facilities has a material effect on average  
19 Medicare expenditures, CMS should make an adjustment to fee-  
20 for-service expenditure estimates at the county level. The  
21 use of VA and DOD facilities is more likely to occur in  
22 areas where those facilities are located. Therefore, this

1 is a very localized issue that needs to be looked at on a  
2 county-by-county basis.

3 We would also mention, as we discussed in the  
4 mailing material, that an adjustment can go in either  
5 direction. That is, benchmarks can go up or down in a  
6 county depending on utilization rates and risk scores of the  
7 users of these facilities.

8 Another fact to consider is that beneficiaries may  
9 continue to use VA and DOD facilities even if they enroll in  
10 MA. In its recently-published notice of MA rates --

11 [Laughter.]

12 MR. ZARABOZO: See, I've lost my voice now.

13 [Laughter.]

14 MR. ZARABOZO: CMS found that based on the VA  
15 data, county rate adjustments were not warranted for 2010.  
16 However, CMS will continue to look at this issue in the  
17 future.

18 A separate issue that we want to talk about in  
19 connection with the fee-for-service estimates is what is  
20 referred to as the ratchets, or the one-sided way in which  
21 county fee-for-service expenditure estimates determine a  
22 county's MA benchmark. Because of the operation of the

1 provision of the law that determines when a county's fee-  
2 for-service rates become the county MA benchmark, in a  
3 ratchet situation, counties have only seen their benchmarks  
4 rise. Such counties do not have reductions in their  
5 benchmarks even if there has been a downward trend in the  
6 county's fee-for-service expenditure levels over the years.

7           The ratchet effect has been significant. As of  
8 2009, over one-third of MA enrollees are in counties with  
9 this effect. The dollar impact of this feature of the  
10 payment system for 2009, that is the amount by which MA  
11 rates exceed fee-for-service due to the ratchet effect, is  
12 several billion dollars.

13           We will now turn to Scott for the next part of the  
14 presentation. Scott will provide a follow-up to last  
15 month's discussion of alternative approaches for setting MA  
16 benchmarks.

17           DR. HARRISON: I am going to now tidy up some of  
18 the discussion of the alternative benchmark setting  
19 approaches from last time.

20           One way to set benchmarks would be to use the  
21 plans' bids. The theoretical argument for setting  
22 benchmarks through bids is that a competitive market would

1 provide the best local cost information and the plans' bids  
2 are as close as we can come to the cost of an efficient  
3 local provider.

4           There are many possible ways that plan bids could  
5 be used to set benchmarks. Payment systems that use  
6 different methods could result in very different initial  
7 benchmarks and different behavioral responses from plan.  
8 Important design features would include, for example, which  
9 bid would set the benchmark, the lowest bid, the medium bid,  
10 the 75th percentile. Would there be an upper or lower limit  
11 on the benchmarks? Once the rules are set, how will plans  
12 respond to the new bidding rules and what strategies will  
13 they use to deal with competition?

14           Regardless of the specific bidding option chosen,  
15 there is a practical problem for quantitative simulation of  
16 a competitive bidding option. Plans do not currently make  
17 county-level bids. They make one bid for an entire service  
18 area, which usually includes multiple counties.

19           If bids determine benchmarks, plans would face  
20 pressure to vary their bidding by county across a service  
21 area and the current bidding data would not be a good proxy  
22 for the resulting bids. We believe that they would try to

1 manage risk by bidding separately for each county. For this  
2 technical reason, we do not present quantitative analysis of  
3 setting benchmarks using the plan bids.

4           However, I do have a slide to let you know what  
5 the current bids look like, but don't get wedded to these  
6 exact numbers because they will change slightly in the  
7 report. The fee-for-service spending numbers along the  
8 bottom are not for counties, but are for plan-specific  
9 service areas. So we have five groups of plans with  
10 differing levels of fee-for-service spending in their  
11 service areas.

12           The chart shows the distribution of the plan bids  
13 relative to fee-for-service spending for each of the five  
14 groups. The group of plans on the left have service areas  
15 where fee-for-service spending averages less than \$675 per  
16 month. The median bid of those plans was 1.13 times fee-  
17 for-service spending, or 13 percent above fee-for-service  
18 spending. We also show that the 25th percentile bid was 108  
19 percent and the 75th percentile was 120 percent of fee-for-  
20 service.

21           Now, as we move to the right, average fee-for-  
22 service spending in plan service areas increases. The ratio

1 of bids to fee-for-service spending declines. And the  
2 variation in bids relative to fee-for-service increases. At  
3 the high end, when the fee-for-service spending averages  
4 over \$900 per month, the median bid is 75 percent of fee-  
5 for-service spending. So if we used bids to set the  
6 benchmarks, we would likely have benchmarks well above fee-  
7 for-service in low-spending areas and benchmarks well above  
8 fee-for-service in high-spending areas.

9           Now, before we leave this slide, I want to make  
10 sure that you know I am saying that the ratio of bids to  
11 fee-for-service are declining, not the bids themselves. On  
12 the left, the bids for areas under \$675 in fee-for-service  
13 spending averages under \$700, while the group on the right  
14 have average bids approaching \$900. So the bids themselves,  
15 which are not displayed on the slide, do increase as fee-  
16 for-service spending increases.

17           Remember last time we examined four different  
18 administrative benchmark setting options. This slide  
19 summarizes the simulation of those options. The first  
20 option would set each payment area's benchmark equal to 100  
21 percent of local fee-for-service spending. The second  
22 option is a hybrid, with a floor of \$618, a ceiling of \$926,

1 and is equal to local fee-for-service in between the floor  
2 and the ceiling. The third option is a 75/25 local/national  
3 blend that was designed to approximate plan costs. And the  
4 last option is an input price-adjusted blend that was also  
5 designed to approximate plan costs while removing variation  
6 in the benchmarks resulting from variation in the local  
7 volume of services in fee-for-service Medicare.

8 All these options are financially neutral to fee-  
9 for-service Medicare, meaning in the first year, they are  
10 equivalent to the option that CBO has scored as saving about  
11 \$150 billion over ten years. But CBO only scored the 100  
12 percent local fee-for-service option, and although all of  
13 these options do start out financially neutral, plan bidding  
14 behavior and beneficiary enrollment choices could result in  
15 differences between these options over the long run.  
16 However, for now, we can only simulate results based on  
17 current bidding behavior.

18 Now, in the first two columns here, you see the  
19 range of benchmarks that would be produced by the different  
20 options. The largest range would be for the 100 percent  
21 local fee-for-service option, where the county benchmarks  
22 would range from \$453 to \$1,285 per month. The input price-

1 adjusted blend has the narrowest range, along with the  
2 hybrid.

3 In the next two columns, we look at the range of  
4 benchmarks relative to local fee-for-service spending.  
5 Under the local fee-for-service option, each county, by  
6 definition, would have its benchmark equal to local fee-for-  
7 service. By contrast, the price-adjusted blend would have  
8 benchmarks in some counties either well above or well below  
9 local fee-for-service spending. One county would have a  
10 benchmark set at 54 percent of its fee-for-service spending  
11 and another county would have a benchmark set at 156 percent  
12 of local fee-for-service spending.

13 Moving over a column, the price-adjusted blend  
14 resulted in the highest availability in our simulations,  
15 probably because it did the best job of recognizing plan  
16 costs. And finally, the local fee-for-service option  
17 allowed for the highest average level of extra benefits  
18 because it would maintain the benchmarks in the high fee-  
19 for-service counties, which also tend to have plans  
20 providing the highest levels of extra benefits.

21 On this slide, the first column represents the  
22 simulation availability results from last time. Some

1 Commissioners were interested in seeing these results using  
2 slightly different assumptions or metrics and I have  
3 included those tables in your mailing materials and I will  
4 briefly summarize them here.

5           Remember, the simulations measure plan  
6 availability by whether the current plan bids are above or  
7 below the simulated new benchmarks. We assume that plans  
8 that bid below the simulated benchmarks would continue to do  
9 so and therefore be available, although the extra benefits  
10 they offer would probably be reduced. This is a  
11 conservative assumption in that plans might bid lower than  
12 they currently do in order to attract or retain market  
13 share.

14           Nancy asked us to examine the likely effects of  
15 benchmark changes by simulating plan availability for  
16 current MA enrollees. Although plans may be available in  
17 all areas, enrollment penetration varies, and if plans left  
18 low-penetration areas, proportionately fewer MA enrollees  
19 than Medicare beneficiaries would be affected, and indeed,  
20 we find that plan availability would be higher under all  
21 options if it were measured for current MA enrollees rather  
22 than for all Medicare beneficiaries. For example,

1 availability would reach 98 percent of all MA enrollees  
2 under the price-adjusted blend compared with 94 percent of  
3 all beneficiaries.

4           And Glenn in particular was interested in seeing  
5 how our larger payment areas might affect availability, so  
6 we simulated overall plan availability using the MSA HSA  
7 definition of payment areas. We assumed that if a plan  
8 served more than 50 percent of the Medicare beneficiaries in  
9 the area, the plan would serve the entire payment area.  
10 Otherwise, they would not serve any of that payment area.  
11 The findings show the same patterns as the simulations using  
12 county-level payment areas, but the availability numbers are  
13 all a point or two lower.

14           And John noted that our simulations assumed the  
15 2009 bidding rules, but MIPPA requires that private fee-for-  
16 service plans have provider networks where two other network  
17 plans are available starting in 2011. CMS recently  
18 published a list of counties where private fee-for-service  
19 plans would need a network in 2011. To address this  
20 impending change, we simulated plan availability assuming  
21 that private fee-for-service plans would not be available in  
22 the listed counties. Under this assumption, plan

1 availability would drop under the base case and all options  
2 when the 2011 private fee-for-service rules are included.  
3 The general pattern among the options remains the same as  
4 under the 2009 rules except that the two blends are more  
5 comparable. Both blends are simulated to result in plans  
6 being available to 85 percent of beneficiaries.

7           And now I am going to turn it over to David to  
8 deal with the remaining topics.

9           MR. GLASS: Thank you, Scott.

10           Last month, there was a concern that extra  
11 benefits were likely to differ across geographic areas in  
12 many of the options. So this month, we introduce a  
13 modification that will help balance extra benefits across  
14 geographic areas.

15           First, we must recognize that the use of services  
16 in Medicare fee-for-service is high in some areas and low in  
17 others. On the one hand, in some low-use areas, fee-for-  
18 service may be a relatively efficient plan. On the other  
19 hand, high-use areas offer more opportunities for MA plans  
20 to manage volume. Plans could be selective in their network  
21 of providers or otherwise manage care.

22           Under current policy, Medicare retains 25 percent

1 of the difference between the benchmark and the bids in all  
2 areas. The remaining 75 percent is called the rebate and  
3 funds extra benefits. In this modification, Medicare could  
4 differentiate its share of the difference between benchmarks  
5 and bids, retaining more in high-use areas and less in low-  
6 use areas.

7           For example, let's look at a high-use area that's  
8 in the first column there and the low-use area, which is in  
9 the second column. The top section is the situation under  
10 current policy, and the numbers here are just illustrative.  
11 They are not pushing a particular policy decision. In the  
12 example, looking at column one, bids are 70 percent of the  
13 benchmark in the high-use area. The difference between the  
14 bid and the benchmark is thus 30 percent, and extra  
15 benefits, which are 75 percent of the difference, it ends up  
16 being 22.5 percent. So in this line, Medicare is retaining  
17 25 percent of the difference. In the lower-use area, the  
18 bid is 90 percent and the extra benefits turn out to be 7.5  
19 percent. So those are much less than in the high-use area.

20           Under the new policy, Medicare retains 60 percent  
21 of the difference in the high-use area and the extra  
22 benefits become 12 percent. In the low-use area, Medicare

1 retains none of the difference and the extra benefits are 10  
2 percent. The difference is now much less between the two  
3 areas and extra benefits would be more balanced.

4 In both cases, there would be a substantial amount  
5 of extra benefits to attract beneficiaries to the plans, and  
6 Medicare could set the sharing function each year to  
7 preserve budget neutrality.

8 DR. MARK MILLER: Can I just say one thing here  
9 quickly for the Commission and for the public. This report  
10 is a series of ideas. The Hill has asked us to give them  
11 different ideas, and I just want to be clear. This is a  
12 different way to kind of go at it instead of through the  
13 benchmarks, a different way to kind of equalize benefits  
14 through what the government retains. We are not proposing  
15 this as a change, just another idea to put in the report.

16 MR. HACKBARTH: Just on that point, so you see  
17 this as an alternative to the benchmarks, changing the  
18 benchmarks, or in addition to --

19 MR. GLASS: No. This would be in addition to  
20 setting the benchmarks, and it would work under any of the  
21 options. If you think about the 100 percent of fee-for-  
22 service option, you could see how this would kind of

1 balance. In the 100 percent fee-for-service options in very  
2 high-use areas, fee-for-service is quite high and what this  
3 would do would be the calculation of the extra benefits  
4 would be changed. So you'd use the benchmark, the 100  
5 percent fee-for-service to set the benchmark, but then when  
6 you came to how much of that difference goes -- remains with  
7 the plans and how much --

8 MR. HACKBARTH: Let me restate my question. You  
9 began by saying that this was an approach to address  
10 perceived regional inequity in additional benefits. Some of  
11 the alternatives that we're looking at for benchmarks,  
12 changing the benchmarks, are also aimed at addressing that  
13 same issue. So one approach would be to adopt 100 percent  
14 of fee-for-service, local fee-for-service, as a way of  
15 setting the benchmarks and then use this tool to address  
16 perceived regional inequity --

17 MR. GLASS: Right.

18 MR. HACKBARTH: -- as opposed to combining this  
19 approach with benchmark setting policy also designed to  
20 address regional inequity. I wasn't sure which way you saw  
21 it being used.

22 MR. GLASS: Yes. I mean, this most naturally

1 would go with the 100 percent fee-for-service option.

2 MR. HACKBARTH: Yes.

3 MR. GLASS: I think that's the most -- that's the  
4 clearest example.

5 So last month, you discussed the transition  
6 strategy, and briefly, whenever we've recommended setting  
7 benchmarks at the 100 percent of fee-for-service, we've  
8 acknowledged that there should be a transition to the new  
9 benchmarks to limit disruption to beneficiaries. So under a  
10 transition, the new benchmark could be phased in over  
11 several years.

12 Because the Commission is especially concerned  
13 about retaining high-quality plans, a key point of the  
14 transition should be to limit the loss of any high-quality  
15 plans. During the transition, extra payments could be made  
16 to plans that have demonstrated good performance on quality  
17 indicators. As benchmarks are lowered to attain financial  
18 neutrality, high-quality plans' payments would not decrease  
19 as fast and low-quality plans would either improve or likely  
20 exit the program as their payments decreased.

21 Of course, the transition would lower savings for  
22 a few years. CBO's estimated ten-year savings are

1 predicated on full implementation of the 100 percent  
2 benchmarks in 2011. If full implementation were delayed,  
3 savings during the transition would be somewhat lower.

4           You also asked us last month to discuss the goals  
5 of the program in the report, so I will summarize that  
6 discussion here. The original goals of the program were to  
7 import care coordination and other innovations into Medicare  
8 through private plans. Plans could do things that fee-for-  
9 service Medicare could not, such as limit their networks and  
10 manage care. Payments were set to 95 percent of fee-for-  
11 service so Medicare would save money. Over time, as people  
12 became concerned over some areas having private plans and  
13 more extra benefits than other areas, the goals shifted, and  
14 they shifted to private plans in all areas, including areas  
15 where private plans had not been financially viable, and  
16 extra benefits through private plans to all beneficiaries.

17           The result is the MA program of today and our  
18 familiar litany of concerns. The Commission is concerned  
19 that payments under the current MA payment system were too  
20 high. They are well above the cost of caring for similar  
21 beneficiaries in Medicare fee-for-service. Medicare is  
22 subsidizing the participation of inefficient plans that are

1 not designed to coordinate care and improve quality and may  
2 just mimic fee-for-service Medicare at a higher cost. These  
3 extra costs mean all beneficiaries, whether or not they  
4 enroll in MA, pay higher premiums. Higher costs also  
5 increase the burden on taxpayers and are expected to make  
6 the Trust Fund insolvent 18 months earlier. Even though  
7 some beneficiaries get extra benefits from MA plans,  
8 Medicare is heavily subsidizing those extra benefits, as  
9 much as \$3.26 for each dollar of extra benefits in private  
10 fee-for-service plans. Finally, despite high payments,  
11 high-quality plans are available to only 50 percent of  
12 beneficiaries and only 31 percent in rural areas.

13           To wrap up, we're on schedule to report to the  
14 Congress in June. This is our final presentation on this  
15 report. I want to invite your comments and discussion.  
16 Does the proposed modification to balance extra benefits  
17 make sense to you? Are there other approaches you would  
18 like us to consider, such as differentiating Part B premiums  
19 or taking bidding more into account in some areas than  
20 others? Do you have any additional feedback on the  
21 transition policy? Did our discussion of goals for the  
22 program reflect your views? And are there any other issues

1 of concern that you want us to address?

2 MR. HACKBARTH: Thank you. Could I ask a  
3 clarifying question? Could you explain to me how we arrive  
4 at the 75/25 national/local?

5 DR. HARRISON: You mean why we picked the 75/25?

6 MR. HACKBARTH: Yes, right. I've read through  
7 that passage a couple of times and I couldn't quite get it.

8 DR. HARRISON: We ran our regression to see how  
9 the bids varied with fee-for-service costs and we got that  
10 plan bids rose, on average, 75 cents for every dollar rise  
11 in local fee-for-service costs.

12 MR. HACKBARTH: Okay.

13 DR. HARRISON: So in a sense, you're adding -- the  
14 national part is really just a constant. You're adding a  
15 block of dollars and then -- at the beginning, and then 75  
16 percent.

17 MR. HACKBARTH: I'll think about that some more.

18 Let me see hands for round one clarifying  
19 questions. I have Nancy and then Mike and John.

20 DR. KANE: I have two questions. One is on Slide  
21 9. Just explain to me sort of the timing of the way this  
22 would work, because my understanding is that a lot of the

1 decision making on the part of the beneficiary relates to  
2 how those extra benefits appear to them, and so how would  
3 this sort of play itself out in the beneficiaries choosing  
4 plans? How often would those -- how would those extra  
5 benefits change annually, I guess, and even in the  
6 transition? Is it like watching a revolving door, where you  
7 are getting a lot of churning, or would it just -- I'm just  
8 trying to understand the implications for how plans would  
9 market themselves to beneficiaries with that going on in the  
10 background.

11 MR. GLASS: Well, this is related to the use of  
12 Medicare services in each of the areas, so you could  
13 probably -- I don't think that changes that dramatically  
14 year to year. So if you looked at a high-use area, it would  
15 probably be a high-use area the next year. So you can set  
16 this in advance, in other words, and the plans would know  
17 this when they bid, and therefore the beneficiaries would  
18 see the benefit package they would get at the time of open  
19 season.

20 DR. MARK MILLER: The plan would bid knowing that  
21 in their area, that the government is going to treat how  
22 much they take back on the basis of some calculation like

1 this.

2 DR. KANE: So there would be a big change in the  
3 transition years, but then it would sort of annually sort of  
4 be the same, not change a lot once --

5 MR. GLASS: Yes. Yes. The high-use areas tend to  
6 stay high-use areas, yes.

7 DR. KANE: And then my second question, Slide 11,  
8 one of the results you mention is that the Part B premium  
9 is, I don't know, \$3 a month higher. What would be the  
10 implication of having the Part B premium higher only for MA  
11 beneficiaries and taking back the subsidy from all the non-  
12 MA beneficiaries as another way just to address this fact  
13 that it's not fair to make everybody pay for a subset of the  
14 population's choices and extra benefits?

15 MR. GLASS: I'm not sure what the implications  
16 would be. I mean, you --

17 DR. REISCHAUER: How much would it be?

18 MR. GLASS: You mean the \$3?

19 DR. REISCHAUER: What?

20 MR. GLASS: Would the \$3 be different?

21 DR. KANE: If you said, okay, I'm in traditional  
22 Medicare. I'm taking your \$3 away --

1 DR. REISCHAUER: No, it's \$3 for everybody, but, I  
2 mean, you're just going to put it all on the --

3 DR. KANE: The MA people.

4 DR. REISCHAUER: -- twenty-X percent that are --

5 DR. HARRISON: Are you looking for like \$350  
6 million a year? Is that what you're looking for?

7 MR. HACKBARTH: Roughly, what, 45 million, and  
8 roughly 20 million are in MA --

9 MR. GLASS: Twenty-two percent, yes. About --

10 MR. HACKBARTH: Twenty-two percent, excuse me,  
11 right. Yes. And so -- yes.

12 MR. GLASS: I have always been told not to do math  
13 in public, so --

14 [Laughter.]

15 DR. KANE: The \$15 a month for the MA person as  
16 opposed to the \$3 a month.

17 MR. GLASS: But the MA plans are allowed to reduce  
18 the --

19 DR. KANE: Well, they have to use their benefits -  
20 - okay. They have to use their rebates for that.

21 DR. REISCHAUER: They have less of something else.

22 MR. GLASS: Yes, so they --

1 DR. KANE: Should we be also considering that as a  
2 less-disruptive way to level out some of the inequities of  
3 the current way it works? Just a thought.

4 MR. GLASS: That's an idea.

5 MR. HACKBARTH: Yes. At the last meeting, I had  
6 suggested the idea of, you know, if we want to benefit  
7 Medicare beneficiaries in low-use areas and we want to give  
8 them additional benefits in as low-cost way as possible, the  
9 lowest-cost way to do that is to reduce their Part B  
10 premium, and so what you are suggesting is sort of a cousin  
11 of that idea. It's not exactly the same thing.

12 DR. MARK MILLER: She raises the premium for the  
13 MA beneficiaries, and you were saying raise and lower in the  
14 high- and low-utilization --

15 MR. HACKBARTH: And so I would be saying reduce it  
16 for traditional Medicare beneficiaries in low-use areas and  
17 Nancy is saying increase the premium for --

18 MR. GLASS: But the other thing, Nancy, is if you  
19 reset the benchmarks to 100 percent of fee-for-service --

20 DR. KANE: That's another -

21 MR. GLASS: -- then you don't need to do that, I  
22 don't think.

1 DR. KANE: This is a separate policy option, I  
2 meant.

3 MR. GLASS: Oh, I see. Okay.

4 DR. KANE: I think it's --

5 MR. GLASS: Given that you don't reduce the other  
6 part --

7 DR. KANE: If we have -- or in the transition  
8 process of all the -- I am sure there is a little political  
9 opposition to reducing the MA to 100 percent, although I  
10 know it's been spent five times in the way we're going to  
11 finance health reform, but what would be the option instead  
12 of just making it, okay, you're in MA but your Part B  
13 premium has to reflect the cost of that program, and  
14 changing it to reflect that. And that would be the trade-  
15 off, I guess. People could sort of think about which  
16 political option would be better.

17 MR. GLASS: It would also be a little less  
18 targeted because everyone in MA, whether they were getting a  
19 tremendous amount of extra benefits or very little extra  
20 benefits, would be paying for it rather than -

21 DR. KANE: Even modify that, too.

22 MR. HACKBARTH: I have Mike and then John.

1 DR. CHERNEW: So if I understand how you did the  
2 simulations behind all of the charts, you basically looked  
3 at current bids, assumed that there was essentially no  
4 behavior change one way or another, and if the bid was under  
5 or over the revised benchmark according to the formula, you  
6 assumed the plan was in or out, and you didn't discuss a lot  
7 what would happen. I think the line in here is something,  
8 they would probably change their benefits accordingly. But  
9 I think what you assumed literally is the bid stays the  
10 same, so by definition the extra benefits have to change.  
11 If the benchmark goes down, there is less coming back. So  
12 my first question is, is that the right characterization?

13 My second question, which right now I just want  
14 sort of the yes/no question, is have you looked at how those  
15 assumptions in the simulation match up with some of the  
16 other literature on how plan behavior has changed when  
17 benchmarks have changed. So there has been some literature  
18 that has used changes in benchmarks. Kaiser has some paper  
19 and stuff that has tried to say what's happened when we've  
20 done this. And I'm just not sure -

21 DR. HARRISON: No.

22 DR. MARK MILLER: The other part of that answer --

1 I know it was just yes/no --

2 [Laughter.]

3 DR. MARK MILLER: So you did respond, but he  
4 didn't say it to me, yes/no. One thing you should know is  
5 that Carlos has written extensively on what happened last  
6 time we got changes and how plans moved around. So if for  
7 part of your discussion later or elsewhere, Carlos can tell  
8 you in some detail what kinds of things happened the last  
9 time there was some shifting among the plans.

10 MR. BERTKO: Just a quick question here to confirm  
11 what I think you've been saying. Focusing strictly on the  
12 MSA/HSA payment region type of things, I think you can  
13 probably combine that with any of the four -- actually five  
14 payment change versions that you put and, one, I'm a big fan  
15 of that because I think it smooths out what are currently  
16 some very funny irregularities in places. Is that a true  
17 statement?

18 MR. HACKBARTH: Any other clarifying questions?

19 Let me see hands for round two questions,  
20 comments.

21 DR. DEAN: I just have a question about how this  
22 all came about, this whole extra benefits concept came about

1 in the first place, because it seems to me that it really  
2 confuses the whole issue, that if -- wouldn't it be simpler,  
3 and I obviously don't understand how this all evolved, but  
4 just to have a fixed benefit package and let the plans bid  
5 on that, because we're trying to get -- that's where the  
6 problem has originated, because we didn't have a standard  
7 set of benefits and so we started adding in things and then  
8 people got upset because somebody in one place was getting  
9 more than somebody else and the subsidies got all confusing  
10 and so forth.

11           It seems to me we have made it -- it's almost --  
12 there's sort of an analogy with private insurance where you  
13 can't compare one policy with another because none of them  
14 are comparable. They all have a different set of benefits.

15           MR. GLASS: Well, that's the approach CPAC took,  
16 and Bob could speak to why. But that's exactly the approach  
17 they took. They defined the set of benefits in an area.

18           DR. REISCHAUER: I mean, but in a sense, the MA  
19 plans are bidding against A/B for a standard beneficiary, so  
20 in effect, they are, but they're then influenced -- how much  
21 they get paid is influenced by the existence of these  
22 benchmarks.

1 DR. DEAN: It seems to me that we've sort of taken  
2 away the incentives for the plans to really manage the care  
3 because they don't really get any of the benefit if they do,  
4 because the lower their bid, it just has to go for extra  
5 benefits. Now, they may get more enrollees, I suppose --

6 MR. HACKBARTH: They get more enrollees and they  
7 get more profit through that mechanism. So they do have an  
8 incentive to bid low. So the difference -- there are a  
9 couple of differences. One is that, as Bob says, they are  
10 bidding on the A/B benefit package, so it is a fixed benefit  
11 package. But they are bidding against benchmarks that are  
12 administratively set. They're not driven by the competitive  
13 prices.

14 And then there is basically the requirement that  
15 they give back the difference in the form of added benefits  
16 and reduced premiums and the like as opposed to just -- or  
17 provider reimbursement as opposed to just cash discounts to  
18 the beneficiaries. What is that?

19 DR. CHERNEW: By lowering the Part B premium.

20 MR. HACKBARTH: Yes. But you could say, in  
21 addition to that, I'm going to give you a check. That's not  
22 one of the options on the table.

1           MR. ZARABOZO: But part of the reason for the  
2 extra benefits historically was, you know, in 1982 when they  
3 were trying to figure out how much is the appropriate  
4 payment for plans, that's when the 95 percent of fee-for-  
5 service, there was still -- people knew at that time that  
6 plans were getting better selection based on history of  
7 group practices and what kind of Medicare beneficiaries they  
8 were getting. So the question was, how much do we pay these  
9 plans? Ninety-five percent gets us around the risk  
10 adjustment issue since we don't know how to do risk  
11 adjustment.

12           One of the options at the time was for the plans  
13 to accept essentially what they bid, to use the modern  
14 parlance, and return the rest to the government. Another  
15 option was to provide extra benefits, and one of the reasons  
16 they wanted to provide extra benefits is because at that  
17 time, preventive care, for example, was not covered by  
18 Medicare. So it was viewed as a reasonable thing to have  
19 plans provide things like preventive care, which would be a  
20 non-Medicare-covered benefit, using dollars from the  
21 government to do so. So there's a little bit of a long  
22 history related to extra benefits, but how it's turned out

1 today is a little bit different probably from what the  
2 original view might have been.

3 DR. STUART: This will be quick. Did we learn  
4 anything about Puerto Rico's experience other than what  
5 happens in Puerto Rico? And the reason I say that is that  
6 here's a case where you have a very high penetration of  
7 managed care. You have a very low utilization of, or uptake  
8 in Part B, which is obviously unique to Puerto Rico. But it  
9 does provide an opportunity to examine what happens in terms  
10 of selection into plans at one extreme.

11 And I guess the question is -- well, one of the  
12 questions I had in reading this -- this is really quite  
13 fascinating to anybody who's ever gone to Puerto Rico, I  
14 guess. But the reason for the low uptake in Part B is  
15 presumably because the prices of medical services are so  
16 cheap relative to the national standard Part B premium?

17 MR. ZARABOZO: And relative to the income in  
18 Puerto Rico. Very low income in Puerto Rico, yes. And  
19 there's a lot of issues involved in how people get into the  
20 MA plans. There's the dual eligibles, that Puerto Rico is  
21 filling in the Part D, the Medicaid Part D coverage through  
22 the MA plans in many cases, through agreements with the MA

1 plans. So there are many factors involved in the situation  
2 in Puerto Rico.

3 DR. STUART: So the answer is we don't learn  
4 anything about it --

5 MR. ZARABOZO: So it sounds like it's specific to  
6 Puerto Rico.

7 MR. HACKBARTH: Puerto Rico is unique, right?  
8 Let's see, I have Nancy and then Jay.

9 DR. KANE: Well, I guess I'm just sort of getting  
10 at the issue of what goals should we have here at this  
11 point, and they've obviously shifted to something I don't  
12 really -- I think even that, the goals that they've shifted  
13 to, I think people are willing to say that's not the  
14 greatest set of goals anymore because we can't necessarily  
15 afford them.

16 But I'm wondering what our goals should be going  
17 forward. To me, one of them should be the MA beneficiaries  
18 should bear their fair share of MA costs, that it shouldn't  
19 be somehow subsidized by the rest of the program. I mean,  
20 that was part of that Part B question, too. If you're going  
21 to have this kind of option, you shouldn't say the whole  
22 program should subsidize it. It should be an equitable

1 distribution of who's benefitting, especially from the extra  
2 benefits.

3           And I would think we'd want to choose a mechanism  
4 that minimizes the disruption to existing enrollees, not  
5 just -- so one of the goals was everybody should have a  
6 choice of these plans, but in the five, six years that  
7 they've had this, we've had it, we've got about 20 percent  
8 of people in them now and it's that 20 percent I would  
9 rather protect than worry about whether the 80 percent have  
10 access to a plan that they're not going to choose, in  
11 looking at the different options. So there are some that  
12 seem less disruptive to existing enrollees than others. So  
13 I just --

14           DR. REISCHAUER: So you're thinking about what the  
15 third box should be on the table, which is --

16           DR. KANE: Yes, off to the right. Yes. What  
17 should --

18           DR. REISCHAUER: -- not what was, what is, but  
19 what should be?

20           DR. KANE: What should be, yes. Yes. And see if  
21 we can articulate that, because then I think it'll guide us.  
22 I mean, this was fascinating to read, but it was also mind-

1 boggling. I'm just trying to think, how do you make this  
2 simple and say where you're heading and where are you going  
3 with it and what do we want to achieve here, and I'm just  
4 trying to put some of those principles on the table and  
5 welcome other people's principles.

6 MR. GEORGE MILLER: Glenn, could I ask a question  
7 just on Nancy's point? Is your proposal that the \$3 extra  
8 would cover all the costs that all of us are subsidizing?  
9 Would that mathematically substitute, or would that just be  
10 -- I mean, do we not still subsidize?

11 DR. MARK MILLER: And I was --

12 DR. KANE: Taxpayers are also --

13 DR. MARK MILLER: Yes, because remember, the Part  
14 B premium is set to cover 25 percent of the cost.

15 DR. KANE: Right.

16 DR. MARK MILLER: So even if you said your premium  
17 has to reflect the total amount of the beneficiary's piece  
18 of that in MA, you still would have a government -

19 DR. KANE: The taxpayer.

20 DR. MARK MILLER: -- in a very significant --

21 DR. KANE: And I don't know how you equalize that  
22 part, but it seems like we're paying an awful lot to have

1 this choice that costs us an awful lot, and the most  
2 inequitable piece is that the beneficiary is affected by it.  
3 So at a minimum, that should be a goal, is to eliminate the  
4 fact that the beneficiaries who don't have this plan are  
5 paying more for it. I don't know how to deal with the  
6 taxpayer part.

7 DR. CHERNEW: But there's a Miami-Minnesota issue  
8 in traditional Medicare, as well. There's a lot of these  
9 subsidies flying around. So to get to making the  
10 contribution equitable is a lot more than just --

11 DR. KANE: Well, that's why I sort of stopped with  
12 just the Part B premium as opposed to going on into all the  
13 other subsidies.

14 DR. CHERNEW: That's also a Part B premium issue,  
15 right, the fact --

16 DR. KANE: It belongs all over the country, so I  
17 think you're not changing -- people belong to MA all over  
18 the country, so you still have the Miami to Florida subsidy.

19 DR. CHERNEW: But that's for Part A. The Part B  
20 premiums are probably higher than they would be because  
21 they're spending so much money in Miami. I think that's  
22 right.

1 DR. KANE: That's true, but I'm not trying to deal  
2 with that inequity. I'm just saying the fact that you're MA  
3 or not MA should be a goal. Now I agree, we should  
4 certainly try to fix those others, but I don't have a plan  
5 for that.

6 DR. REISCHAUER: In one sense, this is less  
7 inequitable, inequity than some of them because the people  
8 in Minnesota have the choice of getting on the gravy train  
9 or not, and with traditional, they don't. I mean, the  
10 Miami-Minnesota one, they don't have the choice of getting  
11 their services in Miami.

12 MR. HACKBARTH: Could you restate your second  
13 goal?

14 DR. KANE: Oh, yes. So this was something I  
15 brought up last time, and you addressed it a little bit.  
16 Who's disrupted when you start to go to 100 percent fee-for-  
17 service under the different models, and just to me, it would  
18 be best -- my top priority would be to minimize disruption  
19 to those who are already enrolled rather than guaranteeing  
20 choice to all beneficiaries. So all beneficiaries. And  
21 some -- I think you'd probably come out with the same model  
22 either way, but it was a little -- it's a lot to understand

1 here, but you've presented this as let's make sure we have  
2 guaranteed the maximum number of plan choices geographically  
3 and I'm kind of going, why don't we just make sure that the  
4 current enrollees -- that we protect them first and protect  
5 choice second.

6 DR. HARRISON: So that would be the second column.

7 DR. KANE: Yes. The current MA enrollee be the  
8 criteria by which we decide which of these options might be  
9 the most easily -- the least disruptive.

10 DR. REISCHAUER: But then you want to raise their  
11 premiums --

12 DR. KANE: Yes. I still want to raise their  
13 premiums.

14 DR. REISCHAUER: Nancy speaks with a forked  
15 tongue.

16 DR. KANE: I don't want to take away their choice.

17 DR. CROSSON: Yes. I wanted to focus just for a  
18 second on the page and a half in the text on the transition  
19 considerations and see if I understand it. We've talked  
20 about this before, but it looks to me like there are sort of  
21 two parts to this and two phases that you describe, and I  
22 want to make sure I understand it right because it looks

1 like it implies two different quality performance comparison  
2 processes.

3           So the first one would be during the transition,  
4 and then there would be some quality performance comparison  
5 made among plans. For example, earlier in the chapter, it  
6 describes the star rating system as a way to do that. And  
7 then at the end, it talks about after the transition, a  
8 second, you know, quality-based set of considerations that  
9 would impact payment. But in the second one, it talks about  
10 comparing presumably high-quality MA plans to fee-for-  
11 service. I just want to make sure that is -- because that  
12 then --

13           MR. GLASS: That's correct. Yes --

14           DR. CROSSON: That then is going to, I think, be  
15 an issue, or it's going to come up for discussion, or it  
16 will be impacted by the discussion we have in the next  
17 session, which has to do with the complexity of measuring  
18 Medicare Advantage versus fee-for-service. So that is the  
19 intention, is to have --

20           MR. GLASS: That's correct.

21           DR. CROSSON: -- one process during the  
22 transition, another set of recommendations after the

1 transition, and the second set of considerations would be  
2 Medicare Advantage, presumably high-quality Medicare  
3 Advantage plans versus a measurement process in fee-for-  
4 service.

5 MR. HACKBARTH: And the reason for the bifurcated  
6 approach is just the necessity. One, it has to happen in  
7 the short term before we have the comparison to the ambient  
8 level of fee-for-service quality, before that technology is  
9 in place. And so in the short run, all she can do is use  
10 cross-plan comparisons.

11 Ron, earlier today, you raised the issue related  
12 to this --

13 DR. CASTELLANOS: It really is the same issue, but  
14 I think I'm putting the cart before the horse. We have to  
15 have equal comparison before we can make any determination.

16 What I was concerned about is your last sentence  
17 there, that after the transition, if the MA plan provides  
18 better quality than the fee-for-service plan, they would be  
19 paid more than the fee-for-service plan, and I was concerned  
20 about we always talked about equity, equal equity.

21 MR. HACKBARTH: And so this is a question as  
22 opposed to a definitive statement, but the question I always

1 ask myself is why would you ever pay more than it costs  
2 traditional Medicare to provide the same services, given our  
3 budget problems and sort of multiplying and not getting  
4 smaller? In the one answer that I can think of that is a  
5 plausible one is if the plan provides demonstrably better  
6 quality than would exist in the community otherwise, you  
7 might say, okay. We are willing to pay you for that. And  
8 so that is the idea there, but it's a suggestion for  
9 consideration as opposed to a definitive statement of that's  
10 what the Commission is proposing.

11 DR. CASTELLANOS: I'm okay with that.

12 DR. SCANLON: Related to that point, though, that  
13 may be sort of a situation that never arises, because if we  
14 think that there's so much inefficiency and waste in  
15 Medicare that this good-performing plan may also be able to  
16 generate significant efficiencies and therefore some of the  
17 reward is allowing them to keep the efficiencies, we don't  
18 have to pay beyond what the inefficient fee-for-service  
19 system cost. I mean, you could have the pay-for-performance  
20 reward, but you also can sort of capture some of the savings  
21 from better efficiencies --

22 MR. HACKBARTH: I see what you're saying, but sort

1 of the case that I was thinking of is what about Oregon or  
2 one of those places where it's challenging for a private  
3 plan to get much below traditional Medicare costs, because  
4 traditional Medicare costs not only have low unit prices,  
5 but also low utilization rates in those places, and low  
6 administrative costs, et cetera, et cetera. And so I'm  
7 thinking very parochially.

8 In Oregon, why would you ever pay a private plan  
9 more than that, and the only plausible reason I could think  
10 of is if they can say, look, I improved the care in this  
11 community above the level that exists in fee-for-service.  
12 I'm not getting rewards by being able to undercut on price.  
13 So the only reward for me would be a bonus for improving  
14 quality. That's the case that I'm thinking about. But  
15 again, it's just a proposal for consideration as opposed to  
16 something that we've endorsed.

17 Let's go through the list. I've got John, Jennie,  
18 Mike. John?

19 MR. BERTKO: Let me, if I can take my time this  
20 time, I'm going to respond to what I think are a good set of  
21 alternatives but also try to focus Commissioners' attention  
22 on maybe a couple of them with some points along the way

1 there. And so, again, this is my opinion on what could work  
2 best.

3           Scott, if you could put up, I think it's Slide 8,  
4 which is the one that lists the different variations. No,  
5 it's 6. Sorry. Okay. Looking at these, we are -- I mean,  
6 Medicare needs to save some money. I just accept that.  
7 We're on record for that. The question is how to get from  
8 here to there.

9           My own feeling is we ought to choose a rational  
10 way to get there wherever possible, and on this I'd like to  
11 take two of these and put them on the table and tell you why  
12 the other two fall off the table and then comment on one in  
13 particular which can solve other things.

14           I think competitive bidding is the most rational  
15 way to recognize market differences in an area. Like Glenn  
16 said, Portland has got some issues that I've been aware of  
17 as well as a couple of other localities in the country. And  
18 so it's an automatic way to do it. It's got the automatic  
19 advantage of places where there's a lot of fraud and abuse,  
20 of getting down to a right number quicker than perhaps under  
21 any administrative scenario.

22           I will also say that we probably want to consider

1 an administrative way to set rates, as well, and I'd suggest  
2 that the blend is the best of the three that are here, or  
3 the alternative -- I'm sorry, it's the 75/25 blend, I've  
4 used that word on that -- because it recognizes the demand  
5 side that is a fact of life in a number of markets and  
6 doesn't arbitrarily cut it.

7           The hybrid version, which is the one with the  
8 floors and the ceilings, if I'm remembering right, and I'm  
9 hoping Carlos or Scott nod, strikes me as being susceptible  
10 to tinkering, and so I throw that one out right away.

11           And then the input price-adjusted one, I think is  
12 purely arbitrarily. That is, you showed the example of  
13 Minneapolis versus Miami. I think we could probably show 15  
14 other examples of things that make little sense.

15           So with that, let me then go and talk about the  
16 competitive bidding mechanism and try to convince you. I  
17 realize I'm on my soapbox now, but I ask for your ability on  
18 this. If you could flip back one more slide -- yes.

19           So here, even if -- I would suggest two things can  
20 be learned from both this slide and from the limited  
21 evidence from Part D. The first is that those bands are  
22 likely to compress under competitive bidding, and so they

1 would also compress downward. And so in the best of  
2 circumstances, the one on the far right side, the 0.69 to  
3 0.89 would probably compress around a range of 0.7-  
4 something, so there are savings to be had there.

5 I would also suggest that when you're bidding --  
6 and Tom, this is a version of your question -- we are in a  
7 benefits competition model right now where the win comes  
8 from enrolling people at whatever benefit level you can  
9 enhance them in here. If you turn it to price competition,  
10 and here I'm going to suggest bidding on the A/B benefit  
11 package, plain vanilla, this would also serve most likely to  
12 drive downward each of those ranges a bit. Some may be in  
13 that left-hand bracket, which is a Portland or somewhere  
14 that's hard to get to, maybe some more on the high-payment  
15 areas, which are the far right-hand side, but generally  
16 across the board, it could serve to save a fair amount of  
17 money.

18 Now, I'm going to take this competitive bidding  
19 model and make it a little bit fancier to satisfy some other  
20 things. Right now, it operates under the KISS principle.  
21 It is really simple. Bid on the A/B. Compress bids towards  
22 things.

1           Number one, let's try to get rid of benefit  
2 differences across regions, and here, rather than -- and you  
3 can set the benefit win a variety of ways which don't matter  
4 too much to me, but rather than give back against the  
5 benchmark, I would suggest that benefit increases be earned  
6 on a p-for-p type of basis, and I can see the somewhere  
7 between four to 6 or 7 percent earned on a step-wise basis  
8 for doing one thing, you know, having providers with HIT,  
9 you win one percent. For doing something else, you win 2  
10 percent. For doing something else, you win a third percent,  
11 et cetera. So across the country, good plans could win the  
12 same five, six, 7 percent. But the bids and the savings  
13 would be in this particular mechanism.

14           I would also say, and just repeat myself here,  
15 that in this right-side where high-payment areas, you could  
16 save the most money and you could immediately attack things  
17 like fraud and abuse because it would be an automatic  
18 mechanism to going after that money. I mean, the plan that  
19 I was with hated fraud and abuse. I'm not sure we were that  
20 much better than Medicare and CMS, but I think we were  
21 better because it was a local basis and in some ways it was  
22 our money that we were spending and saving.

1           Another component of it, if you wanted to put some  
2 suspenders on my belt of competitive bidding, is you put a  
3 cap in on the top end of the bid, and arbitrarily I'll say  
4 it's 110 percent, because there is some recognition that no  
5 matter what happens, there ought to be some pressure on the  
6 top end to get particularly good deals.

7           Let's see. I think that is all the points I was  
8 trying to make.

9           DR. KANE: Would you put a benchmark in there?

10          MR. BERTKO: No benchmark. You do not -- you  
11 don't need a -- well, you could. I mean, I said 110 percent  
12 because I'm going to recognize that there are some areas  
13 where it is not only difficult, but exceedingly difficult to  
14 get down to 100 percent. I mean, I'm aware of the Portland  
15 situation and I agree with Glenn's comments, and there are a  
16 couple of others that are in that, where there are good to  
17 very good plans that would be there.

18          Oh, I know the last part of this. In the win on  
19 one percents, there is yet more room for competition. I'm  
20 aware that -- for example, I would send the benefits to a  
21 particular source of things as opposed to have as much  
22 benefit variation as we do today. Some plans might be able

1 to pay for a maximum out-of-pocket with one to 2 percent of  
2 their revenue. Other plans might need 2 to 3 percent, and  
3 inefficient plans that still qualified might need 3 to 4  
4 percent. And so there would be competition within that and  
5 the competitive bid mechanism itself might add a small  
6 amount of money, in the \$10 range, whether you were above or  
7 below the way the competitive bidding benchmark was set.  
8 And so in every instance, I've suggested here making a  
9 mechanism that increases competition, thus driving down  
10 costs.

11           And the last -- oh, the very last comment is why  
12 should we stop at trying to be at 100 percent of fee-for-  
13 service? Most of the revenue -- I won't say most. A lot of  
14 the revenue, and I'll look to Carlos, Scott, or David to say  
15 this, is driven from high enrollment in high-payment areas.  
16 Those are the places where we can go below 100 percent, and  
17 I think we owe it to the mechanism that we redesign to go  
18 below wherever it's feasible and to float above wherever we  
19 can't possibly get there.

20           Okay. Sorry for the long discursion.

21           MR. HACKBARTH: Let me just say a word about what  
22 we're doing. We're not striving in this report to produce a

1 recommended method. Our task here is to lay out different  
2 approaches and analyze their impact, their conceptual pros  
3 and cons. So I just wanted to make sure everybody  
4 understands we're not trying to get to a point where we say,  
5 oh, that's the combination that I'm prepared to vote for.

6           The second point is that as John's comment  
7 illustrates, there are ways that you can take a type, you  
8 know, one of these methods and modify it in various ways,  
9 add bells and whistles to achieve certain policy goals. So  
10 there are a lot of different permutations of things and  
11 trying to come up with the right combination, the right set  
12 of permutations, I think is beyond the scope of what we can  
13 do in the next few minutes.

14           So just a couple of comments to try to frame the  
15 further discussion. I had Mike -- you had your hand up --  
16 and Jennie dropped out.

17           DR. CHERNEW: Thank you. So I have a few  
18 questions that I think are brief, but the answers might be  
19 longer. The first one is, I would love to hear Carlos's  
20 view of what we learned from the other literature about how  
21 plan behavior changes in response to benefit benchmark  
22 changes. What do the plans do when we change their

1 benchmarks and how will that fit with the assumptions?

2 I'm very interested in your thoughts about how the  
3 idea of a spillover between the systems, between the MA  
4 system and the fee-for-service system, would influence your  
5 thinking about this. I think the literature overwhelmingly  
6 suggests there's a connection between the markets, that what  
7 happens in markets with a lot of MA plans influences what  
8 care and practice patterns and a whole bunch of things in  
9 TM, and I'm interested in how that connection might  
10 influence how one would think about payment.

11 And the last thing I'm interested in is there's  
12 this box on page -- it's not quite a box, but it looks like  
13 it's going to be a box -- on pages 35 and 36 that gives us  
14 the history of competitive bidding for Part C and there's  
15 two ways to read that, depending on how early I've woken up  
16 in the morning and how many boxes of Cheerios I've had. One  
17 of them is this was such a good mechanism for driving out  
18 excess profits from the plans that the plans just stopped it  
19 politically, but if they were forced to do it, it really  
20 would have been great.

21 And the other way to read it might be that there  
22 were real problems or concerns with what happens if one

1    tried to do the competitive bidding.  And I'm mostly  
2    interested in the one example, which is the Denver example,  
3    because that's the one that you cite where they had these  
4    sort of good results, but Denver wasn't randomly chosen in a  
5    bunch of ways.

6           And I'm very -- so as an economist, I like bidding  
7    just naturally.  That's like the movie I would like to go  
8    see if there was a movie on bidding, as opposed to one on  
9    administrative pricing, because that's how I was trained.

10           [Laughter.]

11           DR. CHERNEW:  But I'm worried about issues like  
12    the stability of what happens if you have a bidding system  
13    over time.  I don't believe that a bidding system inherently  
14    gets plans to bid their costs.  I do believe there's a lot  
15    of potential for behavioral change and, you know, a whole  
16    bunch of things can happen in these bidding models that you  
17    might not see happening in the sort of limited  
18    demonstrations.  So I'm interested in your views about what  
19    we might have learned from Denver and how we would worry  
20    about those other problems.  That was longer than I thought.

21           MR. ZARABOZO:  Well, on the first point, you're  
22    referring to the Peizer and Frakt article about what

1 happened with BIPA --

2 DR. CHERNEW: I think there's others.

3 MR. ZARABOZO: Yes. On that subject, generally,  
4 what happens, if the payments go down, benefits go down.  
5 The Peizer-Frakt situation was the payments went up, or the  
6 particular article that I'm thinking of, which they went up  
7 in March. So the benefits had already been announced for  
8 2001 and then there was an increase through BIPA and so  
9 plans were given options of what to do with the money, and a  
10 lot of them increased benefits. One of the options then, as  
11 John pointed out, was to provide money to providers. Now,  
12 this is not an option currently with rebate dollars. If  
13 you're providing money to providers, that goes into the A/B  
14 bid. So at that point, you could just pass this on to  
15 providers, so much of the money went on to -- passed on to  
16 the providers, not in the form of extra benefits to people,  
17 because the competitive situation was already kind of set  
18 up.

19 DR. CHERNEW: But there were some payment changes  
20 around the BBA, I think, that had a lot of plans dropping  
21 out --

22 MR. ZARABOZO: Yes, which is a different --

1 DR. CHERNEW: -- so there have been studies about  
2 plan entry and exit.

3 MR. ZARABOZO: Yes, and I want to point out also,  
4 on the BIPA, one of the options that they had was at that  
5 time, there was still the Benefits Stabilization Fund where  
6 they could just keep the money for a future year to provide  
7 the same level of benefits as they previously had, and that  
8 fund had not been used by very many people except Kaiser in  
9 a couple of cases. But that particular year, when they got  
10 a bump-up in March, a lot of them just said, well, we don't  
11 even know what to do with this money. We'll put it in our  
12 Benefits Stabilization Fund, and, you know, because we're  
13 already in the market. We have a set benefit package and so  
14 on.

15 What happened in the Medicare+Choice experience  
16 around the BBA, a lot of people say because of the BBA cuts,  
17 that's what caused the departure of all the plans and so on.  
18 A lot of that was related, as is mentioned in the mailing  
19 material, to the overall market of what was happening in  
20 managed care. That is, at the point when the BBA was  
21 enacted, it seemed like a reasonable assumption that what  
22 was happening in the private sector, which is managed care

1 plans are going to bring down costs, could also happen in  
2 the same way in Medicare and they could do it throughout the  
3 country.

4 MR. BERTKO: Carlos, could I add to your  
5 statement? Everything you said is correct, but the BBA in  
6 particular had one of the what's called prongs of payment  
7 which compressed high-payment areas towards the median and  
8 it compressed it so much that in virtually all of the high-  
9 paying areas, it then flipped into the second prong, or a  
10 different prong, which was the 2 percent increase, and  
11 virtually all of the high-payment areas looked into their  
12 future and can say, 2 percent increase a year, many of whom  
13 had great difficulty living under 2 percent each year for  
14 the next few years, thus causing the withdrawals from the  
15 market in many areas, in my opinion.

16 DR. CHERNEW: I could see that happening under  
17 some scenarios on a bidding or another scheme or the 75  
18 percent, so I think that's a relevant -- I understand the  
19 BBA is unique, but I do think there's lessons to be learned.

20 MR. BERTKO: The 2 percent maximum increase for  
21 many years in the future is considerably different than  
22 either the 75/25 blend or a competitive bidding model.

1           MR. ZARABOZO: And, of course, in that first year,  
2 the 2 percent actually gave them an increase. They would  
3 not have gotten an increase in that year had it not been for  
4 the 2 percent, so -- Medicare spending went down, and under  
5 the old methodology, it would have been a reduction in  
6 payment to the plans, actually. So that provision  
7 guaranteed it.

8           But the pull-outs were sort of in waves. That is,  
9 there was a big movement into Medicare by private plans,  
10 partly because they were looking at what was happening in  
11 the private sector with premiums going down and it looked  
12 like Medicare was going to be going up for the duration. So  
13 markets became over-saturated, in a sense, so the new  
14 entrants who had to match the benefit levels existing in the  
15 areas were the first leavers. And then around -- 1999 was  
16 the high year for plans and enrollment.

17           Two-thousand and 2001 is when you saw the big  
18 departures, and a lot -- some of that is also the increase  
19 in drug costs, because the big extra benefit was drugs at  
20 that time and it was like mid-year in 2000 or maybe 2001  
21 where drug costs shot up and the plans could not offer the  
22 kind of benefits, those that remained, that they had

1 previously been offering.

2 Now the second part --

3 [Laughter.]

4 MR. HACKBARTH: Others? I don't know about you  
5 folks, but I'm finding it difficult to keep focused on the  
6 forest as opposed to getting lost in the timber here and  
7 looking at all the bark on the trees, and that's not in any  
8 way a criticism of the work you folks have done. I think  
9 you've done a real good job in laying out options and  
10 analyzing them so far as possible.

11 I do think the really big issues here have to do  
12 with what are our goals for the program, and as it's  
13 described in the paper, the goals have, I think, migrated  
14 for Medicare Advantage for reasons that I understand and  
15 sympathize with.

16 If you put up number 11, that describes the shift  
17 in goals, you know, I would sort of modify that right-hand  
18 box. There are people who want universal availability of  
19 private plans for philosophical, ideological reasons. But I  
20 think more typically -- you know, the real issue is added  
21 benefits for their constituents, and there is a feeling of  
22 inequity under traditional Medicare, that the States that

1 have very low traditional Medicare costs feel some sense of,  
2 in some cases, outrage when they see beneficiaries in parts  
3 of the country that are profligate in use of taxpayers'  
4 dollars getting added benefits while their States that are  
5 low-cost and efficient, they get no reward under Medicare  
6 Advantage. And beneath that, they know that they are paying  
7 the same tax rates and same premiums and they're getting  
8 fewer benefits under traditional Medicare and they're sort  
9 of fed up with that situation. And what they've elected to  
10 do is use Medicare Advantage as a vehicle for redressing  
11 that sense of inequity in traditional Medicare.

12           So I understand the feelings, but I think the base  
13 problem here is that Medicare Advantage is an ineffective  
14 tool for redressing the problems that they've identified,  
15 and I think legitimately -- as an Oregonian, legitimately  
16 identified. By using the wrong tool, we're creating a whole  
17 different set of problems.

18           So I would say, you know, it's up to Congress to  
19 set the goals, but if the goal is to redress the regional  
20 inequity in traditional Medicare, I would say that there are  
21 much lower-cost and more efficient ways of redressing that  
22 regional inequity, one example being to change the financing

1 and starting with the Part B premium say, we're going to  
2 give lower Part B premiums to the people in the low-cost  
3 areas and higher Part B premiums to people in the high-cost  
4 areas. You know, that's the straight shot, not running it  
5 through private insurance companies.

6 Or alternatively, taking affirmative steps to  
7 reduce traditional Medicare spending in the high-cost parts  
8 of the country, either through rates or, as has been  
9 happening in Florida recently, intensive review of claims  
10 for certain services that are suspect. Again, address the  
11 problem directly. Don't use this side avenue of Medicare  
12 Advantage as the vehicle because it's ineffective, and  
13 that's the key problem for me.

14 Under any of these options, alternatives, that  
15 result in paying more for private plans in low-cost parts of  
16 the country, we're increasing spending at a time that we can  
17 ill afford it. We ought to be leveling down Miami towards  
18 Oregon, not trying to move Oregon up towards Miami, given  
19 our fiscal situation. But Medicare Advantage is working  
20 against that.

21 And so my thoughts about this report are, our role  
22 is to support the Congress and do the analysis that they

1 asked, and that is what the first two-thirds of the report  
2 are about. Here are different options. Here are their  
3 impacts. But the piece of this that I feel strongly about  
4 is let's just get the goals straight and then choose the  
5 most efficient means for achieving those goals, and I don't  
6 think higher payments to private plans achieves any  
7 reasonable goals that I've heard anybody articulate.

8           Now, having -- so that's my overall view. Among  
9 these options, I do think that some are better than others,  
10 and I know John said that of the options on page seven, he  
11 thought the 75/25 blend was preferable. And rather than --  
12 again, our goal here is not to endorse a particular option,  
13 but I wonder if we can just say a little bit more in the  
14 text about how to think about these parameters and assess  
15 options.

16           What strikes me about the 75/25 blend -- actually,  
17 it is not page seven that I wanted. It's page six that has  
18 the -- yes, page six. You know, the columns that I look at  
19 here, I look at the benchmark on the fee-for-service, the  
20 middle columns there, the minimum and maximum. You know,  
21 one of the things that I'd want to do is minimize that  
22 spread, because the bigger that spread, the more distortions

1 you're going to get. If you have a big spread, you're going  
2 to get plans enrolling a lot of people, increasing costs in  
3 low-cost parts of the country. So I'm looking to reduce  
4 that spread between the benchmark and fee-for-service.

5 And then you look at the next column and you see,  
6 well, 75/25 does a pretty good job of limiting that spread.  
7 Plan availability is still pretty high. And the average  
8 extra benefits are still pretty high.

9 DR. REISCHAUER: It's the second worst at  
10 narrowing the spread.

11 MR. HACKBARTH: Well --

12 DR. REISCHAUER: I mean, 100 percent fee-for-  
13 service is the worst and it's the next worst and the other  
14 two narrow the spread the most.

15 MR. HACKBARTH: No. I'm looking at the next two  
16 columns, the comparisons of the benchmark to fee-for-  
17 service, not the dollar columns. And so it's obvious to  
18 everybody that my personal preference if I were king, would  
19 be 100 percent of local fee-for-service, but as I look at  
20 the other options and compare it to that, then I see 75/25  
21 gives you less spread between the minimum and maximum on the  
22 second set of columns. It gives you a high level of plan

1 availability and a high level of average extra benefits.

2 Now, I don't know if that's a rational way to  
3 think about this or not, but I think that's what Congress is  
4 looking for. What are the parameters that we should be  
5 looking for to find a better system than we've got now?

6 MR. GLASS: Scott, tell me if this is correct. On  
7 the extra benefits, on the bottom line there, where the  
8 input price-adjusted blend is \$38, so that's the average  
9 benefit for people who get extra benefits. But a lot more  
10 people get extra benefits under that plan than get extra  
11 benefits under the 100 percent fee-for-service option.

12 DR. HARRISON: A lot more areas do.

13 MR. GLASS: A lot more areas do. So even though  
14 the --

15 MR. HACKBARTH: It's a tradeoff.

16 MR. GLASS: Yes. There's \$75 for those that get  
17 them, but fewer get them.

18 DR. HARRISON: And the other trade-off that you  
19 would have would be once you get down to a certain level of  
20 extra benefits, you can't deliver them or beneficiaries say,  
21 not enough. And so in spite of what I would call probably  
22 accurate modeling, this one might be closer to much less

1 availability because plans would make a call that says, oh,  
2 I can only offer \$10 here. We're out of here.

3 MR. HACKBARTH: The other comment that I'd make is  
4 I think the bigger that spread is in the second set of  
5 columns, benchmark compared to fee-for-service, the more  
6 difficult it is to estimate the ten-year effect of this and  
7 the greater the likelihood that the ten-year saving is not  
8 going to be equal to 100 percent of local fee-for-service.  
9 And so if we can help them understand that point as they  
10 look at the analysis, I think that would be useful.

11 Okay. Any other comments on this? It's been a  
12 very good piece of work. It's very complicated. It makes  
13 my head hurt to --

14 MR. BERTKO: That's why actuaries get paid for  
15 this.

16 MR. HACKBARTH: Right.

17 DR. MARK MILLER: We agree, though, that none of  
18 us want to go to the movies with Mike Chernew.

19 [Laughter.]

20 MR. HACKBARTH: Right.

21 DR. MARK MILLER: Is everybody squared away on  
22 that?

1 MR. HACKBARTH: A competitive bidding movie.

2 DR. KANE: I haven't said anything yet except  
3 stutter. I have Chart 5. Do we have a preference for where  
4 we'd rather preserve MA plans on that chart, because my  
5 sense is you'd want to preserve the ones that get you below  
6 fee-for-service spending.

7 MR. BERTKO: Let me give Glenn's opinion said  
8 differently, which is I think there are good coordinated  
9 care plans in various regions of the country, some of which  
10 live on the left-hand side of that, that deliver excellent  
11 value. They just can't deliver it at 100 percent.

12 DR. KANE: Well, that's okay, but if we have to  
13 sacrifice something here, would we rather sacrifice the low-  
14 cost people who are getting less benefit and they're mad  
15 because they're paying taxes and not getting as much  
16 benefit, or do we want to sacrifice the plans that are  
17 actually reducing the cost below fee-for-service?

18 MR. HACKBARTH: And my answer to that is clearly  
19 the plans are most useful where they can do things that  
20 traditional Medicare cannot and thus reduce costs.

21 DR. REISCHAUER: While it's not in our bailiwick  
22 to think about political viability, the whole reason we got

1 into this was because there was nobody over on the left-hand  
2 side --

3 DR. KANE: But I think we need to talk about these  
4 options with respect to that.

5 DR. REISCHAUER: -- and if we eliminate them,  
6 somebody will invent floors and ceilings.

7 MR. HACKBARTH: Yes, but again, the reason that  
8 they invented them, I think in most cases, was not any  
9 particular affinity for private plans, but they wanted to  
10 provide drug benefits originally --

11 DR. KANE: They were taking drugs or they wanted  
12 to provide drugs?

13 MR. HACKBARTH: Drug benefits. Drug benefits.

14 DR. MILSTEIN: Glenn, could you clarify whether  
15 the output you anticipate in the report would simply be a  
16 portrayal of the categories of consequences of different  
17 solutions or are you looking for something that would do  
18 that and prioritize which ones we think ought to be more  
19 highly valued, because this conversation and the input has  
20 sort of drifted back and forth between those two different  
21 concepts of our deliverables to Congress.

22 MR. HACKBARTH: Yes. I don't think that we should

1 be trying to propose a particular option. I do think it  
2 would be legitimate for us in that last third of the report  
3 to say, you know, the goals are very important. Setting the  
4 goals are very important, and here are the goals that we  
5 think are important, but they may not -- that's ultimately  
6 Congress's responsibility to set the goals.

7 DR. DEAN: I guess I just was going to echo that.  
8 We keep getting ahead of ourselves, I think, because there  
9 are so many of these questions you can't answer unless you  
10 really know what the goal is, and we, I think, keep jumping  
11 ahead of ourselves and then stepping back to try to decide  
12 what was it we were trying to accomplish. I think you said  
13 it to begin with.

14 MR. HACKBARTH: Let me just play it back to make  
15 sure that we're in agreement. I think goal one ought to be  
16 to bring private plans into the Medicare program when they  
17 can help us reduce cost and improve care. And so the  
18 greatest opportunities are on the right side of that graph.

19 We understand as another goal addressing regional  
20 inequities. The issue would be, is this an effective tool  
21 for addressing the regional inequities, and I think the data  
22 show that it is not, that if you pay private plans

1 significantly more than traditional Medicare costs, you  
2 don't get innovation. What we got was private fee-for-  
3 service. We got plans mimicking traditional Medicare,  
4 except at a higher cost.

5 DR. DEAN: I guess that was my problem with all  
6 the extra benefit issue, is it just introduces another  
7 confusing part. If our goal is really to push -- to try to  
8 deliver something more efficiently, then that's what we  
9 should focus on rather than adding more benefits.

10 MR. HACKBARTH: So I'm stumbling here, but bear  
11 with me. Arnie, what I envision is I'd like to see that  
12 last section, that last third that frames the issue make a  
13 statement that we think the appropriate goals are these:  
14 Improving efficiency in the delivery of medical care for  
15 Medicare beneficiaries and reducing government costs. And  
16 if we can take some out of this right-hand side to reduce  
17 Federal outlays, I'm all for that, too.

18 MR. GLASS: So, Glenn --

19 MR. HACKBARTH: Were you looking for a  
20 clarification, David? If so, just go first.

21 MR. GLASS: Yes, briefly. So first, our goal is  
22 for the Medicare program as a whole, correct, and then we

1 talk about goals for the MA program underneath that?  
2 Because you've said that you can't -- the first goal should  
3 be to stop having areas with incredibly high service use and  
4 poor quality in the fee-for-service program --

5 MR. HACKBARTH: No, the way I would state it is  
6 the goal for Medicare Advantage ought to be to enlist  
7 private plans in the task of improving efficiency and  
8 quality, and through that reducing Federal expenditures.

9 And then sort of the second paragraph is, we  
10 recognize that there are other legitimate policy goals and  
11 one of those would be to redress regional inequities. Our  
12 concern here is not with the goal, but rather using Medicare  
13 Advantage as the vehicle for trying to achieve that goal.  
14 We don't think it's a very effective one and alternative  
15 ways of addressing that goal would be through the  
16 traditional Medicare payment structure, the traditional  
17 Medicare financing structure. Those are the straight paths  
18 to addressing regional inequity.

19 DR. CROSSON: If I could just make a point, what  
20 occurs to me is you didn't make up that goal. The goal you  
21 just stated for Medicare Advantage was, in fact, as I  
22 understand it, the original goal.

1 MR. HACKBARTH: Yes.

2 DR. CHERNEW: We're negotiating. I think that  
3 Medicare Advantage is best understood as a tool to achieve  
4 broad Medicare program goals, and in the spirit and related  
5 to this conversation, I think it's important to recognize  
6 that the importance of private plans in Medicare, at least  
7 some private plans in Medicare, is not only to provide  
8 benefits and care to the people who actually choose those  
9 plans, but I don't think we can ignore the fact that the  
10 presence of the Medicare, the private plans in Medicare,  
11 influence the markets overall.

12 They share the same provider networks. They  
13 influence the diffusion of imaging services. They innovate  
14 in terms of when we can have outpatient surgeries as opposed  
15 to not having outpatient surgeries. I think there's a lot  
16 of innovation in the care of people that are often done in  
17 the better MA plans that because they're sharing providers  
18 spill over into the traditional Medicare program.

19 And so I think that the traditional Medicare  
20 program we have is not the Medicare program we would have  
21 had if we had never had any MA plans. And it's that balance  
22 of understanding that I think becomes important in how you

1 use Medicare Advantage, not just to provide care for those  
2 people who choose Medicare Advantage, but how Medicare  
3 Advantage and private plans in general might support the  
4 overall goals of the Medicare program and help the health  
5 care system become more efficient.

6 MR. GEORGE MILLER: I'm going to try to state it a  
7 little bit different. If you start at the overall premise  
8 of sustainability of the Medicare program overall as the  
9 ultimate goal and each area we deal with, and each chapter  
10 has that overarching, then in this particular chapter  
11 dealing with MA, what we come up with, what we end up with -  
12 - the question is, will it still have a -- at least in my  
13 mind, will we still have to subsidize someone to provide  
14 those services?

15 If it is better quality, then I think that's a  
16 different issue. We may want to address that. But even in  
17 addressing that, we've still got to look at, at least in my  
18 mind, the overall goal is sustainability of the program.  
19 Just fundamentally, I have a little bit of a problem  
20 subsidizing something that I may not -- if I'm in an area of  
21 the country where I can never get that benefit, why should I  
22 subsidize that benefit for a smaller number? So I think we

1 have to address and wrestle with those issues, also.

2 MR. HACKBARTH: Okay. Other thoughts on this?

3 Okay. Thank you very much.

4 Okay. Next up is the next-of-kin report, also  
5 MIPPA on how to compare quality between Medicare Advantage  
6 and fee-for-service Medicare.

7 MR. ZARABOZO: Good afternoon. John and I are  
8 here to discuss another report mandated by MIPPA, which is  
9 the report to the Congress on the topic of quality, as Glenn  
10 mentioned, and Medicare Advantage and the traditional fee-  
11 for-service sector.

12 The congressional mandate for this report is  
13 consistent with recommendations the Commission has made in  
14 the past to the effect that Medicare should collect  
15 information on quality that enables the comparison between  
16 the two sectors, Medicare Advantage and fee-for-service  
17 Medicare. The main subject of the report is an analysis of  
18 the methodology that should be used to compare MA with fee-  
19 for-service along with an examination of the methodology for  
20 making comparisons of quality across MA plans. The report  
21 is due in March of 2010.

22 The statute specifically directs the Commission to

1 address technical issues such as the implications of new  
2 data requirements and benchmarking performance measures.  
3 The report is to include any recommendations for legislative  
4 or administrative changes that the Commission finds  
5 appropriate.

6           Since presenting our work plan for the study to  
7 the Commission last fall, we've conducted about two dozen  
8 interviews with CMS staff and stakeholder groups  
9 representing health plans, providers, beneficiaries, quality  
10 measurement and reporting organizations, and health services  
11 researchers specializing in these issues.

12           As a result of what we're learning from these  
13 interviews and from our ongoing review of the literature,  
14 we've developed a draft framework for our analysis that John  
15 will go through in more detail after a discussion of some  
16 general issues.

17           I should mention, though, that one of the issues  
18 that John will highlight is the question of tradeoffs  
19 involved in going from the current systems of quality  
20 measurement to alternative systems, and to what extent any  
21 changes could strain the already limited administrative  
22 resources available to CMS, as well as impose new burdens on

1 plans and providers.

2           To begin the general discussion, this slide  
3 presents a high-level comparison of the major sources of  
4 data on quality currently in use in the two sectors, MA and  
5 fee-for-service. In fee-for-service Medicare on the  
6 lefthand side, quality for the most part is measured and  
7 reported at the provider level. That is, the results tell  
8 us how a specific provider performed for the patients that  
9 provider actually served. In contrast, MA quality for the  
10 most part is reported at the plan level. That is, the  
11 results tell us how the plan as a system of care perform for  
12 its entire enrolled population.

13           There's one important exception to these general  
14 rules, and that's the CAHPS MA and CAHPS fee-for-service  
15 surveys that I'll discuss after this slide. This slide  
16 shows that quality measurement in fee-for-service Medicare  
17 is structured around specific provider types, as shown in  
18 the first bullet of the lefthand box.

19           Setting aside physicians for a moment, for the  
20 other provider types, CMS gathers data for specified sets of  
21 quality measures, and then publicly reports the results on  
22 the Medicare website. CMS also has implemented incentives

1 for providers to report on measures.

2 Most of the quality measures currently used in  
3 fee-for-service are process measures that assess whether a  
4 specific service was performed for patients who met the  
5 inclusion criteria, but the skilled nursing facility, home  
6 health, and dialysis measure sets include more outcome  
7 measures, such as changes in functional status. CMS is also  
8 introducing outcome measures such as mortality and  
9 readmission rates into the hospital quality reporting  
10 system.

11 The Commission, in the past, has made  
12 recommendations for improved quality measures and fee-for-  
13 service. For example, in the case of measures that skilled  
14 nursing facilities should report on. For physicians in fee-  
15 for-service, the physician quality reporting initiative is  
16 used to gather data and provides bonus payments for  
17 physicians who meet the program's reporting criteria. CMS  
18 does not publish the performance rates on the PQRI measures,  
19 though it recently added an indicator on the Medicare  
20 Physician Finder to inform users when a particular physician  
21 successfully participated in PQRI in the previous year.

22 The other quality measurement system in fee-for-

1 service is a version of the Consumer Assessment of  
2 Healthcare Providers and Systems, or CAHPS that was  
3 developed specifically to be fielded for the Medicare fee-  
4 for-service population.

5 Like all of the CAHPS instruments, the CAHPS fee-  
6 for-service survey measures respondents' perceptions of  
7 quality and access to care. Almost all of the questions in  
8 the fee-for-service version of CAHPS ask about the  
9 respondent's experience with ratings of his or her care  
10 providers.

11 In MA, the Healthcare Effectiveness Data and  
12 Information Set, or HEDIS, is used to measure plan-level  
13 performance on a number of process and intermediate outcome  
14 measures.

15 In the last round of published HEDIS measure  
16 results for Medicare, there were 48 indicators in total, 7  
17 of which were intermediate outcome measures, such as  
18 maintaining a specific level of blood glucose or blood  
19 pressure control.

20 There are two beneficiary surveys in MA, CAHPS and  
21 the Health Outcome Survey. Like the fee-for-service version  
22 of CAHPS, the MA version, which actually was developed

1 first, asked respondents for their perceptions of the  
2 quality of and access to providers within their health plan,  
3 as well as the quality of health plan services, such as  
4 member services.

5           The Health Outcome Survey was developed  
6 specifically for the Medicare population and is designed to  
7 measure changes in respondents' self-reported physical and  
8 mental health status over a two-year period, as well as  
9 collecting information about other aspects of cares and  
10 interactions with healthcare providers.

11           Having briefly reviewed the available systems of  
12 quality measurement, we now consider some of the options  
13 for building on the current measurement systems to compare  
14 quality between MA and fee-for-service Medicare.

15           One option that has been used in the past is to  
16 compute HEDIS-like values for the fee-for-service program by  
17 applying HEDIS measures to fee-for-service claims data.  
18 This is how Fisher and colleagues for the Dartmouth Atlas  
19 Project have developed fee-for-service measures for the  
20 Robert Wood Johnson Foundation, aligning forces for quality  
21 program.

22           Technically, this is straightforward, but fee-for-

1 service scores on some of the HEDIS measures, particularly  
2 those that rely on data such as laboratory test results,  
3 pharmacy data, and intermediate outcomes that require  
4 medical record review would yield incomplete results if the  
5 fee-for-service results were based solely on claims data.  
6 Part D information could be combined with Part A and Part B  
7 claims information to obtain drug data in fee-for-service.  
8 Lab information would have to be obtained in fee-for-  
9 service, which is something the Commission recommended in  
10 2005. Based on our discussions with provider  
11 representatives, purely claims-based approaches may not  
12 viewed as an accurate measure of quality in fee-for-service.

13 Another issue in such a comparison is defining the  
14 appropriate geographic unit. It is not clear what the  
15 appropriate geographic unit would be for a population-level  
16 comparison between MA and fee-for-service. There are other  
17 measure sets that currently exist that could provide more  
18 information on quality in each sector. These other measure  
19 listed on the bottom of the slide include outcome measures  
20 and measures of care management and care transitions.

21 There are also two beneficiary surveys in use that  
22 can be the basis of comparisons between MA and fee-for-

1 service, the CAHPS MA and fee-for-service surveys have been  
2 used on the past to compare MA and fee-for-service on a  
3 national, state, and in some areas, local level.

4 The Health Outcome Survey, or HOS, also offers a  
5 technically feasible method for comparing the results for MA  
6 and fee-for-service. In the past, researchers have used the  
7 equivalent of fee-for-service HOS results to compare fee-  
8 for-service and MA results on changes in beneficiary  
9 perceptions of their healthcare status over time.

10 For both these surveys, because they are  
11 population based, they may be less valuable for promoting  
12 improvements among fee-for-service providers versus their  
13 potential for promoting improvement within a system of care  
14 like MA.

15 John will now walk you through a draft framework  
16 for evaluating different approaches to quality measurement  
17 by looking at the tradeoffs among several criteria.

18 MR. RICHARDSON: The framework we have drafted is  
19 a matrix that we can use to compare the strengths and  
20 weaknesses of the various quality measurement systems in  
21 meeting a set of criteria. This tool can highlight the  
22 tradeoffs among these often-conflicting criteria when

1 deciding which quality measurement system could be used to  
2 compare quality between MA and fee-for-service and to  
3 improve quality comparisons within MA.

4           Our first cut of these criteria are listed in the  
5 rows that are visible in this slide. We selected these  
6 criteria based on the terms of the congressional mandate,  
7 earlier input from the Commission, and the results of our  
8 research and analysis to date. These criteria are also  
9 reflected in the discussion questions on pages 27 and 28 in  
10 your mailing materials. I will briefly touch on each of  
11 these in a moment when I walk through an example of using  
12 the framework, but first we need to finish building it out.

13           The next step in building it is to array each of  
14 the major quality measurement systems in the table's  
15 columns, including the provider-level measures used in  
16 Medicare fee-for-service, the HEDIS system, CAHPS, the  
17 Health Outcome Survey, a system that would use enhanced  
18 administrative data, which could include medical and  
19 pharmacy claims data, encounter data recorded by health  
20 plans, and other types of administrative data such as  
21 laboratory test results and hospital discharge records, and  
22 finally, a system that uses clinical data that are available

1 only in medical records, such as are used in the original  
2 ACOVE measure set.

3 With the skeleton of the framework in place, the  
4 next step would be to assign a value in each cell based on  
5 whether each measurement system meets each criterion.

6 In your copies, Commissioners' copies of this  
7 slide, we have filled in each cell with our preliminary  
8 assessments of these values, but to make this thought  
9 process more concrete, I'll walk through an illustrative  
10 example of using the tool.

11 In this illustrative example, we will use only the  
12 three measurement systems listed at the top of the table:  
13 current fee-for-service provider quality reporting, HEDIS,  
14 and an enhanced administrative data system. Also in this  
15 example, we have assessed whether or not each system meets  
16 each criterion simply with a binary yes or no indicator in  
17 most cases. These evaluations could be made more nuanced by  
18 assessing the degree to which each option meets the criteria  
19 and assigning a numeric value, say, on a scale of 1 to 5.  
20 But in this simplified example, we will use a  
21 straightforward yes or no assessment in most of the cells.

22 I also should emphasize that all of the entries

1 shown in this example are for illustrative purposes only.

2           So, the first two criteria assess whether the  
3 measurement approach is useful for meeting the two basic  
4 mandates set forth in the MIPPA provision: Is it useful for  
5 comparing MA and fee-for-service Medicare, and is it useful  
6 for comparing among MA plans? Now, the term useful here can  
7 be defined to encompass whether the performance measures in  
8 a given system would be broadly accepted by CMS plans,  
9 providers, and beneficiaries as valid measures of quality,  
10 whether the measures are technically capable of  
11 distinguishing differences between the units of analysis in  
12 a statistically valid and reliable way, which could include  
13 risk adjustment when appropriate, and whether they enhance  
14 our ability to measure and report on disparities in the  
15 quality of care among communities with certain demographic  
16 or socioeconomic characteristics.

17           Against these two criteria, we determine that the  
18 current fee-for-service provider quality reporting system  
19 would get Ns in both of the cells. Since it is currently  
20 designed, it is not useful for comparing MA to fee-for-  
21 service or for comparing among MA plans.

22           In contrast, HEDIS and an enhanced administrative

1 database system could potentially be used for both those  
2 purposes, so they get Ys in those cells.

3           Next, we would evaluate the potential increases  
4 relative to the status quo in the costs and the  
5 administrative burden for each approach. The cost and  
6 burden increases could be borne to varying degrees by CMS  
7 plans and providers, but at the risk of oversimplifying,  
8 we've reduced the question to one dimension. Overall, will  
9 the proposed change increase costs and administrative  
10 burdens for providers' plans in CMS or not?

11           Next, we would consider whether each system could  
12 provide actionable information to fee-for-service providers  
13 and MA plans such that they could design and implement  
14 activities to improve their quality. From the assignment of  
15 yeses and noes in this illustrative example, one could  
16 conclude that these criteria could be met separately by the  
17 fee-for-service provider and HEDIS systems respectively, or  
18 for both sectors by one system that incorporated enhanced  
19 administrative data.

20           Next, we would look at the unit of measurement  
21 supported by each system. Would the system accommodate  
22 measurement and reporting at the level of individual

1 providers or groups of providers, at the level of a plan for  
2 MA or population for fee-for-service, or both?

3           We should note here that the degree of  
4 disaggregation that would be feasible under a provider-level  
5 approach would depend heavily on the specifications of the  
6 quality measures and the availability and reliability of the  
7 administrative data used.

8           Next, we would assess the geographic area for  
9 which each system could measure and report quality.  
10 Different systems could allow for measurement and reporting  
11 from the national level all the way down to the level of  
12 individual hospital referral regions.

13           As with the preceding provider or plan unit of  
14 measurement discussion, the more granular one wishes to get  
15 with the geographic area, the greater the costs and  
16 administrative burdens one would place on the system.

17           Next, we would look at the types of quality  
18 measures used in each system, and here we could decide to  
19 put more or less emphasis on certain types of measures  
20 compared to others. For example, if one decided that  
21 outcome measures or patient experience measures should be  
22 priorities, that decision could guide you towards

1 measurement systems that included those types of measures.

2           And the final major element is an assessment of  
3 whether quality reporting under each system is useful for  
4 beneficiaries when they make decisions about which provider  
5 to seek care from, whether to enroll in MA, and if they do,  
6 which MA plan to select.

7           In this context, we propose to focus on the intent  
8 or potential of each system to inform beneficiaries, but we  
9 also fully acknowledge the information that's detained in  
10 the literature and conveyed to us personally by beneficiary  
11 stakeholders that many, if not most, beneficiaries currently  
12 make little use of the quality information that is  
13 available. In response to these concerns, this criterion  
14 could be defined to include whether a quality measurement  
15 system makes quality information more or less accessible to  
16 beneficiaries in practices as well as by design.

17           So, in summary, we are presented a draft framework  
18 for sorting through the interconnected tradeoffs involved in  
19 responding to the congressional mandate. To advance to the  
20 next phase of our work in actually filling in the matrix and  
21 evaluating specific courses of action to meet both aspects  
22 of the mandate, we seek your input, particularly on the

1 draft framework. Are there other criteria that should be  
2 factored into the analysis? Are there other measurement  
3 systems we should include? And more broadly, are there  
4 specific goals for a quality measurement system that can  
5 guide us in filling in the framework and evaluating the  
6 tradeoffs?

7 We're also interested in your views on the extent  
8 to which we might address improving quality reporting and  
9 measurement by capitalizing on the forthcoming investments  
10 in health information technology that were authorized by the  
11 recently enacted economic stimulus law.

12 Thank you, and we look forward to your questions  
13 and discussion.

14 MR. HACKBARTH: Okay. Round one questions.

15 DR. CROSSON: Just a technical question about the  
16 Health Outcome Survey. As I looked at that, or at least  
17 looked at a subset of the questions, the ones that are  
18 included in the Star survey, it occurred to me that it might  
19 be hard to differentiate in at least some of those questions  
20 between underlying health status and the impact of the care  
21 delivered by the providers or attributed to the plan or  
22 whatever unit.

1           Is that the case? Is there a way to mitigate  
2 that?

3           MR. ZARABOZO: I think that's the case. I'm not  
4 sure if they make some sort of an adjustment at the  
5 individual beneficiary level for the response.

6           MR. RICHARDSON: I believe that they do make an  
7 adjustment. We heard the same concern during our meetings  
8 with various stakeholders of whether the adjustment that is  
9 made in the instrument itself is sufficient to capture what  
10 you're getting at. So, there are really two different  
11 questions. One is, is there a technical adjustment made  
12 there, and I believe that there is, but we can certainly  
13 verify that for sure.

14           But I think another part of your question is, even  
15 if there is an adjustment, to what extent does that actually  
16 get at the differences in the underlying health status in  
17 people's responses to that.

18           DR. CROSSON: That's a better question than I  
19 asked.

20           MS. HANSEN: Just as a question of clarification  
21 on the data collection itself, are all of these tools built  
22 up in a way that they do collect race and ethnicity as part

1 of the question, just because I know there has been at least  
2 one study that has pointed out to some of the disparities,  
3 even though Medicare does have access?

4 MR. ZARABOZO: There has been a lot of work on  
5 CAHPS, in particular, to attempt to identify race and  
6 ethnicity. So, I would say that they are probably  
7 relatively good on a relative scale, because they have paid  
8 particular attention to that issue and how best to identify  
9 race and ethnicity, not exclusively using, for example, the  
10 Social Security information or Medicare-based information.

11 MS. HANSEN: But the CAHPS is more just the  
12 patient experience, but in terms of the actual clinical data  
13 itself.

14 MR. RICHARDSON: I think you've put your finger on  
15 one of the issue among many of using administrative claims  
16 data in particular, and we could certainly -- I don't want  
17 to read into what you're saying, but that could be one of  
18 the criterion we use to evaluate the quality of the data, if  
19 you'll pardon the expression, in using that, is that if it  
20 is important to be able to have good measures of  
21 disparities, but the data you're using aren't going to help  
22 you do that, then that's one of the things we need to

1 balance.

2 DR. CHERNEW: They're not powered for that often,  
3 either, which is a separate issue. The data, there's a  
4 power to be able to use.

5 MR. GEORGE MILLER: In this work is the comparison  
6 of the quality data between fee-for-service an the MA plans.  
7 Is the goal to have less or an equitable amount so that  
8 we're not creating more data gathering. I'm thinking of  
9 small, rural hospitals and rural hospitals, whether they're  
10 small or large, quite frankly, if we're not duplicating or  
11 making extra work. Quality measurement is very, very  
12 important. I'm not making light of that, but I'm wondering  
13 if we're setting a separate standard for an MA plan and a  
14 separate standard for the fee-for-service measurements.

15 MR. RICHARDSON: I think that's one of the  
16 critical issues that Congress is looking to us to help them  
17 trade off against the other goals one might have for quality  
18 measurement systems, but it is an explicit part of the  
19 mandate.

20 MR. GEORGE MILLER: So, in your work, you're  
21 talking about a coordinated effort and not a comparison.

22 MR. RICHARDSON: No, not necessarily. If one of

1 the criterion -- if a great amount of emphasis is put on the  
2 criterion of we need to be mindful of the cost and the  
3 burden placed on the providers and the system, CMS, as well,  
4 then that is going to help us figure out some other things  
5 that we might otherwise do if that wasn't a criterion. I'm  
6 not being very linear here.

7           If that is the predominant criterion and we  
8 recommend that that is a major one, then what we could do in  
9 the report is say these are the kinds of things you could do  
10 with that constraint in place, if you want to look at it  
11 that way.

12           MR. GEORGE MILLER: And just a quick follow-up:  
13 Have you talked to everyone that would be involved, rural  
14 providers, physicians, and all those folks who have respond  
15 to that gathering of data for measurements?

16           MR. RICHARDSON: We have spoken with some of the  
17 representatives. I'm not sure if we did with rural groups  
18 in particular, but we can certainly do that.

19           MR. GEORGE MILLER: That would be a good thing.

20           MS. KANE: Maybe I'm just overly influenced by  
21 Massachusetts, but don't most MA plans basically pay claims  
22 to fee-for-service type providers, and isn't there a way --

1 well, you're shaking your head, but we have three plans that  
2 pay claims and they're MA plans. I'm just saying, isn't  
3 there a robust number of MA plans that could reasonably be  
4 compared because they have claims. They are paying fee-  
5 for-service providers, or you could look at -- I guess one  
6 question is, when you're looking at hospital compare and  
7 nursing home compare, you're looking at the providers'  
8 experience in achieving infection or discharge instructions  
9 to the patient, and do we really think that they're  
10 different whether they're an MA patient or a traditional  
11 Medicare patient? So, wouldn't it be possible, even if the  
12 MA plans don't want to give you their claims data to say,  
13 well, which hospitals do you use in your network  
14 proportionally and then say, well, for these plans -- I'm  
15 just trying to think of ways you can use what's there and  
16 allocate them even to the plans if they don't want to give  
17 you their claims data.

18           It just seems like some of the stuff that we use  
19 for hospital compare, they're just using the same hospitals  
20 as everybody else, and you could compare the plan's  
21 particular network using the traditional Medicare data. I  
22 don't know what proportion it is, but I would guess it would

1 be a fairly large proportion.

2 MR. RICHARDSON: Well, in fact, hospital compare  
3 data are all adults in the hospital. It's a sample of --

4 MS. KANE: All payer.

5 MR. RICHARDSON: All payer, thank you. But the  
6 sample isn't large enough to distinguish between MA and fee-  
7 for-service. I know that's not what you're suggesting.  
8 You're saying you could use those results to reflect the --

9 MS. KANE: The provider profiles of who signed up  
10 in which MA plans.

11 MR. RICHARDSON: Right. Now, we have come across  
12 another study that researchers at AHRQ did where, if you  
13 aggregate up to a larger geographic area, say, a state, then  
14 you can start to see some differences between MA and fee-  
15 for-service, at least in the -- they didn't look at quality.  
16 I think they looked at the quality indicators that look at  
17 ambulatory care sensitive indicators, which is one of the  
18 things we talked about in the paper, but they were more  
19 concerned with utilization differences, and they were  
20 probably seeing differences in the plans networks versus  
21 fee-for-service.

22 My point being, it depends on the level of

1 geography. If you abstract it away from the provider-level  
2 measurement up to a higher level of geography, you could  
3 actually start to see differences between the two systems.

4 MR. BERTKO: Nancy, if I could just -- I was  
5 disagreeing only with your use of the adjective most and  
6 more in the physician side than in the hospital side there  
7 are a fair number of physician groups taking capitation  
8 where you'd have difficulty attributing to that. Perhaps on  
9 the hospital side it might work better.

10 MS. KANE: Most of the traditional -- I guess most  
11 fee-for-service reporting isn't physician-side anyway, it's  
12 institutional. If you look at hospital compare, nursing  
13 home compare, home health compare, dialysis facility care --  
14 but the physician one just tells you whether they report or  
15 not. So, I'm not sure that that's the -- but of the four  
16 traditional measures, it seems like we could approximate  
17 what that network looks like and see if the network in the  
18 MA plan has better or worse performance than the more  
19 generic network in that state. It's a simple, cheap way to  
20 do a comparison early.

21 DR. MILSTEIN: Just a question about the form in  
22 which you're envisioning our recommendation would appear.

1 In some ways it can parallel to the prior conversation. I  
2 think there are a number of options.

3 Option 1 is we simply take all these measurement  
4 systems and show the positive and negative consequences of  
5 each measurement method, and we can rate that either in  
6 binary or on a Star-rating system. That's option a for how  
7 we answer Congress's question.

8 The second is we take a step further and we lay  
9 out that matrix, but we star the criteria we think are more  
10 important.

11 And then, the third option is it's the all things  
12 considered question. Well, in view of this analysis, all  
13 things considered, we think these are -- these are the  
14 measurement methods we should use to compare the two  
15 programs and perhaps augment that with some collateral  
16 suggestions that would make a difference.

17 So, my question is, which of those three outputs  
18 are you envisioning would be the form of our answer to the  
19 question Congress has asked?

20 MR. RICHARDSON: I think the most hopeful,  
21 anticipating -- based on the mandate is the last example,  
22 which is, some -- I think just giving them the matrix on the

1 one hand, on the other hand would be somewhat less helpful  
2 than saying, in the Commission's view, the priorities are  
3 the burden on providers, for example, if that was one, or  
4 the ability to report on ethnic and racial disparities,  
5 whatever those are, as you guys help us figure this out,  
6 then I think those would be the most helpful things, and  
7 there may be some specific administrative changes that may  
8 improve certain technical aspects of the way that the  
9 current systems work.

10 I don't know if you want to mention the plan.

11 MR. ZARABOZO: Yes, that was what we mentioned,  
12 for example, in the mailing material about the health plans  
13 and the level of reporting statewide versus a small area,  
14 the Tallahassee situation.

15 DR. MILSTEIN: If I understand correctly, then  
16 you're saying we would go to the second level but not the  
17 third level, the second level being, of the possible  
18 consequences of the different measurement methods, these are  
19 the consequences that we think should be most highly  
20 prioritized, but we would not recommend a set of measures.

21 Is that what you --

22 DR. MARK MILLER: What John was saying is that if

1 we thought we could get to recommending a specific path, we  
2 would, and then what I thought you were qualifying was,  
3 unless -- and putting it out in front view -- the concerns  
4 were, well, this doesn't quite get to my concern for  
5 disparities, burden, whatever the case may be, which then,  
6 as a Commission, we might have to take a step back. I think  
7 the objective is to try and give a fairly coherent plan of  
8 how we want -- use this instrument or don't use this  
9 instrument, use these measures or don't use these.

10           Now, having said all of that, we're going through  
11 a fairly complex and difficult process in trying to put this  
12 together, and all I want to say is that's the objective, is  
13 to try to get to the point where we can name what we think  
14 they ought to do, but this is very complicated going, here,  
15 in case that hasn't come across; I'm sure it has.

16           And so, as always, I'm the guy to bring everybody  
17 down and all of that. So, I want to just -- our objective  
18 is to get you to a recommendation, but --

19           DR. CHERNEW: I just wanted your thoughts on the  
20 comprehensiveness of some of these. So, say process of  
21 care, and sometimes these things -- oh, this measures  
22 process of care as if there's one outcome, but oftentimes

1 there are very limited measures within those categories.

2 And I think I can just Arnie about to say  
3 something, which is good, Arnie.

4 So, I'm not trying to argue that we shouldn't take  
5 one step because we can't take the best step, but I just  
6 want to be sure that we're clear that, because we have this  
7 set of measurements and we compare, say, MA and fee-for-  
8 service, it's possible that one of the systems or one plan  
9 versus another looks better on the measures we have that may  
10 or may not imply they're better overall.

11 MR. RICHARDSON: As if there's some objective  
12 best. Yes, I think it is going to be -- and part of the  
13 difficulty Mark was alluding to is there will probably be  
14 some dissatisfaction with whatever -- in other words, there  
15 will be limitations to whatever we try to do, and I think --  
16 and part of what we struggle with is how do we square all  
17 these circles, and we may just end up with a triangle.

18 DR. STUART: I fully concur that looking of the  
19 value of the measure compared to the burden that it places  
20 is important, although it strikes me that burden to CMS is  
21 really quite a different character than burden to the  
22 providers for the simple reason that if we thought that a

1 particular set of measures was valuable and it would  
2 require that CMS expend resources in order to get it, we  
3 could make the recommendation conditional on giving CMS the  
4 resources.

5 In fact, I think that's something that we should  
6 consider as a Commission in all of the things that we do.  
7 If we make a particular recommendation, I've heard over and  
8 over and over again about how constrained CMS is. Well,  
9 let's be proactive about that so when we come up with  
10 something like this, then let's say, okay, well, they need  
11 more resources to do it and this is what we think they  
12 should get.

13 MR. HACKBARTH: Other questions? Comments?

14 We have migrated from One to Two.

15 MS. KANE: So, it seems that this is saying, well,  
16 here's where we are today under current fee-for-service, and  
17 then here's some things that are out there today for the MA  
18 plans. But given that all we've been talking about for the  
19 last couple of years in terms of strong recommendations  
20 involve some form of ACO or medical home or episode or some  
21 type of Part A/B bundling.

22 Couldn't we, instead of trying to fix what's not

1 working in the historic structure, try to go towards  
2 recommending quality measures that would work under ACO,  
3 medical home, Part A/B bundling and be more comparable,  
4 rather than trying to twist something that doesn't twist too  
5 well, on a traditional system that doesn't work so well?  
6 I'm just wondering if there's not a way to say, well, yes,  
7 maybe add as a criteria, anyway, that this could work if we  
8 had -- your biggest problem is you don't have a denominator  
9 for a lot of the fee-for-service measures. You don't know  
10 who's in there. But you would know who's in there for a  
11 medical home, you'd know who is in there for an ACO, you'd -  
12 - I don't know about episodes.

13 But anyway, just start thinking about it more in  
14 terms of where we hope the delivery system is going rather  
15 than just putting a huge infrastructure of quality reporting  
16 in something we're hoping will go away.

17 DR. CROSSON: As typical, I was going to make some  
18 similar comments. Nancy and I tend to think a lot alike.

19 Some of this is obvious, and I apologize, but I  
20 think some criteria that occurred to me is, as we look at  
21 these possible ways of doing it is we want whatever we  
22 recommend to be doable. There's no point in suggesting

1 something that's not practical.

2           It probably needs to be something or some process  
3 that's as accurate as possible, therefore is as objective as  
4 possible, and it should measure important stuff. There's a  
5 lot of things you can measure, and some things are more  
6 important than others in terms of their impact on health and  
7 impact on cost and the like, and I have a bias towards  
8 clinical information in that regard.

9           As was mentioned in the report, it should support  
10 improvement, in other words, be actionable, something that  
11 can actually -- it's interesting to compare things, and we  
12 may want to use comparisons to move money around, but  
13 ultimately it is most important if it actually changes care.

14           I think, and I don't know how to do this -- and  
15 this is sort of where Nancy was -- I think that what we  
16 should do should support or presage where we're going to be  
17 in the future. And in the future, where we're going to be,  
18 in part, is we're going to be in possession of a good deal  
19 more clinical information than we have now through clinical  
20 information technology. We don't have that now, except in  
21 some places, but we will, most likely. And therefore,  
22 whatever we put in place at least should not take us

1 marching off into a very different direction so that when  
2 that information is available we have to completely reverse  
3 course, tear everything up, and go in a different direction.

4           The issue that I find the hardest is this issue of  
5 level of attribution and the difference between Medicare  
6 Advantage and Medicare fee-for-service in terms of who you  
7 actually hold accountable, not just because it is what it  
8 is, which is, in one case, you have entities, and in the  
9 other case, you have individual practitioners, but because  
10 that difference also feeds back into what you can measure.

11           So, for example, and I'll say this because it's  
12 probably more complex than what I'm saying, but if you  
13 wanted to measure the mortality rate from coronary artery  
14 bypass surgery, let's say, a 48-hour mortality rate from  
15 coronary artery bypass surgery, you could do that pretty  
16 much equally in both settings. If you want to measure  
17 something as important as the long-term sequelae from  
18 diabetes mellitus, it becomes -- that's something that an  
19 entity, whether it's a plan or integrated delivery system  
20 can be accountable for over time. It's much harder to  
21 understand in the fee-for-service environment how you would  
22 do that. Who would be held accountable for those results?

1           And therefore, that difference, in the end, limits  
2 those things that you can measure. So, I think trying to  
3 tackle -- and I think this is where Nancy was going --  
4 either temporizing or trying to figure out how to tackle  
5 that issue may be among the most important.

6           MR. HACKBARTH: This is a conceptually appealing  
7 thing to do, but the more I think about it, the more  
8 difficult it sounds. This isn't a proposal but a question:  
9 Maybe we need to consider as a possible outcome that, no,  
10 this isn't worth the effort, with existing technology, that  
11 we'd end up spending too much doing backward-looking things  
12 and it's a task that's better tackled when we've got better  
13 information technology in place, whatever. Again, that's  
14 not a conclusion that I've reached, but sometimes that's the  
15 right --

16           DR. REISCHAUER: Arnie is ready to go after you.

17           MR. HACKBARTH: I know. I can see his jaw  
18 clenching.

19           Let me get back to my last before I give Arnie a  
20 chance to talk.

21           MR. BUTLER: He's going to be loaded for bear.

22           I tried to reorganize this in my simple mind and

1 see what might evolve realistically. On the positive side,  
2 if you look in, whether it's the hospital or the nursing  
3 home -- look in the various silos of services, and I think  
4 we have got some momentum on quality measures and also tying  
5 them to payment, if not now, more aggressively in the  
6 future. I think we can point to some successes in the  
7 components of care, and so we don't want to slow that down.

8           So, what are we trying to marry that with? We're  
9 trying to marry the added value of the assembler of care,  
10 the MA plans, and saying, okay, what's the difference. So,  
11 it's almost like if you could lay out -- this plan is using  
12 this nursing home, this hospital, this doctor, and you could  
13 somehow aggregate the score of the performance of those  
14 individual units, you'd get a sense of what the network of  
15 what the value is, and you'd continue with the HEDIS  
16 measures, which the individual components of care can't do  
17 at this time, but maybe in an ACO world they will if we wait  
18 a little bit. But right now, don't expect them to do that,  
19 because we're just not ready for it.

20           So, if there was a way to display it that way and  
21 -- I don't know, that's how I would organize it in my own  
22 mind.

1 DR. MARK MILLER: Can I just draw one other point  
2 out, as long as Peter is on point. This comes from a  
3 conversation that we had on the phone and then a couple of  
4 comments that have occurred here.

5 So, when you think about the notion that we're  
6 headed -- I think it was your comment somewhere along in  
7 here -- perhaps to more EMRs, the notion that some of these  
8 things depend more on medical records rather than claims,  
9 let's build for the future, not necessarily the past, those  
10 types of things -- all things considered, Arnie.

11 Then, you have this new HIT money that has kind of  
12 come into the process. And one wonders whether there's a  
13 leveraging there that would warrant comment here and perhaps  
14 elsewhere, but if we're trying to build something here for  
15 the future and we have some money at the moment that is  
16 directed towards the future -- Peter, this is stuff that  
17 you've brought up in conversations that we've had over the  
18 phone. And I don't expect people necessarily to react on  
19 point but listening to some of the - are we kind of working  
20 with what we have or are we thinking about what we could  
21 have if there's some leveraging there. There's still that  
22 big piece of the HIT money which is -- I always forget each

1 time -- meaningful use, which is still to be defined, and  
2 maybe there's an opportunity here to define what that might  
3 be.

4 MR. BERTKO: Glenn, I'm not going to throw my  
5 hands up on this. What I was going to say was maybe  
6 agreeing partly with Jay, having a starter set that we use.  
7 And Mark used the word "path." I had that written down  
8 earlier of where we get to. And I can see adding in at some  
9 point, even before HIT, lab values. A lot of people are  
10 using statewide reference labs which are now reporting back  
11 to health plans, and no reason that CMS wouldn't pull in  
12 that kind of data, too, as well as the Part D data which is,  
13 I think, very useful.

14 The comparison I might suggest -- I mean, Jay also  
15 gave a great comparison of -- was it CABG mortality? Yes,  
16 that's available everywhere. But I'll go beyond that and  
17 say, suppose we use the EHMS model to attribute to certain  
18 places.

19 Flagstaff Medical Center owns everybody over 65,  
20 and Flagstaff was not in a managed care plan. That one is  
21 simple. It's more complicated in other places, but there's  
22 no reason we couldn't use that and get what I would hope

1 would be pretty good results and pretty good comparisons,  
2 and I think that comparison, even on the starter set, would  
3 be worthwhile to people.

4 MR. HACKBARTH: Just for the record, because  
5 Arnie's coming up here, I'm not ready to throw up my hands,  
6 either. And I think it might be possible to do some initial  
7 steps that could be constructive, but I also am sensitive to  
8 what Bruce said about resources. If we lived in a world  
9 where CMS was rolling in resources as well as healthcare  
10 providers and didn't have a lot of other things on its  
11 plate, it might do one thing, but the tradeoffs look very  
12 different in a resource-constrained world.

13 Just one constructive thought, or hopefully  
14 constructive thought about this, I'm drawn to this idea of  
15 using existing data on institutional providers. Broadly  
16 speaking, a plan can improve care through two mechanisms:  
17 One is through network selection, and this addresses that  
18 specifically. The other is through care coordination and  
19 programs that sort of knit together independent providers;  
20 that's what HEDIS tends to measure.

21 And so, if you could say the network selection  
22 activity of the plan is doing well or doing poorly in terms

1 of quality, and then use its HEDIS measures -- maybe not to  
2 make a direct fee-for-service comparison, but say it's  
3 really good compared to other plans in terms of care  
4 coordination and HEDIS-type activity. That could be a  
5 significant step forward in terms of information for people.  
6 And so, that's one type of path to crawl forward even if we  
7 can't run very fast.

8 MR. GEORGE MILLER: Well, before Arnie gets in  
9 I'll make a couple of brief comments.

10 I agree with Jay's comments about putting together  
11 a goal. And let me see if I can just frame it in just a  
12 very minor way. And again, speaking from a hospital  
13 perspective and having to pull all this data together -- and  
14 I appreciate, Glenn, your comment about the concern for  
15 resources to pull all this together. It is important to  
16 have, but one question I would have, what are we learning?  
17 What are we trying to learn? Where are we trying to go?  
18 And then, what can we let go of? After we learn something,  
19 is there something that can come off the table? And how can  
20 we improve the system?

21 It would seem to me that the quality improvement  
22 measures to help us take better care of our patients and the

1 delivery of care that we have to our patients. So, that  
2 should be one way to look at it, according to effort between  
3 both MA and fee-for-service.

4           And then, I think it was you, Glenn, that made the  
5 comment about technology and having the EMR, especially in  
6 rural areas, all of us don't have that, but we do have  
7 measures that we could use to improve. And again, I just  
8 wanted to emphasize again we want to make sure that, with  
9 the limited resources we have we're not adding an additional  
10 burden.

11           DR. MILSTEIN: A couple of comments.

12           First, I think it's important to remind ourselves  
13 that Congress hasn't asked us for a recommendation with  
14 respect to how we should measure performance in every facet  
15 of the healthcare system; they've asked us a narrower  
16 question, which is, how do we go about comparing fee-for-  
17 service with Medicare Advantage.

18           And if you think about that more global, analytic  
19 charge, many of the concerns expressed so far having to do  
20 with, well, how do we attribute to an individual doctor,  
21 diminish, because that's really not particularly relevant to  
22 the question we're being asked now.

1           Second comment is that I think this idea that we  
2 might frame our recommendations for what they would be with  
3 and without a world -- some day, EMRs are relatively  
4 universal. I think that makes a lot of sense, but there's  
5 also an opportunity to essentially also comment in relation  
6 to a more modest set of enhancements of our health  
7 information in Medicare that's far short of all doctors, or  
8 95 percent of doctors, implementing EHR. And it's that  
9 subset of things we've periodically commented on, and this  
10 might be a great time to remind Congress about things like  
11 laboratory values being appended to laboratory bills, and a  
12 few of the other things that we've commented on, and we  
13 could actually expand and take a look at what the National  
14 Committee on Vital Health Statistics, which thought about  
15 this question. Short of EMRs, what would make a big  
16 difference in our ability to measure? They had some very  
17 thoughtful recommendations they made five years ago, and  
18 this might be a nice opportunity to point in that direction.

19           Third point is just, as we appropriately sweat  
20 adequacy of measures coming out of any particular system, I  
21 think it is really important to keep mindful of the lessons  
22 that have come from other industries within this country and

1 from the health industry in other countries. This noting  
2 that you, if you're going to make a performance judgment,  
3 you have to explain to the producer of the service what  
4 actionably they can do, that's not something that's honored  
5 in any other industry in the United States. Nobody ever  
6 said to the airline industry, listen, we're not going to  
7 judge you on customer complaints unless we can also explain  
8 to you what you should to correct a high-complaint level.  
9 That's a standard that is just not applied in any other  
10 aspect of public performance measurement.

11           And last but not least -- this is probably self-  
12 evident, but there is always an inclination on the part of  
13 me, and psychologists have said it's true of all people, to  
14 be towards what's called status quo bias, sort of accepting  
15 the status quo as pretty good and then there needing to be a  
16 pretty high standard for moving beyond it. And I would say  
17 the evidence suggests that the status quo, with respect to  
18 our quality, one contributant to which is relatively low  
19 transparency on quality -- our status quo is not very good  
20 and we should not be biased toward it and be so cautious,  
21 and therefore be too cautious about moving forward with  
22 measures, imperfect though they may be.

1           If you talk to people in the UK who first went  
2 forward with their public reporting of risk-adjusted  
3 hospital mortality, there were just a million methodologists  
4 that came out of the woodwork saying this is crazy, it's not  
5 good enough, wait ten years. They move forward, and as a  
6 result their measures on risk assessment mortality have  
7 moved up much more quickly than ours have.

8           MR. HACKBARTH: Other questions or comments?

9           Okay. More on this later.

10           And last for today is medical education and its  
11 relationship to delivery system reform. Whenever you're  
12 ready.

13           MR. LISK: Good afternoon. Cristina and I are  
14 back to discuss the chapter on Medical education in the  
15 United States, supporting long-term delivery system reform.  
16 Today we're going to review some additional information that  
17 has been included in the chapter in response to some of the  
18 questions you had at the last meeting. After we do that, we  
19 will start you off on a discussion of future work you can  
20 consider.

21           At the last meeting, the issue of diversity was  
22 raised, and we have no included some information on this in

1 the chapter. This chart shows the distribution of medical  
2 students according to family income levels expressed in  
3 quintiles. And as you can see, most medical students come  
4 from higher-income households. In 2005, 55 percent of  
5 students came from families in the top quintile of family  
6 income, as shown in the gray bars on this slide.

7           If we look at the lowest quintile, however, less  
8 than 5 percent of students came from the lowest quintile  
9 group, and only about 10 percent came from the lowest two  
10 income quintiles.

11           As you can also see, these trends in the  
12 distribution of medical students by family income have been  
13 fairly consistent for the past 20 years, although the  
14 portion coming from the top quintile has edged up five  
15 points between 2000 and 2005.

16           Although medical students are significantly more  
17 likely to come from higher-income families, many graduate  
18 from medical school with sizable student debt from medical  
19 school tuition and fees. In 2008, medical students reported  
20 an average debt load of \$141,000, and almost a quarter  
21 carried educational debt of more than \$200,000. Service on  
22 this debt currently averages 9 to 12 percent of after-tax

1 income once in practice.

2           This next chart shows the racial composition of  
3 the U.S. population, applicants to medical schools, and  
4 medical school entrants or matriculates in 2007. The racial  
5 composition of the medical schools is not representative of  
6 the population at large. For instance, African Americans  
7 accounted for 12 percent of the U.S. population but just 6  
8 percent of students entering medical schools. Similarly,  
9 Latinos and Hispanics accounted for 15 percent of the U.S.  
10 population but just 7 percent of those entering. Asian  
11 Americans, on the other hand, make up just 4 percent of the  
12 U.S. population but account for 20 percent of entering  
13 students.

14           The racial composition of medical schools,  
15 however, roughly parallels the medical school applicant  
16 pool; therefore, enrollment in medical school is affected  
17 more by application rates than by acceptance and admission  
18 rates.

19           Similarly, rural students, also generally thought  
20 to be underrepresented in medical schools, have similar  
21 types of issues. Women, though, now account for about half  
22 of all entrants and graduates in medical school.

1           Efforts to diversify the socioeconomic and  
2 demographic make-up of the physician workforce are thus  
3 hampered by circumstances that affect students' eligibility  
4 or decisions to apply to medical schools, such as college  
5 graduation rates and financial status and debts after  
6 college. Thus, if we are concerned about the demographics  
7 of our physician workforce, this issue needs to be addressed  
8 at an earlier stage in the pipeline before we get to  
9 graduate medical education.

10           I want to next move on and discuss rules for Part  
11 B billing for supervising physicians, which was also brought  
12 up at the last meeting. Supervising physicians can bill for  
13 services provided by residents if they meet basically three  
14 criteria: They need to be physically present for the  
15 critical or key portion of service, or actually perform the  
16 service. They must also participate in the overall  
17 management of the patient and document their presence during  
18 the service, including who provided each portion of the  
19 service. So just a signature on the resident's medical  
20 record is insufficient for the physician to be reimbursed.  
21 They need to document their participation. And as you may  
22 recall from the past, there were the PATH audits --

1 physician and teaching hospital audits -- that caught many  
2 hospitals not having sufficiently documented their service,  
3 and they had to pay back substantial amounts of monies for  
4 being in violation there. So there has been a lot more  
5 focus on this.

6           Now, there are some exceptions on the present  
7 rules. There are some relaxed rules for lower-level E&M  
8 services in primary care centers, and there's also some  
9 stricter rules for more complex procedures such as many  
10 surgical procedures and stuff. And if you want me to go  
11 into those, I can go into those in more details in  
12 questions.

13           We have also included in the chapter a discussion  
14 of the economic costs and benefits of participating and  
15 teaching activities by hospitals and physicians. This  
16 discussion was summarized very well by Peter at the last  
17 meeting. Here on this slide we list some of the economic  
18 costs and benefits. In terms of costs, you have, of course,  
19 the compensation for residents and the faculty. You have  
20 program overhead expenses for running the program. You have  
21 the facility infrastructure costs. Because of having  
22 residents, it may mean more office space and things like

1 that and a more complex medical library.

2           There is also the natural inefficiencies  
3 associated with the teaching process that takes place in  
4 terms of residents ordering more services, for instance, and  
5 additional documentation that may need to occur. And also,  
6 teaching hospitals often and being associated with academic  
7 practices may attract a more complex mix of patients.

8           On the benefits side, hospitals will receive  
9 Medicare direct and indirect GME and IME payments.  
10 Residents also provide labor for the hospital or the  
11 practice, sometimes at lower costs, providing potentially  
12 more timely service delivery of certain services and on-call  
13 coverage.

14           There is also the prestige associated with being  
15 associated with teaching that may lead to higher patient  
16 volume and other benefits.

17           Another benefit is allowing physicians to keep  
18 current on research, the latest research and technologies  
19 because of being associated with these practices and  
20 training residents, and also the ability for physician  
21 recruitment. You have physicians that are in an apprentice  
22 type role, and you get to see them and observe them, and

1 that potentially has an advantage in terms of potential for  
2 future recruitment, both for the hospital and for a  
3 physician practice.

4 With that, Cristina will continue on.

5 MS. BOCCUTTI: So from our discussion last month,  
6 we heard a consensus for us to move forward on our analysis  
7 of policy options to increase residency experience in non-  
8 hospital settings for certain specialties. So these  
9 approaches could include the first three bullets that we  
10 have on the slide. I'm sure that there's more, and we'd be  
11 happy to hear them. But for the sake of example, I'll just  
12 mention these three. So we'll look at relevant regulations  
13 and draw attention to any unnecessary regulatory barriers.  
14 For example, we can focus on the distinction in training  
15 between didactic and hands-on care for the purposes of  
16 direct GME payments. We can also examine ways to reduce the  
17 substantial financial disincentives that teaching hospitals  
18 face for residency training outside the hospital. So these  
19 would include the disincentives of the labor costs and the  
20 loss of GME revenue that they are getting when the residents  
21 train outside the hospital. We'll also assess the approach  
22 of establishing requirements for non-hospital training to

1 obtain direct and indirect GME.

2           Next on this slide you'll see -- you'll recall  
3 that the results from our RAND study showed many lapses in  
4 residency training on topics that are important for delivery  
5 system reform, such as multidisciplinary experience and  
6 quality measurement. So, again, I've listed three possible  
7 approaches we could look at for addressing this issue in  
8 future work, and, again, you can mention more.

9           We can analyze mechanisms to encourage accrediting  
10 organizations to focus more attention on specific items in  
11 their auditing process, and this can include continuing  
12 medical education, which many people brought up at the last  
13 meeting that physicians are life-long learners, so we could  
14 be looking at those objectives as well.

15           We can also look into ways that GME funding can be  
16 used to support research on best practices in training -- in  
17 other words, investing in training the trainer. And we can  
18 also examine requirements or financial incentives for  
19 sponsoring institutions, such as teaching hospitals, to  
20 ensure their residency programs include specific criteria.  
21 These could either be a condition of funding or a means for  
22 increasing or decreasing funding.

1           On this last slide, we've developed three main  
2 questions for discussion, and hearing your comments on this  
3 will help us move forward with additional work.

4           First, it seems that an important feature of  
5 medical education funding should be that it be distributed  
6 equitably and efficiently. And since Medicare is the  
7 largest contributor to graduate medical education, teaching  
8 hospitals with lower shares of Medicare caseloads receive  
9 proportionately less funding, and this occurs more often in  
10 low-income communities, as Nancy pointed out in the last  
11 meeting.

12           So how should all payers contribute? And what  
13 mechanisms should determine fund distribution? For example,  
14 some expert panels have suggested trust funds and  
15 independent boards for determining the allocation of  
16 graduate medical education funds.

17           Second, we could also focus our thinking on  
18 linking education subsidies to actually delivery system  
19 reforms. For institutional incentives, the teaching  
20 settings would be the leaders in delivery reform. So, for  
21 example, teaching hospitals with certain infrastructure,  
22 such as comprehensive health IT, could garner more favorable

1 medical education payments. And as Peter has mentioned, it  
2 is important here that the health IT be actively used rather  
3 than just purchased, and we can talk about more details on  
4 that. But I think we did a little bit in the last session.

5           Institutions can also be leaders in payment policy  
6 reforms, so, for example, teaching hospitals that agree to  
7 bundle Parts A and B payments could receive higher GME and  
8 IME payments. And here residents would learn the skills  
9 needed for delivery system reform by working in settings  
10 that actually do them.

11           We can also draw from our previous work on  
12 curricula and examine requirements and incentives regarding  
13 delivery system reforms. Here, in addition to items such as  
14 formal multidisciplinary care, we can also include  
15 incentives for training in the basics of geriatric care  
16 across all specialties to address the aging of the patient  
17 population.

18           Moving to the third question there, the Commission  
19 may also examine ways for medical education subsidies to  
20 help generate the most efficient mix of generalists and  
21 subspecialists. And by generalists, I mean primary care  
22 physicians and also general surgeons. Payment policies

1 around the number and type of residency slots that Medicare  
2 subsidizes could be a tool for balancing these specialties.

3 Adequate nursing and nurse training is also  
4 important for successful delivery system reform as many of  
5 their skills and care coordination are essential.

6 Some of the demographic information that Craig  
7 presented showed the importance of even attracting lower-  
8 income and minority students into the field of medicine.  
9 Loan forgiveness programs and other strategies to encourage  
10 applications to medical school could be important to  
11 increase the economic, racial, and geographic diversity of  
12 health professionals.

13 Finally, to improve patient access to care, all  
14 physicians could be required to conduct minimal public  
15 service in exchange for the subsidies that Medicare paid for  
16 on their behalf. For example, physicians could be required  
17 to provide occasional on-call services. Having an adequate  
18 panel of local physicians on call is a crucial component of  
19 our nation's health care, yet in recent years, fewer  
20 physicians are even agreeing to take call.

21 So these are some of the topics that we really  
22 look forward to your discussion at the end of the day, but

1 I'm sure it will be a good one.

2 MR. HACKBARTH: Thank you. Okay. First round,  
3 clarifying questions.

4 MR. GEORGE MILLER: Yes, on your last comment, I'm  
5 just curious. How do you propose that the social benefit  
6 for the subsidy of their residency program would work? Can  
7 you give me some examples of how that would work or you  
8 suggest it would work?

9 MS. BOCCUTI: Are you saying with the third  
10 bullet?

11 MR. GEORGE MILLER: The third bullet about that,  
12 because --

13 MS. BOCCUTI: We need to talk about this and work  
14 through those ideas. I think what you're getting to is how  
15 the money would go to the hospital and then ensure that the  
16 physician -- this is after the residency program --

17 MR. GEORGE MILLER: Right, right.

18 MS. BOCCUTI: -- fulfilled this public service.  
19 Isn't that what you're talking about?

20 MR. GEORGE MILLER: Yes.

21 MS. BOCCUTI: We need to go through those ideas.  
22 We're aware that it's going to take some logistical issues,

1 but I don't know that that should stop the examination of  
2 that option.

3 MR. GEORGE MILLER: And just to tease that out a  
4 little, if I'm in rural West Texas, in Fort Stockton, Texas,  
5 I would have the same -- an equal opportunity to get a  
6 physician who did his or her residency training in Chicago.  
7 Is that --

8 MS. BOCCUTI: Well, maybe we'll talk about that as  
9 future work comes forward, because we need to think where  
10 the people would come from and what they would be doing. I  
11 think these are great issues to bring up when we talk about  
12 that.

13 MS. HANSEN: Yes, just a request perhaps more for  
14 context. I think the last time we met, I learned that  
15 within GME there actually is funding dedicated for hospitals  
16 who train nurses. There are not that many left, but I just  
17 wondered if a background piece could be included as part of  
18 this GME piece.

19 MS. BOCCUTI: Sure, we'll put a little more  
20 information about that. And we're talking not just about  
21 what exists but maybe what could be expanded as well.

22 MS. HANSEN: Yes, that was going to be part two,

1 but yes, definitely. Thank you.

2 MR. BERTKO: I think I'm asking about the first of  
3 the three bullets on the last page under -- well, it's the  
4 residency subsidies one. I have a couple of things in my  
5 head, but I was curious what you thought was included in  
6 that. Does it include something to generate a larger number  
7 of generalists, or is it more confined than that?

8 MS. BOCCUTI: I think we need to talk about that.

9 [Laughter.]

10 MR. BERTKO: I've heard those words --

11 MS. BOCCUTI: I'm not going to answer this right  
12 now, but I think there are two ways that one could go. You  
13 know, there is the number of slots that you're talking  
14 about, and there could be a redistribution within the  
15 current number. So we could talk about that and what's paid  
16 for, you know, what parts of that is paid for. And then the  
17 other idea would be if there were just simply increases,  
18 say, for primary care, and that's where you're going. So  
19 this is a discussion that we can have.

20 MR. MARK MILLER: For myself, the way we have been  
21 thinking about this is, given the slots, do we want to  
22 discuss redistribution and how we support them. And then it

1 becomes the next question of how many slots.

2 DR. CASTELLANOS: Thank you, and good job. I had  
3 a unique experience last night. One of my partner's son is  
4 here today. He's a medical student. And we were talking a  
5 lot about medical school and the education they're getting  
6 towards a lot of these concepts. Then I had the opportunity  
7 to talk to Karen Fisher from the AAMC, and one of the things  
8 I noticed in our report and presentation today has been an  
9 absence of any discussion on the student education in  
10 medical school, and these concepts of delivery system reform  
11 need to be imprinted in their basic educational process.

12 Somehow these concepts, we are really missing, I  
13 think, an opportunity to try to change this culture -- and  
14 that's what we're really trying to change, this cultural  
15 approach.

16 So I guess my clarification question is: What  
17 levers of anything we have to make this happen in the  
18 medical school itself? Do we have any levers that we can  
19 use to make these things happen?

20 MS. BOCCUTI: Well, I'll say something about it.  
21 I'm sure Craig might want to come in, too. Two things.

22 One, we have looked a little at what is being

1 taught in medical schools, and the RAND researchers did look  
2 into that to some degree. For reasons of space and, you  
3 know, keeping the chapter at the length that it is, we  
4 focused more on the graduate medical education component  
5 primarily because that is where the levers are right now.  
6 But I don't think that means that the Commission needs to  
7 restrict itself to that when they're thinking about the  
8 whole medical education process. But it is where Medicare  
9 plays the biggest role right now.

10           So I think that we'll continue to try and talk  
11 about medical school, and we talked about it with the PATH  
12 to becoming a physician and what's required there and what  
13 accrediting components are there, and also the importance of  
14 applications and what's going on with medical school.

15           So I think we addressed it to some extent, but we  
16 need to determine what levers that we as taxpayers, you  
17 know, have with this in the sense that this is the health  
18 care for the United States, and Medicare is training a lot  
19 of those professionals.

20           MR. LISK: There is some course work that goes on  
21 in that aspect of things in medical schools, but the details  
22 behind it -- and we were trying to get at that -- are not as

1 certain and potentially inconsistent. And sometimes it's  
2 mandatory in some schools; sometimes it's optional in some  
3 schools, too.

4 DR. CASTELLANOS: You're are absolutely right. It  
5 is happening. But is there any way that we can encourage  
6 this, if nothing else, in our chapter on this?

7 MR. HACKBARTH: I very much agree with the premise  
8 of your statement, Ron. Being a non-physician who hangs  
9 around with a fair number of physicians, it sounds right to  
10 me that there's a certain imprinting that goes on very early  
11 in the educational process. And Tom has talked about how  
12 even in the selection for medical school, important  
13 statements are being made, in effect. So I agree with that.

14 I personally am struggling, though, where we ought  
15 to draw the line on what we can contribute to this very big  
16 and very complicated topic. I sort of think of the  
17 discussion we had earlier on biologics. You know, clearly,  
18 a pathway for follow-on biologics has huge implications for  
19 the Medicare program and the health care system more  
20 generally. But it seems to me that it is a complicated  
21 issue that's outside of our normal purview in the things  
22 that we study and have some reasonable competence about, and

1 I'm always worried about reaching way beyond the familiar to  
2 say, oh, we ought to change this, we ought to change that.  
3 I fear that we run the risk of appearing as dilettantes.  
4 There are a lot of people who spend a lot of time on these  
5 issues, and we are going to spend, you know, a few hours  
6 talking about them.

7           So I don't know exactly where that line ought to  
8 be that's within -- or at least reasonably close to our  
9 distinctive area of competence, but I think we need to be  
10 careful about just drawing this circle ever bigger and  
11 making it ever more inclusive.

12           DR. CHERNEW: I actually second the idea of having  
13 that point, which I agree with, outside of the circle of  
14 this report, and the reason I say that is I actually teach a  
15 class like that to the medical students, and the problem is  
16 that -- and I think it's a very good class, I should say.

17           [Laughter.]

18           DR. CHERNEW: I should say I teach in the class.  
19 It's absolutely not my class. It's Haiden Huskamp's class,  
20 largely, and she does a tremendous job. But a lot of these  
21 issues come up. But I will say, after having, you know, a  
22 semester of going through many of these issues, I'm not sure

1 anyone, any of the students' culture is changed because,  
2 honestly, no matter what you say to them, they tend to  
3 think, you know, endocrinology, or whatever the exam happens  
4 to be. And so I think your point is very well taken, but I  
5 think it is well beyond the type of things we can influence  
6 with these levers because I think it -- that might change if  
7 we change some of these levers. But to try and go at that  
8 directly I think is really very, very hard because -- I  
9 think someone said this when they were here before. They're  
10 all going after their boards, and as long as that's what  
11 they're going after, we have to worry about how to change  
12 the bigger picture and stick in there instead of getting to  
13 that micro level.

14 DR. DEAN: Just to respond to a couple, I agree  
15 completely with what Mike just said, that it has come up in  
16 my discussions with medical educators. We were talking  
17 about the whole issue of teaching professionalism, and I  
18 said, sure, you can have lots of lectures about it, but  
19 really it's determined by what people observe in their day-  
20 to-day experiences, and it only has meaning once they sort  
21 of get into practice and have to make some of those tough  
22 decisions. That's when you need to have the opportunity to

1 discuss some of these issues and have access to that sort of  
2 expertise.

3 I certainly am sympathetic, Glenn, with your  
4 concerns, but on the other side of it, we have set some  
5 goals and set some ideas, at least, of where we would like  
6 to see the system go. And if we can't get there without  
7 some of these changes, then it does, I think, become a real  
8 concern.

9 So it is a real tension, I agree. This is sort of  
10 outside of our realm, and yet unless we see some changes in  
11 this education system, we can't get to where we want to go.  
12 So, I mean, just in response to what you say. I guess I  
13 have one other thing, and I'll shut up --  
14 realm

15 MR. HACKBARTH: Just on that narrow point, though,  
16 I agree that there is a long way to go, and all of these  
17 things that we have briefly mentioned are important,  
18 potentially important factors in shaping the health care  
19 delivery system of the future.

20 I would say, however, though, we shouldn't think  
21 that we're the only ones who have made that observation and  
22 had that insight. You know, the tiny little window on the

1 world that I have is through the work I do with the ABIM,  
2 and I hear a lot of the same themes and how, you know, the  
3 process of specialty certification and maintenance of  
4 certification needs to be improved so that, for example,  
5 there's a greater focus on systems-based practice and  
6 improvement and a lot of the themes that came up in this  
7 chapter. I feel way better than talking about how to do  
8 that and making constructive suggestions than about my  
9 ability to do it. So we have allies in this fight. We're  
10 not the only ones pulling levers.

11 DR. DEAN: The other comment that I would make is  
12 the other response that I've certainly gotten in talking  
13 about some of these issues is just what Mike brought up,  
14 too, that especially the curriculum, especially in the first  
15 two years, is just totally dominated by what's on the  
16 national boards. And they are such a powerful force that  
17 the faculty tell me that their hands are tied. They would  
18 like to introduce some of these issues, but they say, "We  
19 are so obligated to make sure our students do well on that  
20 test that we have no choice."

21 Now, I don't know. Maybe they're overstating it,  
22 but I have gotten that from faculty in several different

1 schools, so I don't think it's just ones -- actually, the  
2 original question I had, Slide 3, I had seen data that the  
3 percentage of students from high-income households had  
4 actually increased significantly over the last decade or so.  
5 I don't know. I'll have to go back and see where I got that  
6 data because this is AAMC. I assume they should know. But  
7 I had certainly seen some data that said that that had  
8 increased quite a lot. So I don't know.

9 MR. LISK: Well, if you look at the top two  
10 quintiles and you look at that orange bar, there's quite a  
11 bit of drop in that orange bar from 1999 to 2005, for  
12 instance. So there has been an increase in upper-income  
13 families, students coming from upper-income families.

14 MR. HACKBARTH: We have to get on to round two  
15 since we are already sort of lapsing into it.

16 DR. BORMAN: Yes, I'm going to structure these  
17 comments to try and come at your questions, which I think  
18 was the purpose here. But I'm going to ask your indulgence  
19 and go in from the bottom up, if we could, because I think -  
20 - for a lot of reasons.

21 Number one, I think the bottom question perhaps is  
22 the one that drives most of the others, because I'm not sure

1 that we've come to a conclusion about what it is that are  
2 the professionals we need. And I think by that, I think  
3 this discussion, because it tees off of GME, certainly  
4 focuses on the physician. But I think that we all could  
5 agree that we're looking for the most efficient provider  
6 level for various services, and I think we tend to default a  
7 little bit to a notion that the overwhelming majority of  
8 this is being provided by physicians. I think we need to --  
9 I personally would like us to be a little bit careful about  
10 the terms "primary care" versus "primary care physician  
11 specialist," because I think that not all primary care  
12 requires a physician to deliver. It requires very high  
13 level primary care physician skill to do certain things  
14 about primary care and to manage a team of extenders or mid-  
15 level providers or whatever you want to call it. But I  
16 think that we really need to be a little bit careful about  
17 that, and I'm not sure that at all times we are.

18           So I'm not sure that we've defined that workforce,  
19 and it may, Glenn, be one of those issues, frankly, that is  
20 ultimately somewhat beyond our purview. Just how far we go  
21 down this road -- and in all fairness, so you don't think  
22 I'm just picking on primary care, I would agree that there

1 are some procedures that surgeons provide that every day are  
2 provided by other than surgeons, and particularly more in  
3 the minor procedure category, can be very credibly provided.  
4 And we need to identify those as well, but I just want to  
5 sort of de-link this notion maybe of physician and, you  
6 know, the professionals we need, that this is a broader  
7 conversation. We can't fix everything through manipulating  
8 GME, and, again, I think that is in part what I hear from  
9 you.

10 In terms of the part about loans and subsidies, I  
11 would say that there are great things to think about. I  
12 personally think they apply to way beyond physicians. There  
13 are people that struggle to go to nursing school, PA school,  
14 respiratory therapy school, da, da, da. And in terms of  
15 supporting a workforce, we should make opportunities for all  
16 those providers, again, trying to get to that mix, whatever  
17 that mix appropriately is.

18 Just a comment about public service. I think that  
19 is certainly a very rational road to go down, to explore,  
20 given the extent of the taxpayer commitment to this not just  
21 through the Medicare program, the Medicaid program, the NIH,  
22 the state contributions. I mean, they're just too numerous

1 to count. And I think it is a very reasonable exploration,  
2 and I would say that many residents certainly seek out  
3 opportunities for international rotations, and I can tell  
4 you that the Residency Review Committee for surgery, which  
5 is part of the ACGME, is certainly having active  
6 conversation about this, because there are so many  
7 applications from residencies to send residents for  
8 international experiences. Well, one might think if they're  
9 interested in international service experiences, maybe we  
10 can interest them in domestic service experiences, or at  
11 least say, you know, from whence the money comes links to  
12 where the service might be provided. And I think we may  
13 have to have a bit of that conversation.

14           The other piece embedded in the chapter is the  
15 part about the overlap, at least in the organizations that  
16 appoint to the accrediting bodies and so forth. And I would  
17 just like to say while I recognize that there is overlap to  
18 a significant degree, I would suggest that the actual  
19 appointees tend to be fairly diverse. And so it's not quite  
20 as incestuous as maybe seems to be implied by the chart that  
21 is in the chapter. And I would want to be a little bit  
22 careful from getting too far from the level of expertise,

1 and perhaps part of the answer is to increase the public  
2 representation, but I am not sure it's to impose a different  
3 level or to undo that whole appointment system.

4           With regards to linking to GME, I think this is  
5 the most rational direction we can go down, particularly the  
6 institutional incentive side I think is the most natural  
7 place for this to go down, because it fits best with the  
8 system that we have right now. It gives us more of an  
9 immediate starting point. The money goes to the teaching  
10 hospitals. It's rational to start moving through that  
11 process while we work on answering what's the mix and  
12 deciding the other things we need to do. And so to do this  
13 in a way that can be more immediately productive.

14           I have a lot of disquiet about curricular  
15 incentives. Medicine is a moving target. The world in  
16 which I practice is very different from the world in which I  
17 trained just in diseases. Peptic ulcer disease, for an  
18 example, has largely gone away as something we operate on  
19 other than acute perforations because of drugs. The same  
20 things ultimately will happen to other diseases. We need to  
21 be very careful about meddling with curriculum, and I think,  
22 Glenn -- and maybe you've inferred that -- there are some

1 pieces of this we do need to leave to the experts.

2 In order to answer some things Jennie has brought  
3 up, I hope you will be encouraged, at least it's my  
4 observation that we do an increasingly better job of  
5 addressing geriatric issues throughout medical school and  
6 residency. And, frankly, that's the way we need to do it as  
7 embedded throughout and not some little focused touchdown  
8 that you check a box and then answer a couple of questions  
9 on the test. So that's that.

10 The top one, I personally think the board just  
11 muddies the water even further, and, again, I would like to  
12 see us think about something better in the way of public  
13 representation to some of the other parts that govern the  
14 system rather than some super board that just gets caught up  
15 in a lot of rehash and perhaps is not empowered to do  
16 anything differently.

17 If I could just mention on the sites of education,  
18 I don't think you've implied this, but I'd want to be very  
19 careful that it's not what people infer. While certainly  
20 most people do not spend 100 percent of their post-residency  
21 practice lives in the hospital, I'd be very careful about  
22 any implication that it should be a one-on-one relationship;

1 that is, if 80 percent of your practice is outside the  
2 hospital, that 80 percent of your education should be  
3 accomplished in non-hospital settings, and that's for a  
4 couple of reasons.

5           Number one, in exposure per minute to diseases,  
6 it's going to be greater in the hospital setting, so there  
7 is an educational efficiency to that. It may not meet the  
8 entire spectrum, but you see a lot more things more quickly  
9 in a hospital setting. So the notion that if we transformer  
10 it to 80/20 the other way, we will have people who don't  
11 know enough about an awful lot of things. So we want to be  
12 careful about not implying that that should be the standard.

13           On the other hand, we should remove regulatory  
14 barriers, and we should get away from this very artificial  
15 language of didactic and hands-on. Residency by definition  
16 is experiential. It needs to be graded responsibility  
17 experiential, and we just need to be careful about that.

18           DR. DEAN: A couple things. First of all, just  
19 quickly, there was a comment in the chapter, something to  
20 the effect that people with bigger debts were more likely to  
21 go into specialties that had loan forgiveness or something.  
22 And I really, I guess, think we need to look at that a

1 little more carefully because I think, in fact, a lot of the  
2 places where loan forgiveness is available is primary care  
3 in underserved areas, and as debts have gone up, recruitment  
4 in those areas has gone down. So I think I have a problem  
5 with that statement. It needs to be looked at.

6           Secondly, in a broad sense -- and I agree with  
7 much of what Karen said -- I think we need to be careful  
8 about getting too specific with some of these things. The  
9 thing that bothers me about the public support for GME is  
10 there is no connection between what the needs of the public  
11 are and where the money is going. And I don't exactly know  
12 how to do this, but I think we need to try to look for some  
13 way that we can have sort of a self-correcting system that  
14 when a need evolves, there is support for a program to meet  
15 it rather than specifying -- you know, I'm all in favor of  
16 more support for primary care, obviously. But there's also  
17 other gaps in the system, as I think Karen has spoken to,  
18 that we need to meet. And we've got to be careful we don't  
19 lock ourselves into a specific structure because, as she  
20 just said, this is a changing field, and the needs are going  
21 to change, and we need to try to develop some kind of a  
22 responsive system that gets the resources to where the needs

1 are. That may be tricky. I don't have an answer on how to  
2 do that.

3 I guess I would quibble a little bit with your  
4 last comment.

5 DR. BORMAN: I would be disappointed if you  
6 didn't.

7 DR. DEAN: I think, yes, there are a lot of things  
8 to be learned in the hospital, but there is also a large  
9 body of knowledge, especially with the spectrum of disease  
10 we deal with now, that simply can't be learned in the  
11 hospital. The management of chronic disease is never going  
12 to be learned in the hospital. And, in fact, some of the  
13 things you learn in the hospital almost work against that.  
14 So I think as far as the time breakdown, I wouldn't argue  
15 with that, but there are --

16 DR. BORMAN: It's just not one of them.

17 DR. DEAN: Yes, I can accept that. But there are  
18 some things that you just will never learn in the hospital  
19 that needs to be done.

20 MR. BUTLER: Of course, I've given this a lot of  
21 thought -- which could be dangerous because most of the  
22 thinking is just on my own. But at the risk of getting out

1 there and making some fairly strong recommendations, I'll  
2 try. And I will come back and say to me it's all about the  
3 middle part of the chart there. You know, these other  
4 things are great, they're important, but we spent \$9 billion  
5 a year between GME and IME, and I don't want to go through  
6 three or six years at MedPAC quibbling over whether it is  
7 4.5 or 5.0 or 3.0. We can do better than that. We can help  
8 articulate what a good GME setting and a good GME  
9 environment ought to be, and I think we can move the ball  
10 forward. So that's kind of a little bit of the punchline.  
11 Let me describe how I think I'd start to do that.

12 First, in terms of the chapter itself, to get my  
13 negative comment out of the way, this last one, just the  
14 last one, the minimal public service, that one just doesn't  
15 make -- I know you said we can clarify and discuss. I just  
16 don't think that that one is going to work and not worth  
17 study. All of the other ones, if we want to at least leave  
18 them in the chapter for now as potential study, I think  
19 they're okay and understandable. But I'd make an argument  
20 that that one come out of the chapter at this point until we  
21 know it better. A small point.

22 I made some comments last month, and you did a

1 terrific job accommodating them, so let me comment on a  
2 couple of them. The title itself, where you said "Medical  
3 education - Supporting long-term delivery system reform," is  
4 much better, especially because you got the long term.  
5 We're training and looking at creating lifelong successful  
6 people, not trying to respond to this year's medical home or  
7 payment methodology that will change next year and we're  
8 going to whip dollars all over the place as a result of this  
9 year's thoughts. So I think you helped capture that in the  
10 title, and that's important.

11           Secondly, you continue and you did a good job of  
12 still saying addressing the regulatory barriers, and I think  
13 that is a contribution we can make sooner rather than later  
14 to CMS, as soon as next year, I think.

15           And, third, you lifted out and highlighted the  
16 ACGME competencies, which, if anybody had read those, you  
17 can even read like the sixth one, a system-based practice.  
18 If you read that language, it says coordinate care, it says  
19 quality and safety and cost -- we couldn't even write it  
20 better. The question is: Is the ACGME kind of pass-fail  
21 system strong enough, or whatever, to make sure that those  
22 things are happening? But the language in the accreditation

1 now isn't that far off of what we want. It's a question of  
2 -- you know, now the question is: How do we make that kind  
3 of happen more? Do you use some of the financial incentives  
4 or some of the mechanism to go right after the program  
5 itself? Or do you sit it in the institutional setting where  
6 the dollars are going now? And I think it is the latter,  
7 because I don't think we're going to send money suddenly  
8 strictly to programs. We're going to send them to  
9 institutional settings. And that kind of gets at the heart  
10 of this second bullet point.

11           At the risk of using "meaningful user" as a  
12 concept, it's such a -- but you can envision, I think, in  
13 let me say a negative setting, if you were at a medical  
14 school or a residency program and you say, boy, this  
15 hospital calls you and they say, you know, we really could  
16 use some coverage, do you have any residents, you know,  
17 we'll pay them and we'll get the IME, and you go into an  
18 environment, there's no IT, there's no coordination of care,  
19 there's just a focus on acute care episodes. You can  
20 imagine -- paint as bad a picture as you want. Would you  
21 really want to send your Medicare GME and IME dollars in  
22 that kind of setting because you're not going to -- no. So

1 that's a negative of saying it. But how would you begin to  
2 say what would be a progressive or a meaningful user? What  
3 would that environment look like? And short of trying to  
4 measure it today, what are the characteristics that would  
5 say if you go into that setting in that environment with the  
6 competencies in mind, you know you're going to get something  
7 out the other end that is going to perform at an extremely  
8 high level.

9           So if we could begin to articulate what that  
10 environment would look like and then eventually or at some  
11 point you take those IME dollars in particular and you say  
12 flex them up, flex them down, whatever the support is, you  
13 could potentially differentiate them out that you're paying  
14 on, depending on the environment that these residents are  
15 going into. And I think that general direction creates the  
16 kind of accountability that would look a lot different than  
17 right now you send -- it doesn't matter what the setting is,  
18 what they're doing, and that's just not good enough.

19           DR. KANE: First, I agree with everything Peter  
20 said, and also, just a couple things that, as I read the  
21 chapter, came to mind, which was -- one is the role of FMGs,  
22 and one of the things I notice is that they seem to be

1 filling all the geriatrician slots and a lot of the primary  
2 care slots. And I'm wondering if there isn't some way to  
3 evaluate whether that's the most efficient way to produce a  
4 primary care capacity in this country, or whether we want to  
5 think about Medicare supporting, if it isn't the FMG - if  
6 American medical students don't want to go into primary care  
7 or geriatrics, perhaps there's another level of people, U.S.  
8 or foreign, that want to go through training. I'm thinking,  
9 you know, physician extenders, nurse practitioners. A lot  
10 of the people from the military who learned to become medics  
11 often want to come back and be effective in the domestic  
12 side. Should we be looking for ways to expand our primary  
13 care capacity? And what are the implications that so much  
14 of it is currently being filled by FMGs? I don't have a  
15 good sense of that, except that I do notice that in the  
16 classes that I do that are like Mike's, the training at the  
17 medical school level is about 30 years behind ours in terms  
18 of acceptance of IT or oversight or accountability or team -  
19 - I mean, maybe not all of them, but some of them are. And  
20 so I just wonder if there's anybody thinking about what does  
21 it cost to untrain and retrain an FMG into this capacity.  
22 And would it be, you know, maybe to try to just start people

1 into the primary care capacity at a different level and try  
2 to expand that capacity?

3           The only other thing I thought of is that -- I'm  
4 the one who's into the lifelong learning thing. Is there a  
5 way to bring into the P4P for physicians that they've  
6 covered certain kind of CME topics, that they've done things  
7 around care coordination or cost/benefit, you know, that  
8 they've achieved those and therefore they get a blip-up? As  
9 long as we're on a P4P kind of mentality, is there a way to  
10 bring in what kind of CME they -- or whether they hit  
11 certain types of CME that relate to the kind of goals that  
12 we have for the Medicare program?

13           DR. CASTELLANOS: Two points. Nancy, just to  
14 emphasize your point about the international medical  
15 graduate, 25 percent of the primary care people in Florida  
16 are international medical graduates.

17           Talking about the medical education subsidies to  
18 produce the professions we need, again, I'm going to talk a  
19 little bit about workforce. I think the Commission has done  
20 a great job with primary care. We have certainly emphasized  
21 a higher pay rate, pay scale. We've tried to boost the  
22 reputation, put them in more of a substantial role, and get

1 that primary care doctor to have more intellectual stimuli.  
2 So I think we've done a lot of things for primary care. And  
3 I think there are some other issues on workforce, and Karen  
4 may want to comment, but general surgery has a real low  
5 role.

6           You know, one of the ways we can at least try to  
7 solve this is by the caps, and perhaps we could even  
8 consider designating certain specialties, not all, on a  
9 trial basis to see if that works to fill some of these  
10 critical shortage areas.

11           DR. CROSSON: Thanks. I think my comments are  
12 rather similar to Peter's in this case. I think just based  
13 on what was presented and based on the discussion, I have a  
14 sense that we're at risk of overreaching a bit in this  
15 particular charge that we have.

16           I agree with the framing, as Peter did, that  
17 talking about, you know, how Medicare might use its leverage  
18 to improve the education, postgraduate education, anyway, of  
19 physicians to promote more effective delivery of care over  
20 time is probably the most comfortable framing. There are  
21 some broader framings in that that are possible, but that's  
22 the one that appeals to me also.

1           So, within that and at the risk of being  
2 minimalist here, I think, again, the issue of the apparent  
3 growing inadequacy of the physician manpower and primary  
4 care is certainly one. And then also the fact that we've  
5 noted during the discussion that residents often come out of  
6 training without any real knowledge about how to practice  
7 medicine in the office, and particularly how to practice  
8 medicine in a judicious and responsible manner with respect  
9 to the cost implications of practice patterns.

10           So, again, and I apologize for being reductionist,  
11 if that's what it is, but it seems to me that among all the  
12 things that we have to look at here, this issue of trying to  
13 move over time to support the separation of a significant  
14 portion of training from the in-hospital experience makes a  
15 lot of sense. It doesn't solve all problems. I think there  
16 are problems, having done it myself, obviously, with  
17 hospital training only and that it's limited in scope. It's  
18 not where most care is practiced anymore, and that's  
19 literally changed in the 30-some-odd years since I was in  
20 training.

21           There's an expensive bias to having training  
22 predominantly in the hospital setting compared with the way

1 other forms of medicine are practiced in offices and other  
2 kinds of group practice settings and the like. And the peer  
3 experience in the hospital setting is somewhat narrow. I  
4 think others have commented on this.

5           So whatever we could do, whether it is trying to  
6 act to remove barriers to support training programs being  
7 more in the non-hospital setting or, in fact, creating  
8 incentives, that is the area where I think we can get --  
9 it's the closest to our charge, in my mind, and it's the  
10 area where I think we can get the most impact.

11           MS. HANSEN: Thank you. I'll mention four points,  
12 and some it has been covered. And, Cristina, when we talked  
13 about the graduate hospital nursing role, in many ways I  
14 think it has been addressed by a number of the Commissioners  
15 here, about thinking about that next level, which is your  
16 point about advanced nurse practitioners or physician  
17 assistants or post-military individuals.

18           The ability to think about what do we need -- and  
19 it ties to the chronicity of care, where sites are going to  
20 be, so I really would like to see that that area just be  
21 discussed. And it may be also to be cross-referenced to one  
22 of the recent IOM reports, "Retooling for an Aging America."

1 So I think referencing, again, where care is increasingly  
2 going to be received and have that aspect.

3           The second point has to do with -- and it probably  
4 falls under, Glenn, your area of other groups like the ABIM  
5 having domain over this, but I think as pointed out, people  
6 will learn what they're going to get tested on, and so it's  
7 not just the first two years, but all the annual  
8 recertification, if that is built into the testing side, not  
9 just the professional societies but the actual testing for  
10 competency, if it's build in there, then it would get  
11 taught.

12           But one kind of complexity with that is that if  
13 existing faculty haven't done this, it's really tough for  
14 students to be learning it. So something has to be done,  
15 and perhaps ABIM is working on that: How do you prepare  
16 faculty? And this is the same issue in nursing faculty,  
17 trying to have them focus a little bit more on geriatrics.  
18 Many people don't have that. So that's kind of a cross  
19 issue.

20           Then the final point, just to pick up on Jay's  
21 last point where having money flow to the sites where people  
22 are going to be practicing outside of the hospital, I think

1 this has been always a tension, just because the requirement  
2 for the GME and IME kind of going into the institutional  
3 hospital setting. But if practice is going to go elsewhere,  
4 there are many sites, whether they're the FQHC clinics where  
5 people are practicing or other outpatient types of settings  
6 where people are getting their chronic care. I know when I  
7 operated the PACE Project, we had residents come through.  
8 The whole question is, you know, were we able to get some  
9 bit of funding to offset our physicians who were doing the  
10 training. And, of course, at that point the answer was no.  
11 But it just seems like some kind of shift on that area has  
12 to be considered.

13 Thank you.

14 DR. MILSTEIN: I'll be very brief.

15 First of all, this is a point that a number of  
16 people have made. I'll just try to make it more explicitly,  
17 and that is, there are a number of potential problems with  
18 current medical education, and our challenge is to figure  
19 out what tools within the jurisdiction of the Medicare  
20 program are a fit for those problems. On primary care,  
21 specialty care mix, you know, this has been pointed out by  
22 others, but the tool that is the best fit to that is

1 Medicare physician reimbursement. It is not beginning to  
2 dictate who comes in and out, you know, who goes into  
3 programs or forgiveness or anything like that.

4           The second comment, the second potential objective  
5 is this issue of improving the equity of slot allocation,  
6 and that is a tough one to solve with Medicare reimbursement  
7 policy because the inflow so much depends on who gets into  
8 medical schools, and Medicare has no grip point, you know,  
9 on that. So I support that social objective. I just can't  
10 figure out how to use Medicare policy to effect it.

11           Then the third is this educational content  
12 dilemma, and I certainly agree with Karen that the federal  
13 government trying to dictate, track, and manage curriculum  
14 content would be very tough. But I think there are some  
15 interesting tools within the purview of the Medicare program  
16 that we could use. For example, the American Board of  
17 Medical Specialties and maybe their member boards are very  
18 anxious to have their board certification process be deemed  
19 equivalent to PQRI participation, and so that is, you know,  
20 a terrific level, I think, because it's something that the  
21 boards want. And we have something in turn we want from the  
22 boards. And my last comment on this is if I had to pick one

1 thing to focus on with them, I would go one level up, and  
2 it's really -- it's the ability to manage performance that  
3 is the generic -- you know, if I had to pick one thing that  
4 sort if you could correct it might make the biggest  
5 difference in improving all aspects of the Medicare program,  
6 it is performance improvement, because that then would  
7 require all the other content areas to pull geriatrics  
8 because it's the Medicare population, it would pull health  
9 care IT. Those are all sort of instrumental to that  
10 objective. So that's at least my attempt to sort of map  
11 these different shortfalls, consequent goals, and then  
12 things that are actually within the jurisdiction of the  
13 Medicare program.

14 MR. MARK MILLER: So in previous conversations,  
15 whenever we've talked about delivery reform, a number of  
16 people -- and you among them -- have said, you know, we need  
17 to get to looking at GME and the education process because  
18 it's part of it. And so I guess some of these -- you talked  
19 about there may be different tools like the primary care --  
20 it's a physician reimbursement issue. I hear that.

21 Could I just get you to say the last point again?  
22 Because I tracked comments where people were saying, well,

1 focus your efforts here. It was your last point, I'm not  
2 sure I got quite the connection. And it feels a little  
3 different than -- you know, it almost feels like we're  
4 pulling back and saying this is not really the place to get,  
5 you know, delivery system change, so that also felt like a  
6 little different than I'd heard from you before.

7 DR. MILSTEIN: Absolutely, and probably I'm  
8 influenced by the discussion, which is appropriate. But I  
9 do --

10 MR. MARK MILLER: Don't let that happen.

11 DR. MILSTEIN: But I think that maybe to have this  
12 better fit with my comments before, you know, based on the  
13 help from people around the table, I thought about what's  
14 the best lever for changing educational content. I am  
15 persuaded that probably the number one choice would be to  
16 change what's on the boards that the physicians take. And  
17 now I see an avenue for achieving that having to do with the  
18 horse trade that, you know, the medical specialty boards are  
19 now -- you know, have been on the Hill lobbying to Medicare  
20 to achieve. I think it is a great opportunity for a trade  
21 if the trade can be -- you know, if the deal could be struck  
22 aggressively.

1           MR. MARK MILLER: And what is the trade? What are  
2 you --

3           DR. MILSTEIN: The trade is rather than as an  
4 alternative to participating in -- this is one of the things  
5 being discussed as we speak, as an alternative to  
6 participating in PQRI reporting. If a physician is  
7 participating in the performance, measurement, reporting,  
8 and improvement system that their specialty board is  
9 delivering, A, that would be the basis for any performance  
10 measures being reported to the public, if we get to that  
11 point; and, B, it also could be a means of satisfying  
12 whatever requirements likely to evolve from PQRI, which is  
13 not just performance reporting but performance improvement.

14           I want to make one last comment, and that is, my  
15 view is, in the spirit of Mark Miller, don't only offer one  
16 option. This is my preferred option for how to change  
17 content of medical education. But if this also turns out to  
18 be very objectionable, then I have a second objectionable  
19 option that I still support, which is not so much, you know,  
20 letting the GME money depend on curriculum, because I think  
21 that's very, very slippery to track and manage, but it's  
22 what I've said before: Let it depend on whether or not the

1 faculty FTE in the teaching program include a reasonable  
2 percentage of people whose primary focus is in these health  
3 reform domains. That's much easier to track than curricula,  
4 and it happens to personally reflect my experience in the  
5 unnamed teaching hospital and medical school that I'm  
6 affiliated with, which is that there's actually quite a bit  
7 of support for these new content areas, until you get to the  
8 point, well, you know, who do we have now within our current  
9 faculty who has the expertise to teach it? And that's the  
10 point at which it becomes clear to the department chairs  
11 that they would have to use some of their precious FTE slots  
12 to hire people with expertise in performance management and  
13 other things, and that's where things break down. That's  
14 why I think if you are going to focus on criteria for  
15 hospitals, it should be on faculty content, not on  
16 curriculum -- faculty mix, not curriculum content.

17 MR. HACKBARTH: Let me just test an idea here.  
18 What I've heard from some people over on this side, I think,  
19 is the idea that if you set up the payment system, used the  
20 dollars that Medicare puts into training as a lever to  
21 reward institutions that are leaders in innovation care  
22 delivery, if those institutions are rewarded for developing

1 the tools and the skills and applying those tools, that will  
2 pull along with it the whole training enterprise, and  
3 they'll start to think about things differently, the  
4 environment in which physicians, young physicians are  
5 trained will be a different environment than we've had in  
6 the past.

7 DR. MILSTEIN: [off microphone.] I like that idea  
8 better.

9 MR. HACKBARTH: Yes, and I think --

10 MR. BUTLER: You said it more simply than I did,  
11 and maybe too simply, but there is a menu or characteristics  
12 you call "infrastructure" up there that really the  
13 institution is spending those dollars to create that  
14 environment, and it could be -- your idea could be one  
15 indicator. You know, I wouldn't say it's X FTEs, but is  
16 there leadership available doing X? You could begin to  
17 create a list of the kinds of things that would be an  
18 innovative, progressive institution.

19 MS. BEHROOZI: But then you also have to deal with  
20 barriers. You are going to create an environment that will  
21 allow for the development of, you know, well-rounded,  
22 educated, and best practices physicians. But then I think

1 that you have to acknowledge the cost barrier as well as the  
2 specialty board certification exam barrier, which you  
3 identified in here, which I don't know -- and this is  
4 consistent with the conversation about what are the things  
5 that we have leverage over as payers. I don't know to what  
6 extent we have leverage over the exams. And I don't know to  
7 what extent we have leverage over the very last thing, the  
8 public service component, which I think is critical. You  
9 know, for all this taxpayer investment, taxpayers ought to  
10 get something explicitly back. But I don't know that we've  
11 got those levers.

12 But in terms of lowering the cost barrier, in the  
13 text box it says that, at least if I'm reading this right,  
14 for residency training programs begun before 1995, there is  
15 a 6-percent premium on GME for certain specialties,  
16 including family practice, general internal medicine, and  
17 geriatrics among them. And I imagine that is somewhat to  
18 offset the fact that the other specialties bring in more  
19 high-paying business to the hospitals, and I don't know  
20 whether that 6 percent is enough to change the balance in  
21 the hospital's view. But certainly that money is not  
22 getting down to the residents themselves.

1           So in terms of what Medicare is able to do, it  
2 looks like Medicare is able to base its payment decisions,  
3 at least to some extent, on what the specialty of the  
4 residency is. So why don't we not just accept things as  
5 they are, but, you know, think about shaking it up a little  
6 bit more and making big distinctions between how much we  
7 will support the specialties that the Medicare population  
8 needs the most or needs the most new doctors, not only to  
9 the extent that it incents the hospitals to develop those  
10 programs and hire the best teachers and invest in IT for  
11 care coordination and things like that, but also to the  
12 extent that we can make it apply to the students and whether  
13 that's in rewarding loan forgiveness program or tuition  
14 abatement programs or those kinds of things, it's really  
15 critical. Just back on whether it is Slide 3 or whatever --  
16 you don't have to go back there, but just the distribution  
17 of quintiles, you know, the students of the upper quintile,  
18 remember, another factor that's not captured by that slide  
19 is that upper quintile's wealth has grown in that period of  
20 time, and that bottom two quintiles' wages have stagnated.  
21 I don't know how they have kept up as much as they have.  
22 And even the small decline, it is hard to tell on that

1 chart, but it looks like it's gone from maybe 18 to 15  
2 percent. That's a bigger percentage drop, you know,  
3 proportionately in that group, and it's not just about who  
4 goes in, but obviously what they choose to do on the other  
5 end and where they choose to practice and things like that.

6           Sorry, just also on the top point, we have not  
7 talked about that because I guess it's the hardest one. And  
8 I know in states where insurance departments get to set the  
9 rules for how insurers pay rates, they -- in New York at  
10 least, there's a graduate medical education component to  
11 hospital rates. I have no idea what Medicare could  
12 recommend. I don't know. It seems like it might be worth  
13 more thinking and development.

14           MR. HACKBARTH: I think if you were to try to  
15 tackle that goal, it would have to be not through the  
16 payment rate per unit of service by private insurers but,  
17 rather, some sort of tax or levy a tax on premiums with the  
18 specific earmarking of it to help finance medical education.

19           MS. BOCCUTI: May I ask a clarifying --

20           MR. HACKBARTH: Sure.

21           MS. BOCCUTI: This is on something that Arnie  
22 brought up with the FTE example and I think what Mark was

1 getting at. What we were hearing, maybe in years, we've  
2 been trying to get to the GME because we've had such a tight  
3 agenda, and what we have been hearing is that, you know,  
4 students and residents are not learning, say, for example,  
5 quality measurement and how to make changes based on their  
6 own measurement of quality. And if they would learn this,  
7 this would help move the quality of care forward by -- you  
8 know, exponentially once they get into the pipeline.

9           But what you're saying, or maybe you could  
10 clarify, that maybe instead of trying to ensure that they  
11 are learning quality measurement, for example, we could  
12 ensure that they have faculty expertise in quality  
13 measurement, and that would be a way of measuring that they  
14 had access to these skills or that they were learning the  
15 skills. Is that the distinction you're making?

16           DR. MILSTEIN: Yes, is that it would be -- I'm  
17 trying to think of what would be easy and practical for  
18 Medicare to track or for -- that would be easy, practical,  
19 and a reasonably valid means of tracking and accountability,  
20 and I just am very -- because I thought about it, you know,  
21 worried about the ability to sort of track and quantify  
22 curriculum content; whereas, it's pretty straightforward

1 from looking at a faculty member's C.V. whether or not they  
2 do or do not primarily focus their teaching and research on  
3 any of these topics -- you know, performance management,  
4 information technology. You can tell that in an instant.  
5 And it also seems, at least in the hospital that I'm  
6 affiliated with, a major barrier to moving forward is the  
7 paucity of faculty that specialize in these topics.

8 MS. BOCCUTI: Do the faculty exist? What I'm  
9 worried about is that if they're not -- are they at some and  
10 not at others? I'm just worried, how do we get the  
11 expertise if it's not there?

12 MR. HACKBARTH: At the risk of really gross  
13 oversimplification, the point I hear Peter and others making  
14 is even leap a step beyond that. If the institution in  
15 which people are trained is paid in a way that causes it to  
16 really focus on quality improvement, then it will be part of  
17 the ethos of the institution, and they'll be recruiting  
18 people of all types, faculty and staff of all types that  
19 have these capabilities, and it becomes part of the culture  
20 of the institution. And that is way better than a course.  
21 You know, it's the way we do things here.

22 MS. BOCCUTI: Right. I hope we're capturing that

1 in our discussion and when we brought these topics up. That  
2 is exactly what we're trying to capture as sort of where we  
3 go from here. It may not be an either/or, if I'm hearing  
4 this discussion correctly. We may have an ideal and a  
5 perfect scenario, I think, as you're describing. But if we  
6 can't get there tomorrow, can we tackle other priorities,  
7 too?

8 I just want to make sure I'm hearing this  
9 correctly. Okay.

10 MR. BUTLER: It's not important that we capture it  
11 here. It's important you capture it in the chapter.

12 But the one point I would make is that -- a little  
13 bit short, I agree. It's a leap beyond, but it doesn't  
14 mean, you know, you've got to be a capitated system or  
15 you're not going to get GME. We're not going that far. And  
16 we're not going to have a checklist, if you are willing to  
17 do accountable care, you'll get it. But there ought to be a  
18 way we can describe what the characteristics of an  
19 organization, and that needs some careful -- and it needs a  
20 shelf life of more than a couple years, is the point. And  
21 we can do better, and I think it's worth a try.

22 MR. HACKBARTH: But I think you're putting your

1 finger on the challenge here. It's easier to say this than  
2 to do this. You know, how exactly do you link payment to  
3 this sort of high-performing, wonderful institution. How do  
4 you operationalize that notion? It's easier to say than it  
5 is to do?

6 MS. BOCCUTI: May I also just say, a lot of this  
7 is for future work, for future chapters. You know, we'll  
8 capture some of this in the chapter now, but the chapter  
9 that's coming for the June report is a little bit more  
10 introductory and won't go into major details on the --

11 MR. BUTLER: And it's a great start. It educates  
12 and it lays a foundation, and I think it's good.

13 MR. HACKBARTH: Okay. Craig?

14 MR. LISK: I have just one follow-up on Mitra's  
15 point. There are only a few states, there is only a small  
16 number of states that do have things like New York, and New  
17 York is the one that has the largest, because they have a  
18 lot of residents, too; there's a lot of interest there in  
19 having payments and the private payers. But it's a very  
20 small number of states where that is explicitly done for the  
21 private payers. So I just want to make sure that -- the  
22 impression is that it's not universal.

1           MR. HACKBARTH: Okay. Good work. Thank you very  
2 much.

3           We will now have our public comment period, and  
4 Karen knows the ground rules.

5           MS. FISHER: I do. I am going to try to limit it  
6 to two minutes. I'm Karen Fisher with the AAMC, the  
7 Association of American Medical Colleges. We represent the  
8 allopathic medical schools and the major teaching hospitals  
9 in the country.

10           We support this Commission discussing this topic.  
11 It is important, it is timely, and, Glenn, you mentioned  
12 that other people are talking about these topics. I think  
13 if focused in the right way, this Commission has a lot to  
14 offer because of the varied perspectives that you bring to  
15 this topic, and not a lot of places have that. And so we  
16 support continued discussions on it.

17           I would say, though, that lots has occurred in  
18 medical education and in residency training over the past  
19 years, and more is going to occur. Our meetings are replete  
20 with discussions of GME leaders and others talking about how  
21 to look at the practice setting that future physicians are  
22 going into and how to make changes to that setting. So you

1 are not out there alone in having these discussions.

2 I also would point out, though, that the AAMC runs  
3 the Medical College Admission Test, the MCAT, and it is  
4 undergoing -- just so that you are aware of this, it is  
5 undergoing a review of the MCAT testing process with the  
6 same goal in mind: to look at what is the practice needs  
7 for the future, and is the MCAT doing its job to test on  
8 those measures to get the right applicants and get the right  
9 people matriculating into medical schools.

10 I think we'd agree, we love discussions. You  
11 could discuss a lot of these issues in further detail, but  
12 probably the best benefit for this Commission would be to  
13 focus more and probably more on the clinical setting where  
14 the GME dollars and where a lot of the training and the  
15 experiential training occurs. And don't forget that the  
16 third and fourth year of medical school mostly occurs in  
17 those clinical settings, so you're going to capture some of  
18 those experiences there.

19 We have a policy on all-payer funding. We'd love  
20 to have you discuss that in that arena.

21 Then, finally, what I would say on the public  
22 service arrangement, you know, there's a lot of that already

1 going on in medical schools and residency programs. A lot  
2 of residents are doing international rotations. They're  
3 spending time in schools. They're spending time in prisons  
4 and in other avenues. I will tell you the regulations don't  
5 allow any GME and IME funding to be paid for that. That's  
6 an issue.

7           But if the issue is that residents should pay back  
8 after they become physicians for the investment by the  
9 public in their education, it makes me a little bit nervous  
10 as a graduate of a state institution that maybe for all of  
11 the state money that went into my college education and for  
12 those going through that now, that if Congress would look at  
13 that, you might say, Well, shouldn't everybody who has had  
14 their education somewhat reimbursed through state and other  
15 mechanisms also do public service? Maybe that is a good  
16 thing, but it shouldn't be limited just to physicians.

17           Thank you.

18           MS. BURNS: Good afternoon. My name is Anne  
19 Burns, and I'm with the American Pharmacists Association.  
20 The American Pharmacists Association represents practicing  
21 pharmacists in all different practice settings. Thank you  
22 for a very informative discussion both today and at the

1 meeting in March.

2 As the Commission continues its deliberations, I  
3 would encourage you to consider including pharmacist-based  
4 residencies in your discussions and potentially in your  
5 report. Each year, over 1,500 pharmacist residents train in  
6 hospital, ambulatory care, and community pharmacy practice  
7 settings, provide medication therapy expertise as part of  
8 the health care team.

9 In hospital residencies, many of the programs are  
10 eligible for and receive GME funding, and I'd be happy to  
11 provide any additional information if so desired.

12 Thank you.

13 MR. CONNOLLY: Good afternoon. Jerry Connolly  
14 with the American Academy of Family Physicians. We really  
15 appreciate the rich discussion that you've had in terms of  
16 the global issues and even the specificity of how you might  
17 tackle graduate medical education and even, Glenn, how you  
18 might operationalize some of these ideas. In two minutes,  
19 just let me make three points, if you will.

20 There is a common adage, and that is, what you pay  
21 for is what is produced. And right now, with particular  
22 emphasis on primary care training, we're still training

1 essentially in a 1960s model. We're training in an  
2 inpatient hospital model when 95 percent of the care the  
3 primary care physicians deliver is in the outpatient,  
4 ambulatory, community-based setting. Since most primary  
5 care is delivered in that arena, we should incentivize the  
6 training so that that kind of education, that kind of care  
7 can be produced. In other words, we are talking about  
8 modernizing the graduate medical education system for  
9 primary care.

10           The second point, a couple of elements on the way  
11 to how to modernize this. Do we incentivize the institution  
12 to create more non-hospital setting opportunities? Or do  
13 you incentivize the residency programs that create those  
14 opportunities and train those physicians? We think perhaps  
15 the latter would be the better way to go about that. In  
16 other words, don't lock yourself into the mechanism of  
17 funding the institution when actually the residency program  
18 should be more responsive to the community needs and produce  
19 the primary care physician who is actually going to be a  
20 member of that community, practicing in that community, and  
21 delivering and serving the needs of that community. The  
22 residency program, the RRC, the accreditation body, can be

1 more responsive to the community needs; therefore, you  
2 create the physician who is a systems-based thinker, someone  
3 who can manage the care of a community, of a population.

4           You could also then incentivize through this  
5 mechanism means by which the necessary inpatient training  
6 can take place. It's just that the dynamic would be in the  
7 opposite direction. You fund the residency program who is  
8 responsive to the community needs, and then they take care  
9 of the necessary training to produce the kind of primary  
10 care physician you need not only for the current population  
11 but for the growing and changing demographic population that  
12 we have.

13           Lastly, let's just talk about the source of  
14 funding, and I'll follow up on what Karen said. Graduate  
15 medical education was linked originally to Medicare to make  
16 sure that we had enough physicians to handle the Medicare  
17 population in 1965. We're now not talking about just the  
18 Medicare population. I know this body does talk about  
19 Medicare. But times have changed. Health care delivery has  
20 changed. And we're no longer functioning predominantly in  
21 an inpatient hospital setting. We're now functioning in the  
22 community. So we need to talk about not only the Medicare

1 population, which I know you are more concerned with, but we  
2 need to talk about now the 47 million uninsured. And if, in  
3 fact, we are talking about a community that needs primary  
4 care, is it only then the Medicare and the Medicaid systems  
5 that should be responsible for funding this?

6           It can be argued that perhaps it is not just the  
7 Medicare program that should be funding it, that that is an  
8 argument for all payers to come to the table and contribute,  
9 particularly to producing the primary care physicians that  
10 are going to be needed in those community settings to take  
11 care of those uninsured.

12           Thank you very much.

13           MR. HACKBARTH: Thank you. We reconvene tomorrow  
14 at 9:00 a.m.

15           [Whereupon, at 5:27 p.m., the meeting was  
16 adjourned, to reconvene at 9:00 a.m., Thursday, April 9,  
17 2009.]

18

19

20

21

22

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, April 9, 2009  
9:04 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair  
MITRA BEHROOZI, J.D.  
JOHN M. BERTKO, F.S.A., M.A.A.A.  
KAREN R. BORMAN, M.D.  
PETER W. BUTLER, M.H.S.A  
RONALD D. CASTELLANOS, M.D.  
MICHAEL CHERNEW, Ph.D.  
FRANCIS J. CROSSON, M.D.  
THOMAS M. DEAN, M.D.  
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N  
NANCY M. KANE, D.B.A.  
GEORGE N. MILLER, JR., M.H.S.A.  
ARNOLD MILSTEIN, M.D., M.P.H.  
ROBERT D. REISCHAUER, Ph.D.  
WILLIAM J. SCANLON, Ph.D.  
BRUCE STUART, Ph.D.

	2
AGENDA	PAGE
Accountable care organizations -- Jeff Stensland, David Glass	3
Improving providers' performance during hospitalization episodes of care -- Anne Mutti	78
Improving traditional Medicare's benefit design -- Rachel Schmidt	101
Public Comment	144

## 1 P R O C E E D I N G S

2 MR. HACKBARTH: Our first presentation this  
3 morning is on accountable care organizations. David, are  
4 you starting?

5 MR. GLASS: Sure. This morning, this briefing is  
6 a follow-up to last month's discussion of ACOs. We're  
7 responding to your comments. We were going to attempt to  
8 more clearly define the basic concept and introduce two new  
9 variants, one somewhat simplified and one somewhat more  
10 complicated, but it results in patients actively enrolling  
11 in ACOs rather than being passively assigned.

12 First of all, let's start by trying to nail down  
13 what is an ACO. This seemed to frustrate everyone last  
14 month, so here is a concrete definition of what we mean when  
15 we say ACO. An ACO is a combination of a hospital and some  
16 primary care physicians. It could also include some  
17 specialists, although they would not be strictly necessary.  
18 ACO could be an integrated delivery system that was  
19 organized and included one or more hospitals and many kinds  
20 of physicians; or it could be a physician-hospital  
21 organization, or a hospital plus a multi-specialty group  
22 practice, or just a hospital and some independent practices.

1 It could be an academic medical center, however that was  
2 organized. Any of these arrangements could meet our  
3 definition. The other requirement is that there should be  
4 some defined population of patients associated with the ACO.  
5 And the final part of the definition is that the ACO be held  
6 accountable for the total Medicare spending and the quality  
7 of care delivered to the defined patient population.

8 Now, we realize there may not be total agreement  
9 with this definition, and we look forward to your questions  
10 at the end. But we wanted to start with something concrete  
11 to anchor the discussion.

12 The basic thrust of an ACO design is to give  
13 physicians and the hospital joint responsibility for the  
14 quality and cost of care delivered to a population of  
15 patients. It would provide bonuses for high quality and low  
16 cost growth. If a provider meets quality and cost targets,  
17 they will receive a bonus of some percentage of their base  
18 year fee-for-service payment rates. We are defining high  
19 quality as meeting some defined benchmarks, for example,  
20 perhaps low mortality or a lower rate of readmissions. We  
21 are defining an ACO's cost growth as the rate of increase in  
22 total Medicare spending per beneficiary assigned to the ACO.

1 Total spending would include Medicare services patients  
2 receive outside of the ACO. The spending growth in the ACO  
3 is compared to the target, and that is set nationwide. As  
4 we discussed last month, it would sharpen the incentives to  
5 also have a penalty for low quality and high cost growth.

6 Now that we know what an ACO is, let's review why  
7 we wanted them to begin with. Medicare needs a way to  
8 control cost growth. Current spending growth is  
9 unsustainable. Constraining fee-for-service rates in  
10 conjunction with other policies the Commission has  
11 recommended may improve quality and slow growth, but we  
12 don't think that will be sufficient to achieve  
13 sustainability. ACOs could provide the Congress an  
14 additional lever by tying bonuses and penalties directly to  
15 the rate of growth in overall Medicare spending, which is  
16 ultimately what we want to control. In the same way, ACOs  
17 can also help improve quality.

18 The objectives for an ACO policy are to move  
19 towards delivery system reform by improving care  
20 coordination and collaboration among providers, to tie  
21 physician and hospital payments to quality and resource use  
22 via a common set of incentives, to achieve a sustainable

1 rate of growth for Medicare spending, and, finally, to  
2 reduce regional variation by how we set the target for  
3 spending growth. It is a set dollar amount for all, which  
4 results in a more aggressive percentage target for high-  
5 growth areas, as we discussed last month.

6 The hope would be unnecessary services would be  
7 reduced and quality would be improved.

8 Last month, we talked about the two paths towards  
9 ACOs shown on the slide. First, let's review the voluntary  
10 model in the first column.

11 A hospital and some associated physicians would  
12 volunteer to be an ACO. CMS would assign the patients to  
13 the ACO based on the primary care physicians that the  
14 patients go to, and that's why there must be primary care  
15 physicians in the ACO, by definition.

16 Patients are still free to go to any Medicare  
17 provider they choose. There is no patient lock-in. The ACO  
18 would be subject to bonuses and penalties. They would be  
19 held accountable for cost and quality. And providers would  
20 need to be organized to volunteer.

21 In contrast, let's look at the mandatory model we  
22 discussed in column two. Under this model, all providers

1 are in. CMS assigned providers and their patients to a  
2 virtual ACO. There is still no patient lock-in, and there  
3 are bonuses and penalties. In this model, no prior  
4 organization is needed, but providers may decide to organize  
5 to have a better chance to succeed at meeting cost and  
6 quality targets.

7 Presumably, in both models, CMS would first tell  
8 all physicians what hospital they're affiliated with, the  
9 population of patients the ACO would be responsible for, and  
10 a few years of cost and quality history. This information  
11 would be crucial for physicians and hospitals to decide if  
12 they want to volunteer to be an ACO in the voluntary model,  
13 and in the mandatory model, it will help them to start  
14 organizing and know who to organize with to improve their  
15 chance of getting a bonus and avoiding a penalty.

16 Once again, the motivation for talking about ACOs  
17 is to find a way to slow the growth in Medicare spending.  
18 The basic equation for Medicare spending is price times  
19 volume, which means there is a trade-off between the two.  
20 Spending is the product of price, and price here is the fee-  
21 for-service rates, be they hospital DRGs or the physician  
22 fee schedule, or whatever, and volume. You have to

1 constrain on or the other or both to constrain spending.

2 Under the voluntary model, there are weaker  
3 incentives to control volume because the program has to  
4 attract volunteers, so penalties can't be too tough, and not  
5 all hospitals and physicians will join. Those that don't  
6 join will have no reason to constrain the volume growth.  
7 Without a strong incentive to restrain volume, there would  
8 need to be a stronger restraint on fee-for-service rates.

9 Mandatory ACOs, on the other hand, could have  
10 stronger incentives to control volume. Penalties could be  
11 made tougher, and all hospitals and physicians are included.  
12 So incentives for volume control will apply to everyone.  
13 This means there could be softer restraints on fee-for-  
14 service rates. Providers in the ACO are still paid fee-for-  
15 service rates less withholds, so what happens to rates is  
16 important to them, not to mention to everyone else.

17 Finally, it would be preferable to eliminate  
18 unnecessary care -- that is, control volume -- rather than  
19 use the blunt tool of low updates for everyone forever.  
20 Research on geographic variation shows there's plenty of  
21 care that does not contribute to patient welfare that could  
22 be eliminated.

1           The point is there is a trade-off between reducing  
2 volume and reducing rates, and mandatory ACOs could have a  
3 larger effect on volume. However, there would likely be  
4 greater resistance to the mandatory model by providers.

5           Because there seemed to be a preference for the  
6 voluntary path last month, we came up with two new variants  
7 that address some of your comments. One question was would  
8 a bonus-only model be feasible, and we look at that model in  
9 the first column. This is the voluntary model I just  
10 described, except in this case, instead of a bonus and  
11 withhold, there is only a bonus. This model has been  
12 proposed by others when they talk about ACOs.

13           You also wondered if there was a way to give  
14 physicians in an ACO more control over their patients'  
15 Medicare spending because now they would be held responsible  
16 for it.

17           In the second column we introduce a new model,  
18 which is a voluntary ACO paired with a Medigap SELECT plan.  
19 The key difference here is that patients choose to enroll in  
20 the ACO and buy an affiliated Medigap SELECT policy.  
21 Because a Medigap SELECT policy has higher cost-sharing for  
22 out-of-network providers, there is a soft lock-in. Patients

1 can still choose to go to any provider, but they have to pay  
2 more to go to providers outside the network.

3 Our motivation for creating this kind of strange-  
4 looking creature is that we wanted to get some lock-in that  
5 would be attractive to patients, but not get the ACO  
6 involved in insurance functions such as claims processing.

7 Now, Jeff will explain how these work in more  
8 detail as he walks you through the two new models, and he'll  
9 also explain how they compare to the broader spectrum of  
10 payment possibilities.

11 DR. STENSLAND: Now we look a bit more closely at  
12 the bonus-only ACO that David just outlined. Recall that  
13 the ACO concept is grounded in joint responsibility. In the  
14 bonus-only model, physicians that use a common hospital  
15 agree with the hospital to be held jointly responsible for  
16 cost and quality. These could be physicians that are  
17 employed by the hospital, or they could be independent  
18 community physicians that form a physician-hospital  
19 organization.

20 CMS assigns patients to that ACO based on which  
21 primary care physician the patients use for a plurality of  
22 their office visits. To be a viable ACO, the physicians

1 would need to serve at least 5,000 Medicare beneficiaries.  
2 As we said last month, we need at least 5,000 patients so we  
3 can differentiate between random variation in costs and  
4 quality and true improvements in performance.

5           The two key things to remember about this model  
6 are, first, that patients are assigned to the ACO, but they  
7 can still use any doctor they choose; and, second, the model  
8 is bonus only. If the ACO succeeds in consistently  
9 improving the value provided to Medicare beneficiaries,  
10 Medicare and the ACO will share in the savings. If the ACO  
11 fails and practice patterns do not change at all, providers  
12 will not face a penalty. In a sense, the status quo is  
13 accepted.

14           This is just a visual picture of how the bonus ACO  
15 would work. The physicians that use a common hospital  
16 volunteer to be held jointly responsible for the set of  
17 patients they serve. CMS would evaluate Medicare claims and  
18 assign each patient to the primary care physician -- these  
19 are the green circles in the slide -- that a patient sees  
20 for a plurality of their visits. Physicians in the  
21 hospitals would be members of some type of physician-  
22 hospital organization. As I said, this could be a loose PHO

1 or a formal integrated delivery system with common  
2 ownership. Medicare wouldn't prejudge which physician-  
3 hospital structure works best. Anyone that provides high-  
4 quality care at a low cost would be rewarded.

5           The new variant for today is a voluntary ACO  
6 teamed up with a Medigap SELECT supplemental insurance  
7 product. We bring up this option because some of you have  
8 expressed some concern about physicians being held  
9 responsible for all patient care, even when patients use  
10 providers outside of the ACO. The purpose of this option is  
11 to give patients an incentive to stay in the ACO for  
12 services.

13           Note that providers' obligations in this model are  
14 similar to the bonus-only ACO. The providers still need to  
15 form some type of physician-hospital organization and take  
16 responsibility for the patients; however, from the patient's  
17 perspective, things are very different.

18           In the ACO with the Medigap SELECT model, a  
19 patient must enroll in both the ACO and an affiliated  
20 Medigap SELECT supplemental insurance product. The patient  
21 acknowledges that if they go outside of the ACO network for  
22 care, they could face higher cost-sharing. A Medigap SELECT

1 insurance product will have a limited preferred provider  
2 network. The SELECT plan could cover Medicare cost-sharing  
3 for providers in the ACO's network, but the ACO network  
4 would consist of providers in the ACO and providers outside  
5 of the ACO that are needed to create a full complement of  
6 medical capabilities.

7           Providers may look at this and prefer this option  
8 because it could give them greater leverage to control  
9 utilization and where the patient goes for care. This may  
10 lead physicians to be more comfortable being responsible for  
11 the patient's overall cost of care. Some patients may  
12 prefer this option because it could end up giving them lower  
13 Medigap premiums. The restrictions on the network of  
14 providers that they would use could create some savings that  
15 could be passed on to them.

16           This is a picture of how the ACO SELECT option  
17 could work, and this is still just a preliminary idea we are  
18 sharing. There are two differences in this from the earlier  
19 picture.

20           First, note that the Medigap SELECT plan is  
21 affiliated with the ACO. Now, the ACO could operate the  
22 Medigap SELECT plan, or it could be provided by an

1 independent insurer.

2           Second, notice that the patient has to choose to  
3 join both the ACO and the affiliated Medigap plan. In this  
4 picture, the little arrows indicate patients who choose to  
5 buy this type of Medigap SELECT insurance and enroll in the  
6 ACO. In this example, patients 3 and 4 chose not to enroll  
7 in the ACO.

8           Now we just want to recap some of the benefits and  
9 challenges of the ACO SELECT model. The benefit of the ACO  
10 SELECT model is the patient commitment to the set of  
11 providers in the ACO. The weakness of the model is we need  
12 beneficiaries to actively switch from their current Medigap  
13 plan to a new ACO SELECT Medigap plan. Some would do so,  
14 but we expect that many would not.

15           Last month, we showed that an ACO requires 5,000  
16 members to be stable enough to differentiate between real  
17 improvements in cost control and random variation in costs.  
18 If there are fewer patients per physician, then the number  
19 of physicians in the ACO would have to increase. Individual  
20 physicians would then have less of an incentive to change  
21 their practice patterns because more physicians are the ACO  
22 splitting the bonus. In addition, reaching joint decisions

1 to change practice patterns or capacity may be more  
2 difficult if you have a larger number of physicians,  
3 especially if those physicians are not part of a single  
4 practice or a single integrated delivery system.

5           As we have said in the past -- I think we said  
6 this last month -- to truly change practice patterns, it may  
7 be necessary to have a significant share of both Medicare  
8 and private payer patients in each physician panel under  
9 ACO-type incentives. This may require certain physicians to  
10 focus their practice on ACO patients. So maybe the ACO  
11 SELECT model would still be feasible if there was some  
12 physicians that focused on ACO patients and other physicians  
13 that focused on patients that chose not to join an ACO  
14 SELECT type plan.

15           Finally, if we complicate the ACO model by  
16 bringing a Medigap product into it, we would have to  
17 consider some of the complexities of Medigap insurance,  
18 including how to bring low-income beneficiaries into this  
19 type of ACO.

20           Now we just want to do a head-to-head comparison  
21 of the ACO variants we discussed today, just to recap some  
22 of the differences of the two models.

1           In the bonus-only variant, CMS assigns patients to  
2 the ACO where they go for primary care. In contrast, in the  
3 ACO SELECT option, the patient must sign up to be in the  
4 ACO, and there are several implications of this. In the  
5 bonus-only model, all Medicare patients would be assigned.  
6 In contrast, in the ACO SELECT model, many patients will  
7 choose not to switch Medigap plans. Hence, if a physician  
8 was to have a large panel of ACO patients, they may have to  
9 start limiting their practice to patients in the ACO.

10           In the bonus-only model, patients are free to  
11 choose any doctor. In the Medigap ACO model, patients would  
12 face higher cost-sharing for going outside the ACO.

13           Another key difference is how the top options are  
14 funded. Under the bonus-only option, shared savings may not  
15 fully fund the bonuses. Medicare may need to restrain fee-  
16 for-service rates. Under the ACO SELECT option, providers  
17 may be willing to accept withholds due to having greater  
18 control over patients. Incentives for volume control could  
19 be larger, and shared savings and withholds together may be  
20 sufficient to fund the bonuses.

21           In sum, we have yet to find the perfect ACO  
22 concept. The difficulty with the bonus-only variant is it

1 is not clear that fee-for-service rates could be constrained  
2 enough to create a meaningful bonus. The difficulty with  
3 the ACO SELECT option is we're not confident that many  
4 Medicare beneficiaries would select it.

5 Now we contrast the strengths of the ACO models  
6 with the MA plan. Starting at the left, the last time we  
7 talked about mandatory ACOs, the key benefit of mandatory  
8 ACOs is that a large share of each physician's patients will  
9 be in the ACO because it is mandatory, and there would be  
10 stronger incentives put in place under the mandatory model.  
11 The weakness is that physicians may resist being jointly  
12 responsible for care that is outside their individual  
13 control.

14 In the second column, the ACO bonus-only model  
15 wins some points for being the least disruptive. Physicians  
16 still get fee-for-service payments. Patients can still  
17 choose any doctor accepting Medicare patients. The weakness  
18 of this plan is that the bonus would have to be funded in  
19 part by constraining fee-for-service payments, and there is  
20 the question if we have the will to do that.

21 In the third column, the ACO with Medigap SELECT  
22 model wins points for having a stronger commitment from

1 providers and patients. Patients have to enroll and accept  
2 a restricted network of providers. Physicians will still  
3 have more control over patients and would have to accept a  
4 withhold. The withhold would create stronger incentives for  
5 behavioral change and, hence, larger shared savings.

6           The difficulty here is that few patients may join,  
7 and even with a big incentive per patient, if only a small  
8 share of a practice's patients join an ACO, it may not have  
9 much of an effect on the practice's practice patterns.

10           Now, last, we show the MA plans for comparison.  
11 The MA plans have the most restrictions placed on patients  
12 and give providers the strongest incentives to control  
13 costs. However, providers have been reluctant to start  
14 their own MA plans due to difficulty in negotiating rates  
15 with other providers and difficulty absorbing insurance  
16 risk.

17           To kind of summarize, the objective of all four of  
18 these models is to give physicians and hospitals a greater  
19 incentive to keep people healthy. We want to avoid  
20 unnecessary services and counteract incentives in the fee-  
21 for-service system to grow volume. The ACO variants try to  
22 create incentives for efficiency without making the

1 providers take on the insurance risk or to pay claims or to  
2 have to negotiate rates with private payers, the kind of  
3 things that insurance companies do. So kind of the idea is,  
4 Can we get some of the benefits of the incentives of an MA  
5 plan without putting all the burdens of the MA plan on the  
6 providers?

7           Now, over the past couple of months, we have  
8 presented four different variants of ACOs, and now we want  
9 to hear some of your thoughts on which direction to take the  
10 ACO concept. We presented one mandatory option and three  
11 voluntary options. We'd like your thoughts on the relative  
12 merits of mandatory versus voluntary.

13           Second, we discussed a bonus-only option and three  
14 options that could have bonuses and withholds. For the  
15 bonus option, the key questions are: First, can the bonus  
16 be large enough to really change practice decisions? And,  
17 second, will fee-for-service rates be adequately constrained  
18 to fund the bonuses?

19           For the ACO SELECT option, the key question is  
20 whether enough people sign up for it to affect physician  
21 practice patterns. We're concerned that having 20 or 30  
22 percent of a practice's Medicare patients in this type of

1 plan will not be enough for physicians to change practice  
2 patterns. In addition, there may be a need for some special  
3 provisions to allow low-income individuals into the Medigap  
4 plan who do not currently purchase Medigap plans.

5 For both options, a key question is how should  
6 bonuses be distributed, and this would hold for all the four  
7 options we've discussed. In the mailing, we suggested that  
8 each physician and hospital receive a set percentage add-on  
9 to their fee-for-service rates. Others have suggested that  
10 the ACO get a lump sum and then divide the payment.

11 There is a concern that if the PHO is giving a  
12 lump sum of money, the PHO members may spend a considerable  
13 amount of time deciding how to divide the funds among the  
14 hospital, the primary care doctors, and the specialists, and  
15 this could create some conflict when what we are trying to  
16 do is foster cooperation.

17 Another topic for discussion is which option would  
18 be most likely to induce private insurers to create their  
19 own plans with incentives to restrain volume and capacity.  
20 To make ACO incentives strong enough to overcome the fee-  
21 for-service incentives for capacity growth, physicians may  
22 need to face incentives for capacity constraint from both

1 Medicare and private payers. The idea is Medicare alone may  
2 not be enough.

3 Finally, we could discuss having our system of  
4 spending targets for ACOs be synchronized with a system of  
5 spending targets for MA plans.

6 I would like to hear your comments.

7 MR. HACKBARTH: Thank you. Before we start the  
8 round one questions, we're not going to have any votes on  
9 ACO, but as you know, there is a lot of interest in this  
10 idea in Congress. so I am striving for as much concreteness  
11 in what we say about it as possible.

12 Personally, I see the interest in Congress as a  
13 very good sign. It seems that there is a growing acceptance  
14 -- not unanimous acceptance by any stretch, but growing  
15 belief that more organization in the delivery of care is an  
16 important step in improving the health care system. And  
17 that is something that I believe personally and very  
18 strongly. And so the interest in this idea is, you know,  
19 how can we through Medicare foster, support that sort of  
20 organization, so it is a very important topic.

21 I want to thank Jeff and David and Mark for their  
22 patience in dealing with me on this issue. I have led them

1 down a number of alleys, more blind than rewarding, and so  
2 thank you for doing that.

3 Let me see hands of people with round one  
4 clarifying questions.

5 DR. REISCHAUER: Yes, do we envision that a  
6 primary care physician could be a member of more than one  
7 ACO? And do we envision ACOs that might consist of more  
8 than one hospital, a community one and a teaching one?

9 MR. GLASS: I would say no to the first question.  
10 We think that a primary physician would have an assignment  
11 to a particular and only one ACO. But, yes, we think that  
12 multiple hospitals could come together and form a larger  
13 ACO, and that would make particular sense.

14 DR. REISCHAUER: Do we have a distribution of  
15 physicians -- you know, if you did this virtually and we  
16 looked across all primary care physicians, do we have a  
17 distribution of how many, what fraction of their Medicare  
18 patients participated with one hospital?

19 MR. GLASS: Yes, I think we did. Jeff, do you  
20 remember the number? Seventy-five percent?

21 DR. STENSLAND: I don't remember the exact number.  
22 Maybe John remembers the number, but it's fairly high. I

1 think there is a possible benefit of the physician that uses  
2 two different hospitals or is a part of two different  
3 organizations. If indeed one does have higher quality  
4 scores and lower cost, then they would have an incentive to  
5 start admitting their patients over to that more efficient  
6 system, and more patients would be funneled into the more  
7 efficient system because they would get a bigger bonus if  
8 they affiliated themselves with the more efficient of the  
9 two systems.

10 DR. REISCHAUER: But the capacities of hospitals  
11 say within a metropolitan area vary, and you might have a  
12 physician like mine who would send you to one of the major  
13 teaching hospitals for major cardiac surgery, but to a  
14 community hospital for other kinds of things. And I'm just  
15 trying to figure out how that's going to work.

16 MR. GLASS: Yes, but Elliot Fisher has done work  
17 on this, and they have -- I think they call it loyalty to a  
18 particular hospital, and they also have to the next hospital  
19 up, so to speak, to the referring hospital from there.

20 DR. REISCHAUER: [off microphone] [inaudible] of  
21 the area which involves a 150,000-person metropolitan area  
22 versus a 2 or 3 million one, and I'm not sure that that

1 pattern might not exist in the large metropolitan areas to  
2 the extent that his data suggests.

3 MR. BERTKO: Two comments and the preface being  
4 that --

5 MR. HACKBARTH: [off microphone.] This is  
6 clarifying questions.

7 MR. BERTKO: I know. Yes, they are clarifying  
8 questions, but I -- thank you. As David noted, I want to  
9 identify myself as being on the Fisher team for ACOs so  
10 everybody recognizes that.

11 David, if you could turn to Slide 6, I think it  
12 is, where you're comparing spending. I would suggest -- and  
13 I'd look for you to see if you disagree with me on this, and  
14 this is on the borderline, Glenn, so I will ask your  
15 forgiveness. Because the first one where it is voluntary is  
16 subject to presumably big bonuses, I would suggest that the  
17 volume incentive here actually isn't weaker. It is actually  
18 stronger. The money comes, as Willie Sutton said, instead  
19 of from the banks, from the hospital. That is the first  
20 source of savings, and it is pretty high. And then,  
21 secondly, from controls on referrals to specialists. So the  
22 high pressure I wouldn't necessarily say is on fee-for-

1 service rates. It might be on fee-for-service intensity  
2 where you are substituting, for example, primary care  
3 services for lower back pain in place of orthopedic services  
4 for lower back pain. And so the rates per se don't  
5 necessarily have to be constrained, but I would suggest that  
6 the intensity and the utilization have a fairly high  
7 constraint in order to achieve the bonuses.

8 DR. STENSLAND: The basic idea we were coming from  
9 is whatever your bonus, a bonus plus a withhold is going to  
10 have a bigger incentive than just a bonus on itself.

11 MR. BERTKO: I agree with that.

12 DR. STENSLAND: And it is going to be much easier  
13 to get a bonus and withhold system in a mandatory than in a  
14 voluntary, was the idea. Under a voluntary system, it might  
15 be more difficult to get physicians to accept a withhold.

16 MR. BERTKO: I don't disagree with what you said.  
17 What I am suggesting here is you have weaker volume  
18 incentive. I don't think I agree with weaker volume  
19 incentive as that particular adjective.

20 MR. GLASS: The other aspect of that is not  
21 everyone will volunteer. So there will be a large  
22 population of providers out there who have no incentive to

1 control volume. So when you add them up, we think the  
2 volume incentive would be weaker in total.

3 MR. BERTKO: Okay. Well, I'll save that  
4 discussion for the second part. The other clarification  
5 question is -- and you guys I think did a very good and very  
6 clever job on setting out these. I'm going to only make it  
7 slightly more complicated and ask if you considered a soft  
8 enrollment version of the voluntary ACO. And by "soft  
9 enrollment," it means that CMS would attribute members to  
10 their physicians, and then send out a letter that says,  
11 "Dear Mrs. Jones, You seem to have gotten all of your care  
12 in the last two years from Dr. Smith, so you're in this  
13 particular ACO unless you decline. Sign the form on the  
14 bottom if you wish to decline. Otherwise, you're in."

15 MR. GLASS: Then what would you do? Meaning what?  
16 That they couldn't go to other providers or that they'd have  
17 higher copays or --

18 MR. BERTKO: Of course, they could go to other  
19 providers, but it would be an alert to them that they, in  
20 fact, were working with this particular doctor who is part  
21 of this particular ACO.

22 MR. GLASS: So it would be informative, not

1 particularly -- it wouldn't change their behavior in any  
2 way.

3 MR. BERTKO: Yes, there would be -- without  
4 changes to Medigap, there would be no penalties. But it  
5 would be informative in the sense that it confirms where  
6 they are and that they should be looking to have Dr. Smith  
7 as the usual source of care.

8 MR. HACKBARTH: Okay, let me see hands again on  
9 this side, and let's keep it to clarifying questions  
10 because, in fairness to the people who are waiting for round  
11 two, I want to make sure we get to round two. You have a  
12 clarifying question, Jennie?

13 MS. HANSEN: The clarifying question is  
14 assignment, and I guess it's built in that this is still  
15 choice on the part of Medicare beneficiaries, because I know  
16 this has been an issue of a Medicare beneficiary being told  
17 that they are in a place. So this is addressed in this  
18 issue?

19 MR. GLASS: Well, they are assigned -- depending  
20 on which variant we're talking about, but in most of them  
21 Medicare says they're assigned to that particular ACO. But  
22 the beneficiary still is free to go wherever they want.

1 DR. STENSLAND: The decider is the beneficiary.  
2 So the beneficiary goes wherever they want, whenever they  
3 want, at least except for the Medigap SELECT model, that  
4 aside. But in the basic models, they go to wherever they  
5 want whenever they want, and then CMS looks at where did the  
6 beneficiary choose to go. Oh, they choose to see Dr. X  
7 mostly? Okay. Then they'll be assigned to Dr. X. So the  
8 beneficiary is still in the driver's seat of complete  
9 choice.

10 MR. HACKBARTH: And even in the Medicare SELECT  
11 model, there they are making a choice to enroll or not, much  
12 as they make a choice in Medicare Advantage to enroll or  
13 not. So all of these designs in various ways strive to  
14 maximize choice for Medicare beneficiaries as opposed to  
15 force them into a particular delivery system.

16 DR. MARK MILLER: Even in the SELECT model, they  
17 can choose to go in and out of network.

18 MR. GEORGE MILLER: My question follows Bob, but  
19 only from a rural perspective. Can you describe to me how  
20 this would work in a town of 10,000, maybe five physicians,  
21 where two may send to one hospital X and the other three may  
22 send to hospital Y in different directions? I just can't

1 put my arms around how this would work in rural areas.

2 DR. STENSLAND: I think there would either have to  
3 be an exception for small towns to opt out or some special  
4 provision. I could envision a system where they may,  
5 especially in a bonus-only model, choose to band several  
6 hospitals together. For example, these larger rural systems  
7 that may have five different small hospitals, they could all  
8 be banded together and evaluate on the sum total of all  
9 their patients together. I think that would probably end up  
10 being their choice if they wanted to do that.

11 MR. GEORGE MILLER: To follow up, those who are  
12 independent are not part of a large system, they'd just opt  
13 out?

14 DR. STENSLAND: If they didn't want to sign up  
15 with other individuals and just be their own entity, it  
16 would be difficult. You might have to have some sort of  
17 exception because they would have such a small number of  
18 patients, there would be a big volatility in costs, and you  
19 really couldn't measure them adequately.

20 DR. SCANLON: The model you have on page two, I  
21 think it differs from what I had in mind that was an ACO and  
22 it seems like it's somewhere between a medical home and what

1 I used to have in mind as an ACO, so this is a question  
2 about selection or assignment sort of within this new  
3 definition and it goes to sort of what is this idea of a  
4 primary care physician, because I think, in thinking about  
5 an ACO that involves specialists, people with diabetes,  
6 heart disease, COPD, who use specialists as primary care  
7 physicians, they get included. And the question is here in  
8 this assignment model, is there a way that that can be taken  
9 into account?

10 And I guess the other part of the assignment is  
11 the issue of the non-users and sort of what happens to them  
12 in the system, even though they are likely to be low users.  
13 There is also the potential that they develop something  
14 after an assignment period and then they become more  
15 expensive for the rest of the --

16 MR. GLASS: Well, taking the second part first, I  
17 think the definition is, what, plurality of E&M visits,  
18 Jeff, or the -- for who is considered their principal  
19 provider. So I think that a cardiologist would still fit  
20 into that mode.

21 MR. STENSLAND: You could do it -- it's been done  
22 two different ways, and sometimes when the data has been

1 run, it's only looking at primary care physicians and  
2 assigning them that way, and sometimes it adds in  
3 specialists if that's where they got most of their care.  
4 And I think that's probably a detail that we'd have to work  
5 out. There's kind of some difficulties if we start  
6 assigning people based on primary care and how the data  
7 plays out in terms of if we start assigning people to the  
8 specialists and certain hospitals use more specialists than  
9 others, it affects the risk adjustment in the model. So  
10 maybe we'll leave that for a later discussion and a long  
11 footnote.

12 MR. GLASS: But in general, the idea would be  
13 primary care providers would be who you would design it to  
14 and you'd have to figure out what to do with the -- but the  
15 very low users would still, as long as they had one E&M  
16 visit in two years, I guess, would still work. So that's a  
17 pretty low bar.

18 MR. HACKBARTH: Let me see clarifying questions on  
19 this side.

20 DR. KANE: Yes. I guess I'm wondering why is it  
21 Medigap SELECT instead of Part B SELECT or some -- I don't  
22 know what the Medigap average premium is, but the Part B is

1 probably the more meaningful premium that you might want to  
2 lower. I mean, if one was trying to -- anyway, just did you  
3 say it should be a Medigap SELECT rather than a Part B  
4 SELECT --

5 MR. GLASS: You know, I mean, these things exist.  
6 The Medigap SELECT plans exist. I think about 10 percent of  
7 Medigap people are in them now. And so that's kind of the  
8 model we're building off of. It's the existing model. And  
9 I'm not quite sure why. I mean, if a lot of the savings  
10 would be from admissions or readmissions or whatever, I  
11 would think you'd want both A and B in there. But anyway, I  
12 think the current Medigap SELECT ones are -- it's both A and  
13 B. It's all Medicare.

14 DR. KANE: I'm just thinking about the amount of  
15 the premium that might go down if you choose it. Which one  
16 would be the bigger -- how much is an average Medigap  
17 premium?

18 MR. BERTKO: One-hundred-seventy-nine or \$180.

19 DR. KANE: Okay, so that's -- and Part B can be  
20 anywhere from \$100 to \$700, depending on how your income is.  
21 And then the D is \$30. So Medigap being the biggest premium  
22 to cut? In other words, the incentive to join the Medigap

1 SELECT would be you have a high Medigap premium and you want  
2 to lower it.

3 MR. STENSLAND: Yes, and I think we're kind of --  
4 we're striving to find something out in nature that already  
5 exists that we could piggyback onto and that's kind of where  
6 the Medigap SELECT idea worked. If they're able to move 10  
7 percent of beneficiaries already into Medigap SELECT plans  
8 by offering them a lower premium with a restricted network,  
9 we thought, okay, at least that shows that this is something  
10 that has proven to work to some degree.

11 DR. KANE: Just another minor question. If you're  
12 talking about physicians having admitting privileges to two  
13 hospitals and the one with better bonuses is the one they  
14 start sending patients to, how do you make sure that doesn't  
15 look like a kickback?

16 MR. STENSLAND: Well, I think that gets back to  
17 how do you set up the bonuses, and if everybody's bonus was  
18 just a flat add-on to their fee-for-service rates, so if I  
19 was an orthopedic surgeon and I was getting paid \$1,000 for  
20 this surgery, I knew that if I was in a high-quality, low-  
21 cost area, I would get \$1,100, or a 10 percent bonus, and  
22 that would happen no matter which of these high-quality,

1 low-cost things I went to.

2           The kickback problem would get to be more  
3 difficult if we just gave the physician hospital  
4 organization a lump sum and then we said, okay, you can  
5 decide how much the orthopedic surgeon gets for the patients  
6 that go to your hospital, that would be a concern.

7           DR. CROSSON: Yes. I had actually focused on the  
8 same sentence that John had, and I just want to clarify the  
9 clarification, if that fits. So could we go back to Slide 6  
10 for a moment?

11           So I had the same sense that I couldn't understand  
12 necessarily how the voluntary model produced a weaker volume  
13 incentive, and I think what I heard was that the way you're  
14 defining the volume incentive is sort of in global dollar  
15 terms. In other words, the total amount of money, let's  
16 say, saved by the Medicare program would be less than a  
17 mandatory model because everybody wouldn't be in it, not  
18 that the dynamics inherent in the voluntary model would  
19 produce at the level of an individual provider or an  
20 institution a lower incentive. Is that correct?

21           DR. MARK MILLER: I think actually there were  
22 three parts to the answer. One is how many people do you

1 have in a voluntary model versus a mandatory model, the  
2 point you were making.

3 Two, in the exchange between Jeff and John, it was  
4 relative to a bonus plus withhold, this is a weaker  
5 incentive, and part of our conversations have included this  
6 notion of bonus and withhold, and I think part of the  
7 sentence is predicated, well, if you remove the withhold,  
8 you have somewhat weaker incentives.

9 The last piece in my mind, and I'm not sure how  
10 close we got to this point, is this model depends on what  
11 size of a bonus you can give, and that's kind of unclear.  
12 And part of our thinking is predicated on, well, you may  
13 have to pressure fee-for-service to produce a bonus that you  
14 can give to these people, to people who volunteer. And  
15 depending on that, that could be strong or weak, depending  
16 on how deep you go on your fee-for-service side.

17 So I think the complexity is there's three -- at  
18 least three concepts running around in that sentence.

19 DR. CROSSON: So this is a question between the  
20 two slides. The voluntary/mandatory distinction here, on  
21 the next slide, the voluntary option is blown up, if you  
22 could go to Slide 7, on the right, is blown up to include a

1 voluntary mechanism that, in fact, does include a withhold.

2 MR. GLASS: That's correct.

3 DR. MARK MILLER: On the select side --

4 DR. CROSSON: Right.

5 DR. MARK MILLER: -- versus the -- yes. So  
6 between those two, I think some of the argument would be  
7 that we would think that the incentive would be stronger on  
8 the right side than on the left side.

9 MR. HACKBARTH: Except for the fact that since  
10 you're on the right side, you might have fewer beneficiaries  
11 participating and a lower proportion --

12 DR. CROSSON: Because of the complex and double  
13 enrollment.

14 MR. HACKBARTH: Right. Okay. Let me see hands  
15 for round two comments, and we'll just go the other way.  
16 Bruce, and then Peter.

17 DR. STUART: I guess one of the problems I have is  
18 this looks like a bird that keeps getting heavier and  
19 heavier and I'm just not sure that it has wings to be able  
20 to take off, and part of that comes down to the issue of  
21 this is, after all, a fee-for-service system and we  
22 recognize the incentives that fee-for-service provides for

1 making more services available, and I just have trouble  
2 seeing how this is going to provide -- how conceivable  
3 bonuses under a system like this would offset the inherent  
4 incentive in fee-for-service to make more services  
5 available, particularly for non-primary care physicians.

6 I guess my thinking is that Medigap SELECT, we're  
7 pushing -- I think the reason that's there is that I think  
8 that this thing probably can only work if there is some kind  
9 of lock-in. Maybe it's a soft lock-in or something other  
10 than that, but it seems to me that unless the organization  
11 can be fairly well assured that it can control the members  
12 that are under its wings here, that it just isn't going to  
13 be able to take off.

14 This gets back to a point that Mike raised  
15 yesterday, is that we tend to look at these things in silos.  
16 We have had an opportunity to look at medical homes and now  
17 we're looking at ACOs and I can see how something might come  
18 together if you had a combination of a medical home and an  
19 ACO, but I sure have trouble seeing how just straight ACOs  
20 without something that keeps people together is going to  
21 work.

22 And Medigap SELECT, I just can't see it as being

1 the structure that's going to make this thing fly, because  
2 it's not going to affect anybody who's in a retiree program.  
3 It's not going to affect anybody who's in Medicaid. And  
4 it's going to be a small, presumably, subset of people who  
5 are in current Medigap policies. So --

6 MR. STENSLAND: Yes. You would have to hope that  
7 there would be some other people coming into the game, and I  
8 think this is the idea that maybe there would be a Medicare  
9 ACO or a Medigap SELECT. Maybe the employers could set up  
10 some parallel set of incentives in their own supplemental  
11 insurance plan, and the idea is that even private insurers  
12 could set up their own parallel system of incentives. And I  
13 think this is the kind of model that they're trying to come  
14 up with in Vermont right now, where you have the main  
15 private insurers and Medicaid and they're hoping Medicare,  
16 all getting involved with similar incentives where they're  
17 basically saying, your payment per unit of service will be  
18 higher if you have lower growth in your volume of fee-for-  
19 service.

20 DR. STUART: I agree, and nothing of that is here.  
21 I mean, that's the assumption. But what makes that happen?

22 MR. GLASS: Well, I don't think that's the

1 assumption. I think that's the hope, maybe.

2 MR. STENSLAND: Yes. We can go through that, but  
3 that kind of gets back to the detailed things we did last  
4 month on what is your actual incentive to buy an MRI  
5 machine? What's your incentive to build an extra bed?  
6 What's your incentive to hire a cardiologist? And do we  
7 think that the amount of money we're moving around here is  
8 sufficient to change those decisions?

9 MR. HACKBARTH: Let me just react to what Bruce  
10 said. I share your concern about the strength of the  
11 incentives, so long as the underlying payment is fee-for-  
12 service, and we discussed that at some length last month and  
13 I think that's a real issue. What that prompted me to focus  
14 on after the last meeting was thinking about, well, what  
15 about a model based on global capitation as opposed to fee-  
16 for-service with gain sharing? And I spent some time trying  
17 to think through what that model might look like. And you  
18 can conceive of that as sort of an extension of Medicare  
19 Advantage as opposed to building from fee-for-service.  
20 Let's approach it from the other direction.

21 The problems that I ran into on that particular  
22 journey was that you're going to have an enrollment decision

1 then with beneficiaries, and to the extent that you get  
2 lower enrollment, that is another way of reducing the  
3 incentive to change. You're only talking about influencing  
4 a small piece of the hospital's revenues or the ACO's  
5 revenues. So that's a challenge.

6           The second thing in talking to some hospital  
7 people about this was that I had thought the reason that  
8 they didn't do the MA-PSO thing was concern about risk, and  
9 I said, well, we can deal with that. We can attenuate the  
10 risk through risk corridors and various things to make it so  
11 it doesn't seem as risky. And they said, well, okay.  
12 That's nice. But it still means that we need to have  
13 insurance capabilities. We need to be able to pay claims  
14 and deal with providers and negotiate contracts. That's not  
15 the business that we're in. And so it's not just a matter  
16 of attenuating the risk. It's also lots of administrative  
17 functions that they don't have the capacity for.

18           So given that, I've sort of cooled on approaching  
19 this through global capitation and went back to basing it on  
20 fee-for-service. It doesn't alter the fact that you're  
21 right. The incentives, as we discussed last time, are  
22 attenuated. They're not as strong as I would like them to

1 be.

2 DR. MARK MILLER: Just one quick thing. I mean,  
3 the Medigap SELECT point here was in response to comments  
4 about, well, is there some way to get a soft lock-in with  
5 the beneficiary. These were questions you were raising, so  
6 we went out and tried to find something to do that.

7 The other way to think about the Medigap SELECT  
8 point is that maybe that concept needs to be blown up in  
9 order to make the ACO work. Maybe there needs to be a new  
10 Medigap product and maybe structure it in such a way that it  
11 isn't such a small part of the market. But we'd have to  
12 think through exactly how that works, the enrollment rules,  
13 the people being able to transfer from their current Medigap  
14 to this new product, that type of thing. But it would be a  
15 whole different exercise, or additional exercise.

16 DR. STUART: What do you think, though, about  
17 linking the medical home to this concept, because it strikes  
18 me that if you have a real medical home, then the physicians  
19 that are associated with that medical home are going to be  
20 in a much more powerful position to work with the hospitals.

21 MR. STENSLAND: That's -- several people have  
22 thought about that and have the idea of having the medical

1 home embedded in this thing. They start with the little  
2 building blocks of the medical home and then you can build  
3 an ACO around it. I think one of the key questions is do  
4 you have the hospital in there, also, and a lot of these  
5 models, they just have the primary care physicians and maybe  
6 some of the other specialists and they don't have the  
7 hospital in this ACO framework, where we have set it up so  
8 far that the hospital is in there, basically trying to  
9 respond to some of the comments we heard from all of you  
10 that you want to encourage more systemness and cooperation.

11 MR. HACKBARTH: You know, I would think that,  
12 certainly if I were setting up an ACO, I would want to have  
13 medical homes linked up. I'm not sure you need to require  
14 that. I think that's where -- if the medical home model  
15 works, they will gravitate towards that. You don't need to  
16 tell them to do it.

17 DR. STUART: Well, maybe it's a staging issue. I  
18 mean, all of the emphasis that I've heard over the last two  
19 years that I've been here on primary care, I mean, that is  
20 focused on the medical home model. So, I mean, if we said,  
21 okay, we've got a certain number of chits in terms of the  
22 kind of recommendations that we want to make, I would feel

1 much more comfortable in terms of really putting some strong  
2 recommendations on medical homes and then saying, look, if  
3 you can set up a system of medical homes, then it's going to  
4 lead -- it can lead naturally to these kinds of  
5 organizations as kind of a second tier in terms of the  
6 development strategy.

7 MR. BUTLER: Okay. I've got several comments  
8 here. I'd start by saying that my bottom line will be  
9 heavily in favor of the left-hand side, voluntary bonus  
10 model, with some clarifications, and I would say at the  
11 front end somewhat similar to what you said, Glenn, and that  
12 is there's a real beauty here in that not only are you  
13 eliminating the contracting, administrative, and billing  
14 functions, but you're locking in Medicare rates, which  
15 Medicare Advantage plans typically haven't been able to  
16 achieve. So you've got a baseline on the pricing side kind  
17 of solved. As much as hospitals and doctors may not like  
18 that, that's not unimportant in this model.

19 Second, and maybe the most important part, we're  
20 going to talk about episodes of care later and whether to  
21 bundle them and just the inpatient stay or the 30 days and  
22 now this is just another point on the continuum at the ACO

1 level. Now, I think we need to think about where do we want  
2 physicians and hospitals to spend their next energy in  
3 organizing to managed care, and where I come out heavily in  
4 favor of ACOs versus episodes or others is you've kind of  
5 got one shot. If you don't set it at a fairly high level  
6 that ultimately will handle the continuum of care, you're  
7 going to have a lot of short-term energy around bundled care  
8 that is going to create a lot of anxiety behind doctors and  
9 the juice-to-squeeze yield in the long term isn't going to  
10 be there and we're going to spend a lot of energy without a  
11 lot of the dollars.

12           So I think the important part of this concept  
13 relative to the others is that it gets us to organize at the  
14 right level in this next phase of health reform and I think  
15 that's a very important concept.

16           Now, the voluntary side, I think, is extremely  
17 important. I actually am not in favor at all of engaging  
18 the patients at this point. It's another disruption,  
19 another confusion, another -- I would rather have the data  
20 shown to me and how I'm doing, what it looks like, even if  
21 there's no bonus, it's kind of like showing your readmission  
22 rates. To show the data for an institution is very

1 powerful. I can tell you, CMS core measures came out, no  
2 payment tied to it. Guess what? It's improving.  
3 Readmission rates now are starting to -- we understand our  
4 readmission rates much more than we did a year ago. Simply  
5 getting that scorecard out in front will have some powerful,  
6 I think, implications.

7           So you can see I'm kind of headed towards  
8 definitely an ACO as a key model on a voluntary basis. Get  
9 the data flowing and we'll figure out through that data how  
10 to then get the bonuses aligned. But we will have set the  
11 right structure in place if we believe hospitals and  
12 doctors, which I think need to include the specialists, not  
13 just the primary care.

14           Now, why do I -- last comment on this. We do have  
15 a, what you would call a PHO. We have a community hospital,  
16 a big teaching hospital. We have private physicians. We  
17 have full-time faculty physicians. That organization right  
18 now does all of the contracting. We have some capitation  
19 arrangements. Granted, they are not enough -- while we  
20 handle the capitation and hand it out, it hasn't changed the  
21 fee-for-service culture, but it's there. We're a  
22 participant in PQRI. We have HEDIS measures, even though

1 we're not a health plan.

2           And so we kind of have the structure, and I think  
3 I said at the last meeting, bring it on. I'd love to see --  
4 and it's physician-driven, even though hospitals are a  
5 partner, a physician chairs that board. We meet every  
6 month. We'll look at our PQRI results next Monday. So I  
7 kind of say, if you had that scorecard in front of me now,  
8 I'm kind of organized to be ready for that. And so that  
9 kind of model, not get into Medigap and, frankly, confuse  
10 the Medicare beneficiaries at this point in time, that's  
11 kind of the model that I'd favor.

12           DR. CASTELLANOS: You know, this is -- I think  
13 Peter said there's going to be a lot of anxiety in the  
14 medical community. Well, I think there's going to be a lot  
15 of anxiety among a lot of us. I think it's fair for me to  
16 say that we happen to be looking at this model and had made  
17 some inquiries because we recognize we need to change. We  
18 need to change the fee-for-service incentives. But then I  
19 look in my community and my doctors in the community look at  
20 me and say, why do you want to do this? Why do you want to  
21 move away from what we call a very robust, perhaps overly  
22 funded in some respects, less-risk program and to go into

1 something like this? You know, they say, well, what  
2 incentive do I have just to improve quality and resource  
3 use?

4 I kind of tell them, maybe it's going to be done  
5 to us unless we are part of the solution, but I really don't  
6 -- I would like to have explained to me a little bit better  
7 than you have, what's the incentive for the physician to  
8 give up this robust fee-for-service program with less risk  
9 and accepting risk on a financial and a quality on a patient  
10 that may leave my control and go somewhere else for three  
11 years and yet I'm still responsible?

12 I think a lot of this -- and Peter really put it  
13 nicely -- anxiety around the physician, but there's going to  
14 be a lot of anxiety around the hospital. There's going to  
15 be a lot of anxiety around the beneficiary.

16 MR. HACKBARTH: Do you want to take a crack at  
17 that? I have something I want to say on that.

18 MR. STENSLAND: Go ahead.

19 MR. HACKBARTH: I think that you gave them the  
20 right answer, because it's going to happen to you  
21 regardless. You can either organize and try and deal with  
22 the problems or you're going to get squeezed another way in

1 an unorganized system. To me, that's one of the central  
2 conclusions that I've reached about this.

3 I don't think you can require people to form ACOs.  
4 I think you've got to do a voluntary thing. This is a  
5 challenge. You're talking about redefining relationships  
6 among people who haven't worked together, and so I think it  
7 needs to be voluntary. But I think a corollary of that is  
8 that there needs to be pressure on traditional Medicare as a  
9 complementary force, and that strengthens the incentives to  
10 participate and to do well. So I think that's part of the  
11 puzzle, and so I think you gave them the right answer, Ron.  
12 It's going to happen on both traditional Medicare and here.  
13 These actually give you an upside opportunity to win,  
14 whereas the squeezing on traditional Medicare is all  
15 downside.

16 DR. CROSSON: Thank you, and thank you, Jeff and  
17 David, for the work. As Glenn does, I strongly support  
18 this. I think this is, as Glenn said, extremely important.  
19 Even if Congress weren't looking at it right now, it's still  
20 important because I think it represents the right direction.

21 In terms of the alternatives that we have been  
22 discussing, I think I agree with Peter. My general sense is

1 that a voluntary model probably of some sort probably makes  
2 more sense than a mandatory one. The nature of the change  
3 is going to be difficult enough for people to accept without  
4 necessarily right at the beginning feeling like there's a  
5 strong arm here.

6 I do think, on the other hand, that if it's going  
7 to work, specialists need to be part of it, as Peter said.  
8 Otherwise, you lose the strongest lever over the largest  
9 producer of the costs. And if you're trying to save costs  
10 and you don't have the specialist involved, and particularly  
11 if the primary care physician has no leverage over that,  
12 then I think you probably have created a weak system.

13 I think, in addition, the hospitals have to be  
14 part of it, as was part of the definition. I think the two  
15 weaknesses, parenthetically, of the medical home model are  
16 just those, that there is no particular mechanism for the  
17 primary care physician to influence, directly, anyway,  
18 influence specialty costs and there's a relatively weak  
19 relationship in most medical home models with the hospital.

20 I also think, as Peter said, that although  
21 probably in an analysis we're going to be forced to look at  
22 incentives in a relatively simple sort of manner, in fact,

1 the creation of these sorts of organizations is going to  
2 create a much more complex set of incentives. I hesitate to  
3 tread into the area of behavioral economics, but in fact,  
4 once you've created these sorts of models, you then develop  
5 other types of incentives.

6           For example, peer pressure, the influence of other  
7 physicians on physicians in terms of the welfare of the  
8 enterprise, the goal in the end, in the long term, that  
9 individuals have to see that the enterprise is maintained  
10 and the pride that can exist in an enterprise, in this case  
11 an ACO, that is, in fact, improving and does well. And  
12 those are subtle. They're soft and not measurable. They  
13 wouldn't be scored. But in the end, in many ways, they're  
14 at least as important for many, many professionals, perhaps  
15 not everyone.

16           The other thought is that we have to think about  
17 the nature of the change that we're talking about here, so  
18 kind of sort of envision this as a table with the vertical  
19 axis being payment methodology, for example, with pure fee-  
20 for-service at the bottom and, say, pure capitation at the  
21 top and the horizontal axis being the structure, which is  
22 completely disintegrated to completely organized with all

1 elements in there.

2           And what we're embarking on, I think, with this  
3 set of recommendations is the idea that we think the  
4 delivery system needs to move from the Southwest corner, if  
5 you will, to the Northeast corner, and I'm not sure how that  
6 works on the Dartmouth Atlas, but it seems to me that  
7 there's no way that that change is going to occur rapidly  
8 and there's probably no way that that change is going to  
9 occur linearly. It's going to occur most likely with step-  
10 wise changes, probably starting with payment changes, which  
11 then evoke changes in structure, where if, for example,  
12 physicians and hospitals come to work more closely together,  
13 and then that allows further changes in payment that move  
14 more towards the sort of prospective withhold partial  
15 capitation model, which creates then stronger incentives and  
16 the like.

17           And I think we need to realize that that kind of  
18 change, if that's the change we have in mind, and it  
19 certainly is what I have in mind, is going to take time.  
20 And what we ought to be thinking about is constructing how  
21 we speak about it in that way and then making  
22 recommendations for the first step or two in such a way that

1 it at least heads in the right direction and not think that  
2 we can solve every problem, or that we can even understand  
3 the evolution of the best model, or that the best model is  
4 going to be exactly the same in Manhattan as it is going to  
5 be in Minneapolis or as it's going to be in Miami or  
6 wherever.

7           The only last comment I'd make is with respect to  
8 the MSA, or the MA-PSO model, I think the question of the  
9 readiness or the willingness to develop the capabilities to  
10 utilize such a model, given a rethinking of Medicare around  
11 how it might share risk, might very and there might very  
12 well be -- I do believe, in fact, there are organizations  
13 and organizations that could form that would respond to that  
14 and could do that. There's no reason why we couldn't move  
15 in both directions, so that that model, it would seem to me,  
16 which already exists in law, I think, although it's not  
17 being implemented right now, could be made open and could be  
18 improved for those organizations that do have the capability  
19 and willingness to do that.

20           MR. HACKBARTH: It could be one of the  
21 evolutionary steps, developments, as you say, that occurs  
22 with time.

1           Okay. Let's just do a time check. We were  
2 scheduled to end at ten. It's ten after ten. I've got five  
3 people on my list -- John, Jennie, Arnie, Mike, and Karen.  
4 I think this is an important topic and so I'm going to  
5 extend on this. My apologies to Anne and Rachel, who are  
6 going to have to shorten those sessions correspondingly, but  
7 we need to cover this thoroughly. But please, those of you  
8 in the queue, keep in mind our time constraints.

9           MR. BERTKO: All right. Yes, sir, I'll be  
10 concise. So the first thing I'd like to do is say that some  
11 of the bonuses, and Jeff and David are correctly worried  
12 about how they're attenuated, would actually be leveraged.  
13 I'll take Peter's enthusiasm as an example and say that  
14 hospital plus primary care -- and I would suggest a subset  
15 of specialists -- would be where you derive the savings, and  
16 thus paying back to a smaller-than-everybody group makes the  
17 bonuses proportionately a little bigger. And Peter here,  
18 being an early doctor in my example, begins eating the lunch  
19 of his competing hospitals across the street and ten miles  
20 away. He has reduced utilization. He has reduced his  
21 variable cost and covered some of his fixed cost, so he  
22 still has a pretty good incentive there.

1           Secondly, I would say that I personally like the  
2 idea of the enrollment model, just as Glenn and others have  
3 worried about. But I would contrast it with what Bruce was  
4 worried about of what I'll call a population health-based  
5 model. And to the extent that you describe to a community,  
6 and I'll take my small community up in Flagstaff, you are  
7 now responsible for basically everybody in town and you get  
8 a bonus if you do it right, that this could actually be a  
9 reasonable incentive. Enrollment-based would work better,  
10 no doubt, but the population base and the stickiness of  
11 people has been demonstrated to be in that 80 percent range  
12 or so, even though you can migrate out to use the academic  
13 medical center that, Bob, you were describing earlier.

14           Again, I congratulate you two guys and Glenn,  
15 maybe, and Mark on thinking about this SELECT model, so I  
16 will propose one more variation of it, which is you get the  
17 big Medigap player in town, or in the State or a region,  
18 usually a Blue, and you say, let's convert everybody into a  
19 version of SELECT, and maybe it's a new product and maybe  
20 it's a rollover of everybody into it. That solves the  
21 problem. And to Jennie's worry about choice, again, it's an  
22 opt-out. It's like Part B as in Bravo. You get a form

1 which says you're now in this product. It's going to save  
2 you money. And if you want to go pay the old high premium,  
3 you can sign the form on the back.

4           The very last thing is I would be careful and  
5 maybe remove the idea of an ACO becoming a Medigap SELECT  
6 plan for all the reasons that we've talked about. It just  
7 didn't work in the past. I had some personal experience  
8 trying to bring up PSOs, and the moment hospitals and  
9 physicians begin saying, we've got to pay attention to all  
10 this stuff and we've got to deal with the DOI, it's like,  
11 we're done. Sorry.

12           MS. HANSEN: All right. Two comments and a  
13 question. The comment relates to the beneficiary, and I  
14 think perhaps another dimension. I think talking about why  
15 would doctors have any incentive to change, and then I was  
16 thinking from the beneficiary, what benefits the  
17 beneficiary. I think one view I would put is to have the  
18 beneficiary not feel that they're a walking bar code. In  
19 other words, you've got another test. You go in the  
20 hospital. You get some more medications. The idea of  
21 getting care that's right for their best benefit. So I just  
22 wanted to put that bit on the table. Why would the

1 beneficiary want to be in anything? It's transparent to  
2 them as to what it is. Choice is important, but bottom line  
3 is they would like to get probably the best and as little  
4 care as necessary so that they can basically live their  
5 lives.

6           The provider change is a second comment, and that  
7 is I'm struck by the physician piece. It takes -- having  
8 operated what is really probably closest to an MA-PSO in an  
9 integrated capitated system with Medicaid, as well, I notice  
10 that the physician behavior in order to do this culture  
11 change really takes time to knit together and really focus  
12 on the care coordination and the most efficient use of  
13 resources. When we went out and contracted with private  
14 fee-for-service physicians, that interface of culture was  
15 very different, and understanding what the motivation and  
16 the incentives were for the fee-for-service physician was  
17 something that our plan had to figure out -- and did -- in  
18 order to do that. But I must say that this culture change  
19 component that I think Jay alluded to takes a long time in  
20 order to have two different countries, so to speak, come  
21 together and figure out what that bridge really is. So I  
22 wouldn't give that part short shrift at all.

1           And then the last question that I have is when I  
2 heard about, thinking about the medical home vis-a-vis  
3 probably as one of the core possibilities of an ACO, not  
4 required, but it certainly seems like it would be an  
5 advantage, it would be one of the areas that made me think  
6 of all the different things that we study and write about,  
7 whether it's episodes of care, pay-for-performance, medical  
8 homes, ACOs. And I notice that they each generate  
9 conferences. But along the way, the silo approach and the  
10 fact that they're really related in some form, I wonder if  
11 we've ever thought about developing a schematic and seeing  
12 how some of these things really are kind of subsets or  
13 related to the other so that at the end of it, we're about  
14 care quality and volume control with the dollars associated,  
15 and just to see how they articulate and sometimes are  
16 synergistic and sometimes have a little bit of conflict so  
17 that we don't, as I think Peter said, get all the angst  
18 worked up with lots of people thinking about these models  
19 and getting consultants all into developing consultation  
20 when, in fact, some of these things could be thought through  
21 with these conceptual models that we're offering a little  
22 bit more logically.

1           DR. MILSTEIN: I'm very supportive of this line of  
2 development. I think it's important to reflect on the fact  
3 that the prize here is motivating the agent with the most  
4 authority in a health care system to continuously innovate  
5 and discovering better, less expensive ways of delivering  
6 care, and then using sort of the lessons from complex  
7 systems, trying to make sure that you have the fewest number  
8 of rules as you move forward.

9           I have to say that I'm very impressed with the  
10 incidence of failure in the Medicare demos, and for that  
11 matter, the incidence of failure in Medicare Advantage plans  
12 to essentially deliver on what they were after. It's caused  
13 me, among other things, to become more humble in my views as  
14 to what it is that would achieve -- that would sort of  
15 ignite American physicians to be much better and much faster  
16 at discovering better, less expensive ways of delivering  
17 care.

18           And so what I've tried to do is look at those  
19 delivery systems that are actually achieving what we're  
20 looking for and then studying what they're doing. And what  
21 I would extract from three years of such study relevant to  
22 this discussion is that there are two things that I think

1 it's very important that we get right. Number one is  
2 harmonizing physician incentives to improve value across all  
3 patients that a physician is seeing, or as many as possible  
4 as opposed to --

5 MR. HACKBARTH: Not just Medicare.

6 DR. MILSTEIN: Yes, and I think that's very  
7 important.

8 And then, secondly, giving physicians flexibility  
9 in terms of how they innovate, who their partners are,  
10 because there have been -- I saw a number of examples, for  
11 example, in which physicians were affiliated with a  
12 hospital, but over time, that hospital turned out not to be  
13 the best value. And it's the ability to switch that was  
14 very important to their ability to continuously deliver  
15 better.

16 So with those reflections in mind, I guess I would  
17 raise three questions for our consideration. Number one is  
18 since getting as many patients into -- I'm sorry, improving  
19 -- increasing the number of patients whom physicians regard  
20 as being in programs that are aimed at this objective,  
21 should we entertain as one of our options assigning all  
22 enrollees, all Medicare enrollees who don't -- I'm sorry,

1 all Medicare beneficiaries who don't connect with a  
2 voluntary ACO to a default involuntary ACO, so kind of we  
3 get all of the Medicare beneficiaries in, appreciating that  
4 the mandatory version has some disadvantages, but that way,  
5 at least, you have all Medicare beneficiaries -- the  
6 providers treating all Medicare beneficiaries aimed at the  
7 same objectives. So that would be one idea for  
8 consideration. So it is assignment of those beneficiaries  
9 that do not enroll in a so-called voluntary ACO to then be  
10 auto-assigned into a so-called mandatory. That's idea  
11 number one.

12 MR. HACKBARTH: Yes. Can I --

13 DR. MILSTEIN: Yes.

14 MR. HACKBARTH: -- just to make sure I understand  
15 that, Arnie. So when we talk about voluntary ACO, we're  
16 talking about voluntary to the provider.

17 DR. MILSTEIN: Correct.

18 MR. HACKBARTH: They can choose to be paid under  
19 these payment rules or traditional Medicare. So the  
20 voluntary is provider voluntary.

21 DR. MILSTEIN: Exactly.

22 MR. HACKBARTH: And the underlying concept is,

1 it's basically invisible to beneficiaries.

2 DR. MILSTEIN: Right.

3 MR. HACKBARTH: So now with that as the  
4 foundation, I'm trying to understand what it means to assign  
5 beneficiaries who are not in a voluntary ACO to an ACO.

6 DR. MILSTEIN: It's simply a way of enabling all  
7 providers serving Medicare beneficiaries in a given  
8 geography to mentally feel that they will -- they, the  
9 providers, will benefit if they discover higher-quality,  
10 less-expensive ways of taking care of the patients.

11 And so what I refer to is let's say in a given  
12 geography, 30 percent of Medicare beneficiaries are  
13 participating in ACOs that are provider voluntary. I'm  
14 suggesting that one way of synchronizing physician  
15 incentives would be to say for the other 70 percent, those  
16 enrollees are essentially -- then automatically participate  
17 -- participate in what we are calling a provider mandatory  
18 ACO.

19 What I'm trying to do is come up with a solution  
20 whereby --

21 MR. HACKBARTH: I think I understand.

22 DR. MILSTEIN: Okay. What's a little confusing is

1 the provider voluntary versus enrollee voluntary, and I'm  
2 trying to stick with the language we started out with, which  
3 is voluntary and mandatory applied to provider, not to  
4 enrollee. So that's idea number one.

5           The second idea is should we consider not  
6 requiring every ACO - physicians in every ACO to include a  
7 particular hospital, so that the physicians have the  
8 flexibility of switching hospitals if, over time, they find  
9 that a different hospital is going to better serve their  
10 innovation objectives. So that's idea two.

11           And idea three is, and I really -- well, I just  
12 have to say it. Let me go back to where I started, which is  
13 this works best if physicians are facing the same incentives  
14 over as many patients as possible. So idea number three is  
15 should we consider extending certain CMS benefits to  
16 commercial payers that agree to harmonize their ACO program  
17 with Medicare's? So we essentially have a world in which  
18 American physicians are facing a uniform set of goals of  
19 better, less-expensive health care.

20           Nancy is saying, well, for example, what do I have  
21 in mind? I'll put the least controversial and then I'll  
22 leave it to your imagination for the more controversial.

1 But the least controversial would be, for example, no  
2 balance billing rule. That's something that is attractive  
3 to -- would be attractive to many private payers. That is  
4 that if there is a dispute over how much is owed between the  
5 payer and the provider, the patient can't be leveraged  
6 through collection agencies. It's a minor problem for  
7 private payers.

8           And there are obviously other benefits. For  
9 example, probably on the more controversial end would be  
10 what happened in patient private fee-for-service, where the  
11 payers were allowed to pay Medicare rates. I realize on the  
12 commercial side that could be a problem. So maybe some 100-  
13 and-X percent of commercial rates. You fill in the blank.  
14 But I'll just put benefits for harmonization to commercial  
15 payers, and then the nature of those benefits, it's probably  
16 better that I not lay that out, because I think there are a  
17 lot of options.

18           And my last comment is that the demos and the  
19 Medicare Advantage plan show us the low probability that  
20 whatever we come up with is going to work. I mean, let's  
21 face it. The failure rate in terms of Medicare Advantage  
22 plans who are not saving the government money or improving

1 quality and the percentage of demos, that despite best  
2 design efforts and enthusiasm of the leaders were supposed  
3 to add a lot of value didn't.

4           And so my notion would be, again, is there an  
5 opportunity for us to study a little bit more of what's  
6 working. I mean, for example, take a subset of Medicare  
7 Advantage plans that even in relatively low-cost areas are  
8 below Medicare benchmarks and getting good quality. Can we  
9 take private sector exemplars, like the State of Minnesota  
10 Employees Health Plan, that have implemented their own  
11 variant of ACOs, and actually have positive results, lower  
12 spending, lower trend, so that as we make our bets, they can  
13 be maximally informed by what is working elsewhere?

14           DR. CHERNEW: Thank you. So my view of this  
15 loosely is there is probably a set of parameters that we  
16 could come up with which would make this a really good idea,  
17 and in reading the chapter, I'm not sure what that set of  
18 parameters are and what the details are.

19           So I've tried to do some math. I didn't do a good  
20 job. It's not surprising that my favorite parts of the  
21 chapter are Table 2 and Table 5, which are the tables that  
22 try and work through some of these exact examples. But I'd

1 like to ask a question relative to a benchmark that I have  
2 for ACOs. So here's how I see them, and John may correct me  
3 or you may correct me, but let me give you an example of a  
4 type of ACO program which is not what you're recommending  
5 and not what I'm advocating, and I'll say that again to be  
6 clear. This is not what I'm advocating and not what they're  
7 recommending, but at least it helps me as a benchmark.

8           Imagine a world in which every ACO, voluntary or  
9 not, was capitated, had a capitated target. If they  
10 conserved utilization so they were more efficient in a  
11 Bertko way of more efficient, they would get a really big  
12 bonus. They would get all of that bonus. That would be  
13 funded not by fee-for-service rate cuts. That would be  
14 funded by the savings associated with the cost, which is  
15 what I think John was pointing out, and that's how they get  
16 their bonus, and that's about as strong a bonus as I think  
17 you could get. If you wanted to do that in anything else  
18 that we talk about in terms of a bonus, I think it almost by  
19 definition has to be weaker than that.

20           The disadvantage of capitation, which is well  
21 known, of course, is if for reasons -- because they didn't  
22 do a good job or sort of reasons of no fault of their own --

1 their experience is higher than that capitation rate, they  
2 take the entire risk, which, of course, they hate. And so  
3 the idea is to have an ACO that in some sense mitigates that  
4 risk if they go over whatever this particular target is. And  
5 in your tables, like Table 5, I think, for example, you have  
6 this target, but it's not clear how the target's set and the  
7 numbers always kind of work out in the end so it looks like  
8 it's good. But I think if you told me the formulas, I could  
9 go through and give you some behaviors where it might not  
10 work out quite that good, depending what the actual  
11 parameters were.

12           So what I'm worried about or what I see in terms  
13 of the voluntary-mandatory and how this works is imagine  
14 you're a plan or an organization like Peter's and you're an  
15 ACO. So on one hand, you have some bonus if you do a good  
16 job by sending the person to watchful waiting instead of  
17 taking out their spleen or whatever it is you were going to  
18 do.

19           [Laughter.]

20           DR. CHERNEW: Do they do that?

21           [Laughter.]

22           DR. CHERNEW: I don't even know. Do people have

1 spleens?

2 [Laughter.]

3 DR. CHERNEW: But in any case, whatever they're  
4 going to do, they do something more efficient and then that  
5 helps them and they can save money. So that's sort of one  
6 option, which is never take an image of anybody.

7 The other option is, in sort of the Ron sense, to  
8 do whatever they are doing in the robust fee-for-service  
9 world. And the challenge is sort of to work out a set of  
10 parameters so the more conservative, hopefully higher  
11 quality -- and you have set it up with good and poor quality  
12 in your tables -- is more profitable than doing the not-so-  
13 right thing. Over time, that has to be the case, that the  
14 not-so-right thing becomes less profitable, because over  
15 time, if this is going to be effective, there has to be a  
16 growing gap between the profitability of just run with the  
17 system, whatever percentage per year, versus the sort of  
18 bonus model.

19 So when you weaken the bonus, make it weaker than  
20 the capitation bonus for doing the good thing -- in other  
21 words, in your models, I think you use 80 percent gain  
22 sharing. You picked some number. So you weaken the bonus

1 relative to capitation. So that says, you know, I don't get  
2 quite so much. I don't get to save all of the cost savings.  
3 I get 80 percent of it or whatever it is, relative to the  
4 profit if they do it.

5           And working out the math of that to understand  
6 what the alternative is, I think is the key thing to making  
7 this work, because I think relative -- Glenn made a comment,  
8 which I agree with completely, is the problem with putting  
9 everyone into an MA plan, which has this capitated risk  
10 feature to it, is that not all provider organizations want  
11 to take on all of that risk. And so I think we collectively  
12 are struggling with how much risk to give them. The more  
13 you fiddle with that, what happens if they get above how  
14 much fee-for-service, they're going to face some risk.

15           And so I think the challenge in going forward and  
16 the challenge in why it's hard for me to answer the  
17 questions right now is I still am not completely sure about  
18 exactly what's on the table and how we're going to walk that  
19 line between making it strong enough so it works but weak  
20 enough so not so many people have risk and stuff.

21           I guess my view is that I'm hesitant to do things  
22 that are mandatory until I know more. I like the idea of

1 doing things voluntarily. I like the idea of ways of  
2 exploring how to make what I believe is loosely a new type  
3 of MA sort of plan, which is what these big voluntary  
4 organizations would be, with some risk mitigation component.

5           So I think there is something positive in going in  
6 that direction and I think we have to think about what the  
7 exact incentives are, and I agree with Glenn's comment  
8 strongly, which is the voluntary/non-voluntary nature of  
9 this has a lot to do with what the alternative is. And so  
10 per the silo comment, we have to think about this not just  
11 in terms of medical home, but there should be a  
12 comprehensive sense of how we're going to face the quality  
13 problems that we want to improve and how we're going to deal  
14 with the fiscal challenges, how we're going to make sure  
15 providers have enough money to provide good quality care,  
16 that the country has enough money so we actually don't sink.

17           And so I think my final comment will be, I just  
18 think we need a little more work on exactly what the details  
19 we have in mind are of this before we can go say ACOs are  
20 good, because I think there's a certain type that probably  
21 is good and there's a certain type that's probably not and  
22 I'm not sure we're quite there yet.

1 DR. BORMAN: I certainly am not going to elucidate  
2 or articulate an elegant economic discussion. I do have a  
3 couple of comments that I think I can bring some expertise  
4 to bear on.

5 One is I, too, am a bit concerned, although  
6 perhaps in a different way, about the specialist piece of  
7 this model as presented, and I'm concerned for multiple  
8 reasons, but the most cogent, I think, probably are: Number  
9 one, I've heard several people espouse restricting access to  
10 specialists. I think that, frankly, that was one of the  
11 biggest backlash items of previous experiments in this area  
12 and I would be extraordinarily cautious about doing that.

13 On a less psycho-babble way of looking at it,  
14 perhaps, is the issue that for both my primary care  
15 colleagues and myself, I have great concern about setting  
16 somebody up to be an arbiter of a body of knowledge that is  
17 ever expanding while their own body of knowledge is ever  
18 expanding. I do think that an expectation that there will  
19 be a group of individuals who will have sufficient knowledge  
20 to make some of the judgments implicit here when the  
21 challenge of their own field is exploding on a regular basis  
22 may be a bit of a stretch.

1           And so for those two reasons, I'm a bit concerned  
2 about how the specialist piece of this plays out.

3           The second piece is that it's very clear that we  
4 need to constrain costs. Quite frankly, and I think Ron  
5 alluded to a little bit in his conversation, that is not an  
6 intrinsically obvious piece to many parts of our health care  
7 delivery system, including physicians and beneficiaries  
8 both, I would say. You know, a sense of a bigger picture  
9 that there's real bankruptcy and it's in our face is not  
10 something that's universally kind of on the table, like  
11 opening your Cheerios box is on your table in a very  
12 concrete way.

13           So I think that that being said, that I also think  
14 that at least the physician community, who along with the  
15 hospitals are the biggest chunks of the program spending --  
16 one of the very natural reactions, however, is going to be  
17 there appear to be some other system pieces that hold some  
18 low- to medium-hanging fruit and I think that things like  
19 competitive drug pricing, durable medical equipment, some of  
20 those kinds of things where there are demonstrable savings,  
21 some of which have been the subject of conversation at this  
22 Commission, are very legitimately going to be push-back

1 kinds of comments that -- I think if we're all going to say,  
2 universally, we need to constrain costs, universally, there  
3 is going to be some pain and it will need to be shared pain,  
4 then it does truly need to be shared across the system, and  
5 leaving Part D or biologics or whatever it is out of this as  
6 sort of a piece of the puzzle, I think will make this more  
7 difficult to engage folks in. And so I do think that to  
8 engage physician colleagues, we are going to need to be able  
9 to show that there is a multi-pronged attack on cost  
10 constraint, not just the world of the physician.

11 MR. HACKBARTH: Okay. Let me just make a few  
12 comments. My apologies to Anne and Rachel.

13 I've been trying to figure out how to label these.  
14 My working label is ACO design principles, but "principles"  
15 somehow sounds too high-fallutin' for what will follow, so  
16 don't hold me to that.

17 Number one is I think that we can't afford to put  
18 all of our eggs in one basket, and I think this is similar  
19 to some of Arnie's thoughts. As much as I personally  
20 believe that more organization of care is the path out of  
21 the wilderness, I don't think, Peter, we can say, well,  
22 we're just going to do ACOs and we're not going to do

1 bundling, we're not going to do the other things. Your  
2 point is a very important one, that we run the risk of  
3 diffusion of energy and effort, not just among providers but  
4 CMS and the Congress -- I know that's an argument that  
5 Elliott and John and Mark McClellan have made, but at the  
6 end of the day, I just don't think we're confident enough in  
7 this particular basket that we want to put all of our eggs  
8 in it. There's just too much uncertainty about how it will  
9 develop. That's my view.

10           Second is I think it's very important to move in  
11 steps, as Jay has said, and I agree with Peter's point that  
12 the first step of feedback to people about how they're doing  
13 is potentially a powerful one in its own right. And rather  
14 than sort of rush through that, I think we should take some  
15 care to do that and do it well. I think there will be some  
16 benefit.

17           Second is that, for reasons I described earlier, I  
18 think participation as an ACO must be voluntary. We're  
19 talking about forging new relationships among actors,  
20 relationships that have evolved this way over decades. To  
21 say that everybody's going to do a certain thing quickly, I  
22 just think is unrealistic in that context.

1           I also agree with what several Commissioners have  
2   said that we need to be flexible about what an ACO is and  
3   what the exact form of the organization might be. I don't  
4   think that any individual physician should be required to  
5   participate with an ACO. I think that would actually be  
6   detrimental. I think you want people in who want to engage  
7   in this task and see some benefit in it. I can imagine  
8   that, over time, different varieties of ACOs might develop.  
9   Some might be managed by a hospital. Some might be a  
10  hospital-physician joint venture. Some might even  
11  eventually involve a private insurer and we should allow  
12  that evolution to occur over time and respect that we don't  
13  know the right answer at the front end.

14           Next is I don't believe that we should lock  
15  beneficiaries in. For beneficiaries who wish to go into a  
16  closed system, make an enrollment decision, we have Medicare  
17  Advantage, and I believe with a different pricing mechanism,  
18  we can get more productive organizations in Medicare  
19  Advantage, which offer truly meaningful choices to  
20  beneficiaries who are willing to lock themselves into closed  
21  delivery systems. This path is one for those beneficiaries  
22  who wish not to be locked in. That's what we're trying to

1 create here.

2           Next is I think ACO needs to be the place where we  
3 begin to address these equity issues that have been  
4 simmering beneath the surface and increasingly are bubbling  
5 up in very prominent ways, and there are two types of equity  
6 issues that I'm thinking about. One, the inequity for  
7 health care providers who have actually been engaged in  
8 trying to make health care better and more efficient and  
9 have received not only no reward from Medicare for doing  
10 that, they have actually been penalized for it.

11           And so when we set targets, one idea that's  
12 floated around has been, well, you set the target based on  
13 ACO's specific historic costs, which basically says to those  
14 organizations, thank you very much for all you've done.  
15 You're not going to get any reward for it. You've got to  
16 improve from your already low level while the providers who  
17 are at the other end of the continuum are going to get to  
18 reap a windfall. That's not right, it's not just, and I  
19 think it's counter to any principle of reform that I know.

20           Another equity issue is this regional inequity,  
21 and nobody's been more vocal than I in saying that Medicare  
22 Advantage is not the proper vehicle for addressing regional

1 inequity. It needs to be done in traditional Medicare.  
2 Here's the place that I think we need to try to make good on  
3 that. Where it comes in in my view of ACOs is I think ACOs  
4 need to be voluntary, because I said earlier that needs to  
5 be coupled with restraint on traditional Medicare so that  
6 we've got complementary forces there, and a restraint on  
7 traditional Medicare, I think, has to be higher for  
8 providers that have had high historical costs than for those  
9 who have had low historical costs. We've got to start to  
10 squeeze differentially in traditional Medicare.

11           Next is -- I'm trying to do this as quickly as  
12 possible -- next is that, as John and Arnie and a number of  
13 people have said, I believe that, ultimately, the success of  
14 this will hinge on private payers moving simultaneously in  
15 the same direction, and if the typical hospital-based ACO  
16 has 30 percent Medicare revenues and they're getting some  
17 share of their savings on 30 percent of the revenues and the  
18 underlying payment system is still fee-for-service, the  
19 incentives to make really important changes in how they  
20 organize and deliver care are just too weak. We need to get  
21 not 30 percent involved in this game, but as close to 100  
22 percent as we can get.

1           Now, I don't think that there's any simple  
2 mechanistic solution to getting private insurers involved in  
3 this. At least I don't know of any. But I think the step  
4 of data disclosure at the front end is important in laying  
5 the groundwork for that, because that information will  
6 become available to private insurers eventually, as well,  
7 and they'll start to say, well, boy, this is where I want to  
8 try to steer my patients and here is the groundwork for a  
9 shared incentive system with those institutions. I can use  
10 Medicare's model as a starting point for that conversation.  
11 And I think the faster that happens, the more powerful this  
12 can be as a tool.

13           So there are my thoughts, and I think there's  
14 substantial overlap with what I've heard from other  
15 Commissioners, and that's probably because I've been  
16 informed by what I've heard from other people as we've  
17 worked through these issues. I guess that's all I have to  
18 say.

19           DR. KANE: Just as to your getting private payers  
20 to follow, perhaps we might want to consider recommending or  
21 looking into the recommendation of encouraging all-payer  
22 State Medicare waivers and thinking about what that means

1 and how to facilitate those.

2 MR. HACKBARTH: Thank you very much. Great work  
3 over a series of meetings on this.

4 Let's now turn to follow-up on previous  
5 discussions of bundling and episode payment organized around  
6 hospitalization.

7 Again, Anne, I apologize for using up so much of  
8 your time. Anne has graciously agreed to make some  
9 adjustments in her presentation, and much of this is  
10 informational, and it's important information. But we'll  
11 try to keep our discussion limited. Thank you.

12 MS. MUTTI: So a year ago we made recommendations  
13 on readmissions and bundling. In the interim, there has  
14 been increased interest in this, so we thought it was a good  
15 opportunity to come back and update you. To be clear, there  
16 is no June chapter in the 2009 report, and we're obviously  
17 not looking for recommendations.

18 Just to refresh you, we came at this issue because  
19 Commissioners were concerned that the health care delivery  
20 system is fragmented, care not coordinated. Commissioners  
21 expressed frustration with our siloed payment system in fee-  
22 for-service and the fact that it reinforces fragmentation

1 and drives volume.

2 We focused attention hospitalization episodes for  
3 a couple of reasons. First, it's a particularly vulnerable  
4 care juncture for our beneficiaries where a change in  
5 incentives could really improve the quality of their care.  
6 And, secondly, it is a costly episode of care with a lot of  
7 variation in practice patterns, and it suggested an  
8 opportunity to reduce unnecessary utilization.

9 This table we showed you a year, a year and a half  
10 ago. The point of it was to focus you on the fact that when  
11 we look at an episode of care around a hospitalization, a  
12 lot of the variation occurs around readmissions and post-  
13 acute care. I'm not going to go through it any more than  
14 that right now.

15 This is just to refresh you on what our  
16 recommendation was on readmissions: that the Secretary  
17 would reduce payment to hospitals with high readmission  
18 rates; it would be for select conditions only; as part of  
19 it, we would permit shared accountability, otherwise known  
20 as gain-sharing. We encouraged the Secretary to look into  
21 other approaches such as virtual bundling that may be a  
22 little broader, in effect; and that as part of this,

1 information about readmission rates and service use around a  
2 hospitalization episode should be made available first  
3 confidentially and then publicly. These policies, ideas,  
4 have been picked up both in the CBO budget options book as  
5 well as the President's budget.

6 MedPAC also recommended that the Secretary conduct  
7 a pilot to test the feasibility of bundled payment around a  
8 hospitalization episode, and, again, we're talking about the  
9 stay plus some time post-discharge, something like 30 days.  
10 Similarly, it was for select conditions. The pilot was to  
11 be voluntary only, and it was at a minimum to be budget  
12 neutral. So savings or budget neutrality was a requirement.

13 So in surveying the environment around the issue  
14 of bundled payment, we would just want to point out that  
15 right about the time that we came out with our  
16 recommendation on bundling, CMS announced its ACE  
17 demonstration, and that demonstration seeks to bundle  
18 payments for select cardiac and orthopedic inpatient stays.  
19 And it's the inpatient stay only. They're not bundling that  
20 post-discharge period that we talked about. And they were  
21 setting the price for the bundle based on competitive  
22 bidding.

1           Just real quickly, the sites have been selected.  
2     There was only one in each eligible market, so the degree of  
3     competition is a little limited. The kind of discounts they  
4     got were in the range of 1 to 6 percent, and it varied more  
5     by hospital rather than by condition. And that is supposed  
6     to be up and running at least for three of the sites in May.

7           Bundled payment proposals also appeared in the CBO  
8     budget book. A Commonwealth Fund commission has also  
9     recommended this approach, and it was also in the  
10    President's budget. I guess at this point I'd just say the  
11    bundling proposals vary a bit as to what they include and  
12    don't include, so in the next couple of slides, I'm just  
13    going to take a little time to illustrate how it can vary.

14           DR. MARK MILLER: Anne, can I just say one thing  
15    for the Commission and for the public? Another way to think  
16    about what is happening here is this idea the Commission had  
17    been talking about for a couple of years. We came out with  
18    recommendations, and now the environment appears to be quite  
19    fertile. People are now thinking about it in a number of  
20    different directions, and Anne is going to give you some  
21    more detail on that.

22           MS. MUTTI: Here I was just going to review what

1 some of the Part A and B care components are that could be  
2 subject to bundling around a hospitalization.

3 First, there is the admission, and that includes  
4 the hospital services, which in a sense are already bundled  
5 under the DRG and also include care delivered 72 hours prior  
6 to admission. So there is already a sense of bundling built  
7 into hospital services. And also there is the physician  
8 services that are delivered during the hospitalization, and  
9 that is in that left-hand side of the chart here.

10 Then there is the care that is delivered in the 30  
11 days post-discharge, and that can include readmissions,  
12 post-acute care services, physician services, and other  
13 services like lab services. We don't have the Part D drugs  
14 on this chart, but we are aware that they exist out there.  
15 But we've been focusing our attention on bundling for Part A  
16 and B.

17 So currently all of these services are paid  
18 separately, sort of piecemeal, if you will. The ACE  
19 demonstration would bundle those services, and what we  
20 recommended as part of our pilot was to bundle the broader  
21 set of services.

22 In the CBO budget options book, there are two

1 other approaches to bundled payment. One is to bundle the  
2 inpatient stay plus post-acute care in 30 days post-  
3 discharge, and that doesn't include readmissions or  
4 physician services either during the stay or after the stay.  
5 Another option that they talked about was bundling the  
6 inpatient stay with those physician services during the  
7 stay. So what services are included in an episode is  
8 clearly a design issue that people are thinking about.

9           Another consideration is whether bundling is  
10 voluntary or mandatory, and in this first CBO option here,  
11 the stay plus the post-acute care component, it is mandatory,  
12 and the money would go to the hospital.

13           The Commission discussed a mandatory bundling  
14 option, but decided that voluntary was more appropriate,  
15 particularly when we were talking about our broader kind of  
16 episode of the stay plus 30 days. But given, you know,  
17 increased interest in this idea, we thought it might be  
18 helpful to explore some variations on bundling that could be  
19 possibly more palatable on a mandatory basis.

20           One is virtual bundling, and we discussed this  
21 last year, but ultimately recommended that CMS study it  
22 further. Under this, providers continue to be paid fee-for-

1 service but would be subject to a withhold. And so those  
2 who are on average part of high-cost risk-adjusted episodes  
3 would experience a payment penalty by not getting their  
4 withhold back. Bonuses could be awarded to providers with  
5 relatively low costs. So, again, everyone is paid fee-for-  
6 service in this piecemeal approach, but everyone's payment  
7 is adjusted based on overall average spending in the  
8 performance period, and I've indicated the performance  
9 period here with the dotted circle. The test for earning  
10 back the withhold then could be both efficiency or costs  
11 across the episode as well as quality measures.

12           There are several advantages to the virtual  
13 bundling approach. It holds a variety of providers  
14 accountable over an episode creating symmetrical alignment  
15 of incentives, and it should in that way spur conversations  
16 among care partners about coordination and reducing  
17 redundancy. It is a broader policy than our readmissions  
18 recommendation because it addresses variation in post-acute  
19 care spending, not just focusing on readmissions. And at  
20 the same time, it mitigates some of the concern with bundled  
21 payment that we intended to be addressed in the context of  
22 the pilot, and one of the concerns about bundling is that

1 without refined risk adjustment and solid quality measures,  
2 we risk creating an incentive to stint on care. The  
3 potential financial gain from withholding services can be  
4 substantial under bundling. Under virtual bundling, the  
5 gain from stinting is much less.

6           The disadvantages to virtual bundling is that in a  
7 sense, by continuing to pay providers fee-for-service, it  
8 doesn't allow for that payment flexibility, for that  
9 flexibility in creating incentives that bundled payment  
10 permits. For example, it doesn't allow Medicare payments to  
11 be used for e-mails or for nurse home visits or other things  
12 that Medicare does not explicitly pay for now, but under a  
13 bundle, providers could choose to cover it and be more  
14 innovative and perhaps stimulate greater efficiency.

15           Virtual bundling may also present some  
16 administrative challenges to implement, but we're not  
17 thinking that they are prohibitive. But we'd certainly like  
18 to give that a little more thought.

19           Another possible approach is something we call the  
20 hybrid approach, and the hybrid approach simply builds on  
21 the virtual bundling, overlaying bundled payment for the  
22 hospital stay onto virtual bundling. So this means that a

1 single bundled payment for all services during an admission  
2 would be made to a hospital-physician entity. So these  
3 services on the left-hand side would be bundled.

4           At the same time then, all these services across  
5 the entire episode would be subject, say, to a withhold, and  
6 it would be returned if you were a relatively efficient  
7 group of providers. So it's a mix of a bundled approach but  
8 for a more limited set of services than we've talked about,  
9 but then overall holding people accountable for the volume  
10 of services provided in an episode.

11           The advantages of the hybrid approach are that it  
12 could induce greater efficiencies, much like were realized  
13 in the bypass demonstration in the 1990s, where we saw some  
14 reduced consults and lower hospital costs in the area of  
15 ICU, lab costs, pharmacy costs. And it is a step toward  
16 more comprehensive bundling. It is, you know, one step in  
17 that direction, and it may be, therefore, a possible --  
18 since it's a smaller scope of bundling, it may be more  
19 possible to be a mandatory program-wide kind of approach.

20           Among the disadvantages are that, like any  
21 bundling proposal where we're putting hospitals and  
22 physicians together, it could increase admissions, and

1 that's because hospitals and physician incentives would now  
2 be aligned, and they may be more inclined to admit  
3 relatively low-severity, high-margin patients. We have a  
4 couple of ideas to counteract that effect. I won't go into  
5 that now, but it might be possible to balance that out.

6           As with any bundled approach, it could create the  
7 incentive to stint on needed care. In this case, we're  
8 thinking mostly in inpatient physician visits. That could  
9 be mitigated by holding the providers accountable for  
10 service use in that post-discharge period like we're talking  
11 about as well as through quality measures. And the  
12 magnitude of potential savings in this approach is probably  
13 smaller than achieved by bundling payment across a longer  
14 episode because here we are not bundling for those services  
15 that we know have a lot of variability -- the readmissions  
16 and the post-acute care. We are attacking that with a  
17 virtual bundling approach, but it's not bundled, and so we  
18 may have less savings opportunities.

19           I'm just going to switch gears here to say a bit  
20 about looking at Medicare's quality infrastructure because,  
21 regardless of which bundling variation or readmission policy  
22 is adopted, an important consideration is how to support

1 learning of best practices and accelerate the pace of change  
2 in practice patterns, because ultimately we want to promote  
3 the success of providers in responding to these financial  
4 incentives, not just have the opportunity to take some of  
5 their payment. So we need to be mindful of the possibility  
6 of creating payment policies where providers that are ill-  
7 equipped to respond reduce services and in turn compromise  
8 access to care in the community or the quality of that care.

9           At the same time, we don't want to lower  
10 expectations on quality and affordability and not achieve  
11 what is possible. So we could think about promoting an  
12 effective quality infrastructure as a way to ensure that  
13 capable providers have the tools to succeed and that  
14 beneficiaries get that improved care. So as part of that,  
15 we're thinking that as staff we might want to evaluate the  
16 efficacy of Medicare's resources and regulatory requirements  
17 in promoting quality improvement and system-ness, and that  
18 would include taking a look at the QIOs, the accreditation  
19 and survey process, and conditions of participation and  
20 assess whether those resources are being maximized.

21           So, in conclusion, just talking about what staff  
22 next steps could be, we could perform some data analysis to

1 assess the variations of bundled payment that I mentioned  
2 here, also to look into some of the Part D issues, and also  
3 we could investigate ways to improve the Medicare quality of  
4 infrastructure along the lines I just mentioned.

5 MR. HACKBARTH: Thank you, Anne. As opposed to  
6 going through two rounds, let's just have a quick one round.

7 MR. GEORGE MILLER: Just quickly, has the  
8 Commission had the opportunity to do a deep dive to look at  
9 all of the regulatory and statutory issues around pulling  
10 all this together of civil monetary penalties, state  
11 statutes that may have effect on bundling?

12 MS. MUTTI: Not a deep dive.

13 MR. GEORGE MILLER: Okay, because I am concerned  
14 about whether we can all pull this off as a recommendation  
15 without first dealing with the regulatory and statutory  
16 issues around this issue.

17 DR. REISCHAUER: This is really a clarifying  
18 question on Chart 11, the hybrid approach. I'm just trying  
19 to figure out how this works. Everybody in the plus-30-day  
20 column has a withhold, so a hospital in a situation in which  
21 their readmission rate, because of good post-acute care and  
22 physician services, for those readmissions that do occur,

1 get a bonus. I mean, there is a withhold and then a  
2 payment. Their behavior --

3 MS. MUTTI: There could be --

4 DR. REISCHAUER: I'm just trying to figure out how  
5 it works. I can see, you know, on the physician services as  
6 opposed to acute care, what you have is fee-for-service  
7 payment with a withhold. And then if at the end of the year  
8 everything looks good, people get a dividend, in a sense.

9 MS. MUTTI: Right. And the withhold could be  
10 applied -- the way we're envisioning it, the withhold would  
11 also be applied to this new bundled payment, the inpatient  
12 stay plus the physician, so that they, too, would be on the  
13 hook for the volume of services in the entire episode.

14 Do you want me to say it again?

15 DR. REISCHAUER: No, I'm just thinking about the  
16 readmission portion, and if the withhold is applied to it --  
17 or you're saying it will go into the circle to the left?

18 MS. MUTTI: So if a readmission -- do you want to  
19 jump in here?

20 DR. REISCHAUER: What if readmissions went to  
21 zero?

22 MS. MUTTI: For that particular group of

1 providers, they would look pretty good across -- their  
2 resource use would look pretty good across this larger  
3 episode --

4 DR. REISCHAUER: I know they would, but I'm  
5 wondering, does the hospital get any kick in that? And how  
6 does it work?

7 MS. MUTTI: They could if we included a bonus  
8 component to the program also.

9 DR. MARK MILLER: I think what she's saying is  
10 that the withhold applies to the left-hand side circle on  
11 that chart, and if everybody does well on readmissions, they  
12 get it back. And if it's a bonus situation, they would also  
13 experience the bonus. So, in other words, the hospital does  
14 get a benefit from the 30-day episode if readmissions are  
15 controlled. The hospital-physicians on the left --

16 MR. HACKBARTH: The withhold covers all of the  
17 right column services.

18 DR. REISCHAUER: [off microphone] I know, the  
19 right hand, but --

20 DR. MARK MILLER: [off microphone] It actually  
21 covers everything.

22 DR. REISCHAUER: He said it covers everything. I

1 didn't know that. I thought that it was just -- you know.

2 MR. HACKBARTH: I'm sorry. I meant --

3 DR. REISCHAUER: A bundled payment for the first -

4 MS. MUTTI: I'm sorry. I wasn't clear. There's  
5 the bundle but then it, too, is subject to the withhold.

6 DR. REISCHAUER: That is withheld, too. Okay.

7 DR. CROSSON: So, Anne, as I was listening to the  
8 presentation, and this is in relationship to the non-virtual  
9 bundling options or the part of the -- the non-virtual part  
10 of that one, in terms of where the money actually is paid  
11 to, at one point I heard you say hospital, and then at  
12 another point I heard you say hospital-physician entity.  
13 And I'd just like to stress that I think we should think  
14 about it in the latter term, for two reasons:

15 Number one, I think at least when I've discussed  
16 this notion with physicians, the biggest opposition isn't  
17 really to the incentives created or anything. It's just  
18 simply to the notion that the hospitals would receive all  
19 the money, and then the physicians would be sort of one down  
20 in that arrangement at the beginning. So that, you know,  
21 creating the payment to some third entity -- and this would  
22 not need to be complex. I'm not talking about creating a

1 structural entity like a PHO, but simply an agreement  
2 between the physicians and the hospitals to apply for this  
3 opportunity, if you will, or to receive the payment in this  
4 way, would then allow the physicians and the hospitals to  
5 work out how that would be done.

6 The second reason is I think that that discourse,  
7 that dialogue, which could be easy or quite contentious in  
8 the end, would create the basis for a dialogue between  
9 groups that don't necessarily talk with each other all that  
10 much.

11 So for those reasons, I think we might want to  
12 think a little bit more about how we describe who gets the  
13 money and what we mean, you know, when we're saying  
14 physician-hospital entity.

15 MS. MUTTI: Just to be clear, as I've tried to  
16 reflect what you all have said, we have always talked about  
17 provider entities, joint provider entities, hospital-  
18 physician entities. When I mentioned the hospital-only  
19 approach of giving the bundle that way, I was just referring  
20 to CBO's proposal, not ours.

21 DR. SCANLON: Just a comment on the idea of trying  
22 to improve the quality infrastructure. We did about 30 or

1 so reports at GAO looking at sort of oversight on quality,  
2 nursing homes, home health, dialysis centers, hospitals.  
3 And I think one of the strongest messages coming out of that  
4 is not so much that the methods that we have are deficient,  
5 but that we never applied them. We've never given CMS and  
6 the states the resources to actually go out and check  
7 conditions of participation on a timely basis, and so you  
8 don't know if the conditions are deficient or if it's just  
9 the fact that agencies could -- we found home health  
10 agencies that could go five or ten years without getting an  
11 inspection, the same thing for dialysis centers. Nursing  
12 homes are looked at more frequently, but not necessarily  
13 frequently enough.

14           So there is a real issue here about whether we  
15 need to think about using the methods that we've got  
16 correctly as opposed to developing new methods, because  
17 there is no issue that we need to improve the quality  
18 considerably among some of the organizations participating  
19 in Medicare.

20           MS. HANSEN: Thank you, Anne, on covering this  
21 again and bringing it back. I was struck by a comment you  
22 made on Slide 10 about some of the pros and cons of virtual

1 bundling, and the first one is the flexibility issue. It  
2 just basically keeps the same structure, but it doesn't  
3 allow perhaps more innovative or economic ways to achieve  
4 the results that everybody would benefit from. And this  
5 ties back to both George's comment about some of the  
6 regulations that do exist, both on the federal and the state  
7 level, and then Nancy's comment in the last section about is  
8 there some kind of broader Medicare waiver that would allow  
9 for this kind of flexibility.

10           So at some point, it's not just moving the  
11 existing structures. It may call for other ways to do it in  
12 terms of the efficiency of e-mail, you know, technology,  
13 perhaps another kind of workforce that would help bring down  
14 the cost but produce some of the results. So I do want to  
15 highlight that that is -- whether it is just virtual  
16 bundling or it's a broader concept that we have to keep in  
17 mind.

18           MS. MUTTI: Right. I think that point is one of  
19 the reasons why we have been so interested in bundled  
20 payment, because it does allow that flexibility for  
21 providers who are on the ground to make those kinds of  
22 decisions.

1 DR. CHERNEW: First, to clarify -- and I think  
2 this is right -- the bundled rate would include -- would  
3 essentially reflect the average readmission rate, or  
4 whatever it is, average resource use now.

5 MS. MUTTI: It could, right.

6 DR. CHERNEW: Okay, so something like that. And  
7 then my question is: How do you envision the bundled rate  
8 getting updated over time? And if organizations like Peter  
9 are lowering their readmission rates anyway right now  
10 because they're so shamed by -- not Peter's organization.  
11 In a bundled payment rate, that savings gets captured by  
12 Peter, and in the non-bundled payment, that savings gets  
13 captured by the program. So it's just an arithmetic  
14 question.

15 MS. MUTTI: Right, although you could design  
16 bundling so that the program did get part of the savings.  
17 One reason why I say it could, when you asked me is it just  
18 the average, well, you could say we're going to assume that  
19 you're going to do better, and so we're not going to give  
20 you the average, we are going to go for the 40th percentile  
21 or something like that.

22 DR. CHERNEW: And you could deal with Glenn's

1 issue that she was mentioned earlier on the ACO, which is  
2 you don't want everyone -- so a bundled rate that's based on  
3 the average penalizes the high readmissions rate and -- I'm  
4 just trying to understand --

5 MS. MUTTI: But it doesn't necessarily get us  
6 savings.

7 DR. CHERNEW: Right. So my only comment would be  
8 at some point -- I don't know when -- knowing some of the  
9 details about exactly what is put on the table for how the  
10 bundling does work I think would be useful. But I agree,  
11 there's a lot of possibilities to how to do it, and I think  
12 conceptually it is a good idea to begin to move in this way.  
13 But, again, if you're not careful how you do these ways, and  
14 depending on what you assume is going on in the future, you  
15 might actually not save -- you might actually save less  
16 money than you thought you otherwise would have saved,  
17 depending on what you think is going to happen.

18 MS. MUTTI: Right, and we did have some of that  
19 conversation in our 2008 chapter on bundling.

20 DR. MARK MILLER: I'm going to summarize at least  
21 one point that you have made very quickly here, which is,  
22 you know, Anne has also in previous conversations talked

1 about the notion that you start with a readmission policy,  
2 let that run for a few years, telling people that bundling  
3 is coming. Medicare takes those savings. Then you build  
4 the new bundle around a more efficient bundle. And she has  
5 made that point in previous meetings.

6 MR. HACKBARTH: Any others?

7 MR. BUTLER: All right, we won't put all our eggs  
8 in one basket, even though it's Easter on Sunday. Maybe we  
9 will on Sunday. I am just saying there's more yield out of  
10 the ACO than this level for me, and I think at this level  
11 you also create some potentially toxic effect among  
12 physician and physician relationships, more likely than ACO  
13 level.

14 Okay. I have a couple specific recommendations  
15 because my thinking around this has changed in the last  
16 year.

17 I'm less excited about addressing episode than I  
18 am the readmission rates head on, and a year ago, I would  
19 have said, well, you know, doctors admit and discharge  
20 patients, not hospitals. And nursing homes, you know,  
21 offload their sick into the -- and there's not compliance  
22 and all these other things. And I said, well, that's not

1 good enough. Hospitals can do a leadership role in here.  
2 We recommended a year ago that we take three years to kind  
3 of gradually publicly disclose. I would say today publicly  
4 disclose the hospital readmission rates. It would get  
5 everybody focused, and I don't -- you know, get on with it.

6           And then, second -- and this is maybe a stupid  
7 idea, but in my simple mind, I'd say if you could have a  
8 risk-adjusted rate -- so let's say you're 23 percent and  
9 risk-adjusted -- and you're average. If you could give a  
10 carrot and say, you know, you get down to 20 percent next  
11 year, hospital, you keep the savings or half the savings or  
12 a quarter of the savings. If you had a simple thing, it  
13 would very clearly kind of align things, and you wouldn't  
14 even necessarily have to have the physicians, you know, in  
15 all these payment gyrations along with it, and suddenly we  
16 have another scorecard and a carrot opportunity below a  
17 capitated level, and I don't know, it just might -- that's  
18 my crazy idea for this morning, but it would -- I think of  
19 all the health reform buckets where they're looking at the  
20 \$634 billion or whatever the number is up to, I think this  
21 is a ripe opportunity, and I think there may be quicker ways  
22 to get to it than the kinds of episode of illness things

1 we've got on the table.

2 MR. HACKBARTH: That's a very helpful comment. As  
3 I said earlier, I don't think it's a good idea to put all  
4 our eggs in one basket, but having said that, it's important  
5 to look for the most streamlined way to deal with particular  
6 issues, and straightforward readmissions, reward/penalty  
7 opportunity is a lot easier to operationalize, I think, than  
8 bundling, virtual or real. And the reason for looking at  
9 bundling was the concerns that you mentioned, that, well,  
10 the hospital doesn't have all the control, blah, blah, blah.  
11 And, you know, it's helpful to hear it from somebody who  
12 lives in that world to say --

13 MR. BUTLER: I say tough. It will force us to  
14 look at all these relationships head on; particularly if  
15 there is a carrot aspect of it, I think we could make a  
16 difference. And these are the medical cases particularly  
17 that are coming -- frankly, they aren't as profitable as  
18 other ones, anyway. And you can grind down the rates and  
19 say we will only pay you half for those, but you'd still  
20 then say, well, their contribution -- you go through all  
21 this rigmarole, then rather than having a flat-out  
22 incentive, I think would be helpful.

1           MR. HACKBARTH: My understanding -- the striking  
2 thing to me about the readmission date is the variation.  
3 There's enormous variation, which always says to me if you  
4 really are motivated, there are lessons to be learned. You  
5 can find out what other people are doing to have much better  
6 rates, and there are organizations like IHI and others that  
7 are working with hospitals to try to identify what those  
8 best practices are and the things that you can do And so a  
9 simple incentive that says go for that and it's done in a  
10 streamlined way is very appealing to me.

11           Thank you, Anne. I appreciate it.

12           Thanks to you also, Rachel, for your willingness  
13 to streamline and put up with my poor time management.

14           DR. SCHMIDT: So last month, Chris Hogan presented  
15 his analysis of the relationship between secondary coverage  
16 that wraps around the fee-for-service benefit and higher  
17 Medicare spending. Today, I'm going to step back from the  
18 weeds and try to put his analysis into the broader context  
19 of traditional Medicare's benefit design.

20           So just a quick review, Chris provided evidence  
21 that when elderly beneficiaries are insured against  
22 Medicare's cost sharing, they use more care and Medicare

1 spends more on them. I'm not going to go over his results  
2 again, but his analysis suggests that if supplemental  
3 coverage didn't fill in much or all of Medicare's cost  
4 sharing, Medicare could use the design of its fee-for-  
5 service cost sharing as a tool to encourage certain types of  
6 care and discourage care that may be less appropriate.

7           In the interest of time, I'm going to skip over  
8 this slide for now, but I'm happy to go back to this if we  
9 have time later.

10           So just to review, remember that about 11 percent  
11 of fee-for-service beneficiaries do not have supplemental  
12 coverage, and that's kind of an orangish color in the top of  
13 this pie chart. And about a third have individually-  
14 purchased Medigap policies, and here I'm combining the dark  
15 red and bright yellow areas to say that. About a third have  
16 -- a little more than a third have employer-sponsored  
17 retiree coverage, the area in green. And about 17 percent  
18 have Medicaid, in light blue. And another 2 percent have  
19 other sources, like VA. There are some very important  
20 differences in these sources of supplemental coverage that  
21 your mailing materials cover in detail.

22           In the past, we've talked a lot about why so many

1 beneficiaries have secondary coverage and it has to do  
2 partly with fee-for-service Medicare's benefit design. It's  
3 complex and there's no out-of-pocket cap on spending.  
4 Beneficiaries can't predict what services they will need or  
5 what their providers are going to charge, and they dislike  
6 having to navigate through paperwork and any bills that they  
7 might be receiving from providers for their cost sharing.  
8 With many types of secondary coverage, the insurance is  
9 billed automatically for that cost sharing.

10           Let's take a minute to remember what health  
11 insurance is supposed to do and ask ourselves whether the  
12 fee-for-service benefit accomplishes this. One important  
13 function is to reduce an individual's exposure to financial  
14 risk and very high out-of-pocket spending. And at the same  
15 time, insurance shields people from seeing the cost of care,  
16 so many insurers and payers believe that insurance should  
17 deter beneficiaries from using lower-value services by  
18 leaving some portion of covered services unreimbursed.

19           All of you know it's really hard to figure out  
20 which services are a higher or lower value and for which  
21 subpopulations of patients. A more solid base of evidence  
22 on comparative effectiveness of therapies is really

1 important for figuring this out.

2 Right now, our current way of doing things doesn't  
3 really accomplish the overall goals of insurance. Fee-for-  
4 service Medicare doesn't cap out-of-pocket spending, and the  
5 widespread use of secondary coverage doesn't leave much  
6 unreimbursed, which leads us more generally to some problems  
7 with the status quo.

8 The fee-for-service benefit design itself leads to  
9 relatively few beneficiaries owing Medicare for most of  
10 aggregate cost sharing, and one reason is because it does  
11 not have an out-of-pocket cap. In 2007, about 22 percent of  
12 fee-for-service beneficiaries incurred about two-thirds of  
13 the combined \$50 billion in cost sharing owed for Part A and  
14 Part B services. A typical retiree plan through a large  
15 employer or the BlueCross-BlueShield option in FEHBP used  
16 caps and also used combined inpatient-outpatient deductibles  
17 that spread cost sharing around a little more easily. My  
18 comparison, the fee-for-service method, puts more cost  
19 sharing on the sickest beneficiaries through a relatively  
20 high inpatient deductible and relatively low outpatient  
21 deductible.

22 Beneficiaries also have unequal access to sources

1 of supplemental coverage due to differences where large  
2 employers are located, differences across States, and the  
3 rules about whether disabled Medicare beneficiaries under  
4 age 65 can get a Medigap policy, differences in State  
5 eligibility rules for Medicaid and the degree of outreach  
6 they undertake, and also the wide variation in the price of  
7 premiums for supplemental coverage.

8 Chris Hogan highlighted another problem with the  
9 status quo with his analysis, namely that when beneficiaries  
10 have secondary coverage, Medicare tends to spend more on  
11 them. And since so many forms of supplementary coverage  
12 fill in all or most of fee-for-service cost sharing, that  
13 effectively means that Medicare can't use benefit design as  
14 a policy tool. We can't use cost sharing to try to steer  
15 beneficiaries in the way that private insurers do or even in  
16 the way that Medicare Advantage plans and Part D plans can  
17 do.

18 An outcome of the current way of doing things is  
19 wide variation in financing burden for hospital spending.  
20 Along the horizontal axis here, we've ranked all fee-for-  
21 service beneficiaries by their level of Medicare spending.  
22 This is taken from the 2005 MCBS. So the blocks of bars on

1 the farthest left show people who fell into the lowest 25  
2 percent of individuals ranked by their fee-for-service  
3 spending and the farthest right shows the highest spending,  
4 25 percent. And then each color of bar shows a grouping of  
5 beneficiaries with the same type of supplemental coverage.  
6 So orange bars are beneficiaries with no secondary coverage  
7 on the farthest left, and then moving right, the red shows  
8 people with Medigaps. Yellow shows people with Medigaps and  
9 retiree coverage. A green shows retiree coverage, and blue  
10 is Medicaid. The height of the bars shows the median  
11 percent of income devoted to the combination of out-of-  
12 pocket spending and premiums for health care. And in each  
13 case, the denominator is income, beneficiaries' income.

14           So looking left to right, you can see the  
15 beneficiaries with Medicaid as their secondary coverage  
16 spend the smallest percent of their incomes on health, even  
17 after taking their low income into account.

18           Individuals who are fortunate to have retiree  
19 coverage tend to have higher incomes and often have their  
20 employer helping pay for their supplemental premium, too.  
21 So their percent of incomes that they're paying for health  
22 is also relatively low.

1           Notice how the red bars, the people with Medigaps,  
2   tend to pay a high share of income if they've got low use of  
3   Medicare services, and that's largely because of their  
4   relatively high premiums for Medigap policies.

5           But as you move to the right, you can see the  
6   people without supplemental coverage and higher use of  
7   Medicare services quickly end up spending the largest  
8   percentage of their incomes on health. So there's wide  
9   variation, as you can see, from less than 5 percent of  
10  income for those with Medicaid as their secondary coverage  
11  to about 35 percent of income.

12           For the rest of the session, I'd like to start a  
13  conversation among you about the goals that we might want to  
14  pursue for the future if there were changes to the fee-for-  
15  service benefit design and to secondary coverage. I've  
16  listed four here and will go over each in turn.

17           So one goal could be to reshape the fee-for-  
18  service benefit to be more in line with the usual design  
19  elements of insurance, again, to reduce beneficiaries'  
20  exposure to financial risk and yet leave some spending  
21  unreimbursed to deter use of lower-value services. A direct  
22  way to do this would be to add an out-of-pocket cap to the

1 fee-for-service benefit, but this would be very expensive  
2 for the Medicare program, and in order to keep Medicare  
3 spending budget neutral, we'd need to spread out cost  
4 sharing more evenly across beneficiaries, for example, by  
5 using a combined deductible. Putting limits on what  
6 supplemental coverage could cover, for example, not being  
7 able to cover a deductible, could also make adding an out-  
8 of-pocket cap more affordable.

9           This is a big change from the status quo, as I'm  
10 sure you know, and so there will be objections. Still, this  
11 may be an important goal given how uneven the financial  
12 burden is across beneficiaries today.

13           A second goal could be to use fee-for-service cost  
14 sharing to help to begin to address Medicare's financial  
15 sustainability, and one way to do this would be to simply  
16 raise cost sharing requirements for all beneficiaries, which  
17 is essentially the same thing as reducing Medicare's benefit  
18 obligation. This approach could improve Medicare  
19 sustainability, but measures to do this would have to be  
20 balanced against concerns about raising barriers to care for  
21 low-income beneficiaries.

22           Another path could be to set limits on what

1 supplemental insurance may cover, for example, not filling  
2 in the Part B deductible, or as Bob brought up last time,  
3 one could charge an excise tax on premiums for supplemental  
4 insurance policies with the revenues dedicated toward  
5 Medicare. I describe in your mailing materials some CBO  
6 budget options along those lines.

7           A third way is to set priorities on what Medicare  
8 will pay for. In the past, Ron has mentioned the example of  
9 intraocular lenses with cataract surgery, where the  
10 beneficiary must pay out-of-pocket to have vision-correcting  
11 lenses implanted rather than conventional ones.

12           A third goal is to approach fee-for-service cost  
13 sharing much in the way that Mike Chernew and Mark Fendrick  
14 have talked about in a presentation to you a few years ago  
15 about value-based insurance design. And the basic idea is  
16 to use a more targeted approach to cost sharing, charging  
17 different amounts depending on the therapy's clinical value  
18 to the patient. In one approach, for example, you could  
19 charge lower cost sharing for an entire class of therapies,  
20 such as anti-diabetic drugs, in order to encourage diabetic  
21 patients to adhere to the therapy. This works well for  
22 classes of therapies that are only useful to the targeted

1 patients, but not as well for therapies that are used more  
2 widely.

3 A somewhat different version would be to charge  
4 lower cost sharing for certain therapies that we want to  
5 encourage high-risk patients to use, for example, some lower  
6 copays for anti-diabetic medicines only for diabetics whose  
7 blood sugar isn't under control.

8 Some private payers have had success at improving  
9 adherence with this approach and so it holds particular  
10 promise for raising quality of care. But unless you use a  
11 very targeted approach, value-based insurance design could  
12 also increase costs. To help offset this, you might want to  
13 also charge higher cost sharing for therapies that are of  
14 lower value.

15 The last goal I'll talk about is using fee-for-  
16 service cost sharing to help reinforce other changes  
17 underway in provider payment systems. For example, you  
18 spent a lot of time discussing ways to use differential  
19 payments to providers, for example, paying them more if they  
20 deliver higher-quality care and have lower resource use.  
21 Over time, we might want to use fee-for-service cost sharing  
22 to help steer beneficiaries towards those providers. So in

1 addition to being paid more by Medicare, the program could  
2 use tiered copays to encourage beneficiaries to go to those  
3 providers.

4 We could also use lower copays to steer  
5 beneficiaries toward providers who are designated care  
6 managers, for example, medical homes, while charging higher  
7 copays for other providers. Or if there's documented  
8 overuse of certain Medicare services, higher copays could be  
9 used to deter some of that use.

10 In each of these examples, we'd also need to keep  
11 supplemental coverage from filling in that differential cost  
12 sharing in order to make the strategy work.

13 So at this point, I'll leave this to your  
14 discussion. You might want to consider whether some of  
15 these ideas, some of these goals should take priority over  
16 others. And I'd especially appreciate it if those of you  
17 who have given a lot of thought to value-based insurance  
18 design would talk a bit more -- yes, Mike, that means you --  
19 about whether and how it could fit into the context of fee-  
20 for-service Medicare.

21 MR. HACKBARTH: Somehow, I don't think Mike  
22 required an invitation.

1 [Laughter.]

2 DR. CHERNEW: I think this is wonderful and I'm  
3 not sure I have a ton to add.

4 MR. HACKBARTH: Let me just, if I might, quickly  
5 offer reaction to your questions. On page eight, you list  
6 the potential goals, and I don't disagree with any of those,  
7 but I think the one that has the broadest potential  
8 political support and appeal is the first, which is focused  
9 on the equity of the current system and assuring -- using a  
10 restructuring to assure better protection for the sickest  
11 people. That means more cost sharing for some other people  
12 and that's never popular, I know. But of them, I think more  
13 people can rally around number one than trying to use  
14 restructuring to improve Medicare sustainability or steering  
15 people to particular providers. I do think that the third  
16 bullet of encouraging use of high-value services maybe has  
17 some appeal, but it's also the most complex of these to  
18 operationalize. So I'm sort of drawn to the first one as  
19 the priority focus.

20 I have Arnie, John, Mitra, and Bruce.

21 DR. MILSTEIN: Rachel, one of the things that  
22 struck me in the prior presentation on this was the impact

1 on service use of having supplemental insurance. It was  
2 quite profound. Have we attempted to model how much higher  
3 Part B premiums are for beneficiaries who don't have  
4 supplemental insurance as a result of the well-demonstrated  
5 increased demand for Part B services that occur as a result  
6 of other beneficiaries that do have supplemental insurance?  
7 What is the unintended disequity or unfairness that we are  
8 imposing on people without supplementary Med Supp coverage  
9 simply due to the higher service volume associated with  
10 other beneficiaries that do have it? What's the percentage?  
11 Have we attempted to, order of magnitude, estimate the  
12 incremental price tag to the beneficiaries without  
13 supplemental insurance?

14 DR. SCHMIDT: No, we haven't. Last year, we did  
15 some simulations along those lines and I think we're trying  
16 to gear up to a state where we might be able to do similar  
17 sorts of things in the future. But no, we haven't yet.  
18 Last year, in some of the simulations, we were seeing, I  
19 think, lower Medicare spending on the order of 10 percent,  
20 if memory serves, but a lot depends on what estimate one was  
21 -- what assumption one was making about elasticities and  
22 that kind of thing.

1 DR. REISCHAUER: But also, since that would  
2 disproportionately fall on only 11 percent of beneficiaries,  
3 that could have a very substantial impact on the small  
4 number in terms of increased cost to those who -- anyway,  
5 you see where I'm going on that.

6 MR. HACKBARTH: You've got to remember, I mean,  
7 the induced utilization is Part A and Part B, and of Part B,  
8 it's only 25 percent that gets then translated into higher  
9 premiums. So what can be a huge number from the standpoint  
10 of public policy maybe isn't -- I mean, it's a significant  
11 number, to be sure, but it's not sort of an eye-popper --

12 DR. MILSTEIN: I was just following up on Glenn's  
13 point about the equity hook being the most powerful.

14 MR. BERTKO: So first, Rachel, thanks for a very  
15 thoughtful and comprehensive presentation on this. A couple  
16 of comments here.

17 The first is, and this addresses somewhat of what,  
18 Glenn, you brought up. If we were to require some amount of  
19 minimum cost sharing, one of the paybacks here is there is  
20 more of a tradeoff as opposed to a take-away because we are  
21 wanting to reduce from 100 percent of everything to, say, 95  
22 percent of everything. That money theoretically would flow

1 back to beneficiaries in terms of lower Medigap premiums.

2 And so I would make at least that argument.

3           Number two, and I would perhaps think about -- you  
4 might think about adding this, is that my experience  
5 designing benefit plans is that beneficiary seniors like  
6 predictable things, and so taking both the \$135 Part B  
7 premium and the coinsurance being very unpredictable and  
8 having a minimum level of, say, and I'll use this \$5 for  
9 primary care specialties, \$20 or \$25 for specialists, and a  
10 \$100 emergency room copay known at the start, possibly  
11 indexed -- it doesn't even have to be indexed -- you get  
12 the, at least in my experience, the biggest pick-up in  
13 reduction of demand from having anything coming off of zero.  
14 So it could still work out reasonably well that way.

15           And then the third comment here is, and this goes  
16 to your comments, Glenn, about the goals here, I think at  
17 least three of them, counting my tradeoff argument, are  
18 closely aligned in terms of spreading the risk in a better  
19 way; secondly, protecting Medicare's solvency; and then  
20 thirdly, giving us incentives to use these redesigned  
21 systems. And so it could fit together pretty nicely.

22           MS. BEHROOZI: This is really great ,Rachel,

1 putting it all together and having there be a flow to all of  
2 these ideas. I don't think I'm going to be able to be so  
3 smooth in my flow of responses, so just picking out,  
4 starting with the goals, as you say, Glenn, I actually think  
5 the second goal doesn't belong on a list of goals for cost  
6 sharing. Benefit design overall, maybe, but not cost  
7 sharing.

8           And I think that what you're seeing out in the  
9 private payer world is a recognition by employers -- I was  
10 actually just watching Nancy-Ann DeParle yesterday with one  
11 of those roundtables and there were a couple of small  
12 business people at the table saying, I don't want to shift  
13 costs onto my employees. I don't want to do that. There's  
14 nothing of benefit to me in that. It's a bad thing to do.  
15 It's just about I can't afford it so I'm going to make them  
16 pay. So I don't think that that's what Medicare should be  
17 doing -- should be thinking of when it's thinking of cost --  
18 cost shifting is not purposeful. It's just we're not paying  
19 it. Somebody else is going to pay it.

20           And the somebody elses, I think it's really  
21 significant -- you said this in your paper. We had heard  
22 this, I think, last year from Evan that half of Medicare

1 beneficiaries' incomes are at 200 percent of the poverty  
2 level or less. They do not qualify for AMB status or  
3 whatever. But they aren't rich people. The two lowest  
4 quintiles that we were looking at yesterday in Craig and  
5 Cristina's -- well, Craig and somebody's presentation --  
6 sorry -- that distribution, those two lowest quintiles are  
7 below 200 percent of the poverty level. That's not like the  
8 general population.

9           So I think we have to be that much more cognizant  
10 when we're talking about cost shifting that it's going to  
11 have a dramatic impact. It's not a progressive thing. It's  
12 a regressive thing to take the same cost, whether it's 20  
13 percent of the doctor's bill or whether it's a \$25 copay to  
14 see a specialist. It's going to have a widely different  
15 effect on the people who retire quite comfortably in that  
16 probably upper quintile, right, and just about everybody  
17 else.

18           As I said, at that lower end of the income  
19 spectrum, it's going to have a really big effect, and I  
20 think that's demonstrated somewhat, I think, on page 27 of  
21 the paper when you say there was some evidence that relative  
22 to individuals without supplemental coverage, the presence

1 of secondary insurance had a proportionately higher effect  
2 on Medicare spending. So I think that means that if they  
3 didn't have supplementary insurance, they were that much  
4 less likely to seek care, is that right?

5 DR. SCHMIDT: Right. That's actually part of the  
6 slide that I skipped over --

7 MS. BEHROOZI: Right --

8 DR. SCHMIDT: -- in the interest of time. But  
9 yes, when Chris did his analysis, he did find that there was  
10 somewhat more responsiveness. The same amount of  
11 supplemental coverage, the same dollar amount was dearer to  
12 lower-income people, but it was not as large an effect as  
13 you might imagine. I would characterize it as a moderate  
14 effect.

15 MS. BEHROOZI: But I think we also haven't seen  
16 the effect of not having supplemental coverage on higher-  
17 income people, because they're the ones who are buying the  
18 supplemental coverage, you know, to be responsible for a  
19 share of the costs. They could also be less sensitive  
20 because they can afford, especially if you go to things like  
21 a \$5 or \$25 copayment. So I think it really comes down to  
22 the third bullet, which is encouraging use of high-value and

1 discouraging use of low-value services. That moves up, and  
2 I would even actually -- I would rephrase the first one a  
3 little bit. Not distributing cost sharing more evenly, but  
4 more equitably. And Glenn, you used the word equity, but  
5 you were talking about protecting sicker people.

6           This isn't what I think, but there are some people  
7 who would say the sicker people are the users, like the  
8 people who pay tolls to cross bridges, they are the users,  
9 right. It doesn't matter. They need to get to work. They  
10 have to cross the bridge. They've got to pay the toll.  
11 That's not necessarily what I'm advocating, but I think  
12 there's another view of equity which says if it hurts you  
13 more because you've got less money, you might be deterred  
14 from necessary care whether you're really sick or whether  
15 you're not so sick yet and we want to prevent you from  
16 getting sick.

17           So I really think that you have to take income  
18 into account and you have to take the efficacy of treatment  
19 into account if we're moving forward, not just sort of  
20 moving the pieces around on the board but trying to move the  
21 board ahead. I think those concepts have to come into play.

22           MR. HACKBARTH: I have Bruce, Bob, Nancy, Jennie,

1 and Mike. Bruce?

2 DR. STUART: I like this chapter a lot. I think  
3 putting all of these things together makes for a much more  
4 cogent set of arguments that we can use then to help improve  
5 the structure of these benefits and I'm a real fan for  
6 improving the structure of the benefits, both from an equity  
7 standpoint -- I think that Arnie's point is very well taken  
8 that, in fact, people that don't have coverage are forced to  
9 pay more because of the Part B premium, and Mike and I have  
10 also talked about this in terms of we share, I think, the  
11 same view that there is a more rational way to make -- to  
12 design drug benefits -- not just drug benefits, but A and B  
13 benefits that would, in fact, promote efficiency and quality  
14 of care.

15 So there are two issues that I have. One is a  
16 technical issue. Well, maybe three issues. One is a  
17 technical issue, which is the question about, well, how much  
18 do you save if you actually were to impose cost sharing on  
19 people who don't have it now, which is essentially Arnie's  
20 point, which is their utilization would go down if they  
21 faced cost sharing. There is no question about that. I  
22 think every economist believes that there is moral hazard in

1 this market. So it really becomes a question of, well, how  
2 big is it? How big is the number there? And in this  
3 particular case, I think that Hogan has actually  
4 overestimated the savings that could be obtained if, in  
5 fact, you were to take away the secondary coverage of  
6 Medicare cost sharing.

7           And most economists that have looked at this  
8 think, in fact, that there is some active selection into  
9 these programs that's over and above what you can control  
10 for with observable Medicare expenditures. And so I think  
11 that that's something that you really do need to pay some  
12 attention to, and if you were to try to put a number on  
13 Arnie's question, well, how big is the premium increase  
14 going to be, you really have to be pretty precise about  
15 that. So I think that's an issue.

16           The second thing is, and this is really political  
17 and I'm just going to leave it at that, if people have  
18 something, it's going to be damn hard to take it away, and  
19 so you have to think about how you're going to structure the  
20 process. If you come to the conclusion that there is too  
21 much -- that there's not enough cost sharing of whatever  
22 type, then I think there really needs to be some thought

1 given to the mechanism by which you get from here to there.

2           And then the third part is -- and this gets to the  
3 population who are both poor and/or have high Medicare cost  
4 relative to their income, and the assumption that I see in  
5 here, and correct me if I'm wrong, is that you really want  
6 to give the -- you don't use this term, but kind of a free  
7 pass on the cost sharing side. You really don't want to  
8 impose cost sharing on those individuals. But I think that  
9 if you had a more rational way of establishing cost sharing  
10 benefit design, then, in fact, you might well want to do  
11 that.

12           And by saying, okay, well -- and I'll use drugs as  
13 an example because it's a lot easier than the A and B side,  
14 but I think there are analogs on A and B -- so on the drug  
15 side, if you have a generic product that's available, then  
16 you have a low cost share on that product. If you've got a  
17 substitute for that, a branded product that is demonstrably  
18 better, then for these people, you'll probably have a low  
19 cost share, too, because you want to steer use into that  
20 particular product. But if you've got substitutes that  
21 compete with each other and are expensive branded products,  
22 then for those other substitutes, you could pick a preferred

1 product and then have other non-preferred products or have  
2 other, you know, the Medigap insurers and the employer-  
3 sponsored plans putting in those kinds of tiered  
4 arrangements. And I think those could apply just as easily  
5 to people that are low-income and high-spenders as to  
6 everybody else.

7 DR. REISCHAUER: I think I'm next. I think this  
8 is a terrific chapter, Rachel, and a lot of interesting data  
9 and analysis. But I was wondering if we wouldn't want for  
10 completeness here to have at least a box about Medicare  
11 Advantage, because there is a way that people can -- big  
12 smile here. There's obviously been some kind of a  
13 conspiracy. Is there?

14 DR. SCHMIDT: There is one.

15 DR. REISCHAUER: What the average was?

16 DR. SCHMIDT: It's towards the back. There's a  
17 section that discusses it.

18 DR. MARK MILLER: I just want to point out how  
19 fast we reacted.

20 [Laughter.]

21 DR. REISCHAUER: Very responsive. Just to build  
22 on John's comment with respect to if we had an out-of-pocket

1 cap, a lot of this is redistribution as opposed to  
2 additional cost because now many employer systems are  
3 requiring premiums, and those could go down. Medigap  
4 premiums could go down. And then there's a shift from  
5 Medicaid to Medicare that would occur with this. And so the  
6 actual sort of amount of new resources, I think it would be  
7 modest.

8 DR. KANE: Yes. I'm still trying to sort out what  
9 I -- I mean, I'm responding a little bit to your comment  
10 that the most politically popular aspect of this is actually  
11 not the one I would have said I'm the most interested in,  
12 which is the bottom one, about how can we get cost sharing  
13 to reinforce payment reform. I kind of think that's why we  
14 got into it, as a discussion of how do you get people into  
15 medical homes? How do you get people into ACOs?

16 I guess on the first one, I guess one question is  
17 rather than tell people -- well, let me show you how poor an  
18 economist I am. My recollection of the RAND study was that  
19 the cost sharing really affected low-income people more than  
20 anybody else. They made really bad choices and their health  
21 was more at risk than anybody else, but that higher-income  
22 people, I guess, were able to better mitigate the effects.

1           So one of the questions is, is the distribution  
2 and then the subsequent poor behavior choices on health more  
3 disproportionately a problem for low-income people, and  
4 wouldn't that suggest, rather than affecting the people who  
5 have Medigap coverage, trying to get more low-income people  
6 into either Medicaid or LIS or -- I'm just trying to  
7 understand why you want to necessarily take away from  
8 Medigap and give to low-income people when there's other  
9 mechanisms for dealing with low income. For the first goal,  
10 I just think that's kind of -- there's more than one way to  
11 improve the equity of cost sharing, particularly for low-  
12 income people.

13           And I was looking also at Slide 7 and trying to  
14 get a sense of, for the highest 25 percent and those who  
15 have no supplemental coverage, is that because they're  
16 really low income and so the premium and copays put them in  
17 there, or because they lack catastrophic, because if it's  
18 lacking -- I think you have different conclusions as to what  
19 you want to do about it. If the reason you're in that  
20 highest 25 percent is that you have really low income and  
21 therefore the copays and premiums and deductibles puts you  
22 in there, or is that mostly people who are going through

1 some kind of catastrophic, they have gone through all the --

2 DR. SCHMIDT: About 20 percent of fee-for-service  
3 benes have a hospitalization in any year. So at least part  
4 of this is kind of a Part A deductible kind of a thing,  
5 which gets your spending up pretty high. They do have very  
6 low incomes. That's for sure. I can't off the cuff say  
7 they've absolutely hit what one might call a catastrophic  
8 range, but I would say that their cost sharing is pretty  
9 darn high.

10 DR. KANE: Relative to their income?

11 DR. SCHMIDT: Yes.

12 DR. KANE: Yes. So to me, I guess part of what  
13 I'm trying to sort out is some of the problem of the equity  
14 or the lack of protection has to do with low-income people  
15 and how do we protect them. It doesn't really have to do  
16 with shall we make other people cost share more to protect  
17 them. I don't think that's the -- I don't translate that  
18 well. I'm happier sort of thinking, how do we create better  
19 incentives to reinforce payment system reform and use cost  
20 sharing to encourage people to buy better -- you know, use  
21 the right services, but not to subsidize low-income people  
22 because it seems to me we already have other ways to try to

1 do that.

2 DR. SCANLON: Well, it is, I mean --

3 DR. KANE: And I might just be confused about  
4 what's really going on here.

5 DR. SCANLON: At one point, this is a long time  
6 ago, we did some analysis at GAO and we looked at not  
7 incomes, but just at the amount of cost sharing, and there  
8 were, I think, 600,000 people that maybe were spending more  
9 than \$10,000 on cost sharing for Medicare-covered services.  
10 So \$10,000, even if you've got a \$40,000 income, is a very  
11 significant cost share. So that's in contrast with a  
12 private insurance plan that would usually have a \$1,000 cap  
13 at that time, and it's probably much higher today.

14 DR. KANE: Doesn't that say that the \$40,000  
15 person perhaps should be eligible for some type of -- okay.  
16 So I guess, which problem are we trying to solve here? One  
17 is how do we get everybody to be vulnerable to incentives to  
18 get them into better, higher-value plans and higher-value  
19 formulas.

20 I think there's a different set of tools to  
21 address the first problem of the financial protection issue,  
22 and maybe we just need to get people who go in with \$40,000

1 of income who hit \$10,000 get into Medicaid or get into a  
2 LIS.

3 DR. SCANLON: That's a fundamental philosophical  
4 issue, which is do you want Medicare to be a good insurance  
5 program, and most people would say good insurance puts a  
6 catastrophic limit on it, or do you want it to be a poor  
7 insurance program supplemented by means-tested programs --

8 MS. BEHROOZI: Just because I'm thinking that  
9 maybe what you're saying is a little bit in response to what  
10 I was saying about equity having something to do with  
11 income, I just want to make the point that I feel like, yes,  
12 it's three and four -- they're not up there now -- driving  
13 appropriate behavior is the most important thing, but by  
14 having just a fixed dollar amount that you charge for a  
15 service drives behavior differently at different ends of the  
16 income spectrum.

17 MR. HACKBARTH: And just one reaction, Nancy. On  
18 the fourth one, reinforced payment system reforms, in the  
19 abstract, that's appealing to me, too, but most of our  
20 models for payment system reform involve voluntary  
21 arrangements and we're talking here about base Medicare  
22 benefit design and how you use that to reinforce movement

1 into some things that some people are going into, some  
2 aren't even available anywhere. It's just sort of a complex  
3 interaction, number one, and number two, one of the most  
4 difficult things for the Congress is to use benefits to  
5 steer people towards particular providers and away from  
6 others. That's one of the most difficult political sells to  
7 make. So that was my --

8 DR. KANE: I think it's when you start to bring in  
9 the supplemental coverage and how do you want to regulate it  
10 that I start to get confused as to what our goals are here.

11 MS. HANSEN: I think this issue of confounding  
12 elements is probably here, except that I love the chapter  
13 because it does bring in the complexity. I was just  
14 thinking that with the last quartile, the lower income, and  
15 the fact that 35 -- I think it was on page seven -- that it  
16 can go up to 35 percent, I was just wondering about -- this  
17 is where it does confound to another issue of shifting it  
18 possibly back to Medicaid, because if we look at the bar,  
19 the orange bar as compared to the light blue bar, the light  
20 blue is the Medicaid population, right? So it doesn't take  
21 much more perhaps if you're earning \$15,000 a year as a low-  
22 income individual, \$20,000, to tip quickly into Medicaid and

1 I just wonder whether we've looked into kind of that shift  
2 that occurs, even though Part D comes back into Medicare.

3           So it's, A, complex, but I do also think that the  
4 payment reform option, I know we're working on, but I can't  
5 help thinking as a clinician, and bear with me with this  
6 example, how we would sort it out in this benefit design.  
7 Let's just say many people now have five chronic diseases  
8 and what happens as a result is you see ten to 14 doctors a  
9 year. I mean, these are the numbers that have been coming  
10 out. And you have 50 prescriptions a year. So when you  
11 look at that kind of live experience that people have, how  
12 do we do the coordination in some way to address the  
13 delivery system reform to mitigate some of those expenses,  
14 because oftentimes you don't have to take that many  
15 medications. You don't go into the hospital because you're  
16 not on 14 medications. There's kind of a cascade effect  
17 that comes into play with that.

18           So it's possible through delivery system reforms,  
19 which is alluded to in the fourth bullet, could mitigate  
20 actually the spend for whether you're poor or not on this.  
21 I don't know how that gets captured in -- because I think  
22 this is a reflection of what is, but what could be would be

1 as a result of reform.

2 But my first point was just that it sort of seems  
3 like it would make it reasonably easy for people to qualify  
4 for Medicaid after you pay so much out of pocket over time,  
5 that many States have a medically needy-only benefit that  
6 goes into a QMB/SLMB relationship.

7 So as I say, there are many moving parts to this  
8 which make it very textually interesting, but I'm not sure  
9 how to fully sort it out to make it effective and bring it  
10 back to Medigap policies.

11 DR. SCHMIDT: Yes, and just one technical point.  
12 The far right side of the bars, I'm showing you median  
13 percent of income and it's actually higher for mean because  
14 of the medically needy for those who don't have supplemental  
15 coverage. I mean, some would end up being medically needy  
16 and going into Medicaid.

17 I think there are differences across States,  
18 though, in how they treat the medically needy, though, so  
19 that may be some complexity we need to look into further.

20 DR. CHERNEW: As you know, I think this is  
21 tremendous and I can hardly contain my exuberance.

22 [Laughter.]

1 DR. CHERNEW: But let me just make a few points.  
2 The first one is, in your chart of the distribution of  
3 supplemental coverage, that's the distribution of  
4 supplemental coverage as of a few years ago. That's not the  
5 distribution of supplemental coverage we're going to see in  
6 the future, certainly not if costs grow the way they've been  
7 growing. We're going to see employers dropping a lot of  
8 supplemental coverage. Premiums are going to be rising.  
9 We're going to be worried about access for a lot of care to  
10 individuals, and the discussion that I think we're going to  
11 have in the future is going to be a discussion about we want  
12 a -- we're worried about this lack of financial access to  
13 services that people have and this financial burden that  
14 people are facing, particularly the low-income individuals,  
15 and we want to improve their benefit, but that's really  
16 expensive and we're not sure how to do that.

17 My view about how to think about all of this  
18 hinges tremendously on how successful I think all of the  
19 payment reform things are. So if I shut my eyes, imagine a  
20 world with accountable care organizations or a well-  
21 functioning anything, then I have a completely different  
22 view about how I feel about this than if I don't.

1           So while I agree with Mitra's comment about using  
2 cost shifting just so Medicare saves money and beneficiaries  
3 pay more is really unappealing, I don't like that at all, as  
4 opposed to using cost shifting to make the system more  
5 efficient. I just think we can't ignore the financial  
6 impact of what's going to happen and I think we have to  
7 prepare ourselves for a world in which the beneficiaries,  
8 particularly those on sort of the side of that graph, have  
9 dramatically less coverage for a whole range of things.

10           And if technology continues to progress, there  
11 will be dramatically more things that they're going to want  
12 to have access to and we're going to have to worry about  
13 that, which raises a broad complicated philosophical issue  
14 which I'm scared to talk about in public session, but which  
15 is how we deal with the equity of access to care for  
16 everybody, which I think is absolutely crucial and cost  
17 sharing has a tendency, because economists as a profession  
18 don't worry about equity, to cause inequities. It is a  
19 policy situation we just really don't like.

20           And so I think we're going to have to face the  
21 issue of cost sharing, whether we like it or not, not  
22 because we're going to try and find ways to make people pay

1 more to do whatever we want, because we're going to have to  
2 try and figure out what we're going to subsidize as they  
3 lose some of those other sources of care. So that's the  
4 first point.

5           The second point is, related to the other  
6 comments, cost sharing does interact with other aspects of  
7 the system so we need to figure out what happens if you have  
8 someone in an Accountable Care Organization or on an  
9 episode-based payment or some other system where now the  
10 physicians are trying to get people to do various things,  
11 but the people want more and more stuff because they don't  
12 have to pay. You know, the problem, I think you would say,  
13 happened in the past, or at least I would say, there was a  
14 tension between what the patients demanded and the financial  
15 incentives the physicians were under and that created a lot  
16 of problems in the patient-physician relationship that I  
17 don't think should be ignored.

18           I think it's also important to think about aspects  
19 of care. Many of the things that Peter might do or Arnie  
20 might do or I might do to prevent readmissions or to prevent  
21 management of folks to chronic disease is to get them to  
22 follow certain types of care. Make sure if they have

1 diabetes, they take their blood pressure medication.  
2 Medicines are hard to deal with because of the Part D design  
3 split, and I will finesse that for a minute and say the  
4 issue is, in a world where there's a lot of cost sharing, we  
5 need to think about encouraging -- and you could debate the  
6 magnitude, but I think there's reasonable evidence now that  
7 there's some offset, that if you spend more on some  
8 services, I don't think you get that all back, but you get  
9 some of that back through better health, and even if you  
10 don't get a lot of it back, at least you're healthier.

11           So I think figuring out how cost sharing interacts  
12 with other aspects of the system and supports preventive  
13 care, supports physicians if we move to another type of  
14 system, I think is absolutely crucial in doing this.

15           I'm very worried about the -- not very worried,  
16 but I worry a lot about having a catastrophic cap, in part  
17 because I think the economic theory would suggest that you  
18 want to have the cost sharing in the place where you want to  
19 have the efficiency occurring, and I know I don't know that,  
20 and so please don't tell me that I don't know that. I  
21 realize. And I know that's hard to do.

22           But there's an issue, for example, in this country

1 right now, for many people, if you have a heart attack, if  
2 you get cancer or something bad happens to you, you get  
3 taxed a certain amount of money. You just have a heart  
4 attack, here's the money. There's no beneficial incentive  
5 effect. There's no moral hazard reduction, to use an  
6 economic term. You're just taxed. Sorry, you had a heart  
7 attack. Pay whatever you have to pay. And then once you've  
8 paid that, there's no incentive to be efficient at the  
9 higher spending levels.

10           So my mother, who has a situation right now where  
11 she is spending a lot of the taxpayers' money and getting a  
12 lot of expensive imaging done on her has no incentive to  
13 think about that imaging at all because she's paid her tax  
14 and now she's just getting CT scans every six month, which  
15 is actually -- well, I think she's now to yearly. But the  
16 point is so a cap is fine in a standard model, but I think  
17 if you were to think about medical conditions, we would be a  
18 little smarter.

19           And I think there's two big challenges, neither of  
20 which I can speak to authoritatively. The first one is the  
21 politics befuddle me completely, so I have nothing to say  
22 about that.

1           And the second one is the complexity of how to  
2 implement this. You know, it's easy to point out particular  
3 situations where a reasonable person would say, in this  
4 situation, you shouldn't do this. But to figure out how to  
5 make that systematic across the board is harder, and I  
6 realize it's harder. My only plea would be that we don't  
7 get in a situation where the inability to do everything  
8 exactly the way we would want comprehensively prevents us  
9 from making policies which we think would actually improve  
10 the world, and I do think there are situations where people  
11 with certain clinical conditions, where people in certain  
12 income categories, where if the person were standing there  
13 in the public comment and explained to you the situation of  
14 what happened to them and what they have to pay and asked  
15 why the system was set up, you would have a hard time to  
16 answer except saying, you know, we designed the system in  
17 aggregate. We didn't design it for you. So I'm sorry, and  
18 then you just go on your way.

19           I think we could probably do a bit better. I'm  
20 not yet ready to say exactly how, but I'm thrilled that  
21 there's some thought to this because I do think this is the  
22 one area where bringing the Medicare beneficiaries into the

1 system, both in terms of their responsibilities and in terms  
2 of their choices, matters, and I think that whether we like  
3 it or not, we're going to have to deal with it.

4 DR. CASTELLANOS: I really like this chapter, for  
5 a lot of reasons. What we're really talking about is  
6 utilization here, if you really think about it. And what  
7 we're looking at, not for the first time but from a  
8 different approach, is that it's really multifactoral.  
9 There's a tremendous shift from Part A to Part B because of  
10 taking things out of the hospital and you're going to  
11 increase utilization from that. There's no question  
12 physicians have a real role in utilization and over-  
13 utilization.

14 But this is one of the first times, again, that  
15 we're talking about the beneficiary and the beneficiary's  
16 responsibility. What we're trying to do is change the  
17 beneficiary's behavior or incentivize the patient or the  
18 beneficiary. As Mike said, the landscape is dramatically  
19 changing. We need to make sure they have access, but we  
20 need to make sure it's appropriate, what they get, and the  
21 care they get is appropriate.

22 Whether you like it or not, first-dollar coverage

1 does make a difference. Cost sharing does make a  
2 difference. We have a lot of behavioral things where we  
3 have patients, we call them frequent flyers. They show up  
4 wherever they want, whenever they want, in the middle of the  
5 night and get readmitted to the hospital for no reasons, and  
6 they get readmitted because there's nobody else there to  
7 take them home or do something.

8           So what we're doing here really, and I know I'm  
9 not talking about insurance as much as patient, beneficiary  
10 responsibility, incentivizing a better behavior, but making  
11 sure they do have access.

12           DR. BORMAN: In respect to your comment, Glenn,  
13 about what is the most hot-button political implication and  
14 how we deal with that, I happen to find a certain amount of  
15 appeal in part of this equity discussion. Sort of the flip  
16 side of it is the part that you have on one of the slides  
17 about moving more of these people into designated care  
18 managers. And I'm not sure how we phrase that to get around  
19 a little bit about the politically-charged piece of that,  
20 but I think that is a fair tradeoff in that as we attempt to  
21 support you better, recognizing your burden of disease, your  
22 piece of this is that we hope you do it in the way that's

1 most efficient for the system.

2           And so my recollection, and it could be my  
3 ignorance, is that many States have certainly on the  
4 Medicaid side required certain kinds of folks to go into  
5 designated managers, and I wonder if we have any data to  
6 bring from that experience in terms of what really has been  
7 the success of that in terms of health outcomes, in terms of  
8 spending pattern changes, any unintended or unanticipated  
9 consequences for good or for ill that could help inform or  
10 sustain a good quality recommendation that there are certain  
11 groups of people that for them, it is a win to do this, and  
12 for the system, it's a win to do this. And then it starts  
13 to fold into, for example, the ACOs. Is this potentially a  
14 mandated population, if you will, and some of those kinds of  
15 considerations, but maybe there are some data out there that  
16 could help us inform that recommendation.

17           DR. MILSTEIN: Reflecting on this, what you  
18 realize is that asking any beneficiary to pay more is just a  
19 form of political poison. And so the question is, what is  
20 the least toxic variant? And I think the options -- I'm  
21 trying to make sort of a summary comment -- option A is the  
22 beneficiaries pay more if they don't enroll in an efficient

1 delivery system, whether it's a Medicare Advantage delivery  
2 system or a medical home delivery system or an ACO delivery  
3 system. That's option A, and I personally believe that is  
4 probably least toxic.

5           Next toxic is beneficiaries pay more if they don't  
6 select a more efficient provider, and Glenn, you commented  
7 on that --

8           DR. CHERNEW: They pay less if they do. They pay  
9 less if they do select.

10          DR. MILSTEIN: Yes. You can frame it -- framing  
11 it is --

12          DR. CHERNEW: The ability --

13          DR. MILSTEIN: It's always six of one, half a  
14 dozen of the other. The opponents will frame it negatively,  
15 so anyway, that's it.

16                 And then C is pay more -- beneficiaries pay more  
17 if they don't select an efficient treatment option. That's  
18 sort of the most granular.

19                 And those are really the three, I think, primary  
20 choices. Each of them varies in terms of their political  
21 toxicity and their likely impact -- their implementation  
22 difficulty and their likely impact on spending. And

1 modeling that is the best we're going to be able to do.

2 Michael points out the dynamic things that are  
3 happening concurrently, such as the evolution of biologics  
4 that will cause some treatments to be much more expensive  
5 than others. The large molecule phenomenon will actually  
6 make the last option, penalizing people who don't select the  
7 most efficient treatment option, in some ways more toxic,  
8 more of a problem than it has been in the past. So those  
9 are the choices.

10 MR. HACKBARTH: I don't disagree with that  
11 framing. I do think how it's present, you know, whether  
12 it's pay more or pay less is, in the real world, very, very  
13 important. And the way I think about this, and it may be  
14 that I need to get out of this rut, is that the step here is  
15 to define a base Medicare benefit package, and most people  
16 are not in these things yet because they don't exist yet,  
17 and so what I would want to do -- I think the existing  
18 Medicare benefit package is irrational in a lot of ways and  
19 doesn't fairly distribute the cost sharing burden. And so  
20 I'd set, as I said, a top priority, let's get it looking  
21 more like what a real insurance program ought to look like.

22 I don't disagree with Mike's notion that complete

1 coverage after a low threshold has some problems, and some  
2 creativity about how to deal with that, I think would be  
3 appropriate. But I think we do need to do a little bit  
4 better job of protecting the people who are sickest and  
5 charge a little bit more for people who aren't incurring big  
6 bills than the current benefit design does. And so I think  
7 of it in terms of equity and creating a sound insurance  
8 design.

9           Then from there, as we develop some care manager  
10 system that really works and we know it reduces cost, we can  
11 say, oh, we'll reduce your cost sharing or your Part B  
12 premium or both if you voluntarily commit to do that. It's  
13 your choice. You can stay in the other program, but we  
14 think this is good for you and good for us and we're willing  
15 to share the savings with you. I think that politically  
16 feels a lot better than, oh, we're going to do the Medicaid  
17 thing, which is require you to go to a certain care manager  
18 organization. I think that would be very hard to do in  
19 Medicare given the politics around Medicare.

20           So I don't think we're saying different things.  
21 It's really the framing of it and the package. I do believe  
22 that in the area of value-based benefit design, given the

1 growing importance of drugs in effective treatment, this  
2 design of having separate insurance pools for Part D private  
3 insurers versus traditional Medicare and having this fissure  
4 in the system is a big problem.

5 Okay. Thank you, Rachel. Very good job.

6 We will now have a public comment period.

7 [No response.]

8 MR. HACKBARTH: Okay. Thank you very much. We  
9 are adjourned.

10 [Whereupon, at 12:08 p.m., the meeting was  
11 adjourned.]

12

13

14

15

16

17

18

19

20

21

22