

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
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Washington, D.C.

Thursday, September 17, 2009
11:20 a.m.

COMMISSIONERS PRESENT:

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HERB B. KUHN
GEORGE N. MILLER, JR., M.H.S.A.
ARNOLD MILSTEIN, M.D., M.P.H.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, Ph.D.

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MR. HACKBARTH: It is time to get started. This is, of course, the first MedPAC meeting of a new cycle, and I would like to welcome all of the people in the audience. I see a lot of familiar faces as well as some new ones.

As always, we have got a bunch of interesting issues to deal with, both in this meeting and in coming months. For this meeting, we have got important topics like geographic variation and Medicare expenditures, graduate medical education reform, comparing quality in Medicare Advantage and traditional Medicare.

In addition, in future meetings in this cycle, we will be wrestling with our usual array of payment issues and improvements, including in physician payment maybe in particular, and also some issues around benefit redesign.

Those of you who have attended meetings in the past know that it is our practice to have a public comment period at the end of the morning session and then also at the end of the afternoon session. As I regularly do, I would remind you that that public comment period is but one opportunity to talk to the Commission. Frankly, it is not your best opportunity. The most important opportunity to

1 communicate with us and have an impact on our work is to
2 reach out and talk to the MedPAC staff, who go to
3 extraordinary lengths to listen to all input, information,
4 ideas on our work.

5 We will also be exploring some other ways that
6 people might provide input for our work and probably talk a
7 little bit more about that at our October meeting.

8 So, with that preface, let's turn to the agenda,
9 and the first item on today's agenda is a discussion on the
10 context for Medicare payment policy. As you know, each year
11 in our March report, we include such a context chapter.

12 Evan?

13 MR. CHRISTMAN: Sure. Thank you. Good morning.
14 Yes, as Glenn mentioned, I am going to be covering the
15 sustainability and financing challenges facing Medicare.

16 A key financing challenge is that growth for all
17 payers in health care costs has exceeded growth in the gross
18 domestic product. An analysis by CBO compared the growth in
19 health care spending per capita to the growth in GDP,
20 adjusting for changes in demographics, and you can see the
21 results here. It found that over a 30-year period health
22 care spending has exceeded per capita GDP growth by more

1 than two percentage points between 1975 and 2005. For these
2 reasons, health care spending has grown as a share of our
3 Nation's GDP, and it is expected to continue to do so.

4 Here you can see the impact of the excess growth,
5 with health care spending rising from 9 percent in 1980 to
6 about 16 percent in 2007. By 2018, costs are expected to be
7 over 20 percent. The lower three areas are public spending,
8 such as Medicare and Medicaid and other public programs, and
9 the top bar is private sector spending.

10 Public spending by federal, state, and local
11 governments has risen to about half of all health care
12 spending, and it is expected to grow faster than private
13 spending over the next 9 years. About three-quarters of the
14 public spending is Medicare and Medicaid, and I would note
15 that for Medicare these projections assume the SGR mechanism
16 requiring negative updates is not overridden.

17 The rising share of public spending does not
18 suggest that the public sector is less efficient in
19 controlling growth than others. For Medicare, the
20 comparison is sensitive to the periods compared. However,
21 as you saw on the previous slide, over the longer periods of
22 time, the rates of growth for Medicare and private health

1 insurance have been quite similar.

2 The next graph shows how the future growth in
3 expenditures compares to Medicare's revenues. Starting from
4 the bottom, this graph shows the share of GDP for each of
5 Medicare's revenue streams. Note that this display combines
6 revenues for Medicare's separate financing mechanisms for
7 Parts A, B, D, and Medicare Advantage. The two largest
8 areas are payroll taxes collected for Part A, the yellow
9 area at the bottom, and the general revenue transfer for
10 Part B and D, the green area second from the top. Note that
11 this green general revenue wedge grows significantly in the
12 future, more than other sources of revenue. This is because
13 Medicare is allowed an unlimited tap on the Treasury to fund
14 some of the costs of Part B and D. As those costs are
15 expected to rise significantly in the future, the draw from
16 the general fund rises automatically, and consequently,
17 Medicare will be more reliant on the general fund for
18 financing.

19 Another way of measuring this is as a share of
20 corporate and personal income taxes, the primary revenue
21 source for the Federal Government. Between 2009 and 2030,
22 the share of these taxes required to fund the general

1 revenue transfer is expected to roughly double from 11
2 percent to 24 percent. And, again, these projections do not
3 include the impact of any proposed changes such as fixes to
4 the SGR or filling in the Part D cost-sharing.

5 Now, in contrast, funding for Part A is limited to
6 the dedicated funds that are collected primarily through the
7 payroll tax. In 2017, the resources for Part A will no
8 longer be adequate to cover annual benefit expenditures.
9 The red area at the top, labeled "H.I. deficit," shows how
10 over time the gap between Part A's liabilities and revenues
11 will grow significantly. For example, in 2017, the trust
12 fund will only have adequate resources to pay about 80
13 percent of benefits due. By 2030, it will only have
14 sufficient revenue to cover about 40 percent of benefits
15 due.

16 This picture shows how the current spending trend
17 for Medicare has placed the program on an unsustainable
18 path. In less than 8 years, Medicare will no longer have
19 the resources to pay some benefits. Without major changes,
20 over time the share of federal revenues required to sustain
21 benefits will grow significantly. From a fiscal and
22 economic perspective, there is a significant need for

1 constraining growth.

2 This next table examines the Hospital Insurance
3 Trust Fund's finances in more detail. Remember that the
4 H.I. Trust Fund funds all Part A benefits, and it relies
5 mostly on payroll taxes to fund its operation.

6 Since 2008, the trust fund has been in a deficit
7 on a cash basis; that is, its annual revenues from payroll
8 taxes and other sources have not been adequate to cover
9 annual expenses. In the near term, the trust fund has
10 sufficient financial reserves to cover these annual
11 deficits. But in 2017, these reserves will be exhausted,
12 and Medicare will be unable to pay all benefits expected to
13 be due.

14 Next we will look at the graph in the middle here.
15 Every year the Medicare trustees assess H.I. solvency, and
16 this graph shows how the insolvency date for the trust fund
17 has changed in each report. Since 2000, the years of
18 solvency have declined, in part due to changes such as the
19 MMA, but also due to other changes, such as increases in
20 benefit expenditures or changes in revenue.

21 To the left of the yellow bar is 2009. It shows
22 that we have 8 years of solvency, according to the trustees'

1 report for this year, and the black bars count down to 2017,
2 the year the trust fund is currently estimated to be
3 bankrupt.

4 In addition to rising costs, changing demographics
5 will also put pressure on H.I.'s financing. The forthcoming
6 retirement of the baby-boom generation will begin a
7 demographic shift that will over time shrink the size of the
8 workforce relative to the number of retirees. For H.I.,
9 this means relatively few workers paying the annual payroll
10 tax used to pay benefits and more beneficiaries requiring
11 those benefits.

12 While the demographic shift is important, it is
13 worth noting that most analysts consider rising per capita
14 costs as the primary problem. H.I.'s revenues are likely to
15 be strained as long as per capita benefits continue to grow
16 faster than GDP.

17 The factors underlying the past and future growth
18 should be familiar to you. First, most analysts believe
19 that 50 percent or more of the long-run increase in spending
20 is attributable to technology. New technologies and medical
21 techniques can yield improvements in health, but they can
22 also yield new costs and inefficiencies. As the Commission

1 has noted, technology poses a unique challenge because the
2 evidence base to guide the appropriate use of new technology
3 often lags actual adoption. As a result, the costs of new
4 technology may sometimes outweigh the benefits.

5 Second, the nation's income has been rising. Many
6 analysts believe individuals demand more health care as
7 incomes improve, as the marginal value of increased life
8 span or function may be worth more than other goods.

9 The availability of insurance has provided
10 beneficiaries with financial protection from the costs of
11 ill health, but it has also insulated beneficiaries from the
12 full cost of care. Consequently, some beneficiaries may
13 consume more care than they would have otherwise. Estimates
14 of the insurance effect on the increase in per capita growth
15 vary, but range from 10 to 20 percent. A special issue in
16 Medicare is the availability of Medigap insurance that
17 covers the beneficiary cost-sharing for Part A and B.
18 Recent work by the Commission suggests that the availability
19 of this insurance may raise Medicare spending by 17 to 33
20 percent.

21 Because the U.S. system relies on the private
22 sector to deliver most health care services, prices are

1 particularly important in the U.S., and some of the growth
2 in spending is attributable to changes in prices. Prices
3 provide incentives, can affect what services and regions are
4 served, what technologies are developed, and the specialties
5 physicians in training select. In addition, many analysts
6 believe that prices for health care services in the U.S. are
7 higher than other countries.

8 Changes in longevity and demographics will also
9 have an impact on health care spending. With the retirement
10 of the baby-boom generation, the elderly are projected to
11 grow as a share of the population. In addition, life spans
12 are expected to increase. These factors will cause Medicare
13 spending to grow, and CBO has estimated that they will
14 account for approximately 30 percent of the growth in future
15 years.

16 Trends in disease morbidity also affect health
17 care spending. An analysis of patients with chronic
18 conditions found that all of the growth in per capita
19 Medicare spending since 1987 has been due to the increase in
20 treatment for patients with multiple chronic conditions.
21 The number of beneficiaries with five or more chronic
22 conditions increased from 31 to 50 percent between 1987 and

1 2002. This alone would suggest that the burden of disease
2 has increased. However, the share of those with five or
3 more chronic conditions reporting excellent or good health
4 status increased from 33 percent in 1987 to 60 percent in
5 2002. This seeming inconsistency between disease morbidity
6 and health status suggests a higher rate of diagnosis and
7 treatment for chronic conditions, that treatments are
8 improving health outcomes, or that both are occurring.

9 Now, in practice, many of these factors can occur
10 simultaneously in the delivery system. For example, new
11 imaging services can improve care, but numerous incentives
12 can also encourage inappropriate use. Recent work by the
13 Commission noted that physicians who operate their own
14 imaging devices were more likely to order those services
15 than physicians that did not. In this instance, the other
16 factors listed here may reinforce this increasing
17 utilization. Insurance makes consumers less sensitive to
18 the value of the service, and inaccurate prices may
19 encourage more supply and utilization than warranted. That
20 illustrates what many have concluded about our health care
21 system: that reforms need to address the combination of the
22 factors driving excess growth, and there is no single

1 solution.

2 Finally, another factor cited is defensive
3 medicine stemming from malpractice concerns, but it is not
4 considered a major driver.

5 Next we will compare spending in the U.S. to other
6 industrialized countries. This comparison from the OECD
7 shows how much the U.S. spent in 2007 -- about \$7,300,
8 significantly more than other industrialized countries. To
9 the right of the green bar are other major OECD countries,
10 all with significantly lower spending than the U.S. The
11 final is the average of all 30 OECD countries -- about
12 \$3,000, less than half of what the U.S. spends.

13 This graph does not control for other factors that
14 affect spending, such as differences in the burden of
15 disease and personal income. However, many analysts believe
16 that U.S. spending is higher even after adjusting for some
17 of these differences.

18 Also, though the U.S. does have higher spending,
19 annual growth is generally not different than that of other
20 OECD nations. This suggests that all health care systems
21 struggle with high rates of growth.

22 Some analysts question the value of much of the

1 U.S.' health care spending. An influential study by RAND
2 found that a national sample of patients received only about
3 half of the care that was considered appropriate for their
4 conditions. Further, reviews of the geographic variation in
5 Medicare spending indicate that higher spending is not
6 always associated with better quality or outcomes.

7 The U.S.' performance compared to other countries'
8 is mixed. It does better than some countries on some
9 measures, but not consistently better. This mixed result on
10 quality is a contrast to spending comparisons like you saw
11 before, where the U.S. is generally ranked the highest.
12 Also, the level and quality of care also varies among
13 patients in the U.S., and many low-income and minority
14 groups receive care that is inferior relative to the care
15 received by others.

16 In addition to taxpayers and the Treasury, rising
17 Medicare spending will also impact beneficiaries directly as
18 an increase in premiums and cost-sharing. This chart shows
19 how the growth in the Medicare premium has outpaced the
20 growth in the COLA provided for Social Security benefits.
21 The premium has increased by about 80 percent since 2000,
22 while the COLA has only increased by about 20 percent. And

1 in the future, these trends are expected to continue. The
2 average out-of-pocket costs for Part B equaled about 26
3 percent of the average Social Security benefit in 2008, and
4 this share is expected to rise to 40 percent in 2030.

5 However, it is worth noting that many
6 beneficiaries will not be subject to the increase in the
7 Part B premium slated for 2010. This is due to a provision
8 that limits how much can be taken from a beneficiary's
9 Social Security check for the Part B premium. Under current
10 law, a beneficiary's Social Security payment cannot decrease
11 due to an increase in the Part B premium. In 2010, there
12 will be no COLA increase for Social Security. As a result,
13 75 percent of Medicare beneficiaries will not pay the
14 expected increase.

15 The Part B premium increase for 2010 includes the
16 cost of the revenue lost from the hold-harmless.
17 Consequently, premiums will be higher for the 25 percent of
18 beneficiaries that are not protected by the hold-harmless.

19 Some forecasts contain no COLA increase for 2011
20 as well, and so it is possible that this scenario will be
21 repeated. However, once the COLA increase returns, it is
22 expected that fewer beneficiaries will be affected by the

1 hold-harmless.

2 The Commission recognizes that Medicare is not
3 sustainable in its current form and has considered a number
4 of changes to improve the program. These changes address a
5 number of areas, and first there is accuracy and equity in
6 payment. We use the update process to assess payment
7 adequacy and, when appropriate, to constrain costs. We also
8 look at price accuracy, such as in our recommendation to
9 update Medicare's assumptions regarding the use of imaging
10 services used to set payments.

11 Second, we have looked at ways to improve quality
12 and coordination. We have recommended that Medicare move
13 towards pay-for-performance and explore bundling, as well as
14 examined other means for improved care coordination.

15 Finally, we have also examined ways to get
16 providers and patients better information for
17 decisionmaking, such as comparative effectiveness research
18 and public reporting of quality measures.

19 This completes my presentation. Please let us
20 know if there are any other aspects of the Medicare
21 sustainability challenge we should include.

22 MR. HACKBARTH: Thanks, Evan.

1 Let me just say a word about the context for the
2 context chapter. We have got two broad goals in this.

3 First is to speak to an audience that looks to
4 this chapter for updated information on costs, cost trends,
5 you know, status of the Medicare trust funds and the like,
6 and there is a segment of our audience that uses this as a
7 resource each year, and so we would like to meet that need.

8 A second thing that we have often done in the past
9 -- and it is included in this draft -- is provide some
10 summary of, you know, MedPAC's perspective on policy issues.

11 And as we get into the discussion, I would welcome
12 people's thoughts about whether we ought to continue to try
13 to do both of those things in the chapter. For sure we need
14 to do the first, and I would entertain ideas about whether
15 there are other ways to try to do the second piece, which is
16 summarize what our perspective has been and where we think
17 things ought to go in the future with Medicare payment
18 policy.

19 Last year, in the transmittal letter for the March
20 report, we had a summary of sort of my take on where the
21 Commission has been in terms of policy recommendations and
22 how we think Medicare policy ought to evolve in the future.

1 Potentially that is a candidate again this year, so we could
2 strip it out of the context chapter and put it in the
3 transmittal letter. There may be some other approach that
4 people have in mind. But I want to try to break this into
5 the different functions that we are trying to pull off and
6 see if we have got some ideas about how to handle those.

7 Okay. We will use our standard format for
8 discussion, so round one, just to remind people, will be
9 clarifying questions. And I would urge people to keep those
10 very brief, you know, clarifying questions: What do you
11 mean by the statement X? And let's see if we can quickly go
12 around and get all of the needed clarifications.

13 Then round two will be an opportunity for people
14 to make broader comments or suggestions. And then if we
15 have time for a round three, Jay and Mark and I will try to
16 identify a few issues to invite more detailed discussion on,
17 and, you know, I would like to try to get to round three.
18 So let's keep rounds one and two quite focused.

19 Let me see hands for clarifying questions, round
20 one, and we will just go down the row here.

21 MR. GEORGE MILLER: Just a quick one on the
22 financial impact to the Treasury of the hold-harmless

1 provision, the 75 percent of beneficiaries. Do you have a
2 dollar amount of what the magnitude of that impact to the
3 Treasury is?

4 MR. CHRISTMAN: I don't. And if I'm thinking
5 about it right, it doesn't affect the amount that Medicare
6 gets from the general fund. It just affects how much
7 beneficiaries who are not subject to the hold-harmless pay.
8 So, in effect, when we hold that increase back from a
9 certain portion of the population, it gets passed to the
10 other.

11 MR. GEORGE MILLER: It's cost-shifted.

12 MR. CHRISTMAN: In that sense, yes. I think the
13 advocates of this measure argue that, you know, some
14 population is being protected. It should not change the
15 cost of Medicare to the Treasury.

16 MR. GEORGE MILLER: Okay. Thank you.

17 DR. CASTELLANOS: Good presentation. I know it is
18 clarifying. It is on page 17 of the text that you gave us,
19 and you mentioned something about survival gains were
20 stagnated since 1996, especially with myocardial
21 infarctions. But you extended that into cancer, and you
22 said since research also suggests that survival gains for

1 cancer have been stagnated also since 1996.

2 That is not true, at least on some of the
3 literature that I looked at. I was unable to bring up that
4 Cutler article, but perhaps maybe you can get me some
5 information on that at a later date. But I don't think that
6 is a fair or straightforward --

7 MR. CHRISTMAN: We can take a look at that and get
8 you the article.

9 DR. CASTELLANOS: Thank you

10 DR. CROSSON: Yes, Evan, if you could turn to
11 Slide No. 4, which is the long-term projection of Medicare
12 expenditures. You know, often when you see long-term
13 projections like this, you get past a few years in the
14 future and you have some data, and then everything else is a
15 straight line some direction from there. This one isn't.
16 Do you know or could you speculate on why the period of time
17 from about 2020 to 2040 seems to have a much steeper slope
18 either than what we have experienced in the past or what
19 will come after that? Because it seems to me that if you
20 went then to Slide 6, is this the effect of demographics?
21 Is it technology expectation? What is it?

22 MR. CHRISTMAN: I think there are two things going

1 on. One is that the trustees' long-term assumptions on
2 costs causes excess growth to gradually fall over time. So
3 the per capita growth -- they are still high in that period
4 that you are talking, but the excess growth is coming down
5 every year. And that is one effect that you would expect
6 the line to gradually taper off. But you do point out sort
7 of -- I have noticed that, too -- the bump between 2020 and
8 2040. And this is a period where the number -- if I recall
9 correctly, the number of beneficiaries entering Medicare is
10 much higher than normal, and you can kind of see the end of
11 the baby-boom tide, I guess, somewhere around there, around
12 2030 -- in the late 2030s. I would not know that it exactly
13 comes out to the end of what people call the baby-boom
14 generation, but if you look at the annual entry into
15 Medicare, it starts to tail off in that period.

16 [Comments off microphone.]

17 DR. SCANLON: I think why it occurs in that time
18 period is because they use actual data or trends for the
19 first 25 years of the projections, and then they impose the
20 assumptions so that it is only one percentage point more
21 than GDP. So it would be within that time frame that you
22 would see that impact.

1 DR. MILSTEIN: Evan, is there a structural or a
2 conceptual reason why either in framing the problem or
3 discussing potential solutions the chapter does not discuss
4 or consider lack of and opportunities to harmonize with the
5 private payers and their strategies for, in essence,
6 addressing the same value problems?

7 MR. CHRISTMAN: That's something we certainly have
8 discussed in the past, and we can put that back in. I think
9 that that is just something that sort of slipped through
10 this here.

11 DR. MARK MILLER: What we try and do with this
12 chapter is a standard set of information that gets repeated
13 and updated every year, and then sometimes we try and bring
14 in a different focus in a different year to try and mix
15 things up a little bit, that type of thing, bring
16 information in. We did do that at one point. What it kind
17 of got dropped for this year was this notion of should we
18 talk about MedPAC's vision in this chapter, but, of course,
19 Glenn has said maybe there is a different vehicle for that.
20 So maybe it is also part of that conversation, and we can
21 bring that back into the mix.

22 MR. HACKBARTH: Okay. Any other clarifying

1 questions?

2 DR. DEAN: Would you just expand on your answer to
3 George's question. I didn't understand. If what is coming
4 into Medicare through Part B premiums actually goes down or
5 stays flat, I would assume that the government's portion of
6 those payments would have to go up.

7 MR. CHRISTMAN: I guess what I would say is that
8 they set the premiums so that the total amount of premiums
9 paid equals 25 percent of Part B's expected expenditures.
10 And so, as a result of the hold-harmless, they spread that
11 25 percent over a smaller base, and so those people pay a
12 higher premium, but the same amount of total premiums is
13 paid.

14 DR. DEAN: So the premiums will actually go up.

15 MR. CHRISTMAN: They will go up in part because
16 Part B expenditures go up every year, but a second --

17 DR. DEAN: Yes, okay. I thought it meant that the
18 actual premium would be going --

19 MR. CHRISTMAN: I'm sorry. There is sort of an
20 extra layer, yes.

21 DR. DEAN: I see.

22 MR. CHRISTMAN: Part B premiums go up every year,

1 so that is one piece that is driving up the premium. The
2 second piece is that fewer people are paying the Part B
3 premium this year, so obviously it is higher.

4 Right now, there is not a lot of good information
5 from OACT that allows you to quantify that effect. When
6 that comes out -- I think they will do it in the fall -- we
7 will add some detail on that.

8 DR. DEAN: Thanks.

9 MR. HACKBARTH: I saw hands over here. Were you
10 just trying to jump the queue on round two, or did you have
11 round --

12 DR. CHERNEW: [Off microphone.] I thought you
13 were about to say "round two." [inaudible]

14 [Laughter.]

15 MR. HACKBARTH: Right. Any other round one?

16 DR. STUART: This is a real quickie. Obviously,
17 the Great Recession of 2008 and 2009, I assume, is not
18 reflected in this. But is there any qualitative assessment
19 from the Office of the Actuary in terms of how that is going
20 to affect the future? Because it is not just something that
21 is going to be a dip. It is going to change the slopes here
22 at some point, it strikes me.

1 MR. CHRISTMAN: I mean, as I recall, OACT puts
2 together the trustees' report in the January-February time
3 frame, so that March report that came out this year in June,
4 or whenever, sort of reflected what people thought about the
5 economy at the beginning of the year.

6 I would note that the Hospital Insurance Trust
7 Fund insolvency data I believe moved forward 2 years this
8 year, but whether it factors in what people think about the
9 full impact of it, I couldn't say.

10 DR. KANE: Yes, going back to the Part B premium
11 for the 25 percent -- and I know that is supposed to be the
12 higher-income people -- do we have any sense of how many of
13 them are under an employer-based post-retirement coverage
14 and what that might do to employer-based coverage if it
15 keeps going up? In other words, when the Part B premium is
16 loaded onto the 25 percent, it's getting higher much faster?
17 Do we know who that's affecting and how that might affect
18 even like in post-retirement coverage?

19 MR. CHRISTMAN: I guess I'm not sure I entirely
20 follow your question, but there are sort of three
21 populations that are going to be paying the premium: new
22 enrollees who don't have a Social Security check payment

1 from the previous year that would decline; individuals
2 subject to the income-related premium; and individuals who
3 have their premiums paid by State Medicaid programs.

4 So I'm not sure I really know how to tie it to the
5 employer issue that you are talking about.

6 DR. KANE: That's related, so now we know who the
7 three groups are. And then what is the impact of this rapid
8 hit on those different parties.

9 MR. BERTKO: Evan, if I can expand on Nancy's
10 question, I think she's got that second group there for
11 which some retiree benefit plans pay the Part B premium.
12 And so I think you are requesting -- I mean, would more
13 employers cut back CAP or something to that group because
14 we've now got a leveraged impact from the push on the 25
15 percent that are paying?

16 MR. CHRISTMAN: Yeah, I'm afraid that I'm kind of
17 thin on the income-related premium and this angle of it.
18 The only thing I really know about it is that the last time
19 someone did an estimate of it, I believe that about 5
20 percent of the Part B --

21 MR. BERTKO: It's not that group. It's the second
22 group that are not income-related but still are in a place

1 where they might be paying premium.

2 MR. CHRISTMAN: Okay, so that would be new
3 enrollees then would be the group. I don't know the size of
4 that group.

5 DR. MARK MILLER: [Off microphone.] It's not
6 income-related. Is there a secondary impact from their
7 employer? Okay. We'll look at it. I hear what -- I think
8 I...

9 MR. HACKBARTH: Any other round one? Okay. Round
10 two. Who doesn't have a round two? We'll just go down the
11 row.

12 DR. BORMAN: There's a couple of things about the
13 presentation, and starting out, sort of the good part that I
14 like is that, as Mark has pointed out, we see some of the
15 same data presented in a similar way, and it kind of re-
16 grounds us in where the conversation is about. And so I
17 find that very helpful.

18 Looking at that from the flip side, however, it
19 does beg the question a little bit of are there some other
20 ways or other perspectives from which to look at this
21 contextual problem that we have that we are spending money
22 that we don't have and present it in a more -- or in an

1 equally intense, attention-grabbing way.

2 I understand these graphs better every year, but
3 as I talk to colleagues, as I talk to people at various
4 levels of training, when I say to them the H.I. Fund goes
5 into bankruptcy at X time, I get what some have termed the
6 MEGO response, my eyes glaze over. And I think that we are
7 and should be at a point where we want to engage people
8 generally in their thoughts about their health care because
9 in the end there are a lot of choices that have to be made
10 here that are not black-and-white medical science and that
11 will relate societal values.

12 So, to cut to the chase, is there something that
13 we can present as a figure, as a number, as a calculation,
14 that is even sort of more generalizably understandable? And
15 I recognize the report is to the Congress, and I do not mean
16 to impugn their ability to understand complex graphs. That
17 is not the point. I am thinking about the audiences that I
18 talk to, and one that has occurred to me is the notion of
19 the Medicare dollar. You know, we present this in a very
20 traditional way in the sense of Part A, Part B, and to some
21 degree in later things, Part C and Part D.

22 But the reality is if we really want to cut across

1 silos and think about the whole thing that we deliver, it
2 just might kind of be helpful to know, after you
3 appropriately, relatively weight in all the various
4 programs, just how much is out of general revenues and how
5 much on a percentage basis, because the Medicare dollar kind
6 of carries that implication that it's coming out of some
7 dedicated Medicare funding. And I think what a lot of my
8 colleagues and just my neighbors don't understand is how
9 much of this is really sucking from the general revenue.
10 And I just think that might be a helpful thing to be able to
11 get out there, would be some sort of calculation or number
12 that relates to that, and it seems to me that this was the
13 part of where we do that kind of thinking that might be
14 helpful.

15 The other thing that I would comment is that, as
16 always, it's helpful to have a basis for comparison, but I
17 almost think we are starting to lose value from the
18 continued comparison to other countries. There are so many
19 things that make each country different from each other in
20 terms of cultural values, in terms of how data are
21 collected, in terms of expectation of outcomes, how systems
22 are structured, that I think we have enough data of our own

1 to say that, number one, we are spending a boatload of
2 money, we can't continue to spend at this pace; number two,
3 we spend very differently within our own country. Who knows
4 why? Lots of potential different reasons. But we have
5 enough evidence within our own country that we don't really
6 need that external comparison, because I think we have come
7 to the comparison or the result, the conclusion that we
8 can't just wholesale become France or Italy or Japan or
9 whomever in our health care system. We can't do an
10 immediate transposition.

11 So I wonder, I just would sort of increasingly
12 maybe think less about that, and maybe this is an
13 opportunity to use that, our own internal variation tells us
14 the same thing, that we have got to think about this in a
15 different way, if that makes sense.

16 Those are my two comments.

17 MR. GEORGE MILLER: I want to go in the chapter to
18 page 18 and what struck me about the disparities issue and
19 see if we have a remedy or a solution. While I really
20 appreciate the data and the analysis, the concern on my part
21 is how do we change what is, at least apparent to me, an
22 inequitable situation that both racial and socioeconomic

1 Medicare beneficiaries are not receiving the same level of
2 care. How do we address that? What recommendation came we
3 come up with to address this issue? Not only they are not
4 getting the same level of care, but when we do get served,
5 we have higher mortalities. That is a major problem for me.
6 Do we tie in performance, pay-for-performance issue for --
7 and I realize we are looking globally. You know, how do you
8 address it at the level that it is being reported. That is
9 just problematic to me. And, again, it is more than just
10 demographic. It is socioeconomic also. So that's also a
11 problem. I just consider it just grossly unfair and
12 certainly not equitable, but I'm not sure the best ways --
13 do we have best practices to address it? Can we make
14 recommendations? Do we penalize folks? What are the tools
15 to help correct this inequity?

16 MR. HACKBARTH: Let's take a look at how to better
17 address the topic.

18 DR. CASTELLANOS: Evan, can you turn to Slide 6,
19 please? I really appreciate your comment, especially the
20 one about defensive medicine. I think you commented that it
21 really wasn't considered to be a major driver.

22 I think there's been some national attention just

1 recently on the issue of malpractice and defensive medicine,
2 and I think if you look at the provider community,
3 especially the physician community, I think you may get the
4 importance that this is probably more of an issue than you
5 give it credit for.

6 But, more importantly, if possible, is there a
7 policy viewpoint that we can deal with this, especially with
8 the issues of delivery system reform that we are looking at
9 where we can look into controlling some of these excess
10 costs with the defensive medicine?

11 MS. HANSEN: A short comment here relative to just
12 an appreciation of this chapter elevating some of the
13 beneficiary economic status and impact of their rising
14 costs. I know we've talked about it. I think this is the
15 most robust piece I've had the chance to see, so I really
16 just want to say thank you for that.

17 The second thing is I also would love to
18 underscore I think what John and Nancy brought up about what
19 that is going to mean in terms of that 25 percent who will
20 pay more, just with that start cutting into that middle-
21 income population that has started to feel the squeeze from
22 different ways. So I just want to bring that one up,

1 especially with the retirement plans that affect government
2 budgets as well with their pension plans.

3 And just my last comment is that I do think having
4 the context of the recommendations in this chapter seems
5 helpful to just say, you know, this is the status where
6 directionally MedPAC may go, whether we, you know, order
7 this in some other way, but I think it just makes a more
8 complete package.

9 DR. CHERNEW: As always, this was a well-done and
10 sobering chapter. In response to Karen's comments, actually
11 there is a number that they report, like an actuarial value
12 which tells you how much taxes would have to go up to keep
13 everything in balance, and there's some version of that that
14 is sort of understandable.

15 But my quick comments are: I think the chapter
16 does a great job of talking about a lot of the issues, but
17 some nuances that I think are important get lost. One of
18 them is the distinction between the level of cost and the
19 rate of growth of cost, which comes out in other work that
20 we are going to talk about today. But in the second on rate
21 of cost growth, there are several things there that I think
22 are more factors for why costs are high as opposed to why

1 they are growing rapidly. And so I think I'd like to talk
2 more about which ones fit in which bins, if you will. But I
3 think clearly, from the other work we will see today and
4 work I have done, the cause is different. Things that cause
5 high levels don't necessarily cause high growth, and vice
6 versa.

7 The second point I'd like to make relates to the
8 section on the value of new medical technology. I think in
9 general the literature is pretty clear that overall, on ag,
10 the new medical technology which is driving up spending is
11 worth it. In fact, the returns from new medical technology
12 on average are tremendous.

13 I think it's very important to note that that
14 doesn't mean there is not a lot of waste in the system at
15 the margin, that we overuse new technology, so we could do a
16 much better job with the same technologies if we could use
17 them more effectively, because with all the good stuff comes
18 a lot of waste in the system, and we struggle with how to
19 get that out. So the distinction between is it good is a
20 more nuanced answer than yes or no. It is how it's applied.

21 And the last comment I'd make that relates a
22 little bit to what George said is although the Part B

1 premium rising is something we have talked about because of
2 the hold-harmless, I think that's a little bit of an
3 anomaly. The real issue is people are increasingly not
4 going to have access to supplemental coverage, in my
5 opinion, and that is going to create a huge burden that is
6 going to well dwarf the Part B premium issue. And we need
7 to think through -- all the graphs that we present are
8 typically for the average person. We average, you know,
9 what on average are people spending. But in certain subsets
10 of the population, the burden is going to actually be
11 crushing. And it's not the lowest group, but it's that
12 other. And I think those burdens are going to be crushing,
13 and how we think about that will have ramifications for how
14 the policy things around benefit design and stuff get put
15 later. So I think it really does help our context.

16 DR. BERENSON: First, two comments on the purpose
17 of the chapter. As I was reading it, I thought -- this is
18 my first year so I was officially reading it as opposed to
19 in the past when I was unofficially reading it. But as I
20 was reading it this time, I said, "Hey, I've read this
21 before," and it was helpful to have you and Mark clarify the
22 purpose for repeating a lot of stuff. And I see that, and

1 yet to me the most compelling part of the chapter was the
2 new information where you can actually get into some detail,
3 so the box on cost-shifting, I think there will be an
4 opportunity to spend a little more time on is the high
5 spending worth it, with the conversation we're going to have
6 later, Michael's point about exploring in more detail, the
7 increasing data that's available about the difference
8 between baseline spending and rates of growth.

9 So I would like to see the chapter -- I see the
10 purpose now of having some continuity in the same sort of
11 macro topics with updated data, but I really think the
12 emphasis should be on sort of what's the cutting edge and
13 what relates to other work that the Commission is doing that
14 contributes to that data.

15 The second point on this I would make is that I
16 just see a big disconnect between most of the chapter, which
17 is about macro-level trends and findings, and then we're
18 going to bundle payments in Medicare. It just seems like
19 the two don't hang together very well, and I would explore
20 other ways of trying to identify -- unless we have -- vision
21 should go in this chapter, but the stuff of here's the seven
22 or eight specific things we're working on seems to me maybe

1 should be in some different place.

2 And the substantive comment I was going to make is
3 I agree with Ron that defensive medicine -- it's hard --
4 there are estimates all over the world, I mean all over the
5 place, on 1 to 2 percent to 25 percent of health care costs.
6 I don't think there's any way to know at this point. It's
7 incredibly hard research. But I would not dismiss that area
8 as one that deserves to be on the list as a cost driver.

9 MR. HACKBARTH: Bob's comment triggers a thought
10 that I want to throw out so people can comment on it as we
11 go through, if you wish.

12 One piece of this is data that is likely to be
13 pretty much repeated year after year, just in updated form.

14 A second piece of this could be that we, you know,
15 shine a spotlight on one, two, three -- I don't know what
16 the number is -- particular issues, and those might change
17 from year to year. It is sort of here is a focus.

18 And then the third piece is some summary statement
19 about MedPAC's policy views, vision, and I think it might be
20 useful to make a distinction between the recurring data and
21 some new issues that we want to rotate on an annual basis.

22 DR. KANE: Yeah, I think related to whether there

1 are additional topics that may be included, I think this
2 whole issue of how Medicare interplays with other payers,
3 not just the private sector, which Arnie started mentioned,
4 but also Medicaid, and I think we talk a little bit about
5 dual eligibles. But I think as a general theme, we view
6 Medicare and its interactions as fairly passively
7 interacting. And I know I was giving a talk to the Pacific
8 Business Group, thanks to Arnie, a few days ago, and they
9 said, "Well, what could the private sector do to help?" I
10 wish I said, "Work with Medicare." But I couldn't think of
11 any device by which they could do that. And I think we need
12 to -- you know, it would be interesting to start actively
13 thinking of how can Medicare and the private sector even
14 create zones of collaboration or all-payer experiments or
15 some way for Medicare, and Medicaid and the private sector,
16 to try to create an all-payer vision of how resources should
17 be allocated instead of this fragmentation, which we have
18 all noticed but still continue to operate under.

19 The other topic that I thought would be a good way
20 to highlight some of the issues that are sort of brought up,
21 but sort of in a more fragmented way, is the whole issue of
22 program governance and administration. Fraud falls under

1 that. The costs of administration falls under that. The
2 ability to innovate falls under that. But I think that
3 whole topic, when you fragment it, you don't get quite this
4 -- it would be nice to pull it all together and say what
5 should be the organizational structure, the types of
6 resources, and then take the functions of each one and say
7 maybe, you know, fraud, the protections there, should we
8 look at that or, you know, we have been looking at the
9 ability to innovate. But I think that is a big topic, and
10 we just have not highlighted it. It gets buried in other
11 things.

12 So those two would be -- how do we deal with the
13 implications that we're really only one player of many and
14 it has a lot of implications for Medicare as well in terms
15 of the inability to contain cost, but it also has, you know,
16 opportunity and then program governance and administration.

17 DR. MILSTEIN: Just a few technical suggestions.

18 First, I think it's important in the discussion to
19 separate factors that explain our higher level of spending
20 from factors that explain growth in spending. And I think,
21 you know, there's more we can do to help in terms of the
22 reader grasping that. If you look at Slide 6, if you sort

1 of think about it, those things can be expressed either in
2 the amount of those things we use, like technology, which
3 you can use to explain higher spend; but they also can be
4 reconfigured to explain growth in spend, because technology
5 does not explain growth in spend. Growth in technology
6 explains growth in spend. And so helping to clarify that,
7 what do we know that accounts for our higher-level spend and
8 what do we know that drives spending would be helpful.

9 The other thing, I think, at least this year --
10 maybe we have done it in the past. Mark, you can comment on
11 this. But I think it would be really useful in this year's
12 chapter to really pay more attention to the central role of
13 improvement in health industry productivity growth, you
14 know, more health per dollar consumed -- more miles per
15 gallon, in essence, in the health industry -- and our
16 ability to sustain Medicare without increasing beneficiary
17 cost-sharing or increasing taxes, because that's really --
18 it's a central factor, and should we -- at least in this
19 draft, we don't nail it, and maybe it's because we have
20 nailed it in the past. But I think it's very important
21 because the notion that our health industry can't do in rate
22 of productivity growth is -- there's no basis for asserting

1 that at this point.

2 Then last, but not least, I think it would be --
3 we may want to consider, without making this, you know,
4 overly complicated, as we reflect on the different
5 strategies that we lay out broadly, would be in some ways
6 comment or maybe we can have a little rating system as to,
7 you know, the degree to which we think those things have
8 gotten a reasonable try in Medicare versus the degree to
9 which we think there is a big unexploited opportunity,
10 because some of these -- you know, some parts of the mind
11 have been worked over pretty well and have either succeeded
12 or faced degrees of political resistance that caused them to
13 be of less yield than we hoped.

14 MR. BUTLER: So if I can recast your original
15 question, I'd put it this way: At one end of the spectrum
16 is give them the charts they always want year after year and
17 the other is "not only give them the themes but plop in some
18 important things, somewhat randomly, but ones where we think
19 we got mileage, I'm more on "give them the charts" end of
20 the spectrum, because I think when I look at the staff's
21 time and effort, when I look at the timeliness of the -- and
22 the information you'll get from the chapters, it's probably

1 better to firm up that message later on in the year than to
2 spend a lot of time trying to capture it all in this
3 chapter, especially when you're kind of trying to put this
4 to bed, in effect, while we get on with the rest of the
5 work. So that would just be kind of a general response that
6 I would have to that.

7 I think one major exception that we haven't really
8 come back to is it seems when we get into the updates, we
9 suddenly say service after service, we're doing it silo,
10 we're doing it silo, we're doing it silo. So the theme of
11 crossing the silos I'm not sure is quite as apparent in how
12 this is written up as it -- you know, you could hit on that
13 one in particular and how we're really trying to reshape
14 Medicare across the various services, not just provide
15 updates.

16 Now, the one issue that I do have issues with is
17 this cost-shifting one, which is one of those where you
18 would say we have done previous research, now we're shining
19 a light on it, because we think it's interesting,
20 worthwhile, we can make a unique contribution.

21 I agree with all that. I'm not sure that it
22 belongs in the chapter at this time, although I could

1 support it. But I think what we basically have done is we
2 have brought forward not word for word but a somewhat
3 shorter version with less data than exactly what we put in
4 last March's chapter. So it's not new information. It's
5 cast in a little bit different light. But the fact that we
6 use words like "hypothesis" and -- you know, it's almost
7 like a work in progress; whereas, I kind of sense the
8 context chapter should be not kind of that so much. I think
9 it belongs more in the hospital update chapter with
10 additional analysis, is what I would favor. But that's not
11 to say we shouldn't rigorously go after the topic, because I
12 think we should.

13 Now, some of it relates to the words, if I were to
14 just contrast two kinds of comments. And I'm drawing right
15 from the draft. So when we say things like, "Some argue
16 that providers raise prices for private sector payers when
17 their costs exceed their Medicare payments." There are
18 words like that that suggest that they just pick up the
19 phone or run through their charge master new prices, when
20 it's really a rigorous negotiation. Now, they may have
21 incredible clout, and they may do things that are aggressive
22 and so forth. But it's not cast some of these words in

1 quite the way I would perhaps do it.

2 Then there are some other technical things that I
3 think we need to just kind of work more on, and exactly the
4 data that we bring forward I think is extremely important,
5 and we have very limited summary data here where we had more
6 data in the chapter. And so I think if we do bring this
7 forward, I think this particular section needs a little bit
8 more massaging before it's ready to go.

9 MS. BEHROOZI: Actually, before, I had written
10 some comments before Bruce talked about the Great Recession
11 of 2008-2009 and before Mike talked about how Medigap
12 policies or employer-based retiree coverage -- I don't think
13 you said that, but maybe that's implicit -- is likely to go
14 the way of the dodo or whatever it is, but, you know,
15 there's likely to be a lot less of it, particularly as it
16 becomes more expensive, and also your comment about the
17 crushing debt on beneficiaries.

18 I would just suggest, Evan, you've got a lot of
19 this stuff in the paper, but maybe pulling together the sort
20 of picture of the 21st century beneficiary that we had
21 started talking about a couple of years ago, I think. You
22 talk about people under 65 losing insurance, right? I mean,

1 the latest report, you know, another few million people have
2 lost insurance. That puts pressure on Medicare as they
3 retire. You talk about it in the context of the health
4 system overall, but in particular, that has implications for
5 Medicare when those people who have not had access to care
6 retire and suddenly do have access, and maybe portends a
7 change in the health status of Medicare beneficiaries.

8 Long-term high unemployment that, you know, we're
9 already seeing and is predicted to be persisting for a long
10 time means that there -- and we've already seen a real wage
11 decline for those who are working. So, you know, bringing
12 those two things together, people are going to have a lot
13 less money when they retire, whether it's because they will
14 have spent less time in the workforce and their Social
15 Security benefits won't go up the way they should -- not to
16 mention that they have to wait longer to get Social Security
17 benefits -- their retirement savings, if they had any, were
18 decimated at the end of last year. Maybe they're climbing
19 back up close to zero, but not, you know, the kind of money
20 that they thought they were going to have to retire on, and
21 people are simply making less in terms of income to be able
22 to put away.

1 So that what you identify in the paper in terms of
2 the growing costs to be borne by beneficiaries, I think it
3 would benefit from putting it in the context of people
4 having less money to bear that cost. And they are not all
5 going to be dual eligibles; they're not all going to be LIS-
6 eligible. I think it would just be helpful context-wise
7 since that's the chapter.

8 DR. DEAN: Just a couple things. First of all,
9 with regard to the growth of technology as a cost driver,
10 it's also really tied in with the prices for new technology,
11 because each new procedure that's introduced, at least it
12 seems, is introduced at a higher price than some of the
13 predecessors, especially when it's new, and some -- maybe
14 the legitimate costs are, but then it stays at that price.
15 And so more and more there is the attractiveness to use
16 things just simply because of the way they're priced. I
17 don't know what the answer to that is, but it might be worth
18 a comment.

19 The other thing I would comment about has to do
20 with the defensive medicine issue. You know, as Ron and Bob
21 have talked about, certainly quantifying the dollar cost is
22 terribly difficult. I think there is another cost that is

1 even harder to quantify, and that is the whole behavioral
2 aspect of this, and the cynicism and the fear and the
3 rigidity that it sort of introduces into physician behavior
4 that I think may even be a bigger factor in terms of
5 interfering with the efficiency and the smoothness with
6 which the whole system works, that if there was a way to
7 back this influence out of the whole process and take away,
8 like I say, the fear -- which, you know, at least in my
9 practice, I try my best to forget about the whole thing and
10 not to pay attention to it. But it's hard to do, and I know
11 that many of my colleagues, that really is a dominant issue
12 in terms of their whole behavioral approach to how they deal
13 with patients. And it's for the most part a negative one.

14 And so I think working to try to reduce the
15 influence of that is terribly important, even aside from
16 whatever dollar cost it might save.

17 MR. BERTKO: Okay. A couple technical issues,
18 Evan. I am going to follow up Bruce's comment here on
19 payroll taxes, and I am not going to ask you to try to
20 reforecast what OACT does. But having a conversation with
21 them that says, you know, might ask and answer the question
22 of, Are the payroll taxes forecast now less than you did

1 last year? And then directionally saying, If this happens,
2 it accelerates that date forward from 2017 to something
3 else. And we now have a data point because the same thing
4 happened last year.

5 The second part of it is in the longer-term
6 factors you recognize health status, but I am going to
7 suggest you think about whether you specifically would put
8 in something about the upcoming obesity epidemic, both in
9 terms of incidence, and then I at least I think I've read
10 some stuff where it says akin to not having health
11 insurance, being obese for a long period before you're ready
12 for Medicare leads to more co-morbidities, you know,
13 obviously, diabetes, joint problems, and things like this
14 which will, in fact, accelerate the cost.

15 My recollection, although I'll look to Mike and
16 Bill on this, is that when we asked this question in 2004,
17 we got kind of a shrug of the shoulder, "Can't tell," from
18 our colleagues over on the other side of the table. And I'd
19 be interested to know whether they've done anything more
20 since then.

21 Thank you.

22 MR. KUHN: Thank you and, Evan, thank you, that

1 was a good report. I appreciate that. Let me focus on
2 three things, if I could.

3 One, on page 9, where you talk about erroneous
4 payment rates for the Medicare program, there is an
5 interesting final sentence here where we talk about that
6 perhaps might require higher administrative expenditures in
7 order to grapple with this issue. Right now, as I recall,
8 within the Medicare program they spend one-fifth of 1
9 percent dealing with erroneous payments. And so I think
10 putting some context here in terms of what the current spend
11 is, let's everybody know how little they spend compared to
12 what private plans do, where they really make determinations
13 in terms of panels of physicians and others. And so I think
14 making sure we once again kind of differentiate between the
15 two but also show that there is an opportunity for Medicare
16 to improve in this area might be a useful thing to have.

17 Then on page 21, where we talk about the
18 beneficiaries -- and I think that's a very good discussion
19 and talks particularly about the interaction with the freeze
20 on the Social Security update this year and how that impacts
21 the Part B premium, that's going to go on. But we're silent
22 -- and correct me if I'm wrong here, but we're silent on

1 what may happen to the Part C and Part D premiums, that is,
2 for MA and PDP. Those I don't think are constrained by the
3 same activity as Part B, and so Medicare beneficiaries,
4 while they are protected on Part B, they will not be
5 protected on Part C and Part D premiums, and they could see
6 their actual Social Security checks go down next year as a
7 result of that. And I think we need to be very clear about
8 that and recognize that aspect.

9 And then, finally, on page 29, where we're talking
10 about research, I'm a huge fan of research in this area.
11 I'm a big fan of -- I'll wear it on my sleeve -- unabashed
12 fan of CMS' Office of Research. And it would be helpful, I
13 think, to talk in here -- and we talk about how that
14 research budget is declining. But I think OACT has some
15 pretty good information in terms of the ROI that's been
16 achieved for research that CMS has done in the past. And if
17 we could talk to OACT and see some of the returns that they
18 have as a result of research, it would be useful to have
19 that as well.

20 Thank you.

21 DR. SCANLON: Two points and they're kind of about
22 tone, I guess, or maybe contributing to tone. The first one

1 is about the drivers, the factors driving growth, and it
2 relates to the technology. And I think that when we talk
3 about sort of technology being a major driver, it conjures
4 up in many people's minds the idea that in order to control
5 costs, we're going to have to stifle innovation. And I
6 think we definitely want to avoid that because it's not
7 true.

8 Part of it is that the studies I've seen which
9 talk about technology and lead to a conclusion that says
10 it's 50 percent of the growth, they could have used the word
11 "residual" instead of "technology." They controlled for a
12 number of things, and then when they didn't have anything
13 else to control for, they had 50 percent of the growth that
14 was unexplained, and they said, "Well, that's technology."
15 Okay. And I think that there's two different aspects of
16 saying that the residual needs to be broken down.

17 One is it's not all new technology that maybe is
18 driving it. It's how technologies maybe are used as a
19 factor here. If I'm a provider and I give a lab test, you
20 know, the question is: Do I do it for someone with a
21 chronic condition? Do we do this every 60 days? Every 90
22 days? You know, every year? I mean, there are issues like

1 that that are part of this factor that is driving things.

2 And that relates to the second factor, which is I
3 think that provider behavior is a portion of this. You've
4 got to capture it in the organization of a delivery system
5 to a degree, but it's more important, I think, than just
6 that.

7 And so I think we have to be careful about sort of
8 what we ascribe to technology, that putting a number on it
9 is dangerous. At a minimum, what we need to do is describe
10 how complicated this is, that provider behavior is also a
11 factor sort of in this.

12 The second point relates to international
13 comparisons, and I agree with Karen that we're not going to
14 adopt sort of the French or the German or the Swedish
15 system, or anything like that. But I think that -- I mean,
16 I don't mind the comparisons in terms of look how far out we
17 are, I mean, at a simple level, how far out we are in terms
18 of our share of GDP and, you know, ask ourselves, What are
19 we getting for it? I mean, I think that's a very sort of
20 legitimate question to be asking.

21 I think there's research that can be done that's
22 much more intense that says is there anything about what

1 they do that we could apply sort of in the context of our
2 system, and that may sort of have some value.

3 The comparison with the rates of growth and the
4 fact that the OECD average is the same, sort of roughly the
5 same as ours, I think that one is a dangerous comparison,
6 because the OECD average is an average of -- just as it is
7 in the U.S., very different experiences. I saw sort of the
8 details of the OECD average recently. We had Germany, which
9 is one of the lower-level per capita spending, having also
10 low rates of growth, something around 4 percent. We also in
11 the time period that this study was looking at, you had
12 Great Britain, who had a very high rate of growth, but they
13 made a conscious decision saying, "We've invested too little
14 in health care. We're going to expand it."

15 So there is this issue of, Is growth control
16 really impossible or are there lessons, are there examples
17 where you can find ways that you can control sort of the
18 growth? So I think we have to be careful about how we use
19 those kind of data.

20 MR. HACKBARTH: We're just about out of time here.
21 Let me offer an idea. We can maybe have a few comments now,
22 but we're probably going to have to defer longer discussion

1 until the next meeting.

2 Evan, I think you've done a great job here, as
3 usual. There's a lot of good material here. I sense,
4 though, an opportunity to maybe sharpen the chapter a little
5 bit by breaking down exactly what we are trying to
6 accomplish into different elements.

7 I think, as I said before, it is important to
8 serve the audience that looks to this chapter for updated
9 statistics on basic parameters for the Medicare program and
10 health care spending in general. And I would have that
11 section clearly labeled. You know, people can look at the
12 chapter; if that is what they're shopping for, they know
13 exactly where to get our annual statistical update.

14 I would label equally clearly a second section. I
15 can't think of the exact name for it, but I think of it as
16 sort of spotlight issues where in any given year we might
17 take two or three issues that we want to focus on, and a
18 number of them have come up in the course of this
19 conversation: the idea of harmonizing between public and
20 private payers, both Arnie and Nancy mentioned that;
21 malpractice, you know, what's the state of literature on
22 malpractice might be another; levels versus growth could be

1 another.

2 But, you know, my vague vision of this is we have
3 a section that says we're going to shine a spotlight on
4 three important issues this year. No pretense of
5 comprehensiveness. In fact, I think we're sort of getting
6 into trouble by trying to be too comprehensive, so we are
7 touching in a very superficial way on too broad a front.
8 And I think we can gain by narrowing and focusing a little
9 bit more.

10 And then the third piece would be, you know, the
11 summary of the MedPAC perspective. You know, here is what
12 we think the challenges for Medicare are going forward.
13 Here are key recommendations that we have made to that end.
14 Here are broader directions that we think need to be
15 pursued.

16 In my mind, I'm not sure if that third thing is
17 best put in this chapter or someplace else, like the
18 transmittal letter, but we can come back to that.

19 Does that sort of breaking this big chapter down
20 into component parts make sense to people? Anybody have a
21 quick reaction to that?

22 DR. STUART: Just very quick and, that is, I think

1 there actually are some countervailing trends here, and it
2 might be useful to think about what some of those are.

3 For example, anybody who is nearing retirement and
4 is depending upon their 401(k) is rethinking that issue
5 about whether this is the time to retire. And we've seen
6 not just over the last couple of years, but we've seen over
7 the last 7 or 8 years increasing labor participation among
8 the elderly and, in fact, higher rates of increase in labor
9 participation among the older old.

10 What these do is two things. First of all, for
11 people who postpone retirement, it postpones the time when
12 they are actually getting Medicare benefits. Secondly, it
13 means that they are contributing to Medicare premiums over
14 that period of time.

15 Third, to the extent that working has some health
16 benefit, assuming that you are not a worker in an asbestos
17 mine, then it might actually postpone future expenditures.

18 Now, that's just an example, but my guess is that
19 there may be some other countervailing factors if we really
20 thought about it from that standpoint, because all of this
21 is saying everything is pushing it up.

22 MR. HACKBARTH: So to me that might be an example

1 of a spotlight issue that, you know, here's all this stuff
2 that you hear over and over and over again. Here's
3 something that's maybe a little discordant with that.

4 DR. STUART: Right, and we don't know. I mean,
5 it's early in the game, but --

6 MR. HACKBARTH: Right, right. Any other
7 reactions?

8 MR. KUHN: Glenn, I think that's a nice framework,
9 and I think that would pull it all together. The only other
10 thing I would add to that, if there's a way to put it in
11 there -- and to a degree, it's kind of in there now, but,
12 you know, a lot of this is a lot of people saying, "Gosh,
13 look how far we have to go. The road is so long and so
14 hard, and the hill is so big to climb."

15 But, you know, each and every year, whether it's
16 new legislation from Congress, whether it's new regulations
17 out of CMS that implement perhaps recommendations of MedPAC,
18 or other innovations out there, it would also be nice if we
19 could capture it in that chapter and say, "Oh, by the way,
20 and look what has been accomplished this last year." And so
21 we can show the progress that everybody won't say, "Oh, woe
22 is me. This is so far to go." But when you turn around and

1 look behind, they can say, "Look how far we've come," as
2 well and that might be useful to add there, too.

3 MR. HACKBARTH: Okay. Well, let's close the
4 conversation now. We'll be coming back to this, obviously.

5 We'll now have brief public comment opportunity
6 before we break for lunch. Anybody wanting to make a
7 comment?

8 Seeing nobody rushing to the microphone, we will
9 break for lunch and reconvene at 1:30.

10 [Whereupon, at 12:34 p.m., the meeting was
11 recessed, to reconvene at 1:30 p.m., this same day.]

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1 and tables that show some findings from our analysis of the
2 2007 claims information. It is a very rich source of
3 information. The data that will be presented today is only
4 a small portion of what we can learn from the data.

5 Charts and tables in the next couple of slides
6 will show you distributions of spending, characteristics of
7 beneficiaries with high spending, and at a very aggregated
8 level, how the spending and utilization patterns differ for
9 those receiving the low-income subsidy and those who don't.

10 In the second half of the presentation, Joan will
11 talk about what we learned from our recent focus groups. We
12 conducted 12 focus groups with low-income subsidy
13 beneficiaries and non-low-income subsidy beneficiaries with
14 high spending and asked about their understanding of the
15 drug benefit, how they are using or not using the drug
16 benefit, and their experience with plan marketing
17 activities. Our findings suggest that LIS and non-LIS
18 enrollees have different experience using the drug benefit
19 and we are going to tell you what we have learned from
20 analyzing the data and from talking to beneficiaries.

21 This chart shows the distribution of spending by
22 the level of total annual spending. Spending here includes

1 all payments to pharmacies for ingredient costs, dispensing
2 fees, and sales tax, regardless of who paid for them.

3 In 2007, 38 percent of enrollees had an annual
4 spending of \$2,000 or more and accounted for 82 percent of
5 total spending. Twenty percent had spending less than \$250
6 and accounted for about one percent of total spending.
7 Spending on drugs is somewhat less concentrated than Parts A
8 and B spending because more beneficiaries are likely to take
9 some medications during the year, while medical service use
10 may be concentrated in a smaller set of the population.

11 Here, we are looking at the characteristics of
12 Part D enrollees by levels of annual drug spending. As we
13 expected, we found that beneficiaries with high drug
14 spending are more likely to be disabled and receive Part D's
15 low-income subsidy. On the far-right column, you will see
16 the 46 percent of the Medicare population that are under age
17 65. So this is showing that nearly half of the people with
18 spending over \$6,000 are disabled.

19 If you go down to the next set of numbers, you see
20 that 76 percent of those with high spending receive the low-
21 income subsidy. What may not be obvious from these numbers
22 is that in many cases, being disabled and receiving the low-

1 income subsidy are very much related because the disabled
2 population tends to have lower income and so is more likely
3 to be eligible for the low-income subsidy.

4 So what the numbers in this slide show is that LIS
5 enrollees account for 38 percent of the enrollment, but more
6 than half of total spending, and it is because they use more
7 drugs and more expensive drugs, on average, compared to non-
8 LIS enrollees.

9 In 2007, LIS accounted for \$33 billion of the \$62
10 billion spent on drugs covered under Part D. Non-LIS
11 enrollees, who accounted for over 60 percent of enrollment,
12 on the other hand, accounted for only \$29 billion of the
13 total.

14 At the bottom of the table, you will see that LIS
15 enrollees had 4.6 prescriptions per enrollee per month
16 compared to 3.4 for non-LIS enrollees. And the average cost
17 per prescription taken by LIS enrollees was \$71, compared to
18 \$43 for non-LIS enrollees.

19 The next two slides look at difference in drug use
20 by LIS and non-LIS enrollees by type of drugs. The first
21 point I would like to make is that generic dispensing rate
22 for LIS and non-LIS enrollees are different. At the bottom

1 of the table, you can see that generic dispensing rate
2 across all drug classes are lower for LIS enrollees, so 58
3 percent compared to 67 percent for non-LIS enrollees.

4 Here, the generic dispensing rate, or the GDR, is
5 defined as the share of generic prescriptions dispensed
6 regardless of whether certain drugs in the class have
7 generic substitutes. So it accounts for both generic
8 substitutions for drugs with generic substitutes and
9 therapeutic substitutions for drugs with no generics. You
10 can see the GDRs for low-income subsidy enrollees are lower
11 across all five classes shown here.

12 Comparing the GDRs for different groups of
13 beneficiaries can be complicated because it doesn't
14 necessarily reflect beneficiaries' choice of generics over
15 brands or vice-versa. For example, for antipsychotics,
16 generic prescriptions accounted for 17 percent of all
17 prescriptions dispensed to LIS enrollees, compared to 28
18 percent for non-LIS enrollees. But the GDR can be
19 influenced by availability of generic substitutes and the
20 medication needs of the individuals in each group.

21 So the difference in the GDRs could reflect the
22 choices made by the beneficiaries, or the availability of

1 generic substitutes, or the specific medication needs of the
2 beneficiaries in each group, or some combination of all of
3 these factors.

4 So we have seen that the average spending per
5 enrollee was much higher for low-income subsidy enrollees
6 compared to non-low-income subsidy enrollees and the generic
7 dispensing rates for LIS enrollees are generally lower than
8 non-LIS enrollees, even when we compare the rates for drugs
9 within the same class.

10 So here is another way to look at the spending for
11 two groups of beneficiaries. I have chosen two classes,
12 antihypertensive therapy agents, where total annual spending
13 for LIS and non-LIS enrollees were similar, and antivirals,
14 where we saw a very large difference in total annual
15 spending between the two groups.

16 For antihypertensive drugs, the main difference
17 was that for LIS enrollees, the subsidy picked up what are
18 paid for out of pocket by non-LIS enrollees. In fact, the
19 average annual out-of-pocket spending for LIS enrollees were
20 similar across different classes of drugs, which is what the
21 subsidy is intended to do, while it varied widely for non-
22 LIS enrollees, ranging from a little less than \$100 to over

1 \$500 in some classes.

2 For antivirals, the most striking difference is in
3 how much plans paid for antiviral medications taken by the
4 two groups. Plans, on average, paid \$520 per user for non-
5 LIS enrollees, while they paid over \$3,000 per user for LIS
6 enrollees. We saw this in a few other drug classes, and
7 additional research in what plans are doing to manage their
8 costs may shed some light on why we see this kind of a
9 difference in some classes and not in others.

10 Health status and different medication needs are
11 also likely to affect plan costs and may be beyond their
12 control. In the case of antivirals, some of the difference
13 in cost may be due to the fact that medication taken by LIS
14 enrollees are more likely to be for treatment of HIV and
15 AIDS, which tend to be more expensive compared to other
16 antiviral medications.

17 To summarize, there may be many factors that
18 affect the generic dispensing rates. Availability of
19 generics is one. Some drug classes may have very few or no
20 generic substitutes, and even within the same drug class,
21 some drugs may have many generic substitutes while others
22 have none. So differences in medication needs could result

1 in very different GDRs for LIS and non-LIS enrollees.

2 Another factor may be that financial incentives
3 faced by the two groups of beneficiaries are different. In
4 2007, LIS enrollees paid \$1 for generics and preferred brand
5 name drugs and \$2.15 for non-preferred brand name drugs.
6 Non-LIS enrollees, on the other hand, paid, on average, \$5
7 for generics, \$28 for preferred brand name drugs, and \$60
8 for non-preferred brand name drugs, and they may have paid
9 more for drugs on specialty tiers. So compared to non-LIS
10 enrollees, LIS enrollees face a much weaker financial
11 incentive to switch to generics or ask for therapeutic
12 substitutes when such options are available.

13 Finally, plans' use of various utilization
14 management tools may also be a factor. The majority of the
15 LIS enrollees are in stand-alone PDPs and most are in plans
16 with premiums below the regional benchmarks. There may be
17 systematic differences in plans' use of utilization
18 management tools between, for example, stand-alone PDPs and
19 MA-PDs or those with premiums above and below the regional
20 benchmarks.

21 Joan is about to talk to you about beneficiary
22 experiences and I would like to lay out some basic numbers

1 to provide you with a context. Most enrollees are in plans
2 with coverage gaps. Under the standard benefit design, the
3 coverage gap starts once a beneficiary reaches the initial
4 coverage limit, which was \$2,400 in 2007 and ends when he or
5 she has reached the catastrophic limit. In 2007, that
6 occurred when a beneficiary incurred \$3,850 in out-of-pocket
7 spending. After reaching that point, beneficiaries' cost
8 sharing is greatly reduced.

9 In 2007, 8.3 million enrollees had spending high
10 enough to put them in coverage gap, but more than half
11 received the low-income subsidy. LIS beneficiaries aren't
12 affected by the coverage gap because the cost-sharing
13 subsidy effectively eliminates the gap for this population.
14 A much smaller number of people had spending above the
15 catastrophic limit, and the overwhelming majority were LIS
16 enrollees.

17 One of the goals of the focus groups is to learn
18 about the experiences of individuals who hit the coverage
19 gap and to understand how the benefit structure is affecting
20 those with high spending.

21 And with that, I am going to turn it over to Joan,
22 who will talk about the findings from the focus group.

1 DR. SOKOLOVSKY: Well, as many of you probably
2 know at this point, every year, we conduct focus groups in
3 different parts of the country with beneficiaries and
4 physicians and sometimes other providers to hear from them
5 directly about their recent experiences with the program.
6 This summer, we conducted 12 beneficiary groups in
7 Baltimore, Chicago, and Seattle, working with researchers
8 from NORC at the University of Chicago and Georgetown
9 University.

10 Although focus groups cannot have the precision or
11 comprehensiveness of the quantitative findings that Shinobu
12 presented to you, they enable us to gain more real-time
13 knowledge of how the benefit is working. They also
14 supplement our knowledge by providing information on how
15 beneficiaries are using, or in some cases not using, the
16 benefit. We wanted to hear from beneficiaries about how
17 Part D was working for them. The goal was, again, to
18 supplement the knowledge we have gained through PDE analysis
19 with beneficiaries' discussions of how they used the drug
20 benefit.

21 This year, we had six groups of participants who
22 are receiving the LIS subsidy. One focus was to see how

1 these beneficiaries who had to switch plans, some of them,
2 when their original plan's premium no longer qualified for a
3 no-premium LIS participant. We wanted to see if switching
4 plans affected their ability to get their drugs.

5 We also had six groups of non-LIS beneficiaries
6 who had high drug use, and I want to really emphasize here,
7 we were not looking for beneficiaries with average drug use.
8 We specifically screened to see what beneficiaries who hit
9 the coverage gap were doing to continue to get their drugs.

10 The participants in our groups had diverse
11 backgrounds, and particularly among the LIS groups, many
12 were disabled.

13 Overall, we learned that the experiences of the
14 two groups were very different. I will be going over some
15 of the differences in the next few minutes, but the most
16 important difference is the one that Shinobu has already
17 mentioned to you. Those receiving LIS had no gap in their
18 drug coverage.

19 Let me start with the group of beneficiaries who
20 were receiving LIS. In general, many had limited
21 familiarity with the drug benefit. Although we asked many
22 different questions, both to screen people to participate in

1 the focus groups and once they arrived at the focus groups,
2 trying to identify beneficiaries who had to change plans
3 because their plan's premium was now above the low-income
4 threshold, we eventually discovered that for many of them,
5 this was just not a meaningful issue.

6 They had a hard time explaining their enrollment
7 status. For example, they might know that they were in a
8 plan sponsored by Company X, but they wouldn't know if they
9 were in that sponsor's stand-alone drug plan or Medicare
10 Advantage plan.

11 Many had medical and drug coverage that was really
12 stitched together from many programs, including Medicare,
13 Medicaid, a drug plan, sometimes a State pharmacy assistance
14 program, and frequently cards that entitled them for care at
15 a free clinic. To give you an example, one woman told us
16 that whenever she saw a provider, any provider, she gave the
17 receptionist her Medicare card, her Medicaid card, her plan
18 card, and her clinic card and left it to the receptionist to
19 choose which was the appropriate card for this particular
20 encounter.

21 In addition, some people told us they had medical
22 conditions, things that caused chronic pain or memory loss,

1 and that also made it hard for them to cope with plan
2 communications and respond to them in a timely manner.

3 A few beneficiaries did mention receiving a letter
4 telling them that they had to switch plans if they wanted to
5 continue to pay no Part D premium. Most seemed to accept
6 the switch without looking at alternatives, although we did
7 have one beneficiary who said she called the number that was
8 on the letter she received and got a lot of help finding a
9 new plan.

10 A few beneficiaries reported that they were paying
11 Part D premiums, although based on their copays, they seemed
12 to be receiving LIS.

13 Remember, if someone chooses a plan once, CMS will
14 not automatically switch them, even if their plan's premium
15 goes above the LIS benchmark, and we simply couldn't tell if
16 these beneficiaries knew they had a choice and could get a
17 plan without a premium.

18 Since your mailing materials went out, CMS has
19 announced that they are going to start mailing these people
20 letters, telling them that they do have a choice and telling
21 them, I believe, the plans in their region that are
22 available to them with no premium.

1 Now, more people reported switching plans because
2 of contacts with plans. Some of you may remember back to
3 2007 when we reported to you about marketing abuses that
4 targeted the LIS population. We saw more of that this year,
5 particularly for those people who lived in senior housing.
6 An agent, we were told, would knock at the door and say that
7 Medicare sent them. They would try to convince the
8 beneficiary to change plans, sometimes successfully. Only
9 later would the beneficiary discover that her physicians did
10 not accept this particular plan.

11 Most beneficiaries reported no problems getting
12 their medication after switching plans. A few of them
13 talked about delays, sometimes not as a result of switching
14 plans, but because the plan they were in had changed their
15 formulary or because the particular drug they needed
16 required prior authorization. In many cases -- in most
17 cases, the problem was resolved to the beneficiary's
18 satisfaction. One person did tell us that she considered
19 going to a hospital emergency response and getting admitted
20 to the hospital so that she could get her medication, but,
21 in fact, her problem was resolved before she resorted to
22 this strategy.

1 Now, I want to switch gears and talk to you about
2 the beneficiaries that weren't receiving LIS who had high
3 drug utilization. Non-LIS beneficiaries with high drug use
4 reported a very different experience. Most had come to know
5 how the benefit worked very clearly. They knew when they
6 could expect to hit the coverage gap and they were very
7 conscious of costs and felt cost pressure when they knew
8 they were going to go into the gap.

9 In contrast, I should mention that only one LIS
10 beneficiary mentioned drug costs as a problem.

11 Of focus group participants who hit the coverage
12 gap, almost none of them continued to take drugs in the
13 coverage gap in the same way that they had been taking it
14 before they hit it. Every group discussed different
15 strategies in terms of how they coped, and in every group,
16 there were some people who were actually taking notes on
17 ideas that other focus group participants had.

18 A few of the most common strategies that we heard
19 were asking their physician for samples, switching to
20 generic drugs, and sometimes, if there was no generic for
21 the drug they needed, asking their physician if there was a
22 similar drug available that did have a generic that they

1 could switch to.

2 Some of the other strategies that we heard of upon
3 occasion were getting a prescription for a drug that was
4 twice the recommended dosage and splitting the pill, or just
5 splitting the pills that they had so they would go twice as
6 long, taking pills every other day for the same reason, or
7 stopping some drugs. Some people talked about buying drugs
8 from Canada. Other people, and we heard this more than
9 once, the idea was that you would buy your generic drugs
10 from Wal-Mart or some other discount store and not use your
11 insurance card, and here the idea was that if the plan
12 didn't know the cost of the drug, it would hold them off the
13 gap for a little while.

14 Some strategies were done in collaboration with
15 their physicians, but in other cases, they never told their
16 physician, for example, that they had stopped taking some of
17 the drugs.

18 One thing I did notice compared to previous years
19 when we have asked similar questions was that -- and this is
20 just my impression -- it seemed to me that more
21 beneficiaries were telling their physicians, I just can't
22 afford the cost of the drugs. Is there anything we can do

1 to lower the costs?

2 Only one of our participants ever reached the
3 catastrophic phase of the benefit, and she was the only one
4 who expected to reach it this year.

5 Well, we have covered a huge amount of territory
6 in this presentation, so I would just like to summarize a
7 little bit. Beneficiaries with higher annual drug spending
8 are more likely to be disabled and receive LIS. The generic
9 dispensing rate for LIS enrollees is lower than for non-LIS
10 enrollees, and non-LIS enrollees are less likely to have
11 spending that is high enough to reach the coverage gap or
12 the catastrophic phase of the benefit.

13 Most non-LIS participants with high spending
14 reported using multiple strategies for dealing with the
15 coverage gap. LIS focus group participants reported more
16 unsolicited contacts with insurance agents than non-LIS
17 participants.

18 We will continue to talk to beneficiaries about
19 their experiences with the program, and one of the things we
20 would welcome is your suggestion for additional topics to
21 talk about.

22 We are also continuing our data analysis,

1 comparing the LIS and non-LIS experience. One thing that we
2 might look into further is to understand the difference in
3 generic dispensing rates, the role that health status,
4 different cost sharing, and different plan management
5 techniques play.

6 Another focus is to focus on the experience of
7 beneficiaries who switch plans. For example, how does
8 switching plans affect their adherence to drugs?

9 We would like your guidance on future directions
10 to take this research, and with that, I will turn it over to
11 you.

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

13 Let's see the hands for people who have round one
14 clarifying questions. We will start over here.

15 MR. BERTKO: For Shinobu, the comparison on the
16 generics you have perhaps isn't too useful because it
17 reflects a different mix of drugs. Is it possible for you
18 to go through the data and pull out the drug classes that
19 only have generic equivalents and then have that comparison,
20 which would be perhaps a little bit more useful in
21 determining strategies and such?

22 MS. SUZUKI: I think that's the direction that we

1 could go if the Commission is interested.

2 MR. BERTKO: I would say this certainly was
3 something that we looked at at a regular basis as a Part D
4 plan, because otherwise you don't know exactly what -- and
5 it shouldn't be overly difficult with the information and
6 the PDE.

7 DR. DEAN: This is very interesting and somewhat
8 troubling. I was concerned, too, about the generic
9 prescribing rate and it seemed like in some of those
10 categories -- I understand the antipsychotics and the
11 antivirals. There, it is a very confusing situation. But
12 certainly the anti-hyperlipidemic drugs and the peptic ulcer
13 drugs and the anti-hypertensive drugs, there is a wide range
14 of generics available there. And I wonder, do these
15 programs have any criteria that say you need to try a
16 generic first? I mean, some insurance companies certainly
17 do that.

18 MS. SUZUKI: So, yes, that is another area I think
19 we could investigate further, to see if it is the plan
20 benefit -- the formulary design that is affecting the
21 generic dispensing rate.

22 MR. BUTLER: On Slide 5, at the risk of

1 oversimplifying here, but wee if I understand this right.
2 Total spending per enrollee per month, \$300 versus \$156. If
3 you were to say the health status of these enrollees, LIS
4 and non-LIS, are the same --

5 MR. BERTKO: [Off microphone.] They are not.

6 MR. BUTLER: I am just saying, if you were to say
7 they were the same, which you say they are not, and you were
8 to move up to the \$32.9 billion spent on the LIS, if it had
9 been at the same rate, it is like half the spending that
10 would currently -- it is, like, a \$16 billion difference, is
11 that right?

12 So if you were to say that the 156 were the
13 spending rate that LIS was incurring, not just the non-LIS,
14 you would have, like, \$16 billion less spending than you
15 currently do. Granted, there is a huge qualifier in this,
16 the health status of the -- it just kind of points out
17 understanding that dimension, I think.

18 And if I understand it right, the price per
19 prescription is a bigger explanatory variable than the
20 number of prescriptions, but each contribute to that
21 difference.

22 MS. SUZUKI: Mm-hmm.

1 MR. BUTLER: Okay.

2 DR. MILSTEIN: Does MedPAC have available tools in
3 evaluating per capita drug spending to so-called illness
4 adjust so we have a sense, given how sick the population is,
5 given the distribution, do we have a tool that would allow
6 us to essentially -- I have two questions. That is question
7 one. Do we have a tool that would allow us to evaluate per
8 capita spending on a risk-adjusted, i.e., adjusted for
9 illness mix and severity?

10 MS. SUZUKI: We do have Part D risk scores and
11 also medical, sort of chronic condition warehouse-type
12 indicators for conditions. It is possible to look at claims
13 information, although that would be a more complicated thing
14 to do.

15 DR. MILSTEIN: My second -- in terms of following
16 on on John's line of thinking --

17 MR. BERTKO: But can I add to that, just reminding
18 everybody that the risk adjustment that Shinobu refers to is
19 the one that comes from A/B scores and doesn't reflect D.
20 So in some ways, as we heard last December, it is a bit
21 inadequate and outdated.

22 DR. MILSTEIN: I guess what I am asking is, do we

1 have a tool that is specifically designed to adjust per
2 capita RX spending for risk factors that would be likely to
3 affect RX spending as opposed to A/B spending? That is my
4 first question. We do or we don't?

5 MS. SUZUKI: I guess there is -- my understanding
6 is that RxHCC is really used for payment adjustment and it
7 is not intended to capture all the variations in spending
8 that may occur. So in that sense, if you are talking about
9 predicting the drug spending and use perfectly, that is --
10 RxHCC may not give you what you want. But at the same time,
11 it is something that is used for payment adjustment and it
12 is a proxy in some ways for medical -- or the diagnosis that
13 leads to higher drug spending.

14 DR. MILSTEIN: Am I correct that you did apply
15 that in these comparisons?

16 MS. SUZUKI: These numbers are not adjusted, but
17 the tables you have for review will have average risk scores
18 by different groups.

19 DR. MILSTEIN: Okay. That is my first question.

20 My second question is, again, is it pure -- is
21 that patients who are being treated at centers that treat
22 disproportional shares of low-income beneficiaries are

1 eligible for what is called 340(b), you know, advantaged
2 pricing. Do we have any way of -- does that apply if
3 someone has Medicare RX insurance, and if so, do we have a
4 way of reflecting it in our comparisons?

5 DR. SOKOLOVSKY: We certainly heard in our focus
6 groups that beneficiaries were, upon occasion, getting their
7 drugs from clearly what were 340(b) institutions. I do not
8 believe -- and this was, again, why it was so difficult for
9 them to say how much -- what was paying for their drugs. I
10 do not believe that if they were using their drug card, I
11 don't know that that would reflect the 340(b) price.

12 DR. MARK MILLER: Can I just follow up on that?
13 In the data that you have using the -- that you are
14 reporting out, if somebody went and got their drugs that
15 way, it wouldn't be reflected in that data. And if you need
16 to think on this, we can regroup offline and answer that.
17 But just to understand what is going on in the data, I had
18 that thought in my head, too.

19 MS. SUZUKI: I don't think that the 340(b) prices
20 would be reflected. It would be -- the data we have are
21 payments to pharmacies, and 340(b) prices are for entities,
22 very specific entities that qualify for that program, I

1 think, something like FQHCs or --

2 DR. MILSTEIN: I guess my question is, do any of
3 the entities that participate in the 340(b) program also
4 participate in the Part D drug program as dispensing
5 pharmacies, and if so -- you don't have to answer this on
6 the spot, it is for a future report -- and how might we
7 bring this into these comparisons and other analyses so that
8 we can hold that source of variation to the side.

9 DR. STUART: [Off microphone.] There is an answer
10 to this, and that is that to the extent that that
11 information is communicated to the health plan, then it can
12 be counted toward troop, but that wouldn't affect the LIS
13 side. It would be the non-LIS side. So that is how it
14 would have to come in. It would not be part of the PDE
15 data.

16 DR. CHERNEW: The question I -- I'm sorry. You
17 weren't answering --

18 MR. HACKBARTH: [Off microphone.] No. I just was
19 -- go ahead.

20 DR. CHERNEW: No. I was just going to ask -

21 MR. HACKBARTH: [Off microphone.]

22 DR. KANE: So on page seven of the paper, you talk

1 about -- well, actually, you mention it, too, that it is a
2 \$1 copay for both generic and preferred multiple sources for
3 the LIS people. What was the theory behind having that
4 copayment be the same, whereas it jumps up to \$2.15 for
5 nonpreferred? But why is the copay the same for generic and
6 preferred brand?

7 DR. SOKOLOVSKY: I don't know that we can
8 necessarily give the thought, except that many of the
9 preferred brands may not have a generic substitute and the
10 goal was to make the drugs affordable for the LIS
11 population.

12 DR. KANE: So what -- okay. The reason I am
13 asking that question is someone from a drug plan came up to
14 me and said that having them the same means a lot of people
15 are going for the brand rather than generic, and you could
16 just make it \$1.50 and you would make a huge difference. I
17 don't know -- that is just a totally unsubstantiated -

18 MR. BERTKO: I believe Joan's answer is exactly
19 right. It was a policy choice back when the law was
20 written.

21 DR. MARK MILLER: Just to draw this together, I
22 think what Shinobu and Joan were saying at the end of the

1 presentation is the patterns of these data suggest at least
2 three policy areas to look at. What are we doing with cost
3 sharing, even for the LIS population, and I am not saying we
4 are going to go in that direction, but that is the kind of
5 question. What are the plans doing and what tools are
6 available to them, because they also should have a stake in
7 focusing on it. And then the third thing is -- now I have
8 forgotten, but -

9 DR. SOKOLOVSKY: Health status.

10 DR. MARK MILLER: What was it?

11 DR. SOKOLOVSKY: Health status.

12 DR. MARK MILLER: Health status, that was it, this
13 line. [Off microphone.] I think those things -

14 MR. HACKBARTH: Bruce?

15 DR. STUART: I have an answer and then a question.
16 The answer is that these are due to differences in health
17 status. There is no question about that. And once you
18 control for that, you are going to find a lot greater
19 uniformity, at least in the utilization rates. Whether you
20 have the same uniformity in spending rates is another issue.

21 The question, however, is LIS is really a
22 collection of programs. It is not a single program. It

1 includes duals that have been around forever. It includes
2 people who -- most of the LIS population are people who came
3 in under the basic plan, but then there are levels above
4 that. And I am certainly not asking you to completely
5 disaggregate that, because I think that probably obfuscates
6 rather than helps.

7 But there is one thing that is really important
8 here, and that is that even in 2007 -- now, this was the
9 second year of the program -- the people that came in
10 through the dual auto-enrollment route, for the most part,
11 were long-time users. They know the system. Part D is a
12 little bit different, but not a whole lot different. There
13 wasn't as much change as people thought that there might be.
14 And so the patterns of utilization and patterns of spending
15 are going to be driven largely by that.

16 The newer LIS, the ones that came in for the first
17 time that were not Medicaid entitled and just were starting
18 up, whether it was in January of 2006 or whether they came
19 in in 2007, they were learning the system. And I can tell
20 you from earlier experience, looking at a brand new public
21 program in Pennsylvania, that the people who start on a new
22 program who didn't have coverage beforehand, it takes time

1 for them to get used to it. We found that it took almost
2 two years for people to get up to some kind of plateau in
3 terms of their utilization rates.

4 And so you might want to think about that in terms
5 of the comparisons. But at the very least, you want to
6 separate out the duals from the non-dual LIS.

7 DR. CHERNEW: I followed the questions along this
8 line, but I haven't yet gotten exactly the answer. What
9 actual data elements do you have? In particular, do you
10 know what Part D plan the person is in and do you know what
11 medical conditions they have from other claims data, or do
12 you only know what is in the Part D data? So could you
13 identify people with diabetes or people with heart disease,
14 or is that only possible through the medications they are
15 taking?

16 MS. SUZUKI: For this analysis, the data we looked
17 at are mainly Part D claims information. We do have other
18 files that are currently not linked to the Part D PDE data
19 that would have, say, if someone had diabetes in the past
20 year through medical claims.

21 DR. CHERNEW: And those are linked? You have
22 them, but they are not linked, but they are linkable?

1 MS. SUZUKI: Right.

2 DR. CHERNEW: And the Part D data you have does
3 have the plan that the person is in? You know that they are
4 in -

5 MS. SUZUKI: Yes.

6 DR. CHERNEW: Not just the company, like Humana,
7 but the -

8 MS. SUZUKI: The actual plan enrollment
9 information.

10 MS. HANSEN: Thank you. First of all, I just
11 appreciate that this is the first report of this level of
12 detail that we have had a chance to have.

13 My question is probably more on the focus groups,
14 and I know that the sample was such that these were high
15 users. Was there any representative sample on older
16 beneficiaries, because I see that the younger Medicare
17 beneficiaries, or the non-Medicare-aged beneficiaries -- the
18 young disabled who are represented. Was there some
19 representation of the older population?

20 And then a second quick question that just
21 triggered the question that Arnie asked about one set of
22 programs. But the out-of-pocket going to Wal-Mart

1 phenomenon is a newer phenomenon. I don't know that we
2 could capture any of that. Do you have any thought on it?

3 DR. SOKOLOVSKY: First, to your first question, in
4 terms of the older old, I would say that even for the over-
5 65 population, it was geared younger rather than older. I
6 don't think we could say -- it varies from year to year, but
7 my impression -- at some time, we will have it actually
8 collated, but my impression is that they geared younger this
9 time.

10 In terms of your second question -

11 MS. HANSEN: Could I just ask on the data set,
12 then, again, with that data set, is that able to be sorted
13 out by age, as well, across with comorbidity?

14 MS. SUZUKI: Yes. Again, so it is linkable to a
15 file that has chronic condition information.

16 DR. SOKOLOVSKY: Now I am blanking out on your
17 second question -- oh, the Wal-Mart issue. That won't be
18 captured in claims data. That is the very reason why they
19 are using it, so -- and that is one of the things that we
20 hope the focus group adds, because it is not in the claims,
21 but how much it is, we can't say.

22 DR. CASTELLANOS: Good job, Joan. One of the

1 things I really like about it is the focus groups, because
2 it gives you real world experiences. That is where I live.

3 You mentioned that you went to them and talked
4 about their experience with the drug program, but you also
5 mentioned you asked them about access to care. Now, I know
6 that is a little different than your main emphasis here, but
7 we have two really distinct groups of patients, and I was
8 wondering, if you don't have that, if you could get me that
9 information on their access to care. You mentioned you had
10 asked them that.

11 DR. SOKOLOVSKY: I didn't want to kind of scoop,
12 but we will have a full presentation on that issue later.

13 DR. CASTELLANOS: Thank you.

14 MR. GEORGE MILLER: Yes. On your Slide 3, dealing
15 with the 38 percent of Part D enrollees account for 82
16 percent of the total drug spend, were you able to break down
17 the characteristics of those 38 percent and why they spent
18 so much? Is it because they may have had a higher
19 concentration of high-end drugs, chemotherapy or HIV and
20 that type of thing, or do you know what the characteristics
21 are and why they had such a high spend?

22 MS. SUZUKI: So we haven't looked at the

1 characteristics of the drugs used by beneficiaries in each
2 band -

3 MR. GEORGE MILLER: Have not?

4 MS. SUZUKI: Right.

5 MR. GEORGE MILLER: Okay. Have not. Is that
6 something you may do in the future? Let me rephrase the
7 question. Would that give us information that we can use in
8 the future to determine why that large disparity in spend by
9 such a small population?

10 DR. SOKOLOVSKY: One of the things that we did
11 last year when we were looking at biologics -

12 MR. GEORGE MILLER: Right.

13 DR. SOKOLOVSKY: -- was to, in fact, look at LIS,
14 non-LIS -

15 MR. GEORGE MILLER: Right.

16 DR. SOKOLOVSKY: -- and those were, for example,
17 for MS, very highly skewed towards LIS.

18 MR. GEORGE MILLER: Okay. Okay. And just a quick
19 follow-up. Do you know what percentage of people reach the
20 catastrophic benefit? That is Slide 15, but it is just a
21 question. You said non-LIS would not reach the
22 catastrophic. Just overall, do you know what percentage

1 have reached the -

2 MS. SUZUKI: We had 2.3 million, and of those, the
3 majority, I think 1.9, were LIS. That leaves around -

4 MR. GEORGE MILLER: Just curious. Thank you.

5 MR. HACKBARTH: Karen, did you have -- okay.
6 Round two comments. Let me see. Let us start with Herb.

7 MR. KUHN: Thank you both for the presentation. I
8 guess my initial take-away here is we have got a real issue
9 of price sensitivity, particularly with the LIS community,
10 as we think about this.

11 On a go-forward basis, as we want to begin to
12 think potentially down the road about possible policy and
13 perhaps even targeting resources in that area, I think your
14 one notion that you already mentioned in terms of really
15 looking at plan design is important, particularly looking at
16 tiering and step therapy that might be part of those
17 particular plans will be very helpful to know about.

18 But the other part that would be helpful to hear,
19 as you kind of ticked off the various other research areas,
20 it would be nice to get more granular in the data to kind of
21 see where these individuals are. Are they
22 institutionalized, that is, are they in long-term care

1 facilities? So I think if they are in long-term care
2 facilities, that will give us a much better idea if we need
3 to target policies in those areas that could get results
4 that might be helpful in the program as we go forward.

5 And then, finally, what would be interesting to
6 see in the future in terms of additional data runs here, if
7 it is possible, is to kind of see if we have cost and
8 utilization variation across the country. I think there is
9 a hypothesis out there that we have kind of nationalized
10 costs in terms of drugs, and that would be interesting if we
11 could validate that as part of this process, too.

12 MR. BERTKO: Kind of a combination of observation
13 and further question. I think, kind of following on
14 George's question here, you may need to separate out the
15 disabled populations from the elderly population, because I
16 think there are really two different questions there,
17 elderly LIS versus non-LIS elderly, and then the disabled.
18 I think you have carefully told us several times that the
19 disableds are disabled because they are really sick for a
20 variety of reasons.

21 The second question or observation is for Joan on
22 the switch to generics end of it. The question would be, in

1 2007, were people doing coping behavior early on, that is,
2 did they switch to generics at the beginning of the year, or
3 did they switch to generics when they hit the coverage gap?
4 I think, in my mind, 2007, I am guessing, was still a
5 learning year about the coverage gap and that a look at 2008
6 data might be useful if you can put your hands on that, if
7 it is not too early for that.

8 DR. SOKOLOVSKY: To give you a very
9 impressionistic response, and that seems to be what I
10 specialize in anyway -

11 [Laughter.]

12 DR. SOKOLOVSKY: When we first did this, when the
13 drug benefit first started, we heard a lot of talk about
14 suspicion of generics from everybody we talked about, talked
15 to. The non-LIS population, and again, not average
16 beneficiaries. These are people with high drug utilization.
17 These people hit the coverage gap not just this year, but
18 mostly -- some of them were new, but most of them already
19 had this pattern and they had switched to generics, were
20 switching to generics, and in some cases, one woman was
21 talking about the generic giving her a rash but she was
22 going to stick to it at least until January because she just

1 couldn't afford it any other way. So even if they didn't
2 like the generics, they had switched, and mostly they
3 switched and said it was fine and I did not get the
4 impression they planned -- if it was working for them -- to
5 switch back.

6 I had a brilliant idea in our first -- in
7 Baltimore, I was still hearing a lot of suspicion about
8 generics among the LIS and I thought that was going to be a
9 neat theme that would go through, but it didn't hold up, so
10 I had to drop it.

11 DR. DEAN: Thank you. This is very interesting
12 stuff. First of all, I would comment on the fact that so
13 many of the people had difficulty identifying what plan they
14 were in and so forth. That is completely consistent with my
15 experience. I spent a large portion of my time trying to
16 figure out what drugs people are actually taking, even
17 though I was the one that prescribed them. It is a
18 challenge. These are confusing names. People are on four,
19 five, six, sometimes more. It is hard to keep track of it,
20 and I think it just testifies to the fact that these are
21 complicated regimens and we need to be -- and then when you
22 throw in three or four different sources that they might get

1 them from and different payers and so forth, it gets to be a
2 very complex undertaking.

3 Second of all is a question. Is there any data
4 out there about what happens clinically to people when they
5 hit the coverage gap? I know there was a study a while back
6 when some of the Medicaid programs cut back -- I think it
7 was on some of the antipsychotic drugs -- and they showed
8 there was clearly an increase in hospitalizations at that
9 point. Has that been looked at at all, do you know?

10 DR. SOKOLOVSKY: I imagine that there are people
11 out there right now trying to look at that, but I have not
12 seen the results.

13 DR. DEAN: I guess I would also mention, you
14 already answered this question for me, but I think it would
15 be important, and I understand you are already beginning to
16 do that, to look at the geographic breakdown of where these
17 people are, because I suspect, I don't know, but I suspect
18 there is a higher proportion of the LIS people in rural
19 communities, and secondly, that it leads to an ongoing
20 concern that I have had about access to pharmacy services in
21 rural communities because we are seeing a steady decline --
22 you have heard this complaint before, but we really are

1 seeing a steady decline of pharmacies in small communities,
2 especially small independent pharmacies, many of which are
3 the sole providers in their communities, and we are losing
4 them steadily and there is nobody going to take their place.

5 And so if that continues to happen, we are going
6 to have to find some other mechanism to provide access to
7 these services, because, for instance, if the pharmacy in my
8 community, which I think is stable for the moment, but they
9 keep telling me that it is a struggle, if they go out of
10 business or decide not to continue, the next closest
11 provider is about 50 miles away.

12 And Wal-Mart makes this even more complicated,
13 Wal-Mart, Walgreen's, whoever, with their \$4 policy, because
14 more and more we see people that for chronic drugs are
15 willing to do that to get their \$4 prescriptions, and yet
16 when they need something on an urgent basis, they need their
17 antibiotics, they expect the local pharmacy to be there.
18 Unfortunately, in all too many communities, that is not the
19 case right now, and I think the prospects are even more
20 worrisome for the future. I am not sure what the answer is,
21 but I think it is something we need to watch.

22 DR. MARK MILLER: We are obviously shocked to hear

1 you say this, Tom.

2 [Laughter.]

3 DR. MARK MILLER: Two things I would draw your
4 attention to. In the charts that we asked you guys to
5 review that give you some more detailed cuts on the data,
6 there is some breakout on pharmacy availability by
7 geographic area of the country and specifically trying to
8 look at this, so look at those, tell us what additional cuts
9 you want us to get into.

10 And, Joan, it is always awkward to have these
11 conversations in public, we are contemplating some work
12 here, correct?

13 DR. SOKOLOVSKY: We actually have a project
14 ongoing which I had told Tom about before the meeting -

15 DR. DEAN: [Off microphone.]

16 [Laughter.]

17 DR. SOKOLOVSKY: But as you see, it didn't work --
18 to look at, in fact, what is happening to access in rural
19 areas.

20 DR. DEAN: [Off microphone.] -- I think it is an
21 important topic.

22 DR. MARK MILLER: [Off microphone.] Well, I also

1 want to say that out loud -- out loud on the mike that we
2 are aware of this and there is going to be some stuff that
3 we are going to be able to bring forward on it.

4 MS. BEHROOZI: Just anecdotally, we had done focus
5 groups among our beneficiaries in our plan because we
6 noticed that among our home care workers, which is our
7 lowest-wage cohort, who can access generics for free and
8 preferred brands where there is no generic for free, and
9 otherwise they have to pay the full difference, which can be
10 quite a lot of money, not \$2, not \$15, it can be a lot more
11 than that, we noticed that too many of them seemed to be
12 paying that difference and we encountered a lot of distrust
13 of generics and it really broke down rather specifically
14 ethnically, I mean, like from certain islands in the
15 Caribbean, we found more suspicion. Anyway, so I don't know
16 if any of that is useful to you, but I am happy to share it
17 with you and see if you see any of it recurring in your
18 future work.

19 But one thing that I just wanted to draw attention
20 to, I think I sort of mentioned it earlier, where you
21 observed in the paper -- I am not sure it came out quite as
22 strongly in the presentation -- that people's confusion

1 about the premiums they were paying, not just what plan they
2 are on, but what they are paying and what they are paying
3 for and what is all included in the package kind of thing,
4 you observed that this would make it difficult for an
5 individual to shop for the most cost-effective plan choice,
6 and I just want to emphasize that and help us all remember
7 that as we are talking about people making choices and plan
8 designs being different and cost sharing being different.

9 In many cases, people are not really making
10 choices, and the fact that they might stay with a plan, I
11 think that is something that Rachel's research showed, that
12 a lot more people stayed with plans than you might have
13 anticipated. We shouldn't assume that there is too much
14 choice going on there, but rather they don't have to make a
15 choice. That is a better thing. So I think that is a
16 really important observation, and to the extent that future
17 work can kind of dig under that a little more, that would be
18 great if it could.

19 DR. MILSTEIN: Quickly, I guess this is a little
20 bit more round one than round two, but so much of what we
21 talk about is the beneficiary's involvement with choice,
22 whether it is picking supplemental health or benefit

1 redesign options or Part D coverage or the things we are
2 talking about here, and I have never quite gotten a good
3 handle on the percentage of beneficiaries that are
4 cognitively impaired and are in no position to exercise
5 choice and what their profile looks like. It is a little
6 bit like Herb's institutional status question to some extent
7 because those folks tend to be in those kinds of settings
8 more.

9 So do we have any sense -- and they are not in
10 their focus groups, either, because you can't pull them in,
11 yet they may be a pretty high explanatory variable of some
12 of the expenditures that are going on in Medicare. So do we
13 have any idea what the "N" might be for that population? I
14 know over-85 age is roughly 50 percent Alzheimer's, and we
15 hear statistics, but in terms of the beneficiary population
16 overall -

17 DR. SOKOLOVSKY: Honestly, we do have those
18 numbers and neither of us can recall them immediately. But
19 one of the very kind of anomalous things out in the research
20 now is when you look at people who are choosers, the highest
21 percentage of people who are choosing voluntarily are in
22 nursing homes, and we know they are not choosing, but those

1 count as the people who are choosers.

2 DR. MARK MILLER: [Off microphone.]

3 DR. CROSSON: For the record, he did make a choice
4 to turn his microphone on.

5 You know, it seems to me from the presentation
6 that we have at least a suspicion of two suboptimal
7 situations in these two populations, one in the LIS
8 population, perhaps less use of generics than would be
9 possible or appropriate, and in the non-LIS population,
10 suboptimal use of medications, at least on the part of some
11 individuals. And when you look at the benefit structures
12 that you listed out, the out-of-pocket costs, differentials,
13 it is pretty easy to see why that might be.

14 So it would seem to me that if we do further work,
15 and it sounds like there is a general consensus that we need
16 more data to be sure we know what we are talking about, for
17 example, if we are talking about the use of antiviral agents
18 between the two populations, do we have an equal
19 distribution of AIDS versus influenza or are we dealing with
20 AIDS in one group and influenza in the other group? So it
21 seems that we would need to know that.

22 And then, also, the question of when are we

1 talking about situations when generics are actually
2 available and when are we talking about situations when they
3 are not available? Something, we could sort that out, and
4 we still see this difference or these two suboptimal
5 situations persisting, then it seems to me that -- and I
6 would support us doing some work on looking at the
7 differential benefit designs and seeing whether there is
8 perhaps some relatively modest changes that could be made,
9 for example, to the LIS benefit that could result in some
10 substantial improvements in the use of generics.

11 DR. KANE: To follow up on that, I think there is
12 an aspect about copayments, for instance, that actually
13 influences the relationship between the manufacturer and the
14 plan in terms of the negotiation around the prices and
15 rebates, so even -- and this is just something, again,
16 following up on the rumor I heard that even a \$1.50 or \$1.75
17 copay on the multiple preferreds would encourage the
18 manufacturers, the drug manufacturers, to offer a better
19 price to the plans and the plans would care more about
20 asking that than when the copay is the same and therefore
21 there is no incentive to pick the generic.

22 So it would sound like a fairly complicated set of

1 decisions that got involved with this copay structure, and
2 perhaps one recommendation might be to get a focus group of
3 manufacturers and drug plan people together to sort of talk
4 about that, because I am just going from a one-person
5 conversation, but it did sound like it could be a meaningful
6 amount of money if that is, in fact, the way people are
7 actually behaving around the lack of a copay differential.

8 One minor thing. On the chart on page three, this
9 one, it would be much more useful to me if the income
10 breakdowns were based on where the coverage gaps started
11 than the catastrophic gaps started. I just -- so it is like
12 not quite corresponding, so you have got 61 percent under
13 2,000, but there are 67 percent who aren't under the
14 coverage. It would just help to have the income breakdowns
15 of where the coverage gaps occur so that you can sort of see
16 more clearly what proportion of the population is hitting
17 which part of the coverage.

18 And then the piece that I felt was -- we should
19 talk about whether we could do this, and I don't know if you
20 can or not, but it seems to me there is absolutely no
21 quality metrics yet here and that we should be thinking
22 about what might be doable with what we got. I have been

1 sort of the broken record about let's look at the drug
2 benefit, but one might be, you know, the number of enrollees
3 taking drugs that shouldn't be taken together. Is it
4 possible to start looking at that yet? I don't know.

5 Number of enrollees taking less than 12 months of
6 a prescription that they should be taking for 12 months if
7 that's the condition they've got, maybe hypertension and
8 hyperlipidemia, the kinds of things where they should be
9 taking 12 months and they are only taking six or eight.
10 Maybe even by condition for some important conditions to see
11 what kind of the distribution of prescriptions are and how
12 that might compare to, say, a VA person with the same
13 condition, where we know they are in a much more controlled,
14 integrated environment with quality standards and evidence-
15 based protocol.

16 Are there any kind of quality metrics that we can
17 start looking at and developing from what we have got now?
18 Even knowing how unlinked it is to some of the other data
19 files, that would be useful.

20 DR. SOKOLOVSKY: We have started looking into
21 quality issues. I should say that yesterday, I was at an
22 ARC research meeting specifically on pharmacy quality

1 metrics, and this is an ongoing, intensive effort, but they
2 are really not there yet. I mean, even measures of
3 adherence, the different quality groups measure them
4 different ways. So there is a limit to how quickly we can
5 go into that, but we are very interested in it and we have
6 been approaching it in different ways.

7 MS. SUZUKI: Can I respond to Nancy? One thing, I
8 just wanted to clarify, so this is gross drug spending, and
9 the breakdown is pretty arbitrary. One thing is that even
10 if you pick the standard benefit designs, dollar amounts for
11 different parts of the benefit, we wouldn't actually be
12 capturing the right number of people who hit the gap or who
13 went above the catastrophic because it's a true concept to
14 get the number of people who hit the gap or who hit the
15 catastrophic limits, so someone with supplemental coverage
16 that doesn't count toward the troop -

17 DR. KANE: That's okay, but I think just even
18 whether or not they even have to pay out through the gap,
19 how many people are hitting that dollar amount, whether or
20 not they are going to be responsible for paying would be
21 helpful. You have it in here as a number, 67 percent, but
22 it is just -- that is 61 percent. It is just like there is

1 a little bit of inconsistency from the data.

2 DR. STUART: Let me pick up on a number of strands
3 here. We have done a fair amount of work, actually, on LIS.
4 It is for 2006, not 2007, and there are caveats associated
5 with that. We looked at a group of people who have diabetes
6 and used adherence rates with medications typically
7 recommended for diabetes. Once we controlled for everything
8 that we thought we could control for, it turns out that the
9 LIS and non-LIS had virtually the same rates. We're not
10 exactly sure why, because there clearly are differences in
11 cost sharing, but just to share with you that that can be
12 done.

13 To get back to a point that Jay said about cost
14 sharing within LIS, actually, there is a natural experiment
15 by the way that the LIS system is set up so that if you are
16 in a nursing home, which is what Herb was talking about, you
17 face a copayment of zero. Everything is free. Whatever is
18 prescribed is free. And then it goes up gradually, up to \$5
19 for brand name drugs. Now, it is a narrow range, but you
20 can look at the eligibility criterion for which the person
21 has LIS and then you will know what their copayment is. And
22 if you control for other things, you should be able to gain

1 something from that comparison.

2 Picking up on a point that John raised about
3 disabled, one suggestion I have here, and it sounds like it
4 is a really technical one, but I wouldn't use the term
5 "disabled." I would really use the term "SSDI," "Social
6 Security Disability Insurance," and the reason that I say
7 that is that because you have such a high proportion of SSDI
8 enrollees who are in LIS -- in our diabetes study, 37
9 percent of all of our sample were under 65 -- but by the
10 same token, a large percentage of the remainder were former
11 SSDI. So it is not like they weren't disabled in a clinical
12 sense. They were clearly disabled. They just lost that
13 moniker because of the way administrative records for
14 Medicare are kept. And if you look at that group of people
15 who are older than 65 and were former SSDI, they look a lot
16 more like SSI than they do other aged, and so that gives you
17 some flavor of this.

18 And the final point, and this is a real
19 frustration for anybody that is going to do work in this
20 area, and that is that there is no mention here of whether
21 people are in PDPs or in MA-PDs. If you're just looking at
22 the drug side, you can compare MA-PD and you can compare

1 PDP. The problem is, on the PDP side, by definition, you
2 have the A and B claims, and by definition, on the MA-PD
3 side, you don't have the Part A and the Part D claims. So
4 at least contemporaneously, it is impossible to risk adjust
5 to make a comparison between MA-PD and PDP because you only
6 have the information necessary to do the RxHCC or whatever
7 risk adjustor you want to use because you simply don't have
8 information on which there are diagnoses, let alone
9 information to determine what their true risk is.

10 Now, there are ways of getting that information,
11 because there are historical files, as you know. The
12 Chronic Condition Warehouse actually has a file called the
13 Chronic Condition Summary File which maintains a list of
14 selected diagnoses -- and by the way, dementia and
15 Alzheimer's is one of them -- a list of diagnoses for the
16 first time that they show up in Medicare records. So if the
17 individual was old enough, was in Medicare, started out in
18 fee-for-service and then enrolled in an MA plan and stayed
19 in an MA plan, at least you would have that historical
20 indicator that they had Alzheimer's. The last time I
21 looked, if you have it, you always have it. And so for some
22 of these diseases, you will be able to identify cohorts of

1 former fee-for-service enrollees who are currently in MA
2 plans. But you have got to be really pretty careful about
3 those kinds of comparisons. But at least it is something
4 that you could do with these data.

5 DR. CHERNEW: Thanks. I just want to add my voice
6 to two points. The first one is I think it's absolutely
7 imperative to control for clinical condition. I think the
8 level of control even in the vast drug classes and disabled
9 or not is way too crude and I think it's very likely, in the
10 spirit of what Bruce said, that a lot of the things may go
11 away if you don't control, and that's crucial if one begins
12 to try and disentangle. It makes a big difference which of
13 the three things in your slides is really going on for what
14 one thinks one should do. So I think controlling for that
15 is absolutely imperative.

16 The second thing is, I understand that macro
17 measures of quality of care, if you are looking at plans,
18 are still under development in a whole number of ways, but
19 there is a vast literature which I think is pretty
20 replicable where you could find conditions where we think
21 people really should be adhering to these medications much
22 the way Nancy said, that this is a condition, someone has

1 hypertension or someone has hypercholesterolemia, because
2 you don't know -- when you see more or less use, you don't
3 know if that is good or bad, and the reason you don't know,
4 in part, is because it is both.

5 For some areas, when you see the low-income
6 subsidy people using more, you think, oh, that is horrible.
7 They aren't being charged anything. We need to charge them
8 more to get them to use care more efficiently because they
9 are doing this, that, or the other thing. In other cases,
10 if you see the low-income subsidy people are using more, you
11 think that is great because the cost sharing for the other
12 people is pushing them away from taking drugs that are
13 really high quality that we want to encourage.

14 And so I think it is really important to find
15 examples, of which I think is feasible, to be able to draw
16 some normative conclusion, because otherwise when we see the
17 discrepancy, we are apt to not know whether or not the low-
18 income subsidy people should be charged something to make
19 them more efficient or we need to close the donut hole for
20 the non-low-income subsidy people, both of which, I think --
21 and I hate to say this because it is such a pitch for my
22 work -- both of which things like value-based insurance

1 would try and balance as opposed to making us choose
2 something that is going to be bad in both one case or the
3 other.

4 MS. HANSEN: Thanks. Let's see. First of all, we
5 were talking earlier about, probably in our earlier
6 sessions, about making sure that we weave race and diversity
7 through different things, so I wonder if we could also
8 identify some of our data according to that.

9 Secondly, the question of our ability -- we have
10 talked about MTM in the past, too, and I don't know whether
11 it is a way or whether it would be too gross of a manner to
12 correspond the likelihood of using MTM relative to the data
13 that we have with this population, because when you have so
14 many people taking multiple meds, oftentimes, I know the
15 trigger is a gray trigger, because different plans have
16 different floors in which you use MTM. But any way to judge
17 the possibility of using MTM in this process?

18 DR. SOKOLOVSKY: What we learned last year was not
19 only do different plans define who can get MTM in very
20 different ways, but then what they provide is equally
21 different. And CMS is working on -- first, actually, for
22 the first time, saying in the data who is getting it, which

1 we don't have now, but beginning to have plans report that,
2 and they are beginning to look at what are the effects of
3 different interventions on people. When that happens, I
4 think it will be a really good tool, both in terms of
5 improvement and also in terms of research ability. But we
6 don't have that yet.

7 MS. HANSEN: Two final things. One is, of course,
8 that the last part of your findings is troubling relative to
9 marketing, you know, and how a lot of the -- some of the
10 people you have talked to in the focus group are approached
11 by salespeople to possibly switch and so forth. And this,
12 of course, goes back, as I think you mentioned, back to
13 2007, where there are some real concerns about marketing.
14 Is there any more work that can be done on that aspect to
15 basically create more light on this issue?

16 DR. SOKOLOVSKY: I believe that CMS and the IG are
17 working to kind of come up with standards that could be --
18 more enforcement, I should say. I mean, the standards are
19 already in place. What they are doing is illegal to begin
20 with. But I think they are working on ways to improve
21 enforcement.

22 MS. HANSEN: Okay. And then final, just a

1 shameless pitch, as Mike was saying. You know, we found --
2 in the course of the past few months, we have offered free
3 on our website at AARP.org a donut hole calculator that
4 people have been using, and individuals have given direct
5 testimony, with approval to say this, that within, like, a
6 couple of hours, that you could really figure out what drugs
7 you are, back it up into all the different plans, come up
8 with the generics, and then have automatic letters generated
9 to your physician. People have been saving several hundred
10 dollars just in the course of doing that one activity and
11 finding -- knowing much better how much time they save
12 themselves from falling into the donut hole. So this is
13 available. Especially that might be useful for the non-LIS
14 population that would fall into the donut hole.

15 DR. CASTELLANOS: Just two observations. Can you
16 do Slide 14, please? This is just an observation. This is
17 not just limited to the LIS and non-LIS population. This
18 occurs throughout every population, every age group
19 throughout the United States, these strategies that people
20 use for medications. And this is a real world problem.

21 I mean, you talked about Wal-Mart. We have Publix
22 in our community that give out free antibiotics, generic

1 antibiotics in the State of Florida. And I saw a colleague
2 out in the audience who is an ophthalmologist, and reminds
3 me I saw a patient the other day coming in and wearing his
4 wife's glasses. And I said, what the hell are you doing?
5 He says, well, mine are broken and I can't afford any
6 others. So, I mean, this is a real world problem of
7 financing for drugs.

8 But more seriously, and it is really a point that
9 Jennie just made about the unsolicited contacts, both in the
10 health plans, the insurance agent, and I think Peter and
11 Herb mentioned it in the nursing home. This is a real
12 problem. People are forced, or unsolicited or solicited,
13 perhaps they are not capable of understanding everything, to
14 go into other plans, and that has repercussions as far as
15 medications, reactions, loss of physicians, and losses of
16 ability to care.

17 I think, as you said, they are looking into it. I
18 hope it is a problem of enforcement, but maybe we just need
19 stronger rules, and I think we should look into that and see
20 how we can better protect this most vulnerable population.

21 MR. GEORGE MILLER: [Off microphone.] First,
22 Jennie and Ron covered my -

1 MR. HACKBARTH: I have got one summary thought,
2 and then I think Jay has some, as well.

3 During this conversation, as well as almost every
4 previous conversation we have had about Part D, we keep
5 coming back to the point that this portion of Medicare is
6 uniquely designed to depend on the choices of Medicare
7 beneficiaries to discipline the system, and yet every time
8 we look at it, you have got to come away wondering how valid
9 that premise is.

10 Joan, could you talk a little bit -- is there a
11 plan to address that issue systematically going forward?
12 This sort of statistical analysis is very helpful, but that
13 is sort of the big policy elephant that is always in the
14 Part D room. Can we, in fact, count on beneficiaries to
15 make the choices that will drive this system the way, in
16 theory, it is supposed to work?

17 DR. SOKOLOVSKY: I think, so far, what we have
18 seen is that you can't -- so far. We have also wondered as
19 that -- although premiums have been going up in dollar
20 terms, they haven't been going up that much. It could be
21 that people will be more sensitive when the differences are
22 greater. We don't know that going forward.

1 In terms of our agenda, I would be anxious to know
2 what you would like us to do on that issue. I don't think
3 it is on our agenda right now.

4 DR. MARK MILLER: No, I think that is about right.
5 In some ways, you almost get cross signals. You get -- you
6 know, when we look at Rachel's stuff, you see that the
7 premiums jump in significant terms and percentage, but not
8 in dollar, as Joan said, and not a lot of movement. But
9 then you go and you talk to the focus groups and the group
10 that falls into the donut hole suddenly becomes very price
11 sensitive and starts moving to generics. So you are really
12 getting cross signals, at least based on what I can discern,
13 and it is hard to tell at this point how it is going to play
14 out. So I completely agree with you.

15 And I think in terms of the research strategy, I
16 think there is sort of this -- and it is always a slow build
17 and people are never satisfied as we go, but first
18 understanding the D data and getting the right adjustment so
19 that we can focus in on patterns which lead us down the
20 road, linking in the A/B data and starting to sort of begin
21 to see how things work across the two programs. But the
22 notion of sort of testing -- and obviously many of the

1 things that Jennie has said about how you get the
2 information out for the beneficiary to choose and that type
3 of thing.

4 But as a specific agenda item on testing the
5 beneficiary's ability to kind of choose across plans, I
6 don't have a clear picture on how to approach that at the
7 moment, which is not a no, but at least I don't have it at
8 this point.

9 DR. SOKOLOVSKY: One thing I just want to add is
10 although the beneficiaries that were in the donut hole were
11 very price sensitive as far as drugs were concerned, we
12 didn't hear a whole lot talking about, maybe I should find a
13 different plan.

14 DR. CROSSON: Well, I just wanted to thank you,
15 Shinobu and Joan, for bringing this forward, because I
16 think, as you can see, there is a lot of interest here. My
17 sense is that we didn't elaborate at this point a particular
18 central issue that we wanted to debate further into round
19 three, but that there was a lot of interest in having you
20 come back and try to bring some more specifics to the
21 analysis, particularly in the area of the issue of generic -
22 - where we are talking about generic availability, the

1 disease status between the two groups, institutional status,
2 perhaps the question of MA-PD versus PDP plans, so that with
3 you can we bore a little further into this and try to figure
4 out whether we think there are substantial differences here
5 that would then suggest that we try to work on some
6 recommendations with respect to changing the -- or making
7 recommendations for changing the benefits design. So I
8 think if that seems to be the general consensus, that would
9 be my thought.

10 MR. HACKBARTH: Any concluding thoughts from
11 Commissioners before we move on to the next? Tom?

12 DR. DEAN: Just one comment on the generic
13 prescribing rate. My concern was not so much the difference
14 between the LIS and the non-LIS, it is how low those numbers
15 are across the board, because in some of these categories,
16 like especially the lipid-lowering drugs and the
17 antihypertensive drugs, in my view, those numbers ought to
18 be 90 percent in both categories. There really isn't a
19 difference between -- even though they have other
20 morbidities and other clinical conditions, especially in
21 those conditions, those shouldn't vary between the two.

22 MR. HACKBARTH: Okay. Thank you very much. Good

1 job.

2 Next, we turn to measuring regional variation -

3 MR. ZABINSKI: Okay. Today Jeff, David, and I are
4 going to discuss a topic that is of considerable variation
5 to policymakers, that being regional variation in service
6 use among Medicare beneficiaries.

7 Some key findings from our analysis include the
8 following: first, that regional variation in service use is
9 not equivalent to the variation in spending -- that is, the
10 variation in service use is less extreme. Also, not only
11 does service use vary by region, the rate of growth in
12 service use does as well. But there is very little
13 correlation between the regional level of service use and
14 the rate of growth. For example, we find high growth in
15 both the high-use and low-use regions. Therefore, policies
16 that aim to make Medicare more sustainable should constrain
17 both growth and variation in the service use levels.

18 Now, the first step in analyzing regional
19 variation in Medicare service use, we first examined how
20 Medicare per capita spending varies by region. In this
21 diagram, we collected urban beneficiaries in the
22 Metropolitan Statistical Areas, or MSAs, and the remaining

1 non-urban beneficiaries in the rest of state non-metro
2 areas. The spending in each MSA and non-metro area is then
3 weighted by the number of beneficiaries in each region.

4 To provide you with some orientation of this
5 diagram, consider the very middle bar marked by "95 to 104."
6 This bar indicates that about 23 percent of beneficiaries
7 are in MSAs that have spending that is within 5 percent of
8 the national average. The take-away point of this diagram
9 is that there is very wide dispersion in spending across the
10 MSAs. For example, per capita spending in the highest-cost
11 MSA is 107 percent higher than the lowest-cost MSA.

12 The next step in our analysis was to address the
13 spending in each MSA for regional differences in several
14 factors, including input prices, such as the hospital wage
15 index; beneficiary's health status as measured by risk score
16 or CMS HCC risk adjustment model, which uses diagnoses to
17 determine a beneficiary's expected cost. We also adjusted
18 for special payments to providers, including IME, DSH, and
19 GME payments that go to some hospitals; special payments
20 that go to some rural hospitals; and HPSA and PSA bonuses
21 that go to some physicians. Then, finally, we also adjusted
22 for differences in the rate of Part A and Part B enrollment

1 between regions.

2 The result of these adjustments is a measure of
3 service use that reflects regional differences in providers'
4 practice patterns and care decisions. We are interested in
5 this measure of service use because it lets you separate
6 areas where the practice of medicine is more resource-
7 intensive from those where it is less so. This allows
8 policymakers to focus on factors that can help control
9 program spending.

10 On this diagram, we show the distribution across
11 MSAs and non-metro areas of the spending that we showed two
12 slides ago and the service use that we discussed on the
13 previous slide. As you can see, there is less variation in
14 the service use measure than in the spending measure. For
15 example, if you look at the middle bar, 95 to 104, this
16 indicates that 41 percent of beneficiaries are in MSAs that
17 have service use that is within 5 percent of the national
18 average, but only 23 percent of beneficiaries are in MSAs
19 that have spending that is within 5 percent of the national
20 average.

21 A different way to think about this variation is
22 that under the service use measured, the MSA at the 90th

1 percentile is about 30 percent higher than at the 10th
2 percentile. But under the spending measure, the MSA at the
3 90th percentile is 55 percent higher than the MSA at the
4 10th percentile.

5 Two points we want to emphasize on this diagram
6 are that both urban and rural areas fall in both the high-
7 use part of the distribution and the low-use part. Also,
8 there is substantial variation that remains in the service
9 use measure; therefore, there is ample room to bring down
10 service use in high-use areas. However, the regional
11 differences are less dramatic than would be suggested by
12 simply looking at raw spending.

13 On this slide, we show the average level of
14 service use relative to the national average over 2004 to
15 2007 for seven MSAs in the first column of numbers. The
16 second column shows the MSAs' average annual growth in
17 service use relative to the national average from 2000 to
18 2006. The key take-away point from these first two rows or
19 columns is that MSAs with low relative service use can have
20 high relative growth rates, such as MSA-C; and MSAs with
21 high relative service use can have low relative growth
22 rates, such as MSA-F. Indeed, looking at all MSAs, we find

1 a negative correlation between beginning level of service
2 use and the rate of growth.

3 The final column of numbers in this diagram shows
4 the relative expected per capita increase, which is simply
5 the product of the level of the service use in the first
6 column and the annual growth rate in the second column.
7 This last column of numbers reflects the expected annual
8 increase in service use for each MSA. As you can see, some
9 high-use MSAs have lower expected increases than some low-
10 use MSAs. For example, once again MSA-C has low service
11 use, but high expected increase in spending, while MSA-F has
12 a high service use but a low expected increase. This result
13 suggests that to control future spending growth, we need to
14 address both the level of service use and the growth rate.

15 I'll turn things to Jeff, who will discuss some
16 unusual factors that affect service use in outlier regions
17 and also discuss the method and data issues that we ran
18 across.

19 DR. STENSLAND: All right. Dan just showed you a
20 graphic of the relative service use, and he emphasized
21 looking at the difference in service use from the 10th
22 percentile to the 90th percentile, and this was roughly a

1 30-percent difference in utilization, which is substantial.
2 He did not emphasize the extreme outliers.

3 In the lowest category of service use, there are
4 only Hawaii providers. In the highest category, there was
5 only Miami. Service use in Hawaii is under 75 percent of
6 the average, and Miami reported service use as over 135
7 percent of the average, and there is no other large MSA that
8 is close. I will just talk for a couple of minutes as to
9 why we focus on the 10th and the 90th percentile and not the
10 outliers.

11 The low rates of service use in Hawaii, which
12 include low use of hospitals, SNFs, home health, and
13 hospice, may reflect some characteristics unique to Hawaii
14 that result in low use of institutional care. In contrast,
15 reported service use in Miami was more than 10 percent
16 higher than any other large MSA, and the OIG, the Office of
17 the Inspector General, has raised concerns that some of this
18 high level of reported service use may be some abuse in the
19 system.

20 In the green bar, we show 2006 DME and home health
21 spending in Dade County, where Miami is located. Reported
22 spending was over 500 percent of the national average for

1 both services. Now, note that spending in Dade County is
2 also dramatically higher than in the three neighboring South
3 Florida counties, and this suggests there are differences
4 within South Florida, and there are probably great
5 differences among providers within Dade County.

6 The Office of the Inspector General is aware of
7 this high level of billing for DME and home health, so this
8 is nothing new. In December 2006, the OIG has a contractor
9 visit 1,472 South Florida DME providers. After the visits,
10 634, or 43 percent of those visited, had their billing
11 numbers revoked.

12 The point of showing this data on outliers is to
13 explain why we are focusing on the roughly 30 percent
14 difference between the 10th and the 90 percentile. That is
15 because the types of policy innovations we talk about --
16 improving care coordination or a movement toward evidence-
17 based medicine -- may help move that 90th percentile down
18 toward the 10th percentile. But the data we see in the two
19 outliers in the distribution of service use may be driven by
20 factors other than how care is delivered or organized.

21 Now, there are several methodological choices that
22 must be made when evaluating regional variation. For example,

1 we are looking at risk-adjusted spending for the aged and
2 disabled and allocating claims to regions based on where the
3 beneficiary lives. Other researchers may choose some
4 different methodologies.

5 The data we use is Medicare claims that have been
6 aggregated to the county level by the CMS Office of the
7 Actuary. Because our data is at the county level, we need a
8 county-level risk adjuster; therefore, we use the average
9 HCC score in the county, which is what CMS uses to predict
10 the costliness of individual beneficiaries. There are
11 certainly other methods of risk-adjusting, and certainly the
12 different methods of risk-adjusting are open for debate. I
13 also want to stress that the results we have here are
14 preliminary, and there is always room for further
15 refinements.

16 One question that has been raised is whether the
17 regional variation for Medicare beneficiaries is consistent
18 with regional variation for the privately insured. In a
19 2008 article by Baker, Fisher, and Wennberg, they did find a
20 positive correlation between Medicare regional variation and
21 privately insured regional variation, and we have looked at
22 some of the data comparing GAO data on the privately insured

1 folks that are Federal employees and our own regional
2 variation data for Medicare, and we also see a moderate
3 positive correlation. And the general message is that there
4 does seem to be some factors, either common amongst the
5 beneficiaries or common amongst the provider systems, that
6 affect both the privately insured and the Medicare
7 beneficiaries. So, to some degree, you have these things
8 moving together, but they're not moving in perfect tandem.
9 The correlation is not particularly high.

10 So, in summary, there are just a few key points to
11 remember. First, service use varies less than variation in
12 raw spending, but substantial variation in service use
13 exists. And there are some high-use areas that have low
14 growth rates and some low-use areas that have high growth
15 rates. And while the methodological issues we discussed do
16 affect the magnitude of the regional variation, I think it
17 is important to note that there is a general agreement that
18 regional variation exists, and it is not fully explained by
19 prices or patient health. There is also a general agreement
20 across the studies that the rate of growth in Medicare
21 spending across the country is too high. So while there is
22 some difference on methodology, I don't want us to forget

1 the points where there is some general agreement.

2 Now it is open for discussion.

3 MR. HACKBARTH: Okay. Can I see hands for first
4 round clarifying questions? Ron and then Jennie.

5 DR. CASTELLANOS: If you could just tell me again,
6 I don't remember what the HCC CMS risk factors are. Could
7 you just enlighten me?

8 DR. ZABINSKI: Well, it's a risk-adjusted model.
9 It generally uses diagnoses from the previous years to
10 predict current year expenditures. It also includes some
11 demographic variables such as age, sex, Medicaid status, and
12 a few other things.

13 DR. CASTELLANOS: Does it include socioeconomic,
14 body weight, body mass?

15 DR. ZABINSKI: No.

16 MS. HANSEN: On Slide 4 and in the text, I was
17 just -- adjust for spending differences, the last little
18 bullet says Part A and Part B enrollment. Apparently,
19 according to the text that we have here, sometimes in
20 different parts of the regions the Part A or Part B coverage
21 differs significantly from the national average. Could you
22 just explain what may lead to that, these major differences?

1 DR. ZABINSKI: Well, let's see. I think part of
2 it might be due to immigration rates, people who, say, just
3 immigrated and weren't paying Part A, you know, the payroll
4 taxes, throughout their working lives. They immigrate here
5 and, you know, then they become Part A only. Part B.

6 DR. BERENSON: Have you had a chance to look in
7 your research at how your methodologically altered prices,
8 essentially service use variation, compares to the Dartmouth
9 Atlas geographic areas? You said that there are some high
10 service use rural areas, et cetera. I assume there are some
11 variations. Have you looked at it?

12 DR. STENSLAND: We haven't done a formal analysis,
13 but essentially what you're going to see that happens is
14 once you adjust for prices, the coasts don't look as high as
15 they do before you adjust for prices. So there are going to
16 be places out in California along the coast that have very
17 high wages, and maybe if you just look at the raw spending
18 numbers, it's going to look very high. But once you adjust
19 for prices, they're not getting a lot of units of service.
20 And so that will be some difference that would show up.

21 DR. BERENSON: But does Dartmouth do as good a
22 risk adjuster as the HCC?

1 DR. STENSLAND: I don't think we can opine on
2 what's the best risk adjust --

3 DR. BERENSON: Well, all right. But I mean --

4 DR. STENSLAND: There's lots of different
5 Dartmouth analyses out there now. It's hard to -- you mean
6 just on the raw one where they just do age, race, sex,
7 that's one the website? That's one.

8 DR. BERENSON: That's the one that most people are
9 looking at, I believe.

10 DR. ZABINSKI: You know, at times they use the --
11 you know, to control for health status, they use people in
12 the last 6 months of life, that sort of thing.

13 DR. BERENSON: Okay.

14 DR. MARK MILLER: Jeff made a point when he was
15 saying this, that certainly the risk adjustment
16 methodologies were open to discussion, or something along
17 those lines, and this links back to something that Bruce
18 said earlier, which is when you look across the country, the
19 HCC will in part be driven by -- is driven by diagnosis, and
20 that may be driven in part by how frequently coding occurs
21 for a diagnosis. We're trying to look at that right now.

22 DR. STUART: Well, there was one other thing, too,

1 and this may be just completely off the wall. Will local
2 intermediary differences, coverage differences, have an
3 effect here?

4 MR. GLASS: To the extent that this comes from
5 claims data, I suppose that is possible. But I'm not sure
6 how we would ever detect that.

7 MR. BERTKO: But, David, don't the MACs all
8 process claims in virtually the same way? I know there are
9 separate things in some relatively minor areas, but they
10 process a cardiac claim the same way every place, I think.

11 MR. GLASS: I would think so. I mean, there are
12 local coverage decisions, but I mean, other than that.

13 DR. CROSSON: I just want to continue the pattern
14 recognition MedPAC Rorschach test that Bob started. You
15 know, in addition to the pattern change that you saw when
16 you adjusted where you created service use patterns versus
17 actual costs, when you look at the different patterns
18 between absolute service use and growth rate, is there any
19 obvious pattern that jumps out, or does it appear to be just
20 a random scattershot?

21 DR. ZABINSKI: Let's see. One pattern I notice is
22 for some reason the Bay area, central California -

1 DR. CROSSON: Just for coincidence.

2 DR. ZABINSKI: No, seriously. This is the first -
3 - I didn't even think of you being from the Bay area.

4 [Laughter.]

5 DR. ZABINSKI: But, you know, central California,
6 not just the Bay area but even central California, like
7 Stockton and so forth, they started out with their spending,
8 they were sort of lower than average, and they moved down to
9 fairly low levels on service use. That was one that sort of
10 struck me, but I don't know. It largely --

11 DR. CROSSON: well, not to step into it, but what
12 about when you look at growth rate. What I'm saying, is
13 there anything that sort of jumps out at you when you say
14 here is the pattern we see with absolute spending, now here
15 is the map of the United States when we look at growth rate.
16 You said that they're not superimposable, but is there
17 anything obvious from the two different patterns? Or does
18 it just appear to be --

19 DR. STENSLAND: There's nothing dramatic, but
20 there is a negative correlation. So for the ones that are
21 lower, you generally see a little higher growth rate. And
22 it's not always the case, but there is a little bit of a

1 negative correlation there?

2 DR. CHERNEW: Can I say something [off
3 microphone]? Because we actually have a paper on exactly
4 this point that is under review. If you look at the map,
5 you'll see regions that are -- it's not really completely
6 random. You'll see regions that move one way or another.
7 But there are very few variables that predict one -- income,
8 for example, is a variable that predicts higher spending and
9 higher growth, but there are very few variables like that,
10 including if you look at a whole bunch of health status
11 variables like obesity rates from the BRFSS or other things.
12 It's remarkably hard to find variables that look like they
13 predict both and find a really meaningful pattern.

14 DR. CROSSON: Excuse me, but what I was hearing, I
15 thought what I was hearing in Dan saying was that maybe what
16 we're dealing with is a negative correlation which suggests
17 something like reversion to the mean. Is that --

18 DR. CHERNEW: Yes, but it is much -- there is some
19 of that, but it's not a huge -- if you look and say, oh,
20 you're high, you're going to be low, you'll find some that
21 are high and grow faster and others that are --

22 DR. MARK MILLER: To put that a little bit

1 differently, I don't want to overstate that negative
2 correlation. That's a relatively small value.

3 DR. CHERNEW: Right

4 DR. MARK MILLER: I think it's important because
5 people's intuition might be, oh, high and growing fast.
6 That intuition is not necessarily correct, but I don't want
7 to make this strong statement or people to walk away with a
8 strong statement that these are opposite trends.

9 DR. CHERNEW: And most of the cities that you see
10 that look good if you listen to the news in terms of levels
11 are cities that don't look good if you look in terms of
12 growth rate. If you were listen to the news, people say,
13 "Oh, this is a great place," at least in the data we have,
14 we looked at the ones we saw in the press, and we didn't see
15 them looking good.

16 DR. STUART: You mean Lake Wobegon is not --

17 DR. CHERNEW: That's what we found.

18 DR. MILSTEIN: Just to help move things along, I
19 have prepared three short-answer questions.

20 First, is it feasible to adjust these for
21 incidence of Med Sup since we know that's such a powerful
22 driver of service use? Is there even a way of doing that?

1 That's the first question.

2 MR. GLASS: I think Med Sup, basically the
3 knowledge of it comes from the Medicare beneficiary survey.
4 Is that correct, Dan?

5 DR. ZABINSKI: Yeah.

6 MR. GLASS: Yeah, and that doesn't do so well for
7 small areas.

8 DR. MILSTEIN: Okay. Thank you.

9 The second question is: One of the statistics, I
10 think, you know, if you look at our transcripts, that really
11 sticks in our mind is this question of, you know, order of
12 magnitude, by how much would Medicare spending go down if
13 the average Medicare spending kind of emulated the spending
14 of the lowest spending decile? That was, you know, based on
15 something that was planted in a lot of our brains early on
16 because it was in a paper. And so have we had a chance to
17 model that yet so we can know -- because I know the prior
18 number was like 29 percent, and then more recently it has
19 been updated by the Dartmouth team to about 20 percent. Now
20 that you have applied these additional refinements, you
21 know, unit price neutralized, et cetera, what is the -- you
22 mentioned 90th versus 10th percentile. What if the median

1 moved to the lowest spending decile? What's the nature of
2 the -- by how much would Medicare spending go down? Do we
3 know that yet?

4 DR. MARK MILLER: We can do the arithmetic on
5 this.

6 DR. MILSTEIN: Okay.

7 DR. MARK MILLER: And, you know, come back to you
8 and talk to you about it. You know, one of the take-aways
9 from this is if you take raw data and adjust it at least for
10 these factors, you get half the variation, you know, from 55
11 to about 30, between the 90th and the 10th.

12 In answering that question, though, some of it
13 gets into one of the things that Jeff was trying to deal
14 with at the end of the conversation. We talk about the
15 extremes here. And is that a fair way to think about it?

16 And then, two, the reason that that particular
17 number -- and the arithmetic is doable. It just takes a
18 calculator. We can do it. But that statistic has gotten a
19 lot of cachet. What it actually means is what I find
20 difficult in sort of expressing the number. You know,
21 because what policy will get you to that point is the much
22 harder question.

1 So we can go through this exercise. We can
2 respond to this request. But I also want us to talk about
3 how that number gets used, because in some ways that number
4 has driven a lot of conversations. But how you capture that
5 I think is --

6 DR. MILSTEIN: I think the reason I bring it up is
7 it does at least give the Commissioners a sense of the
8 potential size of the opportunity. Then we can go on to the
9 second question. Is there a feasible policy to go after it?

10 The third question is, you know, I think one of
11 the things that was important to all of us in the prior
12 iterations of this that weren't this well adjusted was that
13 there appeared to be either no correlation or a positive
14 correlation between low spending and available quality
15 scores. And my question is simply: Do we intend, you know,
16 in the next version of this analysis to have examined that?
17 Or are we not planning to do that?

18 DR. ZABINSKI: Well, you know, we looked at that
19 relationship the last time we did this, and we looked at the
20 June 2003 report. But as far as -- you know, at that point
21 in time, there was a readily usable quality measure at the
22 geographic units we were using, and right now we're not

1 aware of one that really exists that has been updated. So I
2 don't think it was really part of our plan.

3 DR. MARK MILLER: [Off microphone] she's not
4 speaking to me anymore, but, you know, I think we need to
5 have a hard conversation -- I mean, what Dan is saying is we
6 need to have a hard conversation about what the measure is,
7 and we were not comfortable at this point sort of throwing
8 one up and putting it out -- at this point, anyway.

9 MR. BUTLER: I'm trying to get to the sound bite
10 that is a little crisper or easier to say that the 10th to
11 the 90th has gone from 55 down to 30. What exactly is the
12 percentage of variation that can be explained by service use
13 versus non-service use? Do you simply take the difference
14 between the -- going from 55 down to 30? What would be the
15 -- can you answer that?

16 DR. ZABINSKI: Well, as any number -- I mean --

17 MR. BUTLER: Because I think that's what
18 ultimately gets reported. You won't get all these, well,
19 the difference between the 10th and the 90th is this and now
20 it's this. Somebody will interpret this quickly and say how
21 much variation is explained by service use versus other
22 factors.

1 DR. ZABINSKI: I would say there's a lot of ways
2 you can measure variation. If you want to go with straight
3 mathematics, standard deviation. Standard deviation goes
4 down by about 40 percent when we go from the raw spending
5 number down to the service use number.

6 MR. HACKBARTH: I'm confused by your question. So
7 this is a measure of the variation in service use.

8 MR. BUTLER: Right

9 MR. HACKBARTH: You're using the term explained by
10 service use.

11 MR. BUTLER: We're trying to adjust for the raw
12 spending, right? Do the variation in raw spending.

13 MR. HACKBARTH: Yeah.

14 MR. BUTLER: And say what is the explanation for
15 the variation in raw spending, and so when we adjust for
16 prices, when we adjust for some health status, when you
17 adjust for GME or DSH and IME, et cetera, you've eliminated
18 some of the variation in the raw spending.

19 MR. HACKBARTH: Right

20 MR. BUTLER: How much? What percentage of that
21 variation is, therefore, reduced by adjusting for these
22 factors?

1 MR. HACKBARTH: I see. So -

2 MR. BUTLER: Is there a single number? So that
3 you can say, you know, Dartmouth is saying this but it's
4 really only this?

5 MR. HACKBARTH: So what we've tried to do is
6 develop a measure of variation in service use.

7 MR. BUTLER: Right.

8 MR. HACKBARTH: As opposed to a measure of
9 variation in spending.

10 MR. BUTLER: I understand.

11 DR. MARK MILLER: The way I would try to have this
12 conversation, because there is this real desire throughout
13 to say, "Oh, then what does this mean relative to
14 Dartmouth." And I think part of the reason that they have -
15 - you know, they and I are going to have a hard time
16 explaining or speaking to that is they are -- whether, you
17 know, we're aware of it or not, there's multiple Dartmouth
18 analyses out there which adjust for different things. First
19 point.

20 The second point is if you want to make a
21 statement about the change in variation, probably the
22 closest we can get to it is Dan, which is saying using our

1 data before and after you adjust it, this is what we've
2 found. And we can have some degree -- well, we have
3 confidence in that statement, but I would not want people to
4 say, "Oh, so that's different than Dartmouth because that
5 may be running off of a different metric," if you see what
6 I'm saying. And so I want to be careful about the use --

7 MR. BUTLER: Right. That's what I'm trying to get
8 at, too, the messaging --

9 DR. MARK MILLER: I kind of thought you were.

10 MR. BUTLER: And, obviously, I'm not.

11 DR. MARK MILLER: And among our own data we can
12 say, you know, you reduce the variation, standard deviation
13 by 40 percent when you adjust for these three things. But
14 if someone were to go off and say, "Oh, and, therefore, that
15 means relative to Dartmouth," we would not have the
16 sentences to fill that in.

17 MR. BUTLER: Right.

18 DR. MARK MILLER: Because you may be looking at a
19 data set that's partially adjusted for some things but not
20 others.

21 MR. BUTLER: I'm happy to leave Dartmouth aside
22 and said we explain 40 percent by accounting for these

1 things.

2 DR. MARK MILLER: You guys all right with that?

3 MR. BUTLER: And if it is the 40 percent number --

4 DR. ZABINSKI: Yeah.

5 DR. MARK MILLER: That's what I thought.

6 MR. BUTLER: -- or whatever the number is, that

7 would help.

8 The other question is around the 10th and the
9 90th. I want to be a little clearer, because somebody said,
10 "Oh, that's just Dade County," or "That's just Miami," and
11 they're the only ones in the last 10th. Is that right?

12 DR. ZABINSKI: No.

13 MR. BUTLER: Because, by definition, you've got a
14 10th.

15 MR. BERTKO: [Off microphone] they're the
16 [inaudible]

17 MR. BUTLER: Exactly. So a little bit -- and this
18 is more of a comment than a concern -- is we throw this out
19 and say, "You see, this is why we exclude them." And the
20 rest of the world is going to say, "Wait a minute. I want
21 to know to the extent that that's occurring in the 10th to
22 90th percentile to some degree, as an explanation of what's

1 happening on service use." So by excluding them and saying
2 don't pay attention to them, you're almost inviting just the
3 opposite to occur.

4 DR. MARK MILLER: Would you say that again
5 [inaudible]?

6 MR. BUTLER: Okay. If this is the kind of stuff
7 that we're going to show and we're going to say leave out
8 Dade County because -- don't focus on them too much because
9 they've got this fraud and abuse issue, and \$5,000 of their
10 per capita spending is explained by these two things, so
11 it's not like everything else that is occurring in the rest
12 of the world. I think just the opposite may occur.

13 DR. MARK MILLER: Okay. The first thing I want to
14 -- I'm sorry this is taking so much time. The first thing I
15 want to make sure we're getting the message across -- and it
16 doesn't sound like we did, so I really want to use this as a
17 pivot point.

18 In a sense, what we're doing with the 10th and the
19 90th is trying to say let's be cautious in how we interpret
20 the degree of variation. But, you know, in Miami, we fully
21 think that part of what you see in Miami is the basic
22 variation in practice patterns that could be addressed by

1 some of the policies this Commission hopefully is trying to
2 push out onto the world. It was definitely not, "Oh, just
3 ignore Miami." What we're trying to say is there may be
4 additional factors beyond practice patterns that drive an
5 area even beyond what -- you know, out to the extreme, and
6 that fraud, bluntly, may be part of that story. And if that
7 message isn't coming across to you --

8 MR. BUTLER: I think we would like to think that
9 there is a lot of evidence-based medicine that is not being
10 practiced appropriately that could reduce variation in
11 service use as a Commission. This invites me -- because of
12 all those things I read, that thing just jumped at me. It
13 almost says -- and I'm going to go look at all the other
14 components of the service, like Gawande articulates, and see
15 if there's patterns of abuse or misuse based on economics as
16 opposed to just not applying good evidence-based medicine.

17 I don't know if I'm saying it well.

18 DR. STUART: But there is a mathematical anomaly
19 here that you guys probably have adjusted, and that is that
20 there are zeroes here. And, by definition, all of the
21 zeroes are going to be in the 10th percentile. And I can
22 tell you from some experience that zeroes tend to be

1 persistent. In other words, you've got people that are here
2 that are not using, and it may just be a statistical
3 artifact that some of the people that are in your analysis
4 are Medicare secondary payers, and, you know, they're
5 working elderly and they're in there on the eligibility
6 side, but they're not using any services.

7 So the 10th percentile I think actually may not be
8 what you want to use. Or, to put it another way, you might
9 want to exclude the zeroes and then recast it toward people
10 that are actually using the system, because it's pretty hard
11 to talk about whether the system is doing a good job or not
12 for people who are persistent non-users.

13 MR. HACKBARTH: I think we're confusing things
14 here. This is a distribution not of individual
15 expenditures. This is a distribution of MSAs.

16 DR. STENSLAND: It's MSAs weighted by the number
17 of people in MSAs.

18 MR. HACKBARTH: Right.

19 DR. STENSLAND: So there are no zeroes in that
20 chart.

21 MR. HACKBARTH: Right. [Off microphone] Any
22 clarifying questions?

1 DR. DEAN: You may have already answered this and
2 I missed it, but on Slide 6, could you repeat again how we
3 got to an expected rate of increase?

4 DR. ZABINSKI: It's just simply the product of the
5 numbers in the first two columns. So for MSA-A, it's the
6 0.73 times 1.09.

7 DR. MARK MILLER: Conceptually, what's going on,
8 Tom, is the way to think about that last column is this: If
9 I'm a high-level and a high-growth area, I'm contributing
10 more to growth in utilization than an area that is the exact
11 opposite -- low-level/low-growth. And then what we're
12 trying to illustrate with this chart is you can get the
13 combinations in between -- low-level/high-growth, high-
14 level/low-growth -- and how much they contribute will be a
15 product of those two things. And that's what that last
16 column is trying to capture.

17 DR. DEAN: Thank you.

18 MR. HACKBARTH: Other clarifying questions?

19 [No response.]

20 MR. HACKBARTH: Okay. Round two comments.

21 DR. BERENSON: Let me pick up on two things that
22 have said.

1 One, I very much -- well, it's what Peter was
2 talking about with his outliers. On the one hand, I take
3 his point that we don't want to just sort of eliminate the
4 outliers and say that's the IG's problem. In fact, I want
5 us to think that we are worrying about waste, fraud, and
6 abuse just as much as practice patterns or physician
7 behavior.

8 In fact, in an article I wrote in 2003, I had
9 McAllen, Texas, identified as -- in fact, they were spending
10 as much on home health in 1998 as Miami is spending in your
11 data here. And Atul's article, it was a terrific article,
12 but I've always thought this kind of data could be used as
13 much or maybe even initially for surveillance purposes of
14 what's going on other there.

15 Another example I'll use is I retrospectively --
16 remember the Reading, California, case of the surgeon who
17 was operating on healthy hearts? The 1998 Dartmouth Atlas
18 had Reading, California, three standard deviations away from
19 -- they were way out, and somebody could have been looking
20 at that, and I hope the IG is. But I think it's something
21 that CMS, if they had enough resources, should be actively
22 doing themselves. So that's point number one, but I do

1 agree that we need -- I'm not sure that 90 to 10 works as
2 well as some other metrics, 80 to 20 or reduction in the
3 median or something like that.

4 The second point I wanted to get to was the
5 discussion between Arnie and Mark, and your term was "size
6 of opportunity." I think even if we don't know what precise
7 policies will flow, I think it's important to sort of
8 establish that there still is significant spending variation
9 because it plays into the greater politics around whether
10 anything is going to take care away from Medicare
11 beneficiaries. I think if we have an ability to contribute
12 to the discussion or to the facts around how much spending
13 variation there is that doesn't affect outcomes -- and, you
14 know, this analysis doesn't do that. There's other work
15 that is -- you know, the Dartmouth work attempts to do that,
16 and some other work is attempting to do that. I think
17 there's a value to producing the data even if we're not
18 quite sure.

19 I frankly -- and I have been publicly with Jack
20 Hadley sort of saying that I don't think geography is a good
21 way to base policy. You have individual policies that
22 should result in a reduction in spending variation, but that

1 going after high-cost areas, unless it's fraud and abuse or
2 something like that, might not be the most productive way to
3 proceed. But I think there's a value to the whole sort of
4 enterprise to get this data out, and even if that's all we
5 show, that this supports what Dartmouth has been doing in
6 their careful research, but the magnitudes are not as great,
7 but they're still pretty significant, I think that would be
8 of service.

9 DR. KANE: I think if you go back to Slide 4, some
10 of this is just sort of -- maybe if we just change the way
11 we use the language to describe what we're doing rather than
12 saying adjust spending as though the adjustments excuse it,
13 just say which -- of the raw spending, how much of it is
14 explained by regional pricing health status.

15 For instance, I would not want to excuse the fact
16 that IME is, you know, used variably across the states.
17 Even in Massachusetts, for instance, we have a tendency to
18 way overuse teaching hospitals, and it has helped drive our
19 costs up, and I think that is a reason for our high
20 spending. And you wouldn't want to say, well, we're just
21 adjusting that out.

22 So I think rather than saying adjust spending, say

1 here's the categories that help explain, and then just
2 enumerate them and leave the value judgment out that there
3 might be some reason to excuse it as a way to present this.

4 Another thing, I think -- and I agree with Bob,
5 that calling this sort of a geographic variation maybe be
6 politically important -- or not -- but wouldn't it be more
7 useful to look at variation not geographically constrained
8 but just what's the variation out there by quartile and, you
9 know, cost practice? And then, you know -- I mean, yes,
10 they break down also geographically, but there's huge
11 variation in spending, and for different reasons, across the
12 country. And we can explain some of it, but then there's
13 still this huge variation, rather than kind of burying some
14 of the variability that's within the state.

15 Then finally, I think a lot of this would also be
16 more better packages with an analysis of the degree of cost
17 burden on the beneficiaries. As you see this variability,
18 if you're going to do this geographically, perhaps try to
19 come up with how much cost-sharing variability there is as
20 well, because spending, the way it's presented now, looks
21 like it's a good thing, because, you know, people are
22 getting federal dollars. But, actually, spending isn't a

1 good thing for the population necessarily, unless they're
2 dying because there's not enough spending. Spending is
3 expensive and people are cost-sharing right along with it.

4 So would it be helpful just packaging this with
5 some indication of the affordability of what's going on in
6 the high and the low -- if you want to stick with geography,
7 just say here's the cost-sharing implications of this level
8 of spending.

9 So I think we just need to kind of package this in
10 a way that a little more addresses the purpose to which
11 we're trying to get at, which is it's bad to have high
12 spending unless all the variation is due to quality
13 differences.

14 MR. HACKBARTH: I'm going to pick up on Nancy's
15 first point, and I agree, the way this is packaged, it's
16 very important. You can look at prices and health status
17 and special payments and characterize those as
18 justifications, as it were, for, you know, higher levels of
19 spending. I'd prefer to think about them not as
20 justifications but, rather, steps that you take if you're
21 trying to get to assessing differences in service use.

22 I think there are legitimate policy grounds on

1 which one might disagree with the existing IME indicia
2 adjustments, and I don't want this to be interpreted as, oh,
3 MedPAC thinks that that's all perfect, and that justifies,
4 you know, higher spending in Boston or New York or anyplace
5 else. I don't want that to be the message.

6 These are adjustments we make because our goal is
7 to identify how much use of service varies, and there's
8 plenty of room for legitimate policy debate about whether
9 these are appropriately done within the Medicare program.
10 It is a subtle difference, but I think it's a very important
11 difference in terms of our public message.

12 DR. MILSTEIN: First of all, I think this is
13 extremely high-value information that you're producing in
14 terms of congressional need and policy need. I'm very glad
15 that this is being pursued.

16 Secondly, this is a slight variation on what I
17 think Nancy just suggested, but to make this, I will call
18 it, "policy feasible," you can imagine a policy that might
19 work around this, you know, we know from SGR that group
20 punishment does not -- you know, it turns out to be not
21 policy feasible. And so, you know --

22 MR. HACKBARTH: [Off microphone.]

1 DR. MILSTEIN: Not effective. Yeah. And so my
2 feeling is, you know, within the limits of MedPAC's staff
3 resources, doing this analysis at the level of the hospital
4 and their associated medical staff, what it enables is for
5 there to be winners as well as loses, you know, within
6 metropolitan areas and, therefore, within congressional
7 districts. And I just think it's -- you know, we have to
8 think about policy feasibility, and, therefore, I think it
9 would be very useful to take these wonderful refinements
10 that you've demonstrated and apply it to a different unit of
11 analysis, which is the hospital and their affiliated medical
12 staffs.

13 MR. HACKBARTH: Along those lines, can you say
14 anything about the variation within MSAs, you know, even
15 just examples? Is that something that you've looked at?

16 DR. ZABINSKI: Yeah, we can do it. I haven't done
17 it in this case, but we can do it.

18 MR. GLASS: Remember, this is county-level data,
19 so that's the smallest unit of analysis that you can --

20 MR. HACKBARTH: Oh, right. So you're not building
21 it up from hospital -

22 MR. GLASS: We'd have to use a different data

1 source --

2 MR. HACKBARTH: Yeah, right.

3 MR. GLASS: -- to go out in that direction.

4 DR. MARK MILLER: Let me just thread a couple of
5 thoughts together, because that is exactly -- the first
6 thing I was going to say is this data set's smallest unit is
7 county, and so the variation might not be quite what you're
8 getting at. And there were a couple of statements about,
9 well, why not practice and -- and you and Arnie are really -
10 - tell me for sure, but you're speaking to HRR, that type of
11 thing. So we have interest in that, too. This data set
12 does not easily do that. We haven't given up, but this data
13 set does not easily do that. So I don't want to
14 overpromise. We do understand the objective, and we
15 understand why. And so that is not a "Hell, no," but this
16 data set is going to give us a little bit of fits to try and
17 do that.

18 Remember these thoughts and these statements for a
19 couple of other reasons. Number one, we went through
20 exercises a year, a year and a half ago, on trying to use
21 the episode data to look at practice patterns, and remember
22 many of the questions and statements that you made at that

1 time; two, that there were real questions and concerns about
2 some of that. And that's going to come up again tomorrow in
3 looking at those patterns, and that may inform some of these
4 things. But I do hear you on can we get below the MSA
5 level. We'll keep trying to dig on that.

6 MR. HACKBARTH: Having been reminded that these
7 are county-level data, my recollection is that I've seen
8 work that you've done that says take a state, a low-cost
9 state like Iowa, and look at the variation at the county
10 level within Iowa. And my recollection is that the
11 variation among Iowa counties is almost as large as the
12 national variation on this measure of service use. Is that
13 right?

14 DR. ZABINSKI: Yes, that's right.

15 MR. HACKBARTH: You know, I think that's a point -
16 - you know, it doesn't get all the way to the hospital
17 referral area, but it does remind people that there's
18 variation within the variation.

19 MR. BERTKO: So I'm going to repeat a couple of
20 things with some more push. First of all, this adds
21 additional support to many of our conclusions that variation
22 is still big and still a problem. And going from what Arnie

1 and Glenn and Mark were saying, to get to some attribution,
2 I think it would be useful down to the HRR or some other
3 kind of hospital level. And my suggestion just for
4 explanatory power is if you picked low, medium, and high and
5 the appropriate counties, in some places, like Ohio, where I
6 grew up, you have 88 counties, which almost focus on some
7 hospitals once you get outside of Cuyahoga County with
8 Cleveland and some others. But the attribution methods,
9 whether done, very bluntly, just by zip code or by a
10 Dartmouth-style algorithm, could be done with a lot more
11 work. So this is not to say do it now for this particular
12 report, but maybe put it in the hopper for future work.

13 I think the explanatory value of showing what
14 happens at those very high ones, whether they have huge
15 variation, and the low ones, do they have less variation, or
16 do they still have a lot of variation, would be very useful
17 to us. This is a fruitful area.

18 And, Bob, your comment about surveillance just
19 triggered my thought. This is what private plans, when
20 they're on the top of their game, do all the time. We got a
21 dashboard that showed about 2,000 or the 3,000 counties, and
22 my favorite story is watching human growth hormone pop up in

1 that same county that these guys found there because it was
2 three or four times the incidence, which was, you know,
3 fanatical. You know, we ought to be helping think about how
4 to use that, if for nothing else, we could save money.

5 DR. STENSLAND: Maybe I just want to put a little
6 bit of a damper on some of the optimism.

7 [Laughter.]

8 DR. STENSLAND: When we're looking at the counties
9 -- we did something similar when we did our ACO work last
10 year, and we were looking at these individual hospitals.
11 And when you get into small -- there are two sources of
12 random variation -- or variation. One is just random up and
13 down of these individuals. The other is maybe some
14 systematic differences in the way medicine is practiced.
15 And if we get down to too small of an area, like individual
16 counties, especially small rural counties where you only
17 have a few hundred people, a lot of the variation you're
18 going to see might be random variation, where they look low
19 one year, then the next year they look high.

20 And so we can try to move it down, but if we get
21 down -- you know, we have not done a formal power
22 calculation, but if we get down below, say, 5,000 people, if

1 we get down below that, we get a little nervous that we're
2 picking up ore random variation and not so much systematic
3 differences.

4 MR. BERTKO: Yeah, let me just suggest the Midwest
5 is filled with small counties and lots of eligibility, and
6 that might be a place to just look around. You know, it
7 wouldn't be systematic, but it would be perhaps
8 illustrative.

9 DR. CHERNEW: I think it's important as we go
10 through this chapter to keep in mind what we think the
11 purpose of it is, and sometimes I vary in my view.

12 My opinion in general is, given the current
13 controversy and policy importance of geographic variation
14 literature and the extent to which that literature has come
15 under attack, I think it's useful for an organization like
16 MedPAC to say something authoritative about that
17 utilization. And I think in that sense you've done a good
18 job.

19 I think you could expand it a little bit, because
20 there's a lot of work which doesn't use spending and try and
21 get utilization, but there's whole bodies of literature that
22 say for people with heart attack, do they get

1 revascularized? There's no price adjustment. There's no --
2 you know, there's just a lot of literature that could be at
3 least cited that demonstrates that if you go to different
4 places, practice patterns are different for different people
5 in the care that they get given the condition they have.
6 And it will make the point.

7 I think that it's useful to quantify it, to some
8 extent, but in all honesty, if it's 50-percent variation or
9 30-percent variation, we have to figure out what to do, and
10 we have to be very careful not to blur some possible
11 explanation as meaning that's how we have to act.

12 So if we found, for example, that a lot of it was
13 prices, that doesn't mean just cut rates in those areas,
14 because as I said before, making prices lower in a high-cost
15 area does not make the area look like a low-price area.
16 There's all kinds of system things that go in there.

17 I think that the chapter is strongest if it's
18 limited to making sort of the broader point, the broader
19 descriptive point that there's a lot of variation and we
20 have to go somewhere. And the further we try and use this
21 to motivate policy, the further we speculate beyond what the
22 data really justifies, I think the less credible and useful

1 the chapter begins. I just think, given where we are now,
2 it's useful to defend the point, which I think has come
3 under attack because of magnitudes, but not for the same --
4 so I think emphasizing your agreement slide is really key.

5 DR. BORMAN: Just a relatively quick comment and
6 it really actually builds to some degree on what Mike was
7 saying, I think. I don't want to put words in his mouth.

8 DR. CHERNEW: [Off microphone] I agree with you.

9 DR. BORMAN: But it would appear to me that what
10 I'm hearing is there's variation in variation. We can slice
11 and dice this in a variety of ways. It will be sensitive to
12 the variables that we pick, either on the input side or the
13 output side. There's a hugely important concept that there
14 is variation.

15 As Mike said, where we go beyond that I think is
16 really what we're hinging on, and I would agree with Mike
17 that it's very important that we establish -- and this very
18 elegant thing I think does establish -- that you can make
19 variation say a lot of things, but maybe we do need to be
20 content with there's variation. And instead of taking these
21 parts out as the things to act on, go back to -- you have
22 some of -- what I think Nick Walters said to us a whole

1 bunch of times, let's pick the high-volume, high-risk, high-
2 growth, whatever it is, features and use this about there's
3 variation for those things here and here and what practices
4 can we extract out that help us do better for everyone, find
5 the rising tide that raises all ships of care in this, as
6 opposed to get -- this has almost become our silver bullet -
7 - not necessarily MedPAC's silver bullet, but in a lot of
8 the conversation, this is the silver bullet that if we can
9 only unravel this, we have the answer.

10 You know, it is our national culture to want to
11 find the answer here, and even though we know there is not
12 the answer, we keep searching for the answer. And I think
13 to defuse this concept would be a good thing, and this
14 enables us to do that to some degree.

15 DR. CROSSON: Just one comment to underscore I
16 think what Nancy and Bob said earlier about packaging. This
17 is very good work, and it's very useful and it's very
18 timely. And the report I think is going to be well received
19 and probably fairly widely read.

20 But I think it would be a shame if one of the
21 conclusions that people drew from it was that somehow this
22 meant that there was a limit to what could be achieved down

1 the line in making care more appropriate and the like,
2 because I don't -- I mean, now I'm going to sound like
3 Arnie. Sorry.

4 [Laughter.]

5 DR. MILSTEIN: This is a good thing.

6 DR. CROSSON: Yeah. But, I mean, the assumption
7 in sort of taking the variation from the 10th to the 90th
8 percentile of whatever it was, 55 percent, and saying, well,
9 maybe we get half of that, maybe we could move the high
10 utilizers down to the median, that's just a thumbnail
11 notion. I mean, that's not determinative. It doesn't say
12 anything about whether over time, through some of the
13 changes to delivery system and incentives that we have
14 talked about we can move the whole curve down, right?

15 So I think we just need to make sure that we do
16 not -- that in writing it up, we actually counteract that
17 potential. Does that sound like you?

18 DR. MILSTEIN: [Off microphone] Absolutely.

19 MR. HACKBARTH: I want to pick up with what Karen
20 and Jay were saying, or at least what I think they were
21 saying. One way to look at this is this is an analytic
22 tool. It's useful to invest in trying to refine it in order

1 to provoke certain policy discussions. That's how I think
2 of this.

3 I've been a little bit uneasy as I've seen in the
4 health reform debate some people start to look at this as,
5 oh, this is the framework for a system of policy adjustments
6 that we're just going to wrench these things and line them
7 all up. It's maybe a subtle difference but I think a very
8 important one. I think the work we've done has been very
9 helpful on advancing this as an analytic tool for thinking
10 about policy. I think the step of trying to isolate
11 differences in service use as opposed to just total
12 expenditures raises an important set of questions. So great
13 work on that.

14 Our plan in raising this, our short-term plan in
15 raising this, was to get your reactions to it with an eye
16 towards, if you feel comfortable, producing a policy brief
17 in short order explaining the variation in service use as
18 opposed to this being something that we go back to time and
19 time again to develop a chapter for the March report or the
20 June report. So that was our intent in raising this.

21 Mark, do you want to pick up from there?

22 DR. MARK MILLER: Yeah, I guess so. That was the

1 intent. We did this because this is a subject of
2 conversation. We think that there has been some serious
3 misunderstandings in how to think about this. We can
4 certainly take this set of comments away and be more clear
5 and careful in how we lay these out, for example,
6 particularly the discussion surrounding this slide, as well
7 as other things that were said, and come out with something,
8 say, within a month. You know, we've laundered it, you've
9 reviewed it, that type of thing, and put it out for the
10 debate or for people to see. So that's a plan.

11 The alternative is is if you think, well, no,
12 there's adjustments and different ways to look at this and
13 qualifications, then we can go back to the boards. But I
14 think what Glenn was saying was that where we're headed was
15 trying to put something out in the short term to try and
16 bring some clarity.

17 MR. HACKBARTH: Reactions to that? Let me frame
18 it this way: Anybody have deep reservations about our
19 working towards a policy brief explaining variation in
20 service use within the next month or so? Comments, Bob?

21 DR. BERENSON: I'm all for that. I guess my
22 question would be whether we either comprehensively or at

1 least by example use some geographic areas and identify what
2 happens when you make these adjustments and how it changes,
3 because I do think there is a two -- I mean, there is a food
4 fight going on in Congress, and it's obviously that some
5 places on the east coast and the west coast, in particular,
6 have been fingered as high-cost areas. And to the extent
7 that this analysis would show that some of them are not what
8 one thought, I think it's useful to illustrate that.

9 I guess I'm saying I think our work is very much
10 in support of the basic Dartmouth research, but it differs
11 from some of the Dartmouth Atlas. And to the extent that
12 that is what's driving what's going on on the Hill, to the
13 extent we could be a little specific on that, I think it
14 would be helpful. And we're going to be asked, I assume, so
15 I think we should try to take charge, control over it.

16 MR. KUHN: I, too, agree that this is the right
17 way to go, and the sooner, actually, we can get this out the
18 better, to kind of deal with some of the hyperbole and all
19 the activity that's going on on this issue out there.

20 In terms of Bob's point, to the extent that we can
21 be as illustrative as possible is great, but let's not hold
22 up the process if that's going to take a lot of analytical

1 work. But the sooner the better.

2 MR. BUTLER: You caught my attention when you said
3 "variation in service use." I'm wondering whether you
4 shouldn't have a fundamentally different title to kind of
5 capture what we're saying rather than -- and maybe you're
6 suggesting this. Rather than say "regional variation in
7 service," it, in fact, becomes "variation in Medicare
8 utilization rates" or "Medicare utilization," or something
9 like that, then go right into the public discussion of
10 regional. But it might help kind of capture the themes that
11 you've been hearing.

12 DR. DEAN: I think this has probably already been
13 said, but I think in setting it up, I think it's important
14 to make the point that this is not a justification for the
15 high-cost areas. This looks at one aspect of utilization
16 patterns. It is important. But it doesn't say this
17 shouldn't let the high-cost areas off the hook and say,
18 "Okay, you're fine. You're doing great."

19 MR. HACKBARTH: Other comments?

20 [No response.]

21 MR. HACKBARTH: Okay. Thank you. Good work.

22 Let's see. Next, and our last session for today,

1 is a discussion of the MIPPA mandated report asking us for
2 advice on how to compare quality in Medicare Advantage and
3 among Medicare Advantage plans, on the one hand, versus
4 traditional Medicare on the other. For the audience, this
5 is a report that's due in March 2010. Carlos?

6 MR. ZARABOZO: Good afternoon. Today, I'll
7 provide an update on our work on the Congressionally
8 mandated report on quality comparisons in the Medicare
9 Advantage program and quality in Medicare Advantage as it
10 compares to the traditional Medicare fee-for-service
11 program.

12 This presentation summarizes work that John
13 Richardson and I are doing on this topic. Unfortunately,
14 John is at home sick. He is our principal quality expert at
15 MedPAC, so I can take this opportunity to say that any
16 errors or omissions are entirely John's.

17 [Laughter.]

18 MR. ZARABOZO: Section 168 of the Medicare
19 Improvements for Patients and Providers Act of 2008 requires
20 the Commission to submit a report to the Congress on how
21 performance and patient experience measures can be collected
22 and reported by the year 2011 so as to allow comparisons of

1 the quality of care between Medicare Advantage and fee-for-
2 service Medicare and among Medicare Advantage plans.

3 The statute specifically directs the Commission to
4 address technical issues, such as the implications of new
5 data requirements and benchmarking performance measures.
6 The report is to include any recommendations for legislative
7 or administrative changes that the Commission finds
8 appropriate.

9 Here is a list of the topics that we intend to
10 address in the report. They include a general discussion of
11 the priorities for quality measurement as they pertain to
12 the mandate; a discussion and analysis of the current
13 systems for measuring quality; and a discussion of key
14 issues arising from the mandate and issues of concern to the
15 Commission, most of which we have discussed in past meetings
16 dealing with the MIPPA mandate. As noted, the MIPPA mandate
17 specifically asks that we address data needs and the issue
18 of comparability for comparison purposes.

19 We also discussed the question of disparities in
20 health care as they relate to the evaluation of quality. In
21 addition, we plan to address the question of the resources
22 that CMS would need to undertake any changes in the matter

1 of ongoing stewardship of quality measurements. The report
2 would, of course, contain any legislative or administrative
3 recommendations the Commission would choose to make.

4 I want to pause here for a moment to mention that
5 on the question of disparities, there was a separate MIPPA
6 mandate to have the Secretary report on how to identify
7 disparities, how to report data on disparities, and
8 specifically mentioned HEDIS, for example, of wanting HEDIS
9 to be reported by race, ethnicity, and gender. So that is
10 being somewhat separately addressed.

11 In your mailing materials, we present one option
12 for defining the priorities of quality measurement in the
13 context of the mandate. Our goal in presenting this option
14 is to frame the key issues for your discussion purposes.

15 We suggest that current measures should be
16 improved and expanded and that there should be more outcomes
17 measures. As defined by the Institute of Medicine, outcome
18 measures reflect the end result of care, either from a
19 clinical perspective or a patient-centered perspective. In
20 contrast to process measures that often focus on a single
21 dimension of care for a specific condition, outcome measures
22 provide an integrated assessment of quality because they

1 reflect the results of multiple care processes provided by
2 all the health care workers involved in the patient's care.

3 As the National Quality Forum has stated, outcome
4 measures also focus attention on systems-level improvements,
5 because achieving the best patient outcomes often requires
6 carefully designed care processes, teamwork, and coordinated
7 action on the part of many providers.

8 Regarding the data issues, the National Committee
9 on Vital and Health Statistics report in 2004 suggested that
10 administrative claims and encounter transactions represent
11 an attractive short-term option for capturing additional
12 data elements that represent important health care processes
13 and/or health outcomes while we continue to pursue the
14 benefits of electronic health records and a robust National
15 Health Information Infrastructure.

16 Another issue that we discuss in today's
17 presentation has to do with the question of comparability
18 for comparison purposes, MA to MA and MA to fee-for-service.
19 Specifically, we discussed the issue of the correct
20 geographic unit for reporting purposes.

21 Several types of outcome measures are currently
22 being used as quality indicators, including mortality rates,

1 hospital admission or readmission rates, intermediate
2 clinical outcomes, such as control of blood glucose or blood
3 pressure levels, and patient-centered measures, such as the
4 Consumer Assessment of Health Care Providers and Systems, or
5 CAHPS, which is a set of surveys of plans and providers --
6 of people enrolled in plans and beneficiary views of their
7 providers.

8 In order to have comparisons on these measures
9 between Medicare Advantage and fee-for-service, we need
10 comparable data from each sector, both for determining what
11 care was provided and the outcomes from that care, as well
12 as data that allows for risk adjustment of the results to
13 ensure a fair comparison between the sectors.

14 In the case of CAHPS, we have such comparative
15 data because both MA enrollees and fee-for-service
16 beneficiaries are surveyed through CAHPS.

17 As for other data, some of the information needed
18 for evaluating outcomes is available from claims data and
19 fee-for-service, as those data are currently submitted.
20 However, the Commission previously recommended in 2005 that
21 fee-for-service Medicare should collect laboratory test
22 results to enhance the information in fee-for-service.

1 On the Medicare Advantage side, CMS does not
2 collect similar data from plans, but will do so through the
3 encounter data collection process that will begin in 2011.
4 To the extent that the encounter data are comparable to fee-
5 for-service claims data that includes lab values, the two
6 data sets from the two sectors can be used for risk-adjusted
7 quality comparisons.

8 We would also look to Health Information
9 Technology, or HIT, in the future, where we envision that an
10 aspect of the meaningful use requirements of the American
11 Recovery and Reinvestment Act for Electronic Health Records
12 would include their use in quality measurement.

13 In this table, we show that many of the measures
14 can be used to compare data from Medicare Advantage plans
15 and fee-for-service using fee-for-service claims data.
16 These measures include the rate of preventable hospital
17 admissions for ambulatory care sensitive conditions, that is
18 those conditions for which appropriate ambulatory care would
19 have obviated the need for admission, for hospital
20 readmissions, for preventable emergency room visits, and for
21 mortality for certain conditions.

22 As we noted, for intermediate outcomes, we would

1 need additional data beyond what is current in fee-for-
2 service claims and there would have to be similar data
3 coming from MA plans.

4 Turning now to focus on the situation in Medicare
5 Advantage, the current primary source of clinical quality
6 information in Medicare Advantage plans is the Health Care
7 Effectiveness Data and Information Set, or HEDIS. Medicare
8 plans have been required to report HEDIS since 1997. The
9 HEDIS measures are primarily process measures, but include
10 some intermediate outcome measures for diabetics, people
11 with cardiovascular disease, and blood pressure control for
12 individuals with hypertension.

13 With regard to the use of HEDIS measures as a
14 basis for comparing Medicare Advantage to traditional fee-
15 for-service Medicare, HEDIS measures can be computed from
16 fee-for-service using claims data. In your mailing
17 material, we have a discussion of the comprehensiveness of
18 the HEDIS measures and we examine the issues involved in
19 using HEDIS measures as a basis of performance measurement
20 in fee-for-service.

21 Regarding HEDIs, there is an issue about the
22 comprehensiveness of the measures for certain age groups and

1 for certain conditions. For example, there is a limited
2 number of measures that apply to the oldest Medicare
3 beneficiaries. None of the intermediate outcome measures
4 apply to Medicare beneficiaries over 85, and only one, the
5 measure for control of high blood pressure, is applicable to
6 beneficiaries between the ages of 75 and 85.

7 The measures for diabetics apply to beneficiaries
8 between the ages of 18 and 75. The reason for this, as we
9 understand it, is that even though there is a significant
10 proportion of Medicare beneficiaries over 75 with diabetes,
11 it is difficult to develop uniform measures that are
12 appropriate for an older age group with medical needs that
13 essentially vary from person to person.

14 With regard to using HEDIS as a basis for
15 comparing one plan to another, we have previously discussed
16 the different standards that apply to different plan types,
17 such as the inability of some plans to use medical record
18 review to report a rate on a particular measure. This is
19 also an issue when comparing MA plans to fee-for-service.

20 One way to address this is to use the HEDIS
21 results that are based on administrative data only, that is,
22 without the medical record review component. This still

1 does not give you an apples-to-apples comparison because the
2 administrative data within MA encompasses a broader range of
3 data sources than the claims data of fee-for-service. For
4 example, MA plans can use lab values for reporting their
5 HEDIS results. If fee-for-service claims data included lab
6 values, as we recommended in the past, that would increase
7 the comparability of the two data sources. However, even
8 this enhancement of fee-for-service claims would not make
9 the data completely comparable because, for example, the
10 administrative data that plans have that are the basis of
11 HEDIS reporting can include information from the plan's
12 Electronic Health Record System, and some plans have very
13 advanced electronic health records.

14 The issue of making sure that any comparisons are
15 apples-to-apples comparisons is an issue that has very broad
16 relevance for any measurement system. If we want to judge
17 the relative health outcomes for one group of beneficiaries
18 compared to another group, we would need risk adjustment and
19 other adjustment mechanisms to ensure a fair comparison.

20 Another issue is the matter of the small numbers.
21 For example, in rural areas, providers may have too few
22 patients and plans may have too few enrollees for

1 statistically valid results. In your mailing material, we
2 discuss possible ways to address the small numbers problem,
3 for example, by using three-year rolling averages.

4 Another issue is the question of the appropriate
5 geographic unit for reporting of results. One aspect of
6 this issue is the general question of how to define an
7 appropriate geographic area for comparing MA plans with fee-
8 for-service. We have assumed that MA plan performance
9 should be compared against the performance of fee-for-
10 service in the same appropriately determined geographic
11 area, such as a market area or the "geo units," as they were
12 called, that had been developed for CAHPS reporting. This
13 would also be true for MA plan-to-plan comparisons. The
14 comparisons should be done at the appropriate geographic
15 level. As of now, however, MA plans can be reporting
16 results for very large geographic units.

17 Here is a map of the four Medicare contract areas
18 that one Medicare Advantage HMO used to have in California.
19 Butte County in the north was under one contract. The
20 Oakland-San Francisco Bay Area was under another contract.
21 Most of Southern California was under one contract. And the
22 rest of the counties the HMO covered in the State were under

1 another contract.

2 In the case of Southern California, the structure
3 of this HMO included five regional components, that is, five
4 areas that the organization identified as separate market
5 areas for commercial rating purposes. All told, therefore,
6 this HMO was operating in at least eight separate market
7 areas in California.

8 Today, this organization is reporting CAHPS,
9 Health Outcome Survey, and HEDIS results on a Statewide
10 basis. It seems unlikely that the experiences of care for
11 beneficiaries enrolled in this plan and the performance of
12 its providers is entirely uniform across the State.
13 However, under current reporting standards, the beneficiary,
14 or Medicare, for that matter, has no way of knowing how this
15 plan performs in a specific market area.

16 And for those of you from the Bay Area, I would
17 point out that the Bay Area has finally achieved its goal of
18 detaching itself from the rest of California.

19 [Laughter.]

20 DR. CROSSON: I am going to get on the phone right
21 after the meeting and let everybody know.

22 MR. ZARABOZO: You now have oceanfront property,

1 by the way.

2 [Laughter.]

3 MR. ZARABOZO: In addition to raising any issues
4 to include in the mandated report that you feel we have
5 omitted from our mailing materials or presentations, there
6 are several items that we would like the Commission to
7 discuss. Given the timing and the language of the
8 Congressional mandate, which states that changes should be
9 in place in 2011, our report would be likely to include any
10 recommendations for immediate changes to the current
11 measurement tools.

12 The situation that we just described regarding the
13 geographic area is something that is amenable to an
14 immediate fix; that is, plans and CMS could begin reporting
15 HEDIS, CAHPS, and Health Outcome Survey information at
16 smaller geographic levels.

17 We also may wish to comment on what is feasible to
18 have reported by 2011, using current measurement tools and
19 current or soon-to-be available data sources. For example,
20 the Commission may wish to comment on what form the MA
21 encounter data collection should take in order to include
22 data necessary for quality comparisons.

1 Similarly, the Commission may want to weigh in on
2 the issue of ensuring that Electronic Health Records will
3 become a rich source of data for advances in quality
4 measurement.

5 As a reminder of what the mandate says, there are
6 two parts to the mandate. One is the comparison of one MA
7 plan to another, and the other part of the mandate is the
8 question of how to compare MA to fee-for-service Medicare.

9 The next slide shows that the two parts of the
10 band-aid often parallel each other, but can also be
11 different, especially on the question of the data that
12 should be used for the comparison.

13 For both the MA to MA plan comparison and for the
14 fee-for-service to MA comparison, there needs to be uniform
15 reporting of measures and reporting of the appropriate
16 geographic unit. An MA, for example, PPOs, HMOs, and
17 private fee-for-service plans should all be reporting on the
18 same basis for the same set of measures. Similarly, in the
19 fee-for-service to MA comparison, reporting should be on the
20 same basis in each sector.

21 With respect to the MA plan to plan comparison, we
22 have suggested the need to expand the measures to encompass

1 a wider range of the Medicare population and a wider range
2 of medical needs of the population. We have also suggested
3 that there be more emphasis on outcomes measures. Such an
4 expansion would involve additional burdens on the plans and
5 on CMS. For example, moving to more outcomes-based measures
6 could potentially involve more extensive use of medical
7 chart review, which is labor intensive.

8 For the fee-for-service to MA comparison, the
9 currently available fee-for-service data are the fee-for-
10 service claims. Enhancing fee-for-service claims data with
11 additional information would be an added burden on providers
12 in the fee-for-service sector.

13 The closest analog to fee-for-service claims in MA
14 would be the soon-to-be collected encounter data, if the
15 encounter data specifications are similar to fee-for-service
16 claims specifications. The claims and encounter data can be
17 the basis of measuring outcomes in each sector, and if both
18 data sources include lab values, intermediate outcomes can
19 also be measured.

20 Of course, the type of data collection for quality
21 reporting in MA is burdensome, though it is not clear how
22 much additional burden there would be above and beyond the

1 anticipated burden of the 2011 collection of encounter data
2 that CMS is proceeding with.

3 In the future, where more and more plans and
4 providers move to Electronic Health Records, and if those
5 Electronic Health Records contain the necessary information
6 for improved quality measurement, we would expect to improve
7 data collection with a lower level of burden and improved
8 ability to monitor and evaluate quality and improved ability
9 to provide meaningful reporting of results both within the
10 MA sector and across the two sectors, MA and fee-for-
11 service.

12 However, there is a delicate balance to consider,
13 which is how far should we go with potentially major changes
14 to the current system if a newer, better system is coming?
15 And with regard to the newer system, when will it be
16 available and will it be the rich source of information that
17 we hope it will be?

18 Thank you, and I look forward to your discussion.
19 We have the room -- the room is reserved until midnight, in
20 case you are interested.

21 [Laughter.]

22 MR. HACKBARTH: Well, let's hope. Okay. Let me

1 see hands for clarifying questions.

2 DR. STUART: This is a clarifying question
3 regarding MA encounter data, and depending upon the MA plan,
4 those encounter data actually could be claims. And in the
5 case of private fee-for-service, they are claims. In the
6 case of network HMOs, they are probably claims. In the case
7 of staff-level HMOs, some of them may be claims, too. So I
8 am just wondering, do we have any sense about how much of
9 the data that is flowing into CMS now from MA plans really
10 is claims as opposed to encounters?

11 MR. ZARABOZO: It's not flowing in yet. They are
12 going to announce -- I think 2011 will be the collection --

13 DR. STUART: Oh, 2011.

14 MR. ZARABOZO: -- starting the collection of the
15 information, so -

16 DR. STUART: Okay. But the thing still holds. Do
17 we have any sense about what the proportion would be?

18 MR. ZARABOZO: I think we'll know more later in
19 the year, and again, one of the comments that we made here
20 was, potentially, we would like to say something to CMS
21 about what we would like to see in the way of information in
22 the encounter data.

1 DR. BERENSON: Yes. I am not still completely
2 sure I understand the mandate. Is it to report on the use
3 of measures for beneficiary choice, to be able to have
4 informed information to make decisions about where to get
5 care, or is it for policy makers to know how fee-for-service
6 and Medicare Advantage sort of globally are performing to
7 sort of help the policy making process, or both? I mean --

8 MR. ZARABOZO: Both. We have interpreted it as
9 both, because it says collection and reporting of the
10 information by 2011 and we assume that reporting meant for
11 beneficiaries and also for CMS --

12 DR. BERENSON: So you are interpreting it as both?

13 MR. ZARABOZO: Right.

14 DR. BERENSON: Okay. My second question is a more
15 technical question. It is on Slide 6, administrative data
16 available for outcome measures. The first two, preventable
17 admissions for ambulatory care, sensitive conditions from
18 the AHRQ PQI and readmissions, in the material you gave us
19 to read, you had done sort of some preliminary analysis
20 based on 13 States that have provided from the HCUP
21 database. Could you -- is this available from all States
22 and you just chose to -- what is the status of that?

1 MR. ZARABOZO: No. The situation is that there
2 are 13 States in which you could identify MA enrollees
3 versus non-MA enrollees. And then there are an additional
4 two States, and you and I had a discussion about this -- it
5 is actually Iowa and Rhode Island are the additional two
6 States where that might also be the case.

7 And your next question would be, what about
8 Nevada?

9 DR. BERENSON: I should probably tell people why
10 we are having this. Carlos and I had a little talk earlier,
11 because two days ago, AHIP released, and with a fair amount
12 of prominence, a report apparently using data from two
13 States, California and Nevada, to demonstrate that Medicare
14 Advantage plans were more successful, and I am just
15 wondering whether they are using the same database as what
16 you are referring to, and I guess the follow-up question
17 that should be probably round two but is in round one, is
18 did they cherry-pick the data to just pick States that were
19 where they actually had good data?

20 MR. ZARABOZO: And I think they don't specify why
21 they chose -- I mean, possibly they chose the two States
22 because they are neighboring States, but as you know, they

1 are very different in their managed care make-up.

2 DR. BERENSON: Correct.

3 MR. ZARABOZO: It says it is HCUP data. Now, when
4 we got the list of the 13 plus two States, Nevada is not in
5 that list, so I'm not sure what the issue is with HCUP data
6 coming from Nevada, so I'd have to look into that.

7 DR. BERENSON: But we are talking about basically
8 the data that you're referring to --

9 MR. ZARABOZO: Yes.

10 DR. BERENSON: -- what we could be using is also
11 the data that -

12 MR. ZARABOZO: Correct, and this is the data -

13 DR. BERENSON: I'm not expecting you to have
14 analyzed their study now. I want to just sort of see
15 whether we're talking about the same databases.

16 MR. ZARABOZO: Right, and the mailing material
17 included the AHRQ study of the 13 States where they said
18 they found no significant differences between MA and fee-
19 for-service, different from the findings of the -- and also,
20 it's -- a lot of it is utilization, and the discussion of
21 quality would be things like preventable admissions. They
22 talk about admissions, readmissions, so quality may be a

1 slightly different issue from utilization, and it's only
2 hospital utilization as opposed to all utilization.

3 DR. MARK MILLER: I'd like to just comment on that
4 a couple of ways. The fundamental answer to the question
5 about the availability of the data is it's not for all
6 States.

7 MR. ZARABOZO: Correct.

8 DR. MARK MILLER: Okay, and so as a source that
9 you could comprehensively -- I want to be sure that that
10 came out of that exchange.

11 DR. BERENSON: And no prospect that it will be -

12 DR. MARK MILLER: I want to address that point. I
13 will let Carlos take the prospect question, and you can
14 think about it quickly while I'm running my mouth on this
15 one --

16 MR. ZARABOZO: That's a John question and he's not
17 here.

18 DR. MARK MILLER: Oh, okay. Well answered. We'll
19 find out for you.

20 The thing I do want to get across is, however, if
21 you want claims-based information, which this is largely
22 that type of measure, then it gets you back into the

1 conversation that I think Carlos was framing between the,
2 well, do you want to use the fee-for-service claims data and
3 the encounter data as a way to build that and build it more
4 comprehensively. And so I just want to make sure that if
5 that is a road -- and Jay, I know your views on this -- if
6 that is a road people want to think about, you don't have to
7 depend necessarily on HCUP to do that. You would build it,
8 I think, from those sources. Is that about right, Carlos?

9 MR. ZARABOZO: Right, and if you have the
10 encounter data and fee-for-service claims data, it allows
11 you to do the same thing that the HCUP did, right.

12 DR. MARK MILLER: [Off microphone.] That's what
13 I'm trying to say.

14 MR. ZARABOZO: Yes.

15 DR. MILSTEIN: Thinking about the mandate that's
16 been given to us raises for me a couple questions as to how
17 far afield we are going to go in responding, because at the
18 end of the day, as you were alluding to, this -- it
19 addresses the broader question of how do you measure quality
20 in the Medicare program.

21 But with respect to that, you did reference the
22 idea of EHRs may provide a new source, and obviously there

1 are other changes unfolding in the Medicare program that are
2 sort of in equal areas of new opportunity. I'm thinking
3 about the, assuming the PQRI program continues to move
4 forward, that's another source of -- you know, question one
5 is were you planning to sort of address that as a potential
6 data source and were you also planning to, within the scope
7 of this mandate, talk about the value or utility of being
8 able to link A/B with D data.

9 MR. ZARABOZO: On the D data issue, we have taken
10 it as a given that the D data are available and would be
11 used for this purpose.

12 DR. MILSTEIN: [Off microphone.] In both MA --

13 MR. ZARABOZO: Right, in that sense, that --

14 DR. MILSTEIN: [Off microphone.] -- linkability
15 of -- I'm sorry. What about PQRI?

16 MR. ZARABOZO: On the PQRI, I guess you could say
17 that that may be an issue with the encounter data, as to
18 what do you want to see in the encounter data that would be
19 comparable to PQRI information coming from fee-for-service.
20 So potentially, yes.

21 DR. MILSTEIN: [Off microphone.] You mean -

22 MR. ZARABOZO: Right. The equivalent of PQRI data

1 coming from MA. That is -- yes, via the -- I mean, right
2 now, we're thinking via the encounter data.

3 MR. BERTKO: Carlos, nice job in John's absence
4 here, you pinch-hitting. Your slides, particularly, I think
5 it is Slide 8, give me at least the inference in that first
6 column that there is not much there yet under current
7 measures and that putting a square peg into a round hole
8 might be quite a bit of effort. Am I interpreting that
9 correctly?

10 MR. ZARABOZO: You could say that.

11 [Laughter.]

12 MR. ZARABOZO: I think you just did.

13 MR. BERTKO: You are a difficult guy. Okay.

14 MR. ZARABOZO: Last time, I was described as a
15 hostile witness. I think that was a year ago.

16 [Laughter.]

17 MR. BERTKO: So the second part, and this is a
18 little bit to follow up with Bruce's question, since I am
19 two years removed from doing real work, it strikes me that
20 it is possible you could have a one-by-one expert panel
21 interview of very large MA plans and see where they are on
22 the data stuff in terms of the kinds of data you would want

1 there, because if they are going to be pushing it through
2 anyway, it would seem in 2011, even with flawed data, we
3 would be at a good starting point with very little extra
4 work, and I would suggest to everybody else the penalty for
5 non-submission by other plans is big enough, because they
6 look bad. And so the incentives, I think, are aligned in
7 the right direction here. So it seems a waste, if I can
8 infer from your comment there, to go down path one when we
9 can more clearly go down path two.

10 Note he doesn't say anything again.

11 MR. KUHN: Carlos, thanks. Good presentation.
12 I'm curious to go back to the chart that Bob was talking
13 about earlier, and it looks at the PQI discharge data. And
14 as I looked at that, and I think as the description
15 indicated, it was almost a mirror image of one another, from
16 MA to fee-for-service. And, I guess, is there any
17 information that you all have that indicates that there is
18 no differentiation between the providers that are in the MA
19 plans, or providing services to the MA plans versus those in
20 the fee-for-service? Could that be one rationale why we are
21 seeing this kind of data reflection here? I am just kind of
22 curious. Are they different types of providers that just

1 come up even, or are they commingled here?

2 MR. ZARABOZO: Well, of course, in California, you
3 have Kaiser, which is not a fee-for-service -- I mean, some
4 of the California data included fee-for-service people in
5 the Nevada-California study coming from AHIP and that -- it
6 said emergency, but I think it is the cost enrollees,
7 actually, that are in the what appear to be fee-for-service
8 data in California, because those go through the
9 intermediary.

10 DR. CROSSON: Cost and a small number of people
11 who never converted to risk program.

12 MR. KUHN: Okay. I was just trying to get a sense
13 of who were the providers here, to the extent that --

14 MR. ZARABOZO: The California case, for example,
15 is a special case because of Kaiser, so yes.

16 MR. HACKBARTH: Other round one -- oh, I am sorry,
17 Jennie.

18 MS. HANSEN: I think John asked the question
19 already, because it was back to Slide 8 and it had to do
20 with those measures on the left, for example, the limited
21 number of measures for oldest beneficiaries. I know right
22 now, we have the AHRQ prevention quality indicators that you

1 had on Slide 6, but that, for example, if NCQA that actually
2 has a geriatric physician panel --

3 MR. ZARABOZO: Yes.

4 MS. HANSEN: -- that has been working on this, so
5 this could be possibly an add-on sooner, is that what you
6 were saying?

7 MR. ZARABOZO: As you recall in the mailing
8 material, we included additional measures that were added in
9 2007 from the geriatric panel. So they are adding more
10 measures, and those measures are coming from the Health
11 Outcome Survey. That was the urinary incontinence
12 discussions and osteoporosis testing, things like that for
13 the older population. So they are aware of this issue and
14 are adding measures for the older population.

15 MS. HANSEN: So again, clarifying, it's in the
16 process of being added at this point?

17 MR. ZARABOZO: Well, based on their record of
18 having added measures to date, then I assume they will
19 continue to add, given that they had this geriatric
20 assessment panel. But I don't know what their future plans
21 are.

22 MR. HACKBARTH: Okay. Let me see hands for round

1 two questions or comments. Ron, Mike, Nancy, Arnie, Peter.

2 DR. CASTELLANOS: Carlos, I apologize. I was out
3 of the room and it may have been discussed. I think we're
4 going to have a tremendous bias in the material that you get
5 from the MA plans and the fee-for-service plans. As John
6 said, the MA plans are much more motivated to get this data
7 and they can put the pressure on the physician to get that
8 data. The fee-for-service, unless we have HIT and some
9 meaningful use, that data -- you're going to have claims
10 form data.

11 I can tell you, the attitude in the physician
12 community is, if I don't get paid for it, I'm not going to
13 do it. And I'm sorry, but that's the attitude. I know we
14 want the data, but it's going to be extremely burdensome for
15 the physician community and I think we're going to have to
16 balance the legitimate use of this data to the availability,
17 whether we're going to get it from MA or fee-for-service.

18 MR. ZARABOZO: I think one point that was -- we're
19 talking about using the currently submitted claims data from
20 fee-for-service providers and getting something equivalent
21 from Medicare Advantage plans. So to the extent that you
22 can -- there, you may have a bias in the other direction,

1 which is the data coming from Medicare Advantage is for the
2 purpose of meeting the encounter data submission
3 requirement. It is not for the purpose of getting paid.
4 Whereas in fee-for-service, you don't get paid unless you
5 submit a claim.

6 So to the extent that information about quality
7 can be derived from claims, the bias might go in that other
8 direction if it's encounter data from MA being compared to
9 fee-for-service claims data.

10 DR. CASTELLANOS: You can have a lot of encounter
11 data from the MA plans, but, you know, Slide 8, on the
12 right, you're not going to have that data from the fee-for-
13 service --

14 MR. ZARABOZO: Right. Things like lab values,
15 additional information that you may want to get from the
16 fee-for-service would be an additional burden that doesn't
17 make a difference in payment, or potentially doesn't make a
18 difference in payment. So, yes, it would be a --

19 DR. CASTELLANOS: But it does make a difference in
20 measuring outcomes and quality --

21 MR. ZARABOZO: Right. Right.

22 DR. CASTELLANOS: -- and that's what we're really

1 looking for.

2 MR. ZARABOZO: Yes.

3 DR. CASTELLANOS: So I think there's going to be a
4 bias.

5 MR. HACKBARTH: George, did you have your hand up?

6 MR. GEORGE MILLER: That's okay. Thank you. I'll
7 make the comment I made a little earlier and it concerned
8 page three of the chapter that was sent out. The statement
9 is made that there should be overall financial neutrality
10 between fee-for-service and the MA plans and that there
11 should be -- MA plans should get higher payments if their
12 quality is better. In my reading, I didn't see discernible
13 difference in quality between MA plans and fee-for-service.

14 So my question is, if that continues to be the
15 case and the data and the research bears that out, should
16 there be a different payment methodology for MA plans going
17 forward? Should there be a penalty, or could we as a
18 Commission even recommend, if that bears out, that maybe MA
19 plans have met their usefulness if they are not showing
20 demonstrated improvement in quality?

21 MR. HACKBARTH: What the Commission as a whole has
22 said in years past is that, in terms of the general payment

1 methodology, we think that Medicare Advantage plans ought to
2 be paid the same amount as would have been incurred in
3 traditional Medicare. And then a bit more recently, we have
4 said that the only justification that we can think of for
5 potentially paying more than traditional Medicare incurs is
6 if there were measurable improvements in quality. And this
7 exercise is about laying the infrastructure to be able to
8 make head-to-head comparisons between particular MA plans
9 and fee-for-service in more or less the same area.

10 So, you know, to me, right now, the payment issues
11 are important, but they're not directly related to this
12 task. Now, if it would make you more comfortable, we can
13 include in the report a summary statement of what MedPAC's
14 views have been on payment policy, a neutrality, what I just
15 said, but that's not the principal issue in this report.
16 Does that help at all, George?

17 MR. GEORGE MILLER: Yes, it does, but again, the
18 overall arching concern about the long-term viability -

19 MR. HACKBARTH: Yes.

20 MR. GEORGE MILLER: -- in the earlier discussion,
21 I'm wondering, how do you put that in this framework? I
22 certainly understand that we need to get the mechanisms

1 aligned so we can make the appropriate quality
2 determination, but it seems to me that we have some here and
3 there doesn't seem to be, at least from what I read -

4 MR. HACKBARTH: Yes -

5 MR. GEORGE MILLER: -- a measurable difference in
6 quality so far.

7 MR. HACKBARTH: Well, Carlos can maybe help me out
8 here, but we have some preliminary sort of data, but my
9 recollection of all the tables and accompanying text is look
10 at these with caution because the numbers are not always
11 comparable.

12 Carlos, do you want to pick up there?

13 MR. ZARABOZO: In fact, that was sort of the
14 intent of all that data, which was showing, well, yes, you
15 could maybe do these comparisons, but when you look at the
16 actual numbers, there are so many questions about, well,
17 this result is unusual, this result is unusual, that you
18 can't really draw a conclusion or you need to work with it
19 more to figure out what exactly is happening here, like one
20 question being is it a matter of reporting? Some people are
21 better reporting than other people, things like that.

22 The CAHPS, we had some CAHPS information about the

1 relative -- I mean, CAHPS is the best source, but again,
2 that's a beneficiary perception survey, so that -

3 MR. HACKBARTH: In fairness, there was the one
4 table based on the Masspro analysis where the MA plans
5 tended to look better than fee-for-service, although there
6 again there was an important caveat that often the private
7 plan data was calculated using medical record information,
8 chart information that wasn't available for the traditional
9 Medicare side. So they are really not directly comparable
10 statistics.

11 So my answer to the question, do we know how MA
12 plans compare on quality to traditional Medicare? My answer
13 is, we don't know, and that's what this is about trying to
14 figure out.

15 MR. ZARABOZO: Right, and the mandate is to
16 discuss the methodology for doing such comparisons. It is
17 not strictly to do the comparisons. And the reason that we
18 did these comparisons was, again, to show the point these
19 are really hard to do, a lot of issues involved here. It is
20 not clear that we are quite ready to be able to do this
21 comparison.

22 DR. CROSSON: What I heard George saying, or at

1 least one of the things I heard George saying was let's make
2 sure that the payments to MA plans in some way reflect
3 quality. And if you look at some of the legislation or
4 potential legislation right now, both on the House side and
5 the recently released Senate Finance Committee bill, each of
6 them in their own way contains some element that speaks to
7 that, in the sense that in the process of reducing MA
8 payments down to the level of fee-for-service or
9 approximating that, there's also a suggestion that plans
10 compared with each other that produce higher quality would
11 receive higher payments. That may not come to pass, but
12 that's what's currently there.

13 DR. BERENSON: I just wanted to clarify MedPAC's
14 previous position. I've read that legislation, and
15 actually, there were -- in one version in the House, there
16 was going to be a pay-for-performance and a pay-for-
17 improvement component, and then I saw that Ways and Means
18 took away the pay-for-improvement, I believe. Do we have a
19 position on whether we -- I mean, the way you articulated
20 it, it was if plans compared to local fee-for-service
21 performance could demonstrate improved quality or higher
22 quality, that might be a basis for payment. That's

1 different from any kind of pay-for-improvement strategy, and
2 have we been very specific on what we're recommending?

3 MR. HACKBARTH: We have not. We have not. Help
4 me out here, Mark. But my recollection is that we did not
5 talk about additional payment above fee-for-service levels
6 for pay-for-improvement. We said for, you know, high
7 quality. My recollection, now that I really focus on it, is
8 that we left ambiguous whether that was high quality
9 relative to other MA plans or only high quality relative to
10 fee-for-service.

11 MR. ZARABOZO: The MA P4P recommendation from the
12 past was to use the rebate dollars to -- and it was -

13 MR. HACKBARTH: Well, that even goes sort of
14 further -

15 DR. MARK MILLER: You are talking about the most
16 recent -

17 MR. HACKBARTH: Yes. That goes further back, so
18 bear with me for a second while I sort of build up the
19 steps. Step one is financial neutrality between Medicare
20 Advantage and traditional Medicare, and we've had that
21 recommendation for eight or nine years now.

22 Then a little bit after that, about five years

1 ago, we made a recommendation that P4P be introduced in the
2 Medicare Advantage, and there, it was going to be a budget-
3 neutral system where we would redistribute dollars within
4 the MA program based on quality.

5 And then a little bit after that, we sort of added
6 a kicker and said part of the rebate dollars ought to be
7 added to that P4P fund to give extra punch to P4P and
8 Medicare Advantage.

9 And then, finally, most recently, we said that, in
10 thinking about a transition strategy to get from where we
11 are now, paying on average 114 percent of traditional
12 Medicare costs, to a lower number, one thing that Congress
13 might think about is allowing plans that have demonstrably
14 higher quality to keep some of the additional payment.

15 DR. MARK MILLER: Relative to other plans.

16 MR. HACKBARTH: Relative to other plans.

17 DR. MARK MILLER: Right. But then -- [Off
18 microphone.] So what we said, though, in that report is
19 that as you're going through the transition, so you are
20 right on all the way up to that point. So during the
21 transition, you might say, those plans who do better
22 relative to other plans might not be brought down to 100

1 percent -- one way to think of it is not be brought down to
2 100 percent as fast, but we said a reasonable termination
3 point is that you could pay a managed care plan more than
4 fee-for-service if it had better performance than fee-for-
5 service, and now we're interpreting that as in an area.

6 What the Congress said to us is, great. How? And
7 that's what brought us to this study, where we're trying to
8 now work through the measurement issue to capture that
9 between -- among the plans in one vector and between fee-
10 for-service.

11 MR. HACKBARTH: George, thank you for raising
12 this. You know, I think it would be helpful for this report
13 to sort of have this history to establish context.

14 Let's see. Mike?

15 DR. CHERNEW: Thanks. I think it's clear from
16 some of this discussion that eh report is going to have to
17 have a pretty good limitation section. I wish people would
18 start by reading the limitation section instead of getting
19 bored before they get to it. But I want to add three things
20 or mention three things that I think should be in the
21 limitations section that I think are going to be important.

22 The first one is the analysis is going to try and

1 control for case mix, so one has to think about how one
2 controls for case mix, and part of that is by selecting the
3 measures. So you want to select measures that you think are
4 going to be somewhat, you know, AMI, you think is going to
5 be standard. That is in and of itself sort of case mix
6 adjusted.

7 But to the extent that socio-demographic and other
8 variables are across these or the extent to which different
9 types of people have selected into MA plans versus not into
10 MA plans, it's going to be hard to get a full adjustment for
11 the differences in individuals, even with the type of claims
12 adjustment type things that you do, or even given the
13 quality measures one has. And I think that's going to
14 require a call for studying the effects of the case mix
15 differences.

16 The second one is a conceptual question, which is
17 a lot of the measures, particularly the ones that are
18 sensitive to prescription drugs, like admission rates for
19 congestive heart failure and such like that, but really a
20 lot of them are going to be sensitive to the supplemental
21 coverage that the individual has. So the Medicare Advantage
22 plans typically have better coverage.

1 Are we conceptually trying to compare a Medicare
2 Advantage plan to a person in fee-for-service without
3 supplemental coverage, or a person in fee-for-service with
4 generous supplemental coverage, and the nature of that
5 supplemental coverage is likely changing over time, so I'm
6 not even sure what it means to say a Medicare plan is better
7 than fee-for-service or not because the Medicare plans have
8 an advantage. They provide better coverage. But the AMA
9 plans typically provide better coverage. That gives them
10 sort of a bump. But maybe that's one of the things we want
11 to give them credit for. So there's some conceptualization
12 about what actually the measure is.

13 And the third one, which I think is important for
14 the limitations section, is often in this discussion, the
15 entire framing assumes that these are independent entities
16 in one way or another, and in fact, I believe strongly that
17 when the managed care plans are in an area, their value
18 isn't only in changing care for the managed care in all
19 these, but also for fee-for-service. In fact, HEDIS, one of
20 the main things, was really developed through all the
21 managed care plans and a lot of the gains in HEDIS that
22 you've seen across the whole system, I think could be traced

1 back to efforts largely by originally managed care plans to
2 measure quality of care in a bunch of ways, and I think that
3 there should be some recognition that the value -- that
4 these are not really separate entities on their own islands
5 that we're comparing, but in fact, policy-wise, one needs to
6 think about how these interrelate since they're sharing the
7 same provider system.

8 And the last point I'll make, which I'm not sure
9 it's a limitation or not, but it relates to these two
10 purposes, about whether we want to compare individual plans
11 or whether we want to compare the MA plan or types of MA
12 plans in general to fee-for-service in general, is
13 statistically, it's going to be very difficult, because of a
14 lot of chance and randomness, to do as good a job comparing
15 health plan A to health plan B all the time in some of these
16 measures, and you can do certain statistical analysis to
17 sort of smooth some of those things to answer the average
18 question.

19 And so I think there's a question going in not
20 only in when you do the data, but what type of statistical
21 analyses you want to do in order to answer specific
22 questions. Reporting a whole litany of plans and seeing a

1 distribution is going to have a lot of chance in those
2 plans, my guess is, from year to year, and I think that
3 that's worthy of thinking about depending on how the data's
4 going to be reported and used, because sometimes it's hard
5 to get stable measures in a plan but easier to draw broad
6 conclusions across plan types.

7 DR. KANE: Yes. Actually, just to reinforce what
8 Mike just said, this whole thing has been bothering me a lot
9 because I know, for instance, in our area in Boston, the
10 three health plans have exactly overlapping provider
11 networks, and so I'm not sure what you're really measuring
12 here. I guess -- I think it might be useful to try to think
13 more about what value-added does a plan have as opposed to
14 the fee-for-service. And I agree. If someone has
15 supplemental coverage or not, it would make a huge
16 difference on the fee-for-service side.

17 So maybe the question shouldn't be plan versus
18 plan or plan versus fee-for-service, but one would be, does
19 a provider act differently depending on which type of plan
20 the beneficiary is in, a fee-for-service? You know, we can
21 have a little bit of data that does that. On page ten, I
22 think the hospital stuff suggests no for the 13 States that

1 have the data, and we don't know whether they are perfectly
2 classifying. My experience with that payer data is it's
3 still a little fuzzy, whether the hospital is really
4 properly classifying a patient as Medicare Advantage or not.
5 But it looks like, no, the providers don't seem to treat --
6 the hospital didn't treat them differently.

7 So where should we be looking for the differences
8 where we might get bang for the buck if we put any resources
9 into it at all? And the only place I could really think of
10 would be around maybe primary care and care coordination
11 measures as opposed to these really amorphous things that
12 aren't, to me, picking up much.

13 So I guess I'd like to have us focus more on what
14 kind of measures would really pick up any value-added of
15 managed care, and that might be things like easier access to
16 the appropriate specialists, or some of the things you might
17 actually measure a medical home on as opposed to this kind
18 of claims data that doesn't tell you whether this provider
19 is uniquely fee-for-service or MA.

20 I'm just having a hard time seeing -- you know,
21 until you kind of can tell me that provider is going to act
22 differently for the different types and think about where

1 they're going to act differently, I think we're just fishing
2 here for random variation.

3 MR. HACKBARTH: You know, I think the point that
4 Mike and Nancy have made is an important one. Many, many MA
5 plans -- in fact, probably most MA plans -- are large, open
6 network plans that include a high percentage of the
7 providers in any given community. And given that those
8 plans include virtually all providers in the community, you
9 would think that, A, their results are going to be pretty
10 similar to one another, and B, they're going to be pretty
11 similar to fee-for-service, which uses the same.

12 However, a couple points. One is that not all MA
13 plans are big, open network plans. There are some that are
14 distinctly different, and there you might see pretty large
15 differences.

16 The second point I would raise about this is that
17 in the case where you have these large overlapping networks,
18 and I think this is where you were going, Nancy, the choice
19 of measures may be influenced. I would think that if we
20 have only outcome measures, the likelihood that you're going
21 to detect differences in big network plans is pretty small,
22 whereas even among the big network plans, there are some

1 programmatic differences in outreach and the like that could
2 improve quality at a much more granular level that would
3 never show up on outcomes.

4 Now, I'm not sure, you know, what to do about all
5 of that, but I don't think it means, well, you don't want to
6 measure quality at all -

7 DR. KANE: No, but I think -

8 MR. HACKBARTH: Go ahead.

9 DR. KANE: I think that Carlos's heroic effort to
10 try to find meaningful measures out of what exists, and all
11 of what exists is pretty much at the provider level -- I
12 mean, a lot of the hospital stuff is at the provider level.
13 The HEDIS stuff doesn't exist in the fee-for-service. I
14 think we should just maybe rethink, what's meaningful to go
15 after rather than what exists, because what exists really
16 doesn't address the problem that we have, which is how do
17 providers that are in both behave differently when they have
18 a managed care plan helping them gain access or coordinate
19 the care or, you know -- certainly, Kaiser, you're going to
20 have -- Kaiser is going to look different because they're
21 all one managed care plan and they're exclusive.

22 But when you start thinking about -- you know, a

1 lot of markets where there are big open plans and
2 everything. What's the value added of managed care? I
3 think that's worth thinking about, and is it measurable?
4 But I think the existing measures that you're trying to
5 create comparability across don't ask that question first,
6 and I think that's what's kind of frustrating and I think we
7 maybe need to go back and think more about what those
8 measures are.

9 MR. HACKBARTH: I've been a bad moderator here in
10 sort of -- this is an important issue, but I do want to get
11 to the rest of the queue. People are waiting patiently. We
12 can come back to this in the next round, Mike. So I have
13 Jay and then Arnie.

14 DR. CROSSON: So I will pick up a little bit on
15 what Nancy was saying and what you were saying, Glenn,
16 because I think -- a couple things. First of all, we have a
17 mandate we have to produce a report and it happens to be on
18 these two topics. So I think we're going to have to figure
19 out how to get to the best report that we possibly can.

20 But I think a couple things. I'd like to talk a
21 little bit about the type of measures and the outcome versus
22 process thing, because I -- and this is an odd thing for me,

1 because for years in my own organization, I was arguing to
2 move to outcome measurement because I think that a lot of
3 what had gone on 15 years ago or so was very processy and a
4 lot of the review that went on internally and externally was
5 not producing what it could have been.

6 But now I'm going to argue the opposite, because I
7 think -

8 DR. MARK MILLER: [Off microphone.] No, man, stay
9 with that thought.

10 [Laughter.]

11 DR. CROSSON: While I think outcomes do actually
12 measure the final end point of care, they have that going
13 for them, and they do, as Carlos mentioned, get to things
14 that are complicated and interacting, like care coordination
15 that either results in a good result or it doesn't or not,
16 nevertheless, from a programmatic perspective of trying to
17 apply quality measurement broadly, they're limited. First
18 of all, there aren't that many outcomes that you can
19 measure, that are measurable.

20 I think with respect to process measures, there
21 are many more processes, of course, than there are outcomes.
22 The things that are done, decisions along the way, do this,

1 do that, do it correctly, incorrectly, and the like, which
2 broadens the set. Now, let me be clear. I'm not arguing to
3 move away from outcomes towards process measures. I'm
4 arguing that we probably need to consider moving towards a
5 measurement set that contains both.

6 I think there are time issues with respect to
7 outcomes and process measures. For example, if you wait to
8 measure the care of diabetes for the outcomes, it may take
9 ten years or 20 years, where, in fact, if you measure
10 processes, you can do it more quickly.

11 There's less need for risk adjustment when you're
12 doing process measures than outcome measures. Sometimes
13 that's a problem, and Michael brought up a set of issues
14 like that.

15 And process measures are often more actionable
16 than outcome measurements. I mean, if you show the
17 mortality difference that exists between two hospitals, you
18 still have to understand what it is that's being done
19 differently in one hospital versus another that results in
20 the differences in outcome before you can actually take the
21 steps to change something.

22 So I think my own sense is that although we should

1 emphasize the need to move to outcomes, I think we should
2 also argue in the report for the validity of process
3 measures. And the reason is, not that I think we want to
4 have an army of chart reviewers or the like, but I do think
5 that what the use of clinical information technology will
6 give us in systems that turn processes into data points --
7 this was done or it wasn't done in the care of the patient -
8 - will very soon dramatically expand the number of process
9 measures that can, in fact, be accessed.

10 And this is now my own personal belief, that we're
11 going to get there faster than we think. Part of that is
12 the stimulus money. I think that's going to help. The
13 process of determining what is -- what's the term?

14 MR. HACKBARTH: Meaningful measures.

15 DR. CROSSON: -- meaningful measures, I think,
16 will get the thinking going along. And I also think that,
17 in the end, the capital costs of information technology for
18 practicing physicians will fall once it becomes clear that
19 we're moving in that direction because there will be
20 organizations, companies that arise who can push this
21 technology through the Internet for a monthly charge, which
22 is much more accessible by many more physicians than the

1 situation is now.

2 So I would just argue that we should think about
3 this in two phases. One is a short-term or intermediate-
4 term, where we do what we can, make some changes, make
5 additions that are reasonable, produce the best thing that
6 we can do in the short-term, but make sure that in so doing
7 we don't hamstring the more important long-term effort,
8 which is to make sure that the development of clinical
9 information technology and its spread is done in such a way
10 -- I'm not a technical person, but that the information that
11 is in the system is designed in such a way that it's
12 capturable, so that we could envision a day when the
13 benchmark that we all talk about when we're comparing
14 quality, we all refer back to Beth McGlynn's study, which
15 was actually 454, as I remember it, process measures, and
16 then the subset of that, ACO measures for the Medicare
17 population.

18 I think we can envision a day when some
19 significant number of those can be accessed automatically
20 from a clinical information database and used for comparison
21 purposes, and once that happens, we have an extremely robust
22 quality measurement set and a lot of the problems that we're

1 talking about go away.

2 DR. MILSTEIN: Because I have several points to
3 make, I'll try to make them very succinctly and just run
4 right through them.

5 First, I think it's important to bifurcate the
6 chapter, organize around the two purposes on which Congress
7 has asked us to comment, because I think you land in very
8 different places depending on whether you're talking about
9 information for policy versus information to enable
10 beneficiary choice.

11 Another comment is that this issue of, you know,
12 the scores for MA being higher because some of the plans
13 send armies of medical records folks into doctors' offices
14 to improve the scores relative to what you'd know just from
15 claims data, the good news there is that this is an issue
16 that's been alive for so long, it's actually possible to
17 know for a given measure, on average, how much the score
18 increases when you send the medical records folks out. And
19 so you don't have to standardize. You can just simply
20 adjust for what's known about what is referred to in
21 California as score creep due to hybrid measurement methods.

22 Third is that, with regard to this EHR and the

1 degree to which we say to Congress, it's around the corner,
2 my view is that we should model this in our report. We know
3 what the -- thanks to ARC, we know what the current adoption
4 level and the adoption rate is. Yes, it's true due to, you
5 know, the new stimulus money we don't know how much that
6 rate might increase.

7 But what I'm hearing from the trenches is that for
8 non-large, well-organized practices, this is less like
9 learning to ride a tricycle and more like learning to ride a
10 unicycle. So I think we ought to model the dates so that a
11 lot doesn't get bet on EHR adoption by smaller practices is
12 around the corner.

13 Fourth, just in terms of how we portray this, I
14 would just say we should move as quickly as we can toward
15 not lumping in one line the HOS with CAHPS, two very
16 different concepts in terms of what you're measuring,
17 especially because the HOS happens to be our best available,
18 well-tested, feasible, currently used measure of outcomes.
19 I mean, it's as close to what most beneficiaries who I talk
20 to want to know as anything we've got. It's risk adjusted,
21 change -- it's change in mental and physical functioning
22 over a two-year period relative to what would have been

1 expected based on the baseline status of a large sample of
2 beneficiaries. So I just think if outcomes -- per Jay's
3 comment, we want to balance process and outcomes, it's our
4 best available measure -

5 MR. HACKBARTH: Arnie, I'd be interested in
6 hearing what you have to say about the discussion of HOS in
7 the chapter, which I would -- my take on it was, well, this
8 is not a very discriminating tool. What -

9 DR. MILSTEIN: Yes. I have a very specific --
10 that was my next comment.

11 MR. HACKBARTH: Oh, okay.

12 DR. MILSTEIN: Thanks for asking. That is, one of
13 the reasons that HOS doesn't show any differences among
14 plans or anything in almost comparison is because,
15 arbitrarily, those who have applied it to MA plans within
16 CMS -- I wouldn't say arbitrarily, a decision made within
17 CMS to only show to beneficiaries difference, whether it is
18 different than expected, with 95 percent level of certainty.

19 I think available information on not what
20 statisticians accept, but what beneficiaries would accept as
21 a meaningful difference is all over the map and there's
22 absolutely no reason why you could not enable beneficiaries

1 to not -- there's no reason to blind beneficiaries with
2 respect to differences about which you're 90 percent certain
3 rather than 95 percent certain, because when you do surveys
4 of beneficiaries, it turns out that their tolerance for
5 level of certainty is not the same as professional
6 statisticians. They want to know about differences at lower
7 levels of certainty. And if we were to do that, a lot more
8 -- substantially more MA plans would be shown to be
9 different than expected, both for mental and physical
10 functioning change over a two-year period.

11 So that's -- the other comment I would make is
12 that -- oh, yes. In the section where we addressed this use
13 of this information for -- to support enrollee choice, both
14 MA versus non-MA and then within MA plan, to go further than
15 we've ever gone before -- I'll just give you a broad charge
16 -- on discussing how we might lower the information
17 gathering and cognitive burden on people over 65.

18 And last but not least, this issue of, well, gee,
19 you know, in a situation where in a given area almost all
20 the plans are pretty much using the same providers, why
21 bother, it was just something that was dealt with in
22 California, performance measurement, where a lot of the

1 organized medical groups in California serving the network
2 plans believed that they were adding all the value. The
3 plans were adding no value. And vice-versa, the plan
4 medical directors thought they were adding a lot of value
5 and the medical groups were just, you know, billing pools.

6 And so, fortunately, a nice piece of health
7 services research has been done to basically show us, at
8 least at a point in time, answer the question, to what
9 degree are quality differences attributable to delivery
10 system versus plan, and I can just -- my best memory of the
11 answer is it was pretty even, which shocked both sides. But
12 it's a clue that measuring performance between MA plans,
13 even when the networks are overlapped, may have value,
14 because there is, at least as of five years ago, there was
15 such a thing as value added from network plans with respect
16 to quality.

17 MR. BUTLER: It's very complicated, but I'll just
18 make two brief comments. To me, I think part of this gets
19 tied back to our discussion of the previous session, and
20 that is at the heart of the question is the service use
21 almost. What does a managed care plan -- it's called
22 managed care for a reason. So I think there is a

1 fundamental question, and the outcomes aside, what does the
2 service utilization profile look like in a managed care plan
3 versus a fee-for-service plan? If that is kind of where we
4 are heading in trying to reduce -- and it's consistent with
5 the theme that we have here at the Commission -- so what
6 does that specifically do when we look at the plan versus --
7 or among plans. That's the first half of the chapter, to
8 me, almost the central focus in my own mind, because I think
9 we're never going to get quite as far and as fast as we want
10 on the outcomes or the process measures.

11 The second half of the chapter, I think the eyes
12 of the consumer is does a managed care plan facilitate or
13 are they a barrier in, in fact, coordinating the care for
14 me? It's almost as simple as that. Price aside, which is
15 is this a good deal or not, are they my trusted agent that
16 makes it easier for me to navigate the system or harder?
17 It's almost as fundamental as that, because the rest is
18 based on, is this a good deal in my economics, and I'm going
19 to match up my benefit plan.

20 So there are some ways we could frame this that
21 makes it a little simpler and also be responsive by
22 acknowledging all the problems and shortcomings of the

1 current data.

2 MR. KUHN: Thank you. You know, as I've listened
3 to the construct here, I like the notion of the
4 accountability that we're trying to establish here, that is
5 an accountability on a couple levels. That is between fee-
6 for-service and MA, and then within the MA world looking at
7 the various ones in there, whether it's a PPO, private fee-
8 for-service, or whatever the case may be, and can look at
9 those different issues.

10 And I think part of the charge here that we're
11 going to have to deal with is, okay, where do we sync up on
12 the measures between the both? Readmissions, I think, is
13 one where they all sync up across the way. But, for
14 example, ambulatory care sensitive measures, not really good
15 in terms of measuring on the hospital side. But we could
16 look at and just say kind of, where is the state of the
17 measurement in terms of the bake-off between the two, for
18 lack of a better term, and what additional measure
19 development do we think could help us move in this
20 direction. And I think, yes, we need to be very aggressive
21 in kind of giving CMS some direction on the encounter data
22 as we go forward.

1 But beyond that, and it's kind of a little bit
2 what Nancy was talking about, and I was thinking about this
3 earlier and then more so when she was talking about it, is
4 is there also a chance for us to press the envelope a little
5 bit here and look a little bit harder at the true clinical
6 benefit or the real evidence of managing care that's out
7 there, and let me give you a scenario that I think is what
8 goes on, and maybe Jay and others can tell me if this is
9 really true in the managed care world.

10 But my understanding is that in the managed care
11 plan, when they see a diagnosis code, perhaps comes in for
12 diabetes, that triggers certain actions by the plan to begin
13 managing immediately that person as soon as they see that
14 code the first time as it comes through. Compare that to
15 the fee-for-service side of the world. The MAC gets a claim
16 in with a diagnosis code for diabetes. They pay the claim.
17 Nothing happens. It's basically up to the physician
18 independently on their own devices to go and manage that
19 patient, and they may or may not depending whether they go
20 see a subspecialist, an endocrinologist or whatever the case
21 may be that's out there.

22 So the chance for us to maybe reach a little bit

1 into the future and think about the true role of managing
2 care as perhaps these new delivery systems, whether it's the
3 medical home, ACOs, other things start to go forward. So
4 this report, hopefully, doesn't just look at the here and
5 now, but helps us begin to think five years down the road
6 where we hope some of this stuff will be and really kind of
7 testing that value might be a good value proposition for us
8 to think about as we go forward here.

9 So encounter data, yes. In terms of really kind
10 of managing the true value of managed care, yes. And then
11 in terms of the EHRs, I mean, the fact that we have
12 encounter data now but maybe five years from now -- got our
13 fingers crossed -- we could have a wealth of new information
14 starting to flow through the Health Information Exchanges
15 that are out there, the possibilities kind of boggle the
16 mind here. I don't even know where to begin on that, but I
17 think we have to come back and look at that a little bit
18 more and think pretty hard about it. I don't have any
19 specific direction for you all right now, but this is
20 something that we could not, should not, overlook as a
21 possibility.

22 MR. HACKBARTH: You know, Herb's comment makes me

1 think about another example where you might find a material
2 difference among even plans with big networks, in the
3 readmissions area, based on what sort of investment and the
4 effectiveness of the investment made by a plan to bridge the
5 transition from hospital to outpatient.

6 MR. KUHN: And that's really captured, and again,
7 they have those sensitive measures they're doing now. And
8 again, it's a chance for us to really measure the true value
9 of -

10 MR. HACKBARTH: Right.

11 MR. KUHN: -- managing care and show that
12 differentiation. It could be pretty exciting, pretty
13 powerful.

14 DR. BERENSON: Could I just jump in on that one?
15 I mean, I do think readmission is a good one, but it could
16 be that there are -- I mean, a lot of those readmission
17 issues are marginal -- congestive heart failure -- and it
18 may well be you have patients who in a fee-for-service
19 environment are just readmitted, whereas in a managed care
20 environment are equally sick, but they don't readmit and do
21 something else. And so that's -- I mean, I think
22 readmissions is a good quality measurement. I think you

1 mentioned that it's not a perfect quality measure because
2 you get different behavior. I mean, you just have to take
3 that into account. That was my point.

4 DR. SCANLON: Yes. My comment relates in part to
5 some of the things that Jay was saying, because I think that
6 I would say that, apart from what the major purpose of the
7 report is, that we should take advantage of the opportunity
8 to really push on the whole idea of meaningful use, because
9 I think this goes way beyond sort of this report and there
10 is a real issue that we not squander this investment if we
11 want sort of a better future.

12 I see the possibility with Electronic Health
13 Records that ultimately you get databases that you not use
14 just for quality comparisons, but you can use them for post-
15 marketing surveillance of devices and drugs. You can use
16 them for improving payment methods, improving risk
17 adjustments. You can use them for fraud, waste, and abuse,
18 sort of to identify target areas. You can use them for
19 comparative effectiveness.

20 But getting to that point is not an easy step. I
21 mean, right now, in some respects, there's a possibility
22 that you end up with Electronic Health Records that are

1 sitting in individual physicians' offices and sitting in
2 individual hospitals and it's very hard to get the
3 information out of them.

4 The idea of Health Information Exchanges is seen
5 as one way of getting some of that information. There are
6 very, very few of them around the country, and even if we
7 get more, there's a question of how are we going to -- and
8 ultimately aggregate the data so that we can really use it
9 for the purposes that we want.

10 One thing to consider, and I think there's at
11 least a short-term aspect to this, which is maybe sort of an
12 incremental step, is to think about we should change the
13 nature of claims, or what we have on claims and encounter
14 data. We've got a recommendation from a number of years ago
15 about adding lab values, and our AHRQ has shown that lab
16 values make a big difference in terms of risk adjustment.
17 It wouldn't be much effort to put that into sort of a new
18 kind of a claim for the future.

19 One of the failures that people complain about
20 with respect to HIPAA is we really didn't get claim
21 standardization. We got standardization of kind of the
22 front piece and then there's all kinds of payers are adding

1 on addendums to that and so that providers have to fill out
2 all kinds of different forms. If we got serious about
3 administrative standardization and said, here is the record
4 that we want you to provide because we know you can provide
5 it through your Electronic Health Record, then we would
6 potentially be saving providers a lot of hassle sort of in
7 the process.

8 Jay's point about the future in terms of clinical
9 measures, I think, is also a critical thing to think about.
10 The Policy Committee, the HIT Policy Committee that was set
11 up under the Stimulus Act has portrayed sort of this
12 meaningful use as an evolutionary process, that you can't
13 specify meaningful use today and think that it's going to be
14 satisfactory five years from now or ten years from now.

15 You need to think about it sort of as something
16 where you add requirements as you go along, and that's a
17 somewhat novel concept for government. There's this notion
18 that government says something and then, well, you can't
19 renege. You can't ask for anything different or anything
20 more. And they're saying up front, no, we are. We're going
21 to ask for new things as time goes on.

22 And I think it's good to establish that principle

1 and to stick to it, because the kinds of clinical measures
2 that Jay was talking about, they don't necessarily exist
3 today, okay, but they're going to exist at some point in the
4 future, and when they do exist, we want to say, we want to
5 capture them because we need them in this database, and we
6 don't want to hear that, oh, it's too much to retrofit. No,
7 you should have built in the capacity to retrofit from day
8 one. I mean, that's sort of a key sort of part about this.

9 I think one of the last reasons sort of that I
10 would say why it would be valuable for us to weigh in and
11 say we think meaningful use should be really meaningful is
12 related to the comment that Arnie made, which is a comment
13 that I've heard about, I mean, in terms of people are
14 saying, this is a tough job to implement sort of the IT.
15 And the answer is, yes, maybe it is, but you're capable of
16 it. I mean, when all you folks applied to medical school,
17 you said you were the best and the brightest. Riding a
18 unicycle shouldn't be that difficult, okay. So let's go
19 forward and do this.

20 And I have -- sort of my economist perspective is
21 that it's in your advantage to say it's too difficult to do
22 because then you don't have to do it. But the demand side

1 of this market should be saying at this point in time, we
2 need this information. We need it for a variety of reasons,
3 for quality reasons, for worrying about control over costs,
4 and it's absolutely essential that we get it.

5 MR. HACKBARTH: Okay. We are at 5:15 now, which
6 is the appointed time to end this, so rather than try for a
7 round three, we're going to call it quits for today and Jay,
8 Mark, and I, we'll put our heads together after a careful
9 reading of the transcript and talk to Carlos about how we
10 can significantly advance the ball for the next discussion,
11 which I think we really need to do. We need to start
12 focusing in.

13 DR. MARK MILLER: [Off microphone.] I have some
14 ways to structure the choices.

15 MR. HACKBARTH: Okay. So this -- although it
16 wasn't maybe as entirely focused as we could have dreamed, I
17 think there was a lot of important stuff here that gives us
18 the raw material for taking that next step.

19 Thank you, Carlos, for filling in for John in a
20 pinch.

21 [Off microphone.]

22 MR. HACKBARTH: Yes. So we're now to the public

1 comment period and the usual ground rules. I know Dr. Rich
2 knows his ground rules. Number one is introduce yourself
3 and your organization. Number two is please keep your
4 comments to no more than two minutes. I know that's brief,
5 but as I always remind you folks, the most important way to
6 contribute to our work is by working with the staff, as I
7 know many of you do. After the two minutes are up, this
8 light will come back on, and at that point, please bring
9 your comments to a conclusion.

10 DR. RICH: Thank you, Mr. Chairman.

11 My name is Bill Rich. I'm the Medical Director of
12 Health Policy, American Academy of Ophthalmology, and I wear
13 a new hat. I'm Chairman of the Health Professions Council
14 at the NQF.

15 To address Dr. Kane's point about the need for
16 comparative information to measure physicians and patients'
17 choice of comparative efficacy of drugs, we are looking at
18 appropriateness measures. But that is really going to be
19 dependent upon what is in comparative effectiveness. If you
20 look at the IOM priorities that came out last month, there
21 were very few head-to-head drug recommendations. So I am
22 not as optimistic as I was before the IOM came out.

1 Secondly, the whole issue of how the NQF is
2 looking at measure outcome, we are actually seeing very
3 substantive outcomes measures for the first time. The
4 difficulty is incorporating them in to -- collecting them.
5 That is going to have to be done through something other
6 than administrative claims data. We are not going to have
7 HIT or EMR, especially in specialties, until well after
8 2011. So you're going to see the development of registries,
9 which CMS is pushing and stimulating. Many specialties are
10 in the process of adapting registries.

11 However, there doesn't seem to be -- to help you
12 in your last issue of discussion here, Mr. Chairman --
13 people are not collecting the same data. CMS has really
14 taken the lead and we're not really seeing either MA or the
15 commercial plans adopt any meaningful process or outcomes
16 measures. Hopefully this report will actually stimulate the
17 collection of that comparative data that doesn't exist now.

18 The last comment I'd like to make is on a personal
19 level. Dr. Crosson really put his finger on it. You need
20 meaningful process measures and outcomes measures, and the
21 two are not necessarily linked. A recent article in Health
22 Affairs showed that the outcomes of hip replacement surgery

1 was not related at all to the process measures. However,
2 there are certain process measures that have marked impact
3 on health outcomes: hemoglobin A1C, retinal exams. And so
4 there really has to be a combination of the two.

5 But I would hope that this report will emphasize
6 the need to coordinate common collection of data. We have
7 to figure out a mechanism because HIT, unfortunately, is
8 going to be down the road.

9 Thank you, sir.

10 MS. HELLER: Hello, I'm Karen Heller, Executive
11 Vice President from the Greater New York Hospital
12 Association and my comments are about the topic of
13 geographic variation. I want to praise and thank the
14 Commission for the study it's doing. It is vitally
15 important to get out there standardized Medicare spending
16 data.

17 I understand that there's a controversy about IME
18 and all the other add-ons, but the Commission and various
19 Commissioners are on the record about that. It's important
20 to distill the true differences in utilization. And so I
21 thank you.

22 I also want to point out, I've been working with

1 CMS on this and was a little concerned about something they
2 told me on Monday, which is that the risk scores in that
3 Medicare Advantage section reflect the average of the
4 managed care and the fee-for-service.

5 So even though we're standardizing by the risk
6 score, the risk score is probably -- since the fee-for-
7 service population is generally sicker -- we're probably
8 understandardizing even with this -- even with that. But I
9 agree, it's the only thing that's available.

10 Then lastly, and I'm sure everybody has looked at
11 this already, but a question came up about quality measures.
12 The fact of the matter is that there is an inverse
13 correlation between the spending data and the new risk-
14 adjusted mortality statistics for hospitals. This has been
15 available now since early July.

16 And so I don't think the inverse correlation is
17 strong enough to get into a peer-reviewed article, but it's
18 still something that's there and something to be looked at
19 and added to the discussion.

20 Thank you.

21 DR. ROSINSKY: My name is Ned Rosinsky. I'm a
22 psychiatrist associated with the Johns Hopkins Medical and

1 Surgical Association and an amateur public health
2 researcher.

3 I just wanted to address the point made by Dr.
4 Chernew regarding patient mix, first. The Wennberg Atlas,
5 to my reason, has no socioeconomic data whatsoever.
6 Socioeconomic issues are related to footnotes which, when
7 you trace them back, come to aggregate data based on ZIP
8 codes. And the footnotes to those studies by Elliott Fisher
9 do not support his stated assertion in the articles, that
10 they are reasonable proxies. They are not reasonable
11 proxies.

12 In fact, there is research at the Harvard School
13 of Public Health by Nancy Krieger that shows that between
14 one-third and one-half of poverty is covered up when you
15 compare ZIP code aggregate data with 30,000 people apiece to
16 block track data of 1,000 people apiece.

17 So the lack of finding of these regional
18 variations by Wennberg that is explained by -- it could be
19 explained by socioeconomic differences in the populations,
20 is thrown into question. For Wennberg, it's past history.
21 He doesn't even bother to put it in the atlas. But to my
22 mind, it is very much on the surface, and I appreciate the

1 comment made by Dr. Chernew.

2 I also want to address the issue of severity,
3 which was brought up in terms of the three o'clock
4 discussion. Under general agreement we have regional
5 variation exists and is not fully explained by prices or
6 health status. The question of health status has been
7 buried and is just as murky as the question of socioeconomic
8 data, as far as I can see.

9 Again, the Wennberg Atlas refers back to a 2004
10 study by Wennberg by himself, which then refers back to a
11 1994 study by Lisa Iezzoni -- who happens also to be at
12 Harvard -- who did studies on the severity of illness. And
13 those studies are what Wennberg is referencing, the Iezzoni
14 studies. And Iezzoni correlated severity of illness,
15 particularly chronic illnesses with death in the hospital
16 and correlating with discharge diagnosis. However, death in
17 the hospital is certainly not a measure of anticipated
18 health care costs.

19 So it looks to me like when Wennberg is talking
20 about severity not explaining these issues, he's using the
21 wrong measure. I understand that the measure that you use
22 in the HCC includes Medicaid -- if a patient has Medicaid,

1 which is somewhat of an indicator of socioeconomic status.
2 But I think a better measure was actually done in an
3 analysis of the New Yorker article that I heard referenced
4 here three or four times today, the Atul Gawande article.

5 The same data was looked at by Daniel Gilden, who
6 runs Jen Associates in Cambridge, Massachusetts. And he
7 used a severity indicator called his Fragility Index, which
8 associates bill diagnosis in Medicare with things like
9 vision problems, dementia, poor self-care. And with his
10 fragility index, when you line up patients with equal
11 fragility and compare them between McAllen, El Paso, and
12 Grand Junction, the benchmark city that was in that article,
13 they are identical except that the highest severity of
14 fragility, in which McAllen was 10 percent higher, not 300
15 percent higher.

16 This article by Dan Gilden should be reviewed by
17 your staff to see how he arrived at -- I have copies of it
18 here if anybody wants to look at it -- see how he arrived at
19 his Fragility Index, which just really undercuts this
20 article in New Yorker, which of course President Obama was
21 famous for having raised as this is what we have to fix, in
22 a New York Times article describing his reaction to it.

1 So I just want to say that I think a little more
2 careful look at socioeconomic and severity of illness
3 variables may help to explain a lot of the variation that
4 you've documented, certainly much more than is explained in
5 the Wennberg Atlas.

6 And anybody who wants additional information, I
7 have it here after the meeting.

8 Thank you.

9 MR. HACKBARTH: Okay, thank you and we are
10 adjourned until 9:00 a.m. tomorrow.

11 [Whereupon, at 5:25 p.m., the meeting was
12 recessed, to reconvene at 9:00 a.m. on Friday, September 18,
13 2009.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 18, 2009
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
FRANCIS J. CROSSON, M.D., Vice Chair
MITRA BEHROOZI, J.D.
ROBERT A. BERENSON, M.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.
THOMAS M. DEAN, M.D.
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
HERB B. KUHN
GEORGE N. MILLER, JR., M.H.S.A.
ARNOLD MILSTEIN, M.D., M.P.H.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, Ph.D.

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

2 MR. HACKBARTH: Okay. Good morning. We have a
3 guest this morning. Cristina, will you do the introduction?

4 MS. BOCCUTI: Sure. I'd be happy to. This
5 morning we have Dr. Russ Robertson from the Council on
6 Graduate Medical Education, which is COGME. This is a
7 council set up by the Secretary of Health and Human Services
8 -- I think out of HRSA, right? But he is going to talk more
9 about what the organization is. But by way of introduction,
10 he is also a professor and chair at Northwestern University
11 in the Department of Family Medicine, and he has had a
12 career of thinking about some of these issues. So we are
13 happy to have him here this morning.

14 I'm going to let him stay here on his own so I do
15 not jump in, but I will be right back if we want to have any
16 other talk about the work going forward.

17 DR. ROBERTSON: Thank you very much. It is a
18 pleasure and a wonderful opportunity to be able to be here.

19 Just before we get going, I just want to let you
20 know what a wonderful staff you have. You probably already
21 know that, but having had the opportunity to work with Mark
22 and Cristina and Jim and Craig has been really helpful. And

1 I look at this meeting as really, for me anyway, a continued
2 discussion that I think was able to start with MedPAC, or
3 perhaps revive. As I look back on the previous Chairs of
4 COGME, there had been interactions with MedPAC and its
5 predecessor, and those had sort of gone fallow, so to speak.
6 And it just really made sense, based on the overlapping
7 missions that we have, to really revive the interactions
8 that have been taking place. Kevin Grumbach was here, and I
9 think that he probably commented on some similar issues.
10 And so what I look at what we're going to be doing today is
11 really a continuation of that discussion and hopefully
12 engagement as we all go forward with regard to the missions
13 to which we have been charged.

14 Just another quick comment I wanted to make is
15 that, you know, I'm grateful to be a family physician, but I
16 know at the present time there are certainly controversies
17 or tensions that exist between specialties, and I'm really
18 not here as a part of that today. If you could not think of
19 me as a family physician today and perhaps think of me with
20 my former career in mind as an elementary and junior high
21 school teacher, not because you are at that level with
22 regard to your education, but that's what I really like to

1 do. And that was a lot of what led me into medicine and
2 what led me into family medicine, was that background. So
3 hopefully, if that is an issue, I'd like to at least take
4 that off the table.

5 So I'll jump into my slides here, and as I was
6 saying, a complaint about having to wear glasses at this
7 particular stage of my life. So just a little bit about
8 what -- this is an overview, so I'll be talking about the
9 history of the Council of Graduate Medical Education and its
10 charge. And by the way, I'm going to try really hard to
11 keep this to about 15 to 20 minutes because I'm aware that
12 there's a lot of opportunity for discussion, and I don't
13 want to do anything that would diminish the possibilities of
14 doing that.

15 The council tends to take on issues sort of one at
16 a time, and I think that seems to work best. Right now the
17 issue that we are looking at is: Where are we as a nation
18 with regard to primary care? Where are we with regard to
19 educating the cadre of physicians that are going to be
20 providers of primary care? And by way of explanation, we
21 have a meeting coming up on the 17th and 18th or the 18th
22 and 19th of November. I'm clearly aware that primary care

1 physicians are not the only physicians that are in short
2 supply. We have the president of the American College of
3 Surgeons, Dr. Russell, whom I've invited as a presenter for
4 that meeting because there are clearly issues there. And
5 I'm also aware that for certain internal medicine
6 subspecialties, like infectious disease, rheumatology,
7 endocrinology, there are shortages there.

8 So, believe me, there is a broad awareness that we
9 have of that. But as we look at this from a priority-
10 related standpoint, this seems to be where the council wants
11 to go right now.

12 I'll talk a little bit about what's happening with
13 graduate medical education and how it's growing in hospitals
14 at the present, and then I'm going to go over some COGME
15 recommendations specifically from the 19th report, and then
16 we'll talk a little bit about -- there have actually been
17 three reports that COGME has issued in the past that look at
18 the issue of all-payer. So, with that, I'll jump in.

19 Just by way of me, as well, too, this is actually
20 my second term on the council. I started in 2004 -- or
21 2003, and at the end of that term, I found myself as the
22 Chair and was actually kind of enjoying it, so I asked

1 whether or not there would be the possibility for me to
2 serve a second term, and that request was granted. And so
3 I'll be on the council until 2011.

4 The council started back in 1986, but then it was
5 called GMENAC, if anybody remembers that acronym, the
6 Graduate Medical Education National Advisory Committee; and
7 we sort of have continued to exist based on some periodic
8 congressional reauthorizations. We sort of go on life
9 support for a while, but nobody ever quite disconnects the
10 ventilator, and we are able to continue to move along. And
11 so those are the circumstances right now. We were in the
12 major bill that was passed, so we are authorized through
13 September of 2010. At the present time, we're supposed to
14 provide an ongoing assessment of physician workforce trends,
15 training issues, and financing policies, recommend
16 appropriate federal and private sector efforts. We advise
17 and make recommendations to the Secretary of HHS, the Senate
18 Committee on Health, Education, Labor, and Pensions, and the
19 House of Representatives Committee on Commerce. And those
20 are our primary constituents to which we report.

21 We also have a very broad membership, and just as
22 your membership has some statutory foundations, so does

1 ours. And so it's a wonderful mix of individuals, and so as
2 a consequence, we really do represent a broad consensus.
3 And I would also comment that all of the reports that I've
4 been responsible for have all been approved by consensus.
5 We do not necessarily take a formal vote, but the discussion
6 is sufficient so that, whatever we issue, everybody has
7 generally had an opportunity to have his or her opinions
8 known.

9 I wanted to set the stage a little bit. We
10 brought in a consultant from what is called the Altarum
11 Group, a group of health care economists, to provide us with
12 a context for where the nation is at it relates to primary
13 care.

14 Right now, about 65 percent of all physicians in
15 the U.S. are specialists; 35 percent are primary care
16 physicians. Primary care, the definition that we use, is
17 general internal medicine, general pediatrics, and family
18 medicine. So those are the three specialties.

19 What the consultant did was looked at
20 questionnaires from the 2008 graduates of all U.S.
21 allopathic medical schools and osteopathic medical schools
22 to assess what their interest was with regard to career

1 choice. Of that entire cadre of individuals, only 17
2 percent of them saw primary care, one of those three primary
3 care specialties as their ultimate career choice.

4 What happens is, as a consequence of not everybody
5 getting what otherwise their first choice was, about 27
6 percent of those students will end up in a primary care
7 career. I think part of what we are talking about here are
8 physicians are going to be taking care of adults, and so
9 when you look at that 17 percent, probably about 5 percent
10 drop out. So we're looking at around maybe 10 or 11 percent
11 of current U.S. medical students that see themselves as
12 primary care providers.

13 This was underscored in an article that was in
14 JAMA last year that showed that 2 percent of U.S. medical
15 students saw themselves as future general internists; about
16 4.9 percent saw themselves as family physicians.

17 When you look at other nations that have
18 comprehensive policies with regard to universal access to
19 health, the ratio of generalists to specialists is about
20 50/50. They also generally have a higher per capita number
21 of physicians than we do, and so this is part of what is
22 framing where we are with the second report.

1 So we are talking about where we are with regard
2 to primary care. One of the statistics that is out there
3 recently is that right now in Massachusetts it is a 66-day
4 wait if you want to see a primary care physician. That is
5 relatively recent information. So we've got concerns with
6 potential supply, something I think looks like it may be
7 happening with regard to health care reform.

8 Where are we with regard to the number of
9 physicians that are going to take care of potentially 30 to
10 40 million new Americans? The AAMC has registered
11 significant concerns about that. They project a physician
12 shortfall of about 31,000, and that is across the board.
13 That is not just primary care. A worry that we have is the
14 potential for long waits, the potential for difficulty for
15 access if there are an insufficient number of physicians to
16 be able to do that.

17 There's probably going to be some increased
18 reliance on -- the phrase is always difficult to use --
19 "physician extenders," physicians' assistants, advanced
20 practice nurses. I think that the role that they are going
21 to play, by intent or default, is going to continue to be a
22 significant issue.

1 Some of the other things that are being talked
2 about internationally, the World Health Organization put out
3 a report last year entitled "Primary Care: Now More Than
4 Ever." And one of the phrases that they reference is a
5 phrase called "task shifting" and looking differently at the
6 way that health care tasks are allocated and who does them.
7 And one of the proposals that they have is that some of the
8 tasks that specialists do could be moved to primary care
9 physicians; primary care physicians to physician extenders
10 or others.

11 There was an interesting article that was in the
12 Annals of Family Medicine where it showed that as many as 70
13 percent of all visits to specialists currently in the United
14 States are actually follow-up visits for chronic or routine
15 care, and alleged that some of those visits could actually
16 be performed by primary care physicians as opposed to
17 specialists.

18 The other topic that's out there is there's a lot
19 of talk about interdisciplinary care, interdisciplinary
20 education. The three Title VII and the one Title Committee
21 at HRSA have issued a report about that. We have been
22 working on that collaboratively and where that might go.

1 When we think about the patient-centered medical home and
2 those sorts of issues, I think that's something that's of
3 import to consider.

4 Significant problems with regard to access for
5 underserved populations and communities. There are some
6 remarkable geographic maldistribution issues that are out
7 there right now, and clearly the place where I practice in
8 Chicago is in a medically underserved community, certainly
9 shortages there. And I would imagine that you all are aware
10 of some of the significant shortages that exist in rural
11 settings.

12 One of the options that is being talked about is a
13 proposal called "Teaching Health Centers," the notion that
14 graduate medical education funds, instead of being given to
15 a hospital, would instead be given to an ambulatory or
16 community-based entity that would then be responsible for
17 overseeing the educational process of primarily physicians
18 who are learning and training in the ambulatory setting.

19 One of the things that's popping up now, for those
20 of you who privilege physicians, is: How do you privilege a
21 doctor in a hospital if he or she never sets foot in the
22 hospital to practice? This is happening with family

1 medicine, with general internal medicine, with pediatrics,
2 and with a number of other specialties. So the notion of
3 the hospital as the nexus of graduate medical education
4 certainly then should follow if we are having discussions
5 about where physicians are or are not practicing.

6 I'll talk a little bit about Title VII funding.
7 This is an issue for the primary care specialties. If there
8 is sort of an analog to the NIH for departments that have an
9 emphasis on primary care, you can certainly see that the
10 trend curve is problematic. There was a Macy report that
11 came out this year that shows a really strong correlation
12 between Title VII funding and the production of primary care
13 physicians. And what had happened in the previous
14 administration is that there was a -- the way in which Title
15 VII was scored, they were not able to document what they
16 felt was a good value, and so, historically, the budget for
17 Title VII was virtually zeroed out. And then, you know,
18 with congressional intervention, there was some improvement.
19 But there are a lot of novel GME-related programs that have
20 been historically funded by Title VII that have been
21 significantly depleted as a consequence.

22 I checked yesterday, and I don't know that there

1 is anything specific that has been done with Title VII at
2 the present, but I think there's reasonable hope that there
3 will be improved funding for Title VII funding.

4 This slide is based on an article that came out
5 where Ed Salsberg from the AAMC and Paul Rockey from the AMA
6 were lead authors, and we are looking at sort of what is
7 happening right now with growth in graduate medical
8 education positions. And there actually has been growth.
9 You know, the cap, as you all know, was implemented in
10 December, I believe, of 1996, and so there have been very
11 few new Medicare-funded GME positions. But what has
12 happened is hospitals have, in spite of that, chosen to fund
13 graduate medical education positions, and during the period
14 of time here, there has been about a net 8-percent increase
15 in GME-funded positions, and they're in anesthesia,
16 diagnostic radiology, emergency medicine, pathology, and
17 psychiatry, and decreases in primary care specialties and
18 OB/GYN specialties.

19 There has been about a net 37-percent decrease in
20 the number of family medicine positions, and there have been
21 similar but not quite as significant decreases in general
22 internal medicine and pediatrics positions. So we have this

1 sort of interesting dichotomy where hospitals, you know, for
2 very understandable reasons, continue to fund out of their
3 own revenues positions in specialty areas, while at the same
4 time, and for a couple of reasons that I'll go into in
5 another slide, positions in primary care are diminishing.

6 Just a comment, too, about this slide is that
7 there is a proposal now in current legislation that would
8 redistribute currently vacant GME positions, and I think
9 about 75 percent of those positions are projected to go into
10 primary care and the other 25 percent into specialty care.
11 On the surface, that sounds great. I think what would
12 likely happen when you look at the cost of running different
13 kinds of primary care settings -- and specifically family
14 medicine programs are considerably more expensive to run
15 than are general internal medicine and pediatrics. What we
16 think would happen is many of those positions that would end
17 up in general pediatrics or general internal medicine would
18 perhaps unintentionally -- my choice of words -- still end
19 up being a continued conduit for medical subspecialization.
20 So I think that is a concern that I just wanted to raise.

21 Just a little bit with regard to what's happening
22 in family medicine. This goes up to 2008. You can see the

1 positions have dropped considerably. By no coincidence,
2 they were at their peak in the mid-1990s, and that was when
3 managed care was looking like it was going to be the future,
4 and there were a number of dynamics that really aligned at
5 that time with significant interest in family medicine.

6 I have just two quick stories about how family
7 medicine residency programs closed. One is a family
8 medicine residency program in Racine, Wisconsin. This was a
9 program that was administered by the Medical College of
10 Wisconsin. By pure literal coincidence, I was interim chair
11 of that department for a couple of years, and I moved that
12 residency program from a hospital in Kenosha to the hospital
13 that it found itself in Racine.

14 Racine is a town of about 200,000 people. Case is
15 based there; Johnson & Johnson is based there. So, you
16 know, it's a community that certainly is not on the ropes
17 financially. And the way the residency programs work often
18 in family medicine is that you end up, by default or intent,
19 taking care of the patient population that the private
20 physicians in the community would choose not to take care
21 of.

22 And this particular residency program had a very

1 high percentage of its patients who were on public aid --
2 Hispanic and/or African American and underinsured and/or
3 uninsured. And when you look at the sources of funding to
4 run a residency program, you have the GME funds that the
5 hospital makes available; you have clinical revenues; and in
6 Wisconsin, actually the State of Wisconsin made money
7 available from a legislative perspective to help support
8 training programs.

9 But in this program, literally the bottom line was
10 the bottom line, and when the hospital looked at the cost of
11 running the program, there was pressure on the department;
12 because the program was running at a financial deficit, the
13 program was closed. And so all of those patients that were
14 being cared for that were getting primary care in that
15 setting were more or less left to fend on their own, and
16 based on what we know, more than likely many of them will
17 find their way to the emergency department and ultimately
18 into the hospital. So what often looks like a short-term
19 way to reduce an immediate and apparent loss is translated
20 into higher costs. And from my perspective, the thing that
21 I feel the worst about is people are unintentionally going
22 to suffer as a consequence by lack of access to health care.

1 I think that really should be the driving issue.

2 The other story is a family medicine residency
3 program that was based out of Wayne State University in
4 Detroit. The Detroit Medical Center, which is not a part of
5 the university or the medical school, made a decision, an
6 explicit decision that they were not in the primary care
7 business. And so when they looked at how they wanted to
8 fund residency training slots, they had a very successful
9 family medicine residency program that was located in a
10 medically underserved section of Detroit, and they said, "We
11 don't want it anymore." And the department chair was forced
12 to look for another location for her residency program and
13 ended up actually finding it in Rochester, Michigan, a
14 suburb of Detroit.

15 They got the program started, and I will not go
16 into a lot of details, but there was a CMS ruling that was
17 made formally while that program was transferring, and they
18 are currently struggling right now. They were a 24-resident
19 program. They are looking at dropping to a 12-resident
20 program and just frankly looking at surviving.

21 So those are two stories that are very
22 contemporary with regard to what is happening with that.

1 Here is a slide that we have to talk about a
2 little bit, and it is the whole issue of who is going into
3 what and what are the motivations for why they're doing it.
4 And there are a number of reasons. You know, I am not going
5 to tell you here if you pay primary care physicians a half a
6 million dollars a year, you'll solve the problem. I think
7 that's an overly simplistic solution. And I think in some
8 ways it's almost a little bit morally offensive, and I think
9 that's not an area that we want to get into. But there are
10 a couple of issues here, and a lot of this is supported by a
11 Macy Foundation report that came out this year.

12 One of the problems is that there is what we say
13 is a "hidden curriculum" in medical school. There's the
14 formal curriculum and then there is what gets talked about
15 in the hallway and which specialty you want to go into.
16 And, you know, unfortunately, I will resurrect my role as a
17 family physician, and what happens to a lot of us is what I
18 truly believe are well-intended professors in medical
19 school, when you say that you want to become a primary care
20 physician or a family physician, "Well, you're such a smart
21 person. Why would you want to invest your career in that
22 specialty?" And that happens, and it's happening today.

1 It's just a reality.

2 Now, the other problem is that, particularly in
3 academic health centers, students are exposed to the very
4 best that specialty care can provide. They see absolutely
5 phenomenal environments where literally cutting-edge care is
6 taking place. And often the primary care physicians that
7 they're exposed to -- general internists, general
8 pediatricians, and family physicians -- are struggling.
9 They're struggling economically. They're struggling from a
10 lifestyle-related standpoint. And while they're doing their
11 best to teach, that's not what the students are walking away
12 with.

13 We had a program when I was in Wisconsin where we
14 funded a summer externship for medical students, paid them
15 \$2,000, put them with a family physician in rural Wisconsin,
16 and they came back with two distinct impressions: Dr. So-
17 and-So is the most wonderful person I have ever met. He, or
18 she, is a self-less individual, and no way do I want that
19 lifestyle. And, unfortunately that is an impression,
20 wrongly, that a lot of medical students have. There are
21 some phenomenal things that are being done in primary care
22 right now with the patient-centered medical home. But,

1 unfortunately, students aren't seeing them.

2 The other issue, still, it is the income gap. I
3 think that's something that's out there. And based on, you
4 know, people talk about loan or indebtedness as a driving
5 factor for specialty choice. The AAMC says this and the
6 Macy report says this, that loan forgiveness is a factor or
7 debt is a factor, but it's not the key factor. The key
8 factor, if you're looking at finances, is return on
9 investment. And the difference between a primary care
10 specialty and a procedurally driven specialty over the
11 course of an individual's lifetime is about \$3.5 million in
12 terms of lifetime income. This is information from the Macy
13 report. And so students are aware of that in the context of
14 making their decisions as they decide what they want to do.

15 The other problem that the Macy report has brought
16 up, and others, is medical school admission policies are
17 problematic, that most medical schools, understandably, like
18 to talk about their average MCAT scores, their average grade
19 point averages. Well, the people who best fit that profile
20 come from well-to-do, mostly suburban-urban settings. Those
21 people do not want to go to a remote rural or a medically
22 underserved setting in general. It's not because they're

1 bad people. It's just that that's the consequence of the
2 environment in which they live.

3 There's explicit information out of the Robert
4 Graham Center here in D.C. that shows that the number of
5 applicants to U.S. medical schools from rural communities is
6 a steady state number. They just don't get in. And when
7 they do get in, there is real evidence that shows that they
8 do return to the communities from which they came to
9 practice, and they often go into primary care. So I think
10 it's another issue that needs to be considered as we look at
11 this particular issue.

12 So talking a little bit about the 19th report for
13 COGME, we issued two reports about a year and a half ago,
14 and we came up with four recommendations, and I'll just go
15 into them in a little bit more detail. I think I'm doing
16 pretty good time-wise here.

17 We had four recommendations: that we felt that
18 graduate medical education should be aligned with future
19 health care needs, and we recommended a funded increase in
20 GME positions of about 15 percent to be able to accommodate
21 that, and we felt that it could be accommodated through
22 medical school expansion and through support directed

1 towards innovative training models which address community
2 needs and which reflect emerging, evolving, and contemporary
3 models of health care delivery.

4 The Teaching Health Centers proposal that I
5 referenced really fits that to a T, but that has run into
6 two fairly significant obstacles. First, when you talk to
7 staff from the House Ways and Means Committee and then you
8 look at the patient population that gets cared for in
9 federally qualified health centers, which is what we're
10 talking about, it's maybe 5 to 10 percent of those patients
11 are Medicare-eligible patients. And if you apply Medicare
12 GME rules to a 5- to 10-percent patient population, there is
13 a way that you can fund them, but you'd be nuts to do it
14 because there's virtually no money in it. And when you
15 share this conversation with Ways and Means staff -- and
16 particularly a phrase that I have picked up on is sort of
17 the "pre-Medicare population." I mean, theoretically,
18 you're training physicians that are going to take care of
19 Medicare-related patients. They default to the standards
20 that basically Medicare GME is to be allocated and paid for
21 for larger percentages of Medicare patients, which is the
22 hospital.

1 The other organizations that generally don't look
2 kindly on this is the AAMC. The concern that they have
3 expressed is that, you know, GME money should go to the
4 hospitals, and that's basically the way it is. We've had
5 some good conversations with the AAMC, and they have been
6 really wonderfully engaging. And I think that there are
7 some other ways to perhaps address this. But that's
8 basically where we are with this.

9 The second recommendation somewhat really follows
10 the first, and that is, broaden the definition of the
11 "training venue." You know, again, where are physicians
12 practicing today? You know, why should you have this
13 potentially intensive inpatient hospital-based experience
14 when you're going to spend the majority of your career
15 practicing in a non-hospital setting? That really isn't
16 recognized in any formal way with regard to the way GME
17 funding is currently based.

18 The third recommendation is to remove regulatory
19 barriers to executing flexible GME training programs and
20 expanding training venues. There are some rules right now
21 that CMS has that make it difficult. One of them is called
22 sort of the community preceptor rule and the ability to fund

1 graduate medical education and to support the instruction
2 and/or funding of faculty members who are working in non-
3 hospital settings. I do not believe that CMS is purposely
4 being not cooperative. We have a CMS member on COGME, and
5 he is a wonderful person, a tremendous resource. And so
6 this is not from my perspective an opportunity to complain
7 about CMS. They have a number of other issues with which
8 they're dealing, and I've been very grateful for the degree
9 in which we have been able to communicate with them.

10 And the last recommendation is to make
11 accountability for the public's health the driving force for
12 graduate medical education. You know, basically this kind
13 of calls the question: You know, what does GME exist for?
14 Who are the people that are going to be the recipients of
15 care that is funded by graduate medical education? And are
16 we doing that right now, or is this an opportunity to look
17 differently at the way we pay for graduate medical education
18 and where the training is occurring?

19 We on COGME would argue that there's currently a
20 significant disconnect with this, and I think that is where
21 these four recommendations are derived.

22 Then the last thing that I wanted to talk about is

1 the issue of an all-payer approach to graduate medical
2 education. When I went through the archives of COGME and
3 then talked to Jerry Katzoff, who is our Executive
4 Secretary, who has been there since the beginning -- he is
5 sort of an archival presence as well as a wonderful fount of
6 wisdom. Three times the Council on Graduate Medical
7 Education has advocated for an all-payer system to support
8 graduate medical education. We know that Medicare, through
9 GME funding, is the primary source, but there also are
10 Medicaid dollars that go into graduate medical education.
11 The VA makes a major contribution to GME. We're aware of
12 that, too. And we learned recently that actually the VA is
13 looking at primary care differently and perhaps even willing
14 to look at funding some sort of an approach to family
15 medicine, which would be a substantial change for them. So
16 in terms of people that are out there kind of wondering
17 about what is going on, it is nice to know that the VA is
18 looking at that as well, too.

19 You know, I am sure for reasons that we can all
20 hypothesize, this has never really gained significant
21 traction, and I will not go into a lot more detail because I
22 think I'm beyond my 15 to 20 minutes. But in the COGME

1 reports that came up with this, there were a number of ways
2 that this could be done.

3 One that already is being done right now is in
4 Utah. Utah has a graduate medical education consortium
5 where the GME slots for the state are addressed centrally,
6 and then there's a group that makes -- they have a special
7 waiver from Medicare to be able to do that. And the
8 conversation -- and for the most part, I think, it has been
9 something that people are pleased with. The question is
10 whether or not something like that would work everywhere in
11 the U.S. Utah has one medical school. States that are like
12 that, I think it's easier to put together something along
13 those lines. But one could argue that graduate medical
14 education consortia could definitely be developed in smaller
15 academic communities, but it would require, I think, an
16 unprecedented degree of cooperation and collaboration to be
17 able to do something like that.

18 The methods for funding it would be some sort of a
19 surcharge on private insurance to be able to cover that.
20 The reports did not go into any detail with regard to what
21 that should be. But, again, you know, everybody sort of has
22 a stake in what's going on right now, and I don't think it's

1 unreasonable to look at other sources or payers for graduate
2 medical education.

3 One quick comment is Tzvi Hefter is the person who
4 is on CMS that is on COGME, and I asked him what was
5 happening to the growth in graduate medical education slots
6 before the cap was placed, and they were growing at about 4
7 percent per year. And if you do some back-of-the-napkin
8 calculations, right now there are about 25,000, 26,000 PG1
9 GME positions. If that had been allowed to grow at about 4
10 percent per year, I think I came up with something like
11 38,000 PG1 GME positions. You figure Medicare in spending
12 about \$12 billion a year on graduate medical education.
13 Imagine what that would look like if we had not put the cap
14 into place, and particularly if the continued predisposition
15 of U.S. medical students to choose specialty care had been
16 preserved in the context of that expansion. You can
17 hypothesize this to where we might be with a health care
18 expenditure perspective with that.

19 So I'll end my comments there and be happy to
20 entertain questions.

21 MR. HACKBARTH: Thank you, Russ. That was
22 terrific. We are still very much in the exploratory phase

1 here, learning about these issues, so I think we'll probably
2 have lots of different areas that people want to explore
3 with you. Our practice is to have several different rounds
4 of questions, and the first round focuses just on clarifying
5 specific points that you made.

6 So let me ask Commissioners, are there any
7 clarifying questions for Russ?

8 DR. CASTELLANOS: We didn't have a lot of material
9 to review before you came, but one of the points you made on
10 the COGME was the third point about funding undergraduate
11 education. I would imagine undergraduate may mean medical
12 school education. We've struggled with this point before.
13 We understand the graduate being funded. What direction are
14 you doing to help fund medical school undergraduate
15 education?

16 DR. ROBERTSON: Well, specifically, certainly
17 that's not a charge that COGME has, and so we have not spent
18 time or energy on that. So I don't have an answer for you
19 other than that's not been a part of what our responsibility
20 has been.

21 DR. CASTELLANOS: Thank you.

22 DR. CHERNEW: When they make their forecasts of

1 specialties and shortages, what do they assume about sort of
2 the productivity, the number of patients that can be served
3 by the existing physician base and new physicians?

4 DR. ROBERTSON: Who do you mean by the "they" that
5 make the forecasting?

6 DR. CHERNEW: Well, you had a slide, for example,
7 that talked about the different groups of projected
8 shortfalls of -- I'd have to go back to see what the source
9 of that was, but I've seen others as well.

10 DR. ROBERTSON: Well, I think generally we look at
11 the patient population in the U.S. We compare what goes on
12 here with countries that have taken a different approach to
13 primary care, and that's where the 50/50 numbers come from.
14 That's generally what you find in most Western European
15 countries, and so that's where that projections comes from.

16 The other data that we showed is just real data
17 with regard to what medical students are doing here in the
18 U.S. and how their career choices are defining the direction
19 that the specialty/generalist mix is taking at the present.

20 MR. HACKBARTH: Actually, my clarifying question
21 was along the same lines. Do you make your own independent
22 assessment of long-term needs? Or you are just reviewing

1 literature produced by other organizations?

2 DR. ROBERTSON: Well, for the last report we
3 brought in the Altarum Group. They were the source of
4 information that we built a lot of that one. But we're all,
5 I think, relatively knee-deep in the literature that's out
6 there, and so we try to follow that as well, too. So I
7 think it comes from a variety of different sources. Again,
8 we try to be relatively ecumenical in terms of the way in
9 which we gather and process information.

10 MR. HACKBARTH: Okay.

11 DR. STUART: Could we look at Slide 9 again,
12 please?

13 DR. ROBERTSON: Sure.

14 DR. STUART: Do you have any sense of what that
15 line would look like or where family practice, rather, would
16 be on that line if, say, through some magical intervention
17 the average pay went from under \$200,000 to \$300,000? In
18 other words, is there a sense of how important money is
19 irrespective of all of the other things that you've talked
20 about?

21 DR. ROBERTSON: There are two sources of
22 information that we have for that. One is the Altarum

1 Group that did our projections, and the other is material
2 that came out of the American College of Physicians.

3 The Altarum people said that they would recommend
4 that if you could raise the incomes of primary care
5 physicians to 60 percent of that of specialty physicians,
6 that would make a big difference.

7 The ACP made a much more aggressive
8 recommendation. They picked 75 percent as the threshold.
9 And the dollar figure, nobody really wants to be real
10 specific about that, but when we push, probably it's
11 somewhere between the \$200,000 and \$250,000 per year salary.

12 Just a comment, too, related to that is at least
13 in present legislation there is a recommendation for about a
14 10-percent increase in primary care funding through, I
15 think, Medicare. The Robert Graham Group has done a study
16 on that, and that nets out as about a \$2,000 per year
17 increase in the average salary of a primary care physician.

18 DR. STUART: Then a very quick follow-up. How
19 long do you think it would take before there would be a
20 response, a visible response in terms of students with
21 graduate medical education going into primary care in
22 response to higher pay?

1 DR. ROBERTSON: I think if you just said okay,
2 beginning tomorrow we are going to make sure that every
3 primary care physician in the U.S. makes between \$200,000 to
4 \$250,000, it's going to take a while. The decision points
5 for medical students are in their third year of medical
6 school, so if they are going to choose a primary care
7 specialty, it will be 4 years before they're practicing.

8 DR. STUART: Okay

9 DR. ROBERTSON: In general, internal medicine
10 residency programs, there's theoretically a decision point
11 there. But you still would have to do more than that. You
12 would have to break through to the sort of medical school
13 grapevine to be able to make that transition.

14 DR. STUART: Okay. Thank you.

15 MS. HANSEN: [Off microphone] I'm going to pass on
16 this round.

17 DR. BERENSON: While you have that slide up, I was
18 going to ask a question about it. You've emphasized -- and
19 I appreciated the testimony. Thank you very much. Let me
20 say that first.

21 DR. ROBERTSON: Well, thank you.

22 DR. BERENSON: What percentages of unfilled slots

1 with U.S. seniors are filled with international medical
2 graduates, in general, and then for the primary care
3 specialties?

4 DR. ROBERTSON: Well, the data that I know the
5 best -- and I'll apologize in advance -- is what's happening
6 in family medicine. Last year in family medicine, 49
7 percent of the slots were filled with U.S. medical
8 graduates; 51 percent were filled with international medical
9 graduates. And kind of what sort of happens is that if you
10 are -- and the IMGs are both U.S.-born IMGs and foreign-born
11 IMGs. And what I think ends up happening is that if these
12 are individuals -- and there has been interesting work that
13 has been done that for the foreign-born IMGs, their primary
14 motivation is actually to enter into medical or surgical
15 subspecialties. They have a much different perspective, and
16 when they have the opportunity to do so, that's where you
17 tend to find them.

18 I think what happens to some of the open primary
19 care positions, they end up being kind of a point of access
20 for people who want to practice medicine in the United
21 States. It opens up a lot of cultural issues with regard to
22 the physicians that you have caring for medically

1 underserved patient populations if the individual who is
2 providing the care does not have some sort of cultural
3 alignment with the recipients. So that's --

4 DR. BERENSON: That's where I was going with that.
5 So is there literature that looks at the relationship
6 between sort of where the physician comes from and cultural
7 competence, racial disparities?

8 DR. ROBERTSON: Yes, there is.

9 DR. BERENSON: The second question I had had to do
10 with geriatrics. You didn't mention geriatrics as a primary
11 care specialty. Was that because they're too small to even
12 think about? Or is there a principled reason why they're
13 not in that category?

14 DR. ROBERTSON: Well, definitely they are, and it
15 was on one of the slides. Actually, I have a certificate of
16 qualification in geriatrics. I was a nursing home medical
17 director for about 10 years, so I've, you know, greatly
18 enjoyed caring for that patient population. But if you
19 follow the literature, you know, there are lots of
20 opportunities to do a geriatrics fellowship, but many of
21 those fellowship positions go vacant. It is kind of the
22 perfect storm analogy from a chronic disease population and

1 a reimbursement picture.

2 At a place that I was employed recently, we had a
3 geriatrician who was just a remarkably talented individual,
4 very passionate about the care that she wanted to render her
5 patients. But the practice plan was basically an "eat what
6 you kill" practice plan. So as a consequence, she was
7 constantly well behind. She was not even generating her
8 salary based on the patient population that she was caring
9 for, and that is a significant problem in terms of a real
10 shortage that we have of people willing to care for the
11 elderly.

12 DR. BERENSON: You do consider them part of the
13 primary care --

14 DR. ROBERTSON: Absolutely. Definitely.
15 Absolutely.

16 DR. KANE: I had two questions. One is sort of
17 similar to the income question, but has anybody thought
18 about what the role of being a medical home might do to the
19 supply of primary care practitioners? Would that appeal to
20 them? Are they being trained into knowing how to do that?
21 Or is this just going to make more people say, "Oh, my God,
22 what a nightmare job"?

1 DR. ROBERTSON: You know. there are some really
2 exciting things that are happening nationally around the
3 concept of the patient-centered medical home. There is a
4 project out of Family Medicine called Transformed that's
5 looking at this. This is one area where pediatrics, general
6 internal medicine, and family medicine are really
7 collaborating wonderfully. We were able to put together a
8 meeting at the Brookings Institution in April of this year,
9 and we brought a family physician from Virginia who was
10 basically ready to quit practice. He was really just
11 frustrated, and this was echoed -- I happened to be at a
12 meeting at the AMA last week and sat next to Michael Maves.
13 And one of the things that he commented on is: You have
14 physicians that are, I will say, in my age category who
15 theoretically ought to be at their peak earning years in
16 primary care, and if anything, they are watching their
17 incomes drop. They are spending their 401(k)s in order to
18 remain viable.

19 This particular individual's name is Peter
20 Anderson. He reorganized his practice along the lines of
21 the patient-centered medical home, and the really exciting
22 things that happened were that he was able to hit NCQA Level

1 3 from a quality-related perspective. Patient satisfaction
2 went up. Employee satisfaction went up. And I would say
3 not necessarily by coincidence but last in the order of
4 priority is income went up by a third, and he is happier
5 than ever being a primary care physician.

6 The literature that's out there on PCMH right now
7 is still evolving, so there are some that are very
8 successful demonstration projects that have been identified,
9 and I think what I've been able to deduce is that the more
10 senior a physician is, sometimes the more difficulty he or
11 she has in making the adjustments necessary to transition.

12 Anecdotally, I was talking to the section chief
13 for general internal medicine at Northwestern, and a number
14 of the general internists at or around Northwestern, which,
15 if you know where the medical school is, it's in a
16 relatively well-to-do community, they're looking at doing
17 malpractice reviews as a way to augment their income as
18 opposed to continuing to grow their practice. So just
19 another sort of real-world example.

20 DR. KANE: My second question is: You had
21 mentioned the 66-day wait for primary care. How do people
22 measure that? Is that a 66-day -- or how in general -- is

1 there a standardized way of doing that? Is that looking for
2 a new doctor? Is that for an acute visit? Because it seems
3 like there might be different ways to interpret that wait.
4 If it's for a physical exam for a new doctor, that doesn't
5 sound outrageous. But if it's to get in because you have
6 something wrong, that's pretty --

7 DR. ROBERTSON: Well, I'm sure it's a combination,
8 but I think basically what it means, you decide you want to
9 see a primary care physician, you pick up the phone and you
10 make a phone call, and you find out that unless it's a truly
11 urgent or life-threatening condition, the wait is
12 significant. I know that some of the early literature that
13 came out of Massachusetts after they implemented the
14 statewide insurance plan was that lots of physicians in the
15 Boston area, literally their practices were closed, and
16 patients could not find a doctor to care for them.

17 DR. KANE: Do you know if there is some objective
18 and standardized way of measuring waits by specialty in
19 geographic areas that you're aware of?

20 DR. ROBERTSON: There may be. I am not aware of
21 it.

22 DR. MARK MILLER: Just as Nancy's spokesman, she

1 wanted to also follow up on when you said "income," you said
2 they increase their income by a third in her first question.
3 Could you just very briefly -- was that efficiency or
4 revenue? Which way did that --

5 DR. ROBERTSON: It was real take-home money. This
6 individual's pay went up from about \$180,000 to \$200,000 to
7 over \$300,000 from around 200 --

8 DR. MARK MILLER: [Off microphone.]

9 DR. ROBERTSON: Right. That revenue came because
10 of much more efficient practice. He spent virtually all of
11 his time engaged in direct patient care. A lot of the
12 administrative tasks -- organizing referrals, writing
13 prescriptions, following up for laboratory tests -- were
14 done by staff. So as a consequence, he was not engaged in
15 those activities. He was able to see more patients but,
16 again, directly focus on direct patient care as the primary
17 task.

18 MS. BOCCUTI: Plus when he got the NCQA 3, he got
19 more reimbursement, right?

20 DR. ROBERTSON: Yes, definitely. There were a
21 variety of other sources for that.

22 MR. HACKBARTH: I didn't hear that.

1 DR. ROBERTSON: When they got the NCQA standard,
2 as well, too, there was certainly an income-augmenting
3 aspect associated with that.

4 MR. HACKBARTH: Mm-hmm. Jay?

5 DR. CROSSON: Russ, thank you also for a very
6 clear and to-the-point presentation. I have one specific
7 question and it has to do with the recommendations on Slide
8 10, I guess. So this issue of the training venue and how
9 flexibility might help in that area is one thing that we
10 discussed last year. But I didn't quite get the distinction
11 between the second and the third recommendations. Could you
12 just go back over that?

13 DR. ROBERTSON: Sure. So the second is broaden
14 the definition of training venue, and that essentially says,
15 where is the best place to put a resident while he or she is
16 getting the training that is hopefully going to sustain them
17 for the remainder of their career, and that can be in the
18 office in an ambulatory setting, but if you look at, for
19 example, again, the rules that I know the best are the ones,
20 the RRC Rules for Family Medicine, there is a very explicit
21 requirement there for community-based training.

22 And so that could include school-based health

1 care. That could include going to a nursing home and
2 providing care at a nursing home. That could include
3 working with the city health department on a project with
4 regard to sanitation, and a variety of other issues. So we
5 are in the position sometimes where the RRC guidelines, the
6 Residency Review Committee ACGME-authored guidelines, have
7 specific requirements for training that are not necessarily
8 currently recognized or reimbursed.

9 And I think that feeds into the following
10 recommendation, because there are regulatory barriers.
11 Basically, you can't bill a GME for educational activities
12 that are taking place in settings that CMS does not
13 recognize or authorize, and there have been a couple of
14 situations in the family medicine world where hospitals have
15 been fined by CMS and have had to make major reparations as
16 a consequence of the unintentional violation of those rules.

17 DR. CROSSON: Thank you.

18 DR. MILSTEIN: This really builds on your answers
19 to Michael and Nancy's and Bob's questions. You listen to
20 this and your answers, then you look at the recommendations
21 and I'm sensing a disconnect here. I guess, and I'll sort
22 of jump to a conclusion embedded in my question. My

1 question is, how long -- how do we get to residency training
2 experiences that illustrate sort of modern high-productivity
3 life forms of primary care?

4 I mean, when you described as you send these poor
5 people out to residency slots where these people are doing
6 God's work, but it's with no benefit of any engineering flow
7 concepts, no thought as to how one might go about better
8 leveraging technology, nurse practitioners, medical
9 assistants, community health workers, receptionists, all
10 that, you know, Charlie Berger's sort of nationally cited
11 practice in Maine, which is an illustration of this high
12 productivity primary care practice. So in some ways, it's
13 no wonder that -- but my intuition is that the residents in
14 these programs are not being exposed to that model, and
15 perhaps that in turn might be related to the nature of the
16 faculty training them and what they know and what they can
17 teach.

18 So how do we get -- and I didn't see that on your
19 recommendation list -- to a group of faculty in training
20 programs that actually understand the model and can teach it
21 and can illustrate it in the training sites to which our
22 primary care trainees are being exposed?

1 DR. ROBERTSON: I think that there are a number of
2 ways to do that, and I think that's a very accurate
3 assessment of the situation in which we currently find
4 ourselves. The costs of practice transformation for the
5 practices that elect to do that, and I think Kevin Grumbach
6 quotes a statistic that around 60 to 70 percent of all
7 primary care physician practices in the U.S. are basically
8 onesies and twosies, so you are looking at individuals who
9 have very little in the way of accessible capital. So even
10 if they want to make a change, it's very difficult for them
11 to do so. Certainly, some of the larger organizations,
12 Geisinger and Kaiser and others, have been able to engineer
13 these changes and, I think, provide wonderful settings that
14 would be a fabulous experience for students or residents to
15 participate in.

16 I'm not completely versed with this, but I know
17 that there are demonstration projects that are being
18 proposed in some of the legislation that's out there,
19 funding that would be available, but it requires a certain
20 degree of sophistication that often these individuals do not
21 have in order to be able to identify and then apply for
22 those kinds of funding sources.

1 So I don't think there is an easy answer to your
2 question and I think it's problematic that we find ourselves
3 in this particular situation without an easy answer.

4 DR. MILSTEIN: I'm sorry. My question really was,
5 how do we get to a place where we have faculty that
6 understand this model and therefore are in a position to
7 teach it?

8 DR. ROBERTSON: I think that's a similar area
9 that's transitioning. When you look -- again, I'll speak
10 about my specialty. A lot of the people who are practicing
11 family physicians and who become faculty members, they are
12 individuals who are often community-based physicians who
13 thought that they had some useful knowledge to offer in a
14 teaching setting and so they move into a faculty position.

15 There are problems, I think, in primary care in
16 terms of the degree of sophistication that our faculty
17 members have and their capacity to do exactly what you are
18 talking about. There is very little, unfortunately, in the
19 way of peer-reviewed literature and/or competitive grants
20 that come from certainly the family medicine world, is the
21 one that I know the best. Unfortunately, there is some data
22 that shows in studies that as it relates to research

1 aptitude, which isn't necessarily the direct question that
2 you're looking at, but people who go into family medicine
3 often are the least interested in those kinds of activities
4 and so we, I think, unintentionally produce a cadre of
5 faculty that are not in the position to do exactly what you
6 were talking about.

7 MR. BUTLER: If we all agree, and we all agree
8 here that we need increased capacity in primary care, I have
9 a question of where to put our efforts. One would say the
10 practice environment that the physician lives in and works
11 in for his or her career is the most important element, and
12 you have pointed out that compensation is a factor, but it's
13 insulting if you think it's the only factor.

14 I think some of the support for that comment would
15 come from your slide that says in the managed care heyday of
16 1992, when the primary care physician was not only maybe
17 compensated more, but more of a gatekeeper or coordinator of
18 care, was the kind of environment that felt better. So one
19 way to go is to think that creating that environment would
20 help attract additional primary care physicians.

21 The other is to tinker with the number of slots
22 and the caps and the redistribution and the funding of GME

1 itself. As it's been said, about half of the positions are
2 filled with foreign medical graduates as it is and not all
3 of them are filled, period. So it makes me wonder about how
4 much we are going to yield, we are going to get out of
5 tinkering with the number of slots and how we're doing that
6 process versus focusing on the ultimate practice
7 environment.

8 So where would you put the -- obviously, I have a
9 bias, but tell me what you think about the two. And you
10 can't have both totally.

11 DR. ROBERTSON: Well, just to comment, I think
12 that those of us in primary care made an absolutely colossal
13 mistake in the mid-1990s by embracing the role of
14 gatekeeper. There were some of us who thought, finally,
15 we're no longer at the bottom of the totem pole. We're in
16 charge. And we wrongly embraced that role in a way that I
17 don't think we completely understood what all the
18 implications of that were. We really recognize in
19 retrospect that we should have much more warmly embraced the
20 concept of coordination of care, and I think that's where
21 people are right now. I think that's what undergirds the
22 concept of the patient-centered medical home.

1 You know, again, I'm all with where you are, to
2 tinker with reimbursement, to tinker with slots, whatever
3 metaphor you want to use, the direction that we're heading
4 right now is not necessarily a good one, and I think some of
5 the discussions that are out there about bundling patient
6 care, about providing care coordination fees, about
7 demonstration projects, I think those are things that will
8 begin to make a change.

9 But it's going to take a while and I don't know
10 that there's necessarily a collective will to make that kind
11 of a change. I think that's still a problematic issue as we
12 look at some of the motivations of people who are involved
13 in the graduate medical education discussion.

14 MS. BEHROOZI: This is still a round one question.
15 In Slides 5 and 6, you referred to Title VII funding, and so
16 even though the dollars don't look huge in the context of
17 overall spending on GME, you identified it as an issue that
18 related to the declining care for certain subpopulations.
19 So can you explain a little more about what Title VII
20 funding would be?

21 DR. ROBERTSON: Sure. There are, at least in
22 primary care areas, there are three sources of funding that

1 Title VII has helped with. Undergraduate medical education,
2 so funding medical school departments that are engaged in
3 undergraduate medical education, so it actually gets a
4 little bit to the question that Dr. Milstein raised. And so
5 there were funds that were coming from that that medical
6 schools were able to use, because often, if you are not
7 generating the clinical dollars and if you're not generating
8 the research grant funding, then you have to ask the dean
9 for money and the dean sometimes will say yes, but more
10 often than not, the question to that answer [sic] is usually
11 no, and it's not because he or she doesn't support the
12 educational process, but it's just, I think, a reflection of
13 the number of challenges that the dean has. So there was a
14 lot of money that was being spent and some really very novel
15 undergraduate medical education experiences were in
16 existence across the U.S.

17 The second source of funding was what are called
18 academic administrative unit grants, so those were funding
19 streams that helped support either the start of new primary
20 care residency programs, and of note, there are still about
21 seven or eight hospitals in the U.S. that do not have
22 departments of family medicine, so there are some issues as

1 it relates to that.

2 And then the third are sources of funding that
3 were to support graduate medical education, so to bring in
4 funding that, again, would educate faculty members, that
5 would strengthen the quality of the educational experience
6 that residents were having. So when this drop took place,
7 there were a number of departments across the country -- the
8 University of Washington in Seattle is the first one that
9 comes to mind. They had done a really good job of applying
10 and spending Title VII money in a very meaningful way, and
11 when the Title VII funds virtually dried up, then that
12 really significantly undermined.

13 And as you pointed out, we're not -- a term that I
14 picked up a couple of months ago was HOBODs, hundreds of
15 billions of dollars. In terms of what's happening in the
16 economy right now, I mean, this is pocket change, Title VII,
17 and we were not able even to sustain a reasonable degree of
18 funding there.

19 DR. DEAN: Of the people that enter primary care
20 residencies, we know that in family medicine, most of those
21 will end up in primary care, whereas pediatrics and internal
22 medicine, it's a much smaller number. Do you know what

1 those numbers are or how many -- what proportion in
2 pediatrics and internal medicine actually end up in primary
3 care that enter those residencies?

4 DR. ROBERTSON: Well, sort of the most chilling
5 data was the one that showed that two percent of all U.S.
6 medical students see themselves as practicing general
7 internists, so the other 98 percent are looking at becoming
8 hospitalists or medical subspecialists. In pediatrics, the
9 numbers of pediatricians that are subspecializing are
10 continuing to increase. I'm going to pull a number that's a
11 little bit out of the air, but I think it's getting close to
12 60 percent in terms of what's happening in pediatrics, and
13 my understanding is that there are some significant
14 shortages with pediatric subspecialties.

15 So again, I don't have a particular axe to grind
16 as it relates to that, but I think the point that you make
17 is that family medicine is a destination that will result in
18 a primary care provider. There are certificates of added
19 qualification in geriatrics, sports medicine, and now
20 palliative care, but those individuals still by intent, if
21 not by default, end up becoming lifelong primary care
22 physicians.

1 MR. BERTKO: Russ, just a question on Slide 10,
2 your third recommendation here. It's either to you and the
3 COGME members or maybe even Herb or Bob. Is this, as far as
4 you know, a barrier that could be changed by the Secretary
5 at CMS, I mean, of HHS or the Administrator, or is it
6 something we'd have to go to Congress on to recommend a
7 change?

8 DR. ROBERTSON: My knowledge of the regulations is
9 not that deep to be able to answer that question. I think
10 those of us who are engaged in this would certainly look
11 forward to working with CMS on that particular issue.

12 MR. KUHN: Russ, thank you. I'd like to kind of
13 go back and revisit the issue of the numbers or some of the
14 motivation behind those institutions that are training above
15 the cap. You had talked about the growth prior to 1996, the
16 growth since 1996. The numbers I remember reading in the
17 past is about a third of all residency slots are training
18 above the cap. Is that an accurate number, to your
19 knowledge, and can you talk a little bit more about what is
20 happening now in terms of new programs coming on, those that
21 are training above the 1996 cap?

22 DR. ROBERTSON: Yes. I don't know -- the number a

1 third sounds large to me, when we put together a slide set
2 for another presentation. Right now, again, I think
3 Medicare GME funds somewhere in the neighborhood of 25,000
4 to 26,000 positions, and I actually have something that I
5 could probably page through to try to find, but it would be
6 not a good use of our time to be able to do that.

7 I think the net answer to the question is that if
8 a hospital is looking at adding GME positions, they will
9 find the money to do it, in general, if it's a specialty
10 position and something that will support the specialists
11 that are using their hospital. So maybe not the most
12 specific answer, but it's the best one that I can come up
13 with now.

14 MR. HACKBARTH: I'd like to go back and pick up on
15 Herb's question and something that Peter said. It seems to
16 me that the fact that there are so many positions above the
17 cap, there's an important signal there, important
18 information, and I'm trying to learn more about that. So I
19 assume that most of those positions are in subspecialty
20 areas --

21 DR. ROBERTSON: Yes.

22 MR. HACKBARTH: -- and that institutions, and

1 maybe you can help enlighten me here, Peter, that they
2 choose to do that, are able to do it financially because
3 those programs have good economics, unlike you mentioned
4 family practice programs tend to be seen as not economically
5 advantageous. So if that's correct, that raises a question
6 in my mind about whether it's wise to direct Medicare
7 subsidies to programs that are economically self-sufficient.

8 Now, I think Peter raised an important point, that
9 the issue here isn't necessarily not enough family practice
10 or primary care-related slots. We're just not getting
11 people into them. But I guess the question I come to is,
12 well, could redirect some of those subsidy dollars into the
13 fee schedule or other ways that would more directly attract
14 young physicians into primary care. It doesn't have to stay
15 within the medical education financing area.

16 What am I missing? Am I missing anything?

17 DR. ROBERTSON: Well, I'll go ahead and try to
18 touch on a couple of the points, and if I don't address them
19 directly, please let me know.

20 One thing that actually I will bring up is that
21 the presumption often is that, well, family medicine, it's a
22 non-revenue producer. That have been two studies that have

1 been done, and I can't quote you the exact detail, but they
2 look at downstream revenue based on referrals to hospital-
3 based specialists and the use of ancillary supplies, or of
4 ancillary services, and a primary care physician adds a
5 tremendous amount to a hospital, and there are some systems
6 that just basically choose to employ lots of family
7 physicians and they don't necessarily -- or primary care
8 physicians. They're not even really too worried about
9 whether they make money on a dollar-for-dollar basis because
10 they've done the analysis and they're aware of the potential
11 for downstream revenue. So just in terms of addressing that
12 argument.

13 In terms of what to do with the over-the-cap
14 money, based on what I know about the amount of money that
15 Medicare is spending on graduate medical education, I don't
16 know that there's enough money there that if you
17 redistributed it elsewhere that it would necessarily make
18 the kind of difference that you're talking about, and I
19 think part of what we've all been sort of addressing is the
20 need for a systematic change in the way health care is
21 funded, and specifically primary care.

22 MR. BUTLER: Well, I have a lot of reaction, but

1 just on the cap issue, I think, first of all, a third, I'm
2 sure, isn't the number --

3 DR. ROBERTSON: I think that's too high.

4 MR. BUTLER: It's way, way over. I think it's at
5 the margin, and I think most institutions, if you were to
6 say -- I think, frankly, and again, my own experience, you
7 get -- maybe you're recruiting a chair in a given specialty
8 and there's a certain package that you're providing that
9 makes his or her success critical. You might go over the
10 cap a little in that specialty. But I think as a regular
11 practice, teaching hospitals don't just blow by the cap and
12 say, we're going to fund an extra 100 positions or whatever
13 it is because they're worth it. So I think it's on the
14 margin. I don't think it is something that is widely done.

15 DR. ROBERTSON: Just a comment, too, related to
16 that. I want to be -- I mean, I think academic health
17 centers are absolutely wonderful. They are essential. We
18 need the specialists that they train.

19 I think the concern that I have is that when you
20 sort of move out of sort of large academic health centers
21 into other hospitals that are sort of technically not-for-
22 profit, that's not necessarily the way in which they're

1 operating. That's not an area where I have a tremendous
2 amount of expertise, but I'm not here to bash academic
3 medical centers. I'm grateful to be at Northwestern. I
4 have a great relationship with the hospital. They've been
5 wonderfully supportive of our department.

6 I think one of the challenges that a lot of us in
7 family medicine have, or in primary care, is to translate
8 the value of what primary care brings to the table to people
9 who often don't have a lot of experience with it, and that's
10 been one of the fun things about what I get to do.

11 DR. BORMAN: Just a couple of things about some of
12 the numbers and caps and things. Number one, roughly 30
13 percent of GME -- allopathic GME positions, roughly 30
14 percent are filled by other than U.S. medical graduates from
15 allopathic schools. Okay, it's ballpark 30 percent overall,
16 higher in family medicine, as you've heard, but that's sort
17 of the ballpark-ish number.

18 Secondly, in terms of -- Peter is absolutely
19 correct. Thirty percent over the cap, most places would be
20 bankrupt, I think. The other thing you have to remember
21 when you think about over-the-cap positions, there's a
22 couple of factors. Number one, that the subspecialty people

1 who are by definition past their core residency are only
2 getting funded at a half position at the most, so that when
3 you go over with a fully funded residency slot as opposed to
4 something for which you were only getting half anyway, kind
5 of is a manipulation that is not reflected in the general
6 statistics.

7 So, for example, if you were to add another
8 gastroenterology fellow for whom you're only getting part
9 anyway, it's not cost -- you would already be paying that
10 half, so the increment that you're losing is less, if that
11 makes sense. So there's a different -- the mix of what you
12 have.

13 The other thing is that in the main, you can't
14 just decide de novo to start a residency on over-the-cap
15 stuff. You can, but generally speaking, that's not going to
16 get done, so that the inherent bias is to grow the
17 residencies that you already have because there's economies
18 of scale in doing that. So if you already have an
19 anesthesia residency, you're more likely to expand that than
20 to take whatever dollars it would take to start a family
21 medicine residency or whatever else it might be. So you
22 need to be really cautious about interpreting over the cap,

1 and I think Peter's point that manipulating caps and numbers
2 and things is probably not the most productive way to think
3 about some of this.

4 MR. HACKBARTH: That's helpful. Craig has some
5 information --

6 MR. LISK: Right. In terms of analysis that we
7 did, and this would be, I think, based on 2004 data -- it
8 may have been 2006, I can't remember -- but we counted about
9 8,000 hospitals in terms of Medicare hospitals with about
10 8,000 unfunded GME slots in terms of being over the cap by
11 8,000 that hospitals are funding, paying those without
12 getting any Medicare GME or IME money. And actually,
13 because some hospitals train both -- you know, it's actually
14 an IME, so that's about 7,000 slots and 8,000 on the direct
15 GME side.

16 MR. HACKBARTH: What is that in percentage terms?
17 What's the base?

18 DR. BORMAN: [Off microphone.]

19 DR. ROBERTSON: Yes. There's 100,000 residents.
20 I mean, in terms of Medicare hospitals, about 90,000
21 residents in Medicare-funded hospitals, so --

22 MS. BOCCUTI: [Off microphone.] Less than ten

1 percent.

2 DR. ROBERTSON: So it's less than ten percent, and
3 that fits with the report out of JAMA that said, I think,
4 7.9 percent. So I think it very much aligns.

5 Just a quick comment, just based on Dr. Borman's
6 statement. You can open a new residency program in what is
7 called a virgin hospital, for lack of a better term. If a
8 hospital has never had a GME training program, there is a
9 way that you can apply to CMS to be able to get funded GME
10 positions. The challenge that's associated with that is you
11 have to fund all of the start-up costs of the training
12 program from another source -- faculty salaries, resident
13 salaries -- until the Medicare GME funds begin to flow. So
14 it does happen, but not very often, and you usually need to
15 find a source of income. It's generally, I would say,
16 somewhere in the neighborhood of \$1.5 to \$2 million to be
17 able to make something like that happen.

18 MR. GEORGE MILLER: Great presentation. I enjoyed
19 it. On your recommendation number four about accountable
20 for the public's health, I have a question, and you
21 mentioned a little earlier about disparities. The
22 Commission has done some work on disparities, and you made a

1 comment and I want to make sure I crystalize on the comment,
2 that maybe some of the problems of disparity, if I have that
3 correct, may be linked to foreign medical graduates and the
4 competency issue. Did I hear that correct?

5 DR. ROBERTSON: There are several factors that
6 feed into that, but I don't want to cut you off. Did you
7 want to share anything else?

8 MR. GEORGE MILLER: My major question is, what
9 will the Council's recommendation be to address the
10 disparities overall, and what can you do in the medical
11 school arena to try to eradicate disparities, number one,
12 and then I'd like the first part of my question to be dealt
13 with.

14 DR. ROBERTSON: Sure.

15 MR. GEORGE MILLER: Thank you.

16 DR. ROBERTSON: This is not a specific Council
17 recommendation, but it's something that we've had some
18 extensive discussion about and I think that there are
19 certainly threads of that in this, and that gets back to
20 what I was commenting on with regard to who gets into
21 medical school.

22 You know, there have been some interesting studies

1 about organic chemistry, and that's the one class that
2 usually trips people up. If you don't get a good grade in
3 organic chemistry, the likelihood that you're going to be
4 able to gain admission to medical school is drastically
5 diminished.

6 Interestingly enough, there's an effort underway
7 to reformat the National Board of Medical Examiners. Right
8 now, there are two tests that medical students take, one at
9 the end of their second year and one during their fourth
10 year. There's a desire to fold those two exams into one
11 exam which would then allow a significant transformation of
12 the undergraduate curriculum that is now, some would say,
13 excessively focused on the memorization of the arcane as
14 opposed to practical information.

15 That process of changing the NBME has ground to a
16 halt because most specialty, highly competitive specialty
17 residency programs use Part 1 scores as a way to look at the
18 candidates that they want to consider. So if you're looking
19 at plastic surgery, looking at orthopedic surgery, you
20 really don't have much to go on, because a lot of medical
21 schools, their grades are pass/fail or a grade at medical
22 school X is not equal to a grade at medical school Y, so you

1 use Part 1 of the Boards as the issue for that. So that is
2 one of the problems.

3 The second problem is what I referenced with
4 regard to who gets into medical school. Again, and I
5 understand this, I have a daughter that just graduated from
6 medical school, it's MCAT scores and grade point average. I
7 think medical school admissions should look much more
8 significantly at the background of the individual who is
9 applying to medical school and that should be a factor.

10 One of the nice things about medical school, it's
11 no longer look to the left, look to the right, and you'll be
12 the only survivor. Medical schools have a variety of
13 interests in keeping you there for the entire four years,
14 not the least of which is the fact that you're paying a
15 rather large amount of tuition that is going to be spent in
16 the support of the administration of the medical school.

17 Last, to get at what you were talking about, there
18 are real concerns about the culture of misalignment that
19 takes place when you have individuals from two distinctively
20 different cultures in an exam room trying to talk to one
21 another. I was seeing patients yesterday. I work at a free
22 clinic in the Chicago area. About three-quarters of the

1 patients are Hispanic, but a quarter are actually Polish and
2 speak only Polish. So you rely heavily on interpreters. I
3 think I'm a pretty good doctor, but basically, I'm a white
4 guy taking care of people who come from a much different
5 environment than I do and I know that there have to be
6 things that people don't say to me, not because I'm doing
7 anything wrong, but because I'm coming from a different
8 background than they do.

9 MR. HACKBARTH: Let me see hands of people for
10 round two. Okay. We're down to our last 15 minutes here,
11 so I'd ask people to really be as concise as possible.
12 Karen, did you have your hand up first? Why don't you go
13 ahead.

14 DR. BORMAN: Just a couple of things and to blend
15 some of what you've said with some of the stuff that I know
16 or some data, related data in surgery.

17 I think that one of the things that comes out in
18 the medical student literature about choosing specialties is
19 that they're highly motivated by what they perceive to be
20 the nature of the work and then also the influence of
21 mentors. I think the influence of mentors goes directly to
22 what Arnie has commented to --

1 DR. ROBERTSON: Absolutely.

2 DR. BORMAN: -- and I think that primary care
3 specialties, just as general surgery has had to have to, to
4 some degree, reinvent themselves as mentors and project the
5 positive as opposed to all the griping that goes on in the
6 physician lounge, and that's something that's internal to
7 the specialty and not necessarily a government function or a
8 funding function. So I don't know if there is specific data
9 in the family practice literature, but I can assure you
10 there are in a number of other specialties and general
11 surgery learned that lesson.

12 I think one of the things you offered about the
13 individual who restructured their practice really goes to
14 the heart of this, and that's because the nature of the work
15 does matter. And so you facilitated that individual to
16 function as a physician. And so what I took from that, and
17 you need to tell me if I've made a bad conclusion, was that
18 a lot of what enabled him to do that was the appropriate
19 reengineering of the practice and appropriate use of mid-
20 level providers.

21 And so I think one of the issues here is if we
22 assume that model of care, and this goes to Mike's question,

1 then what really is the physician need, because I think
2 every time I ask, it seems like the projections we're making
3 are made on the current model of care delivery. If that
4 were the primary care dominant model, then perhaps the
5 physician shortage is not as great. I will say that every
6 time you go shopping in the mid-level provider store, it's
7 looking increasingly empty and there are no sales.

8 That also sort of relates to a little bit of why
9 sometimes hospitals are willing to fund over the cap,
10 because even a fifth-year level resident is, by and large,
11 cheaper than a MLP, a mid-level provider, because of all the
12 associated benefits, their relative work hours, and a whole
13 bunch of other things, and so I think that plays into it, as
14 well.

15 I'd be interested -- the other piece is in
16 pediatrics, I think they've had a lesser subspecialty trend,
17 but it's because they more tightly control subspecialty
18 positions, whereas I think probably now something around
19 half of internal medicine residents, I think, go on into a
20 second, or a subspecialization. I can tell you in general
21 surgery now, the number is pushing 80 percent. So that's a
22 huge factor. The pediatrics, we probably should be asking

1 what pediatrics has done because they actually have almost
2 as many shortages in some subspecialties of pediatrics as
3 they do in general pediatrics, and the comparison between
4 pediatrics and others maybe could offer some lessons and
5 that might be something that we want to explore to get some
6 information out of.

7 And then, lastly, just again a general comment
8 that there probably are some patient populations for whom
9 their primary care is well delivered by someone who holds a
10 specialist certificate, and so, for example, CHF, patients
11 at a certain level may very well have a cardiologist as
12 their primary care deliverer. So I think we want to be a
13 little bit precise about when we talk about primary care
14 services and primary care physicians, because it may not be
15 entirely a one-on-one.

16 Have I gone way off base on any of that?

17 DR. ROBERTSON: No. Just real quickly, in order
18 to give other people a chance to comment, interdisciplinary
19 care has the capacity to increase capacity without
20 increasing the number of physicians. I think that's
21 something that's really important. Although if you look at
22 what's happened in the PA world, and actually, we're in the

1 process of starting a PA program in our department, the
2 reported data says only about 39 percent of PAs find
3 themselves in primary care practices. My new program
4 director tells me it's probably now closer to 20 percent,
5 and so that 80 percent of PAs are practicing in hospitals in
6 surgical and/or medical subspecialty settings. But I think
7 there definitely are ways to dramatically increase capacity
8 without necessarily increasing the number of physicians.

9 DR. CASTELLANOS: Two points, and I'll be as brief
10 as I can. One is Arnie brought up this practice
11 transformation, but we need an educational transformation.
12 We need a new cadre of faculty members. And my point about
13 undergraduate education, there's an economic principle. I'm
14 not an economist. You've got to follow the money. So we
15 need to put money into that,. I don't know if there's any
16 basis for that today, but I think we really need to put
17 money into educating a new cadre of faculty, not just for
18 primary care, but throughout every medial specialty.

19 Second is the problem that we're seeing right now
20 is the aging of the physician, and you have a well-educated
21 group of doctors and we have a definite workforce problem.
22 You know, you're not going to catch up for ten to 15 years.

1 You need to do something to incentivize the older doctor.
2 Now, you made some comments about wearing glasses and
3 apologized for it. Well, 14 out of the 17 Commissioners
4 wear glasses. I'm an older doctor --

5 [Laughter.]

6 DR. CASTELLANOS: -- and you need to incentivize
7 the older physician. And one of the examples you used was
8 the hassle factor, your friend. If we can get rid of the
9 hassle factor, I think we can keep a lot of the doctors in
10 the practice, because we all enjoy what we do. We don't
11 enjoy the hassle factor.

12 DR. ROBERTSON: Just a -- I mean, the AAMC has
13 data on physician retirement and/or if they could retire,
14 and I can't quote it in detail, but it's actually a fairly
15 significant number of doctors who would. What's happening
16 right now is the economy has certainly been an incentive for
17 physicians to stay in practice, but clearly is not aligned
18 with what you're talking about. And I think people who went
19 into medicine a number of years ago, it was really fun and
20 it was something that they looked forward to. Your work and
21 fun sort of ought to be aligned and why can't we find a way
22 to get back to that? So I agree very strongly with what

1 you've stated.

2 MS. HANSEN: Again, thank you very much for a
3 great presentation.

4 DR. ROBERTSON: Thank you.

5 MS. HANSEN: And I come from a frame that's
6 interdisciplinary. I worked with the PACE program, the
7 original PACE program, for 25 years, so the whole use of the
8 physician as a team member, coupled with the efficiency
9 factor of allowing the physician to have fun, I think was a
10 factor.

11 Secondly, your point about the place of
12 reimbursing sites, because we trained residents, and I have
13 a real technical question. When you said that, first of
14 all, the penalties that oftentimes might occur if, say,
15 funds flew to a clinical site, do you know if that's a
16 regulatory, fixable, short-term thing before we deal with
17 the bigger issue or not?

18 DR. ROBERTSON: Well, I think the short answer is
19 probably yes, and just another comment. There's actually
20 some interesting literature coming out right now about who
21 are the teachers of physicians and why can't -- I learned a
22 heck of a lot from nurses when I was a resident, but it

1 wasn't formalized. I think that there are ways to revise
2 the medical education system so that there are much more
3 formal roles for that. But the short answer is yes, but
4 that's not an area that I have a tremendous amount of
5 expertise.

6 MS. HANSEN: But using that final set, comments
7 have been made along the way, and if I can reset this to,
8 again, our responsibility for a Medicare population and the
9 sheer numbers now, let alone in the shortages versus what's
10 coming down the pike that we have, the question of the role
11 of COGME relative to thinking about your recommendations on
12 Slide 10. That really is about the population and where
13 should the future go. And some discussion has been advanced
14 relative to mid-level providers or other primary care
15 providers.

16 How does the professional organization take a look
17 at the responsibility of, say, the N, the numbers that are
18 coming down? If we already have a shortage of people
19 waiting 66 days in Massachusetts, how does the profession
20 look at embracing a larger workforce to meet the need rather
21 than trying to keep pulling? I think we still should make
22 sure that the income is there, but rather than pulling

1 people in to change their specialty focus, there's a cadre
2 of people who might deal with chronic disease management and
3 others differently. So where has the organization itself
4 stood relative to embracing this from a population-based
5 approach rather than strictly a professional approach?

6 DR. ROBERTSON: In the 15th report, which was the
7 one that we put out that said we needed 15 percent more
8 medical students and 15 percent more GME slots, there was
9 actually a draft recommendation that specifically addressed
10 physician extenders, other non-physician providers, and this
11 was my first meeting at the Council, so I was sort of trying
12 to get my sea legs and the members struck that provision.
13 We're now in the process of preparing our 20th report and we
14 have an explicit recommendation that is exactly under
15 development that references what you're talking about.

16 So part of what we want to be careful of is we
17 don't want to get beyond what is our prescribed purview of
18 graduate medical education, but I don't think you can have
19 that conversation without talking about other providers. So
20 it's something that I think will be revealed as we move
21 forward.

22 MR. HACKBARTH: Are you able to stay overtime?

1 DR. ROBERTSON: Sure.

2 MR. HACKBARTH: Okay. It's now 10:25, and at this
3 rate, we'll finish at 2:25, by my estimate, so I need to ask
4 Commissioners to limit themselves, both in terms of the
5 number of questions or comments and the length of them,
6 because I really want to get all the way through one more
7 time. So, Mike?

8 DR. CHERNEW: I'm new to this, and what I'm about
9 to say might be heresy, but I find it curious that we spend
10 a lot of time talking about how to pull more people into
11 primary care as opposed to push more people out of specialty
12 care. I don't have a position on that one way or another,
13 but I could see the entire discussion going the other way.

14 DR. ROBERTSON: You know, there's a class that I
15 teach right now at Northwestern. It's The Origins and
16 Economics of Medicine. It's a class that's taught to
17 second-year medical students to try to help them process
18 exactly what we're talking about here. At their second
19 year, they already get it in terms of what their future
20 looks like. And when you talk to them about primary care,
21 and I -- you know, one of the things I made very clear to
22 the dean of the medical school is that I don't measure my

1 success as a chair by the number of people who go into
2 family medicine. I have an academic obligation to expose
3 them to the full range of what's there.

4 But under the present set of circumstances, I
5 don't have a real good answer to that question. I think
6 that some of the practice transformation that we're talking
7 about, some of the potential to alter the clinical
8 experience, I think, that Dr. Castellanos brought up, the
9 experience that they have when they're in medical school and
10 around primary care tends not to be the most positive. But
11 then the really powerful roles of mentors. And if they're
12 with a harried general internist who is complaining about
13 his or her day, that acts as a pretty significant
14 distractor, and unfortunately, it makes the issue that you
15 brought up difficult to address.

16 DR. BERENSON: Are you aware of any medical
17 schools in the U.S. or perhaps Canada that are specifically
18 dedicated to producing primary care physicians and produce
19 40, 50 percent or more that might be models?

20 DR. ROBERTSON: There were a number that were
21 created for that purpose -- Michigan State University. But
22 a lot of the ones that did that, they've seen their numbers

1 drop. There actually is an osteopathic medical school, AT,
2 still in Arizona that has almost a totally community-based
3 educational structure for their medical students. I can't
4 remember if they've graduated a class yet or not -- second
5 year? What they have done is very groundbreaking and very
6 much different than the way most U.S. allopathic schools are
7 located.

8 One of the things that I did in preparation for
9 this, and I won't read it to you, is there is this very
10 specific information with regard to the atmosphere in which
11 medical students learn. What it boils down to is that the
12 medical school is basically a laboratory for them to make
13 whatever decision that they want, and I don't think that
14 many medical schools have a strong sense of obligation with
15 regard to the cadre of graduates that they produce by
16 specialty. I think that it varies across the country, but
17 it still ultimately boils down to the student's individual
18 decision.

19 DR. CROSSON: Russ, I'd like to turn again to the
20 recommendation page, Slide 10, if we could. So one of the
21 questions for us as a Commission going forward as we absorb
22 all this excellent information is what actually should we,

1 can we do within our purview? And we have had discussions
2 on this topic off and on over the last couple of years
3 anyway and it seems we've focused on two things. One of
4 those is what could we do, what could we recommend that
5 would help improve the maldistribution of physicians by
6 specialty. We've not made recommendations yet, but we have
7 had some discussions about that -- specifically not made
8 recommendations with respect to GME, that is.

9 Another area that we've touched on has been the
10 question of the amount of IME payments that are made to
11 hospitals, and we've talked about that from the perspective
12 of whether or not value is being produced for the taxpayers,
13 essentially, because there's some question about the level
14 of payment. And we've had some discussions in that area,
15 which have, I think, been just preliminary and not focused
16 on any particular direction.

17 So as I look at the four recommendations, I think
18 earlier, Glenn addressed a little bit about recommendation
19 number one. While the impact of health care reform may very
20 well produce a need for physicians across the board, I don't
21 know that that's an issue that we have taken or are likely
22 to. And it isn't also clear, as I think Glenn said, whether

1 simply increasing the number of GME slots by 15 percent is
2 going to solve the primary care maldistribution issue.

3 With respect to numbers two and number three, as I
4 said earlier, we have dealt with that and we have made some
5 comments about perhaps CMS could consider creating
6 flexibility in the venue area.

7 The one where I think you have a recommendation
8 that dovetails a bit with discussions we've had is the last
9 one, and that's making accountability for public health the
10 driving force between GME payments, and in the context of
11 the Commission, it would be -- I'm sorry, for GME, it would
12 be GME payments. So I think we're probably going to discuss
13 this question again and I wondered if you could elaborate a
14 little bit on that. If we were to think about this
15 question, given the level of payments, particularly the
16 level of IME payments that are made, and if you're looking
17 at it from the perspective of the public, the taxpayer, and
18 the like, are there some things that could be done to
19 increase the value that accrues as a consequence of those
20 payments in improving public health, access to health
21 services, or whatever value you have in mind with that
22 recommendation.

1 DR. ROBERTSON: Well, you know, certainly
2 recognizing that the process of training family physicians
3 or primary care physicians, general internists is a -- it's
4 a multi-factorial issue. We've talked about a lot of the
5 push-pull factors that relate to that.

6 I think one of the challenges, and as a -- I was a
7 residency program director for 12 years. Every year, you
8 would negotiate with your hospital CEO with regard to the
9 funding that was going to be made available to the residency
10 program. It was always kind of a black box process. I
11 mean, you never really knew how much money they were working
12 with and you were just happy if you got what you needed to
13 run your training program.

14 If there was something that could be done that
15 would make that process explicit, transparent, and dollar
16 for dollar so that the real costs of training -- faculty
17 salaries, resident salaries, the salaries for the support
18 staff, the rent for the clinic, the support for the
19 different training venues -- if something like that were to
20 be enacted, I think that we would be in a much better
21 position with at least being able to fund the positions that
22 we would want in order to produce the physician population

1 that I think that you're referencing.

2 But in addition to that, I still think that there
3 are other issues that are system-based. But right now, most
4 residency program directors, most department chairs, that's
5 the kind of a discussion that they enter into, and unless
6 you take an aggressive role, which ultimately really isn't
7 in your best interest to file a Freedom of Information Act
8 request so you can exactly learn what the GME support is the
9 hospital is getting, both IME and DME, most of us would not
10 be willing to do that because it would upset what I think
11 needs to be a necessarily collegial relationship. But it,
12 dollar for dollar, would make a big difference.

13 DR. CROSSON: Well, let me just ask you one
14 specific question quickly. So one of the topics that has
15 come up here is whether or not we, as MedPAC, should
16 undertake to examine and make recommendations with respect
17 to the nature of the training curriculum, or whatever you
18 want to call it, the training program content for residents.
19 Do you think that's an area that would be of value in
20 improving the accountability of programs for public health?

21 DR. ROBERTSON: Well, certainly that's the purview
22 of the Accreditation Council for Graduate Medical Education

1 at the present and that's an organization that I think takes
2 its responsibilities pretty seriously. We're also,
3 coincidentally, in the process of developing a new family
4 medicine residency program. I look at them as the
5 equivalent of the sort of Good Housekeeping Seal of
6 Approval. The stuff that they put in there, it's there for
7 a reason.

8 I don't know what kind of a discussion it would
9 look like if you chose to interact with them. I think we
10 know how to train who we want to train. I think the biggest
11 challenge that we have is finding more transparent ways of
12 funding it that don't put us in a position of having to look
13 for other sources of support to be able to sustain what it
14 is that we're trying to do.

15 DR. MILSTEIN: Let me try again on what I think
16 Jay was driving at. I think what we've discussed before is,
17 is there a pathway by which we could begin to do with our
18 medical education dollars what we aspire to do with our
19 health care payment dollars, that is shift onto a value-
20 based method of allocating dollars. One element in such a
21 process would be to make sure that the training content is
22 kind of aligned with modern notions of efficient, high-

1 quality production of services in various specialties.

2 I think Jay's question, I think, also gets at a
3 separate issue, which is -- and I don't think this is what
4 ACGME is in the business of doing -- is as you're thinking
5 about allocating monies across different slots, different
6 specialty training slots, is there any -- what direction
7 might -- is there any existing pathway that we might benefit
8 from learning about that would allow some kind of a, I'll
9 call it a value add analysis. In other words, if we produce
10 an incremental dermatologist, there's a certain amount of
11 value to the Medicare program, value to the U.S. health care
12 system. If we produce an incremental primary care
13 physician, trained in sort of the more advanced methods of
14 primary care delivery we talked earlier, that might generate
15 a different value add, in terms of the public's health, or
16 even better, value, public's health divided by how much it
17 costs us to attain that increment in the public's health.

18 If we wanted to move in that direction in terms of
19 ceasing the distribution without conditions of Medicare
20 medical education dollars, which is what we've been doing
21 now, and begin to shift it onto a value-based allocation
22 system, is there any existing information that we might

1 access to begin to think through the implementation of it?
2 That is, how would one go about calculating the value add
3 from training in a given type of specialty versus another,
4 and also assessing the content of that training with respect
5 to more advanced notions of how that specialty ought to be
6 practiced?

7 DR. ROBERTSON: Thank you for the clarification.
8 I apologize if I missed the original point.

9 There's a program out there right now. It's
10 called TransformMED. This is something that has come out of
11 the American Academy of Family Physicians. They opened up
12 applications nationally to residency programs, specifically
13 those were the targeted programs. They had funded to fund,
14 I think, 14 or 15 projects. They had well in excess of 60
15 applicants for it.

16 So this is a process transformation approach
17 toward undergraduate medical education that is being funded
18 externally in addition to currently available Medicare GME
19 funding. There are medical home projects that I believe the
20 American College of Physicians is developing. So there are
21 vehicles that are out there -- I think I'm getting at your
22 question -- that would be able to, would welcome an

1 additional source of funding to effect that transformation.

2 DR. MILSTEIN: Thank you. I think that does
3 address the second part of my question, but I'm still not
4 sure whether or not we have a basis for ascertaining value
5 add to Medicare or society from training an incremental
6 dermatologist versus training an incremental primary care
7 doctor.

8 DR. ROBERTSON: There's actually quite a lot of
9 information that addresses that. I don't know that I can go
10 into it in significant detail but there's tremendous amounts
11 of information with regard to -- there was a statistic that
12 I didn't bring. It was a DALE, Disability-Adjusted Life
13 Expectancy. When you look at nations that have heavily
14 invested in primary care specialties, the differences
15 between where they are and the United States is absolutely
16 dramatic.

17 So yes, there is a tremendous amount of
18 information to support the difference between funding
19 primary care physicians and/or specialty physicians.

20 MR. BUTLER: My comments are related to trying to
21 envision what a deliverable next June, if we do a chapter,
22 would do like. So I have six sections to this.

1 [Laughter.]

2 MR. BUTLER: It will be quick. It will be quick.

3 MS. BEHROOZI: Change your flight, Glenn.

4 MR. BUTLER: No, this is high level thinking about
5 it.

6 The first would be what are the competencies that
7 we want our physicians to have, regardless of specialty.
8 ACGME gives us something to build upon. We could add to it
9 the Medicare filter and kind of embellish it a little bit.

10 The second would be the training environment. I
11 think we can build on our chapter we've already done that
12 says linking to health reform. That's like what does the
13 environment look like that would be overall what we want?
14 It coordinates care, it has a focus on public health, it has
15 IT, all of those kinds of things that says this is the
16 setting that we ought to value purchase, if you will. Okay.

17 The third chapter would be on the mix and the
18 number of specialties and say okay, what are the numbers
19 that we need, of what kind.

20 The fourth would be a specific focus on diversity
21 as we've kind of said ought to be in each chapter. And not
22 just the numbers of types, but a better description of the

1 cultural differences emerging in our patient populations
2 just to highlight that as a particular issue.

3 And the last would be, of course, is the
4 financing, the sources. Where we begin with the
5 reimbursement dollar and probably reinforce that still is a
6 huge, huge driver in all of this. But then pick up on the
7 \$9 billion in DME and IME, highlight the Title VII dollars,
8 the VA dollars, the stimulus dollars going to FQHCs, et
9 cetera. Look at the sources. And then line that up with
10 these other sections and say where would you use these
11 dollars?

12 What I would advocate strongly is that the changes
13 that we ought to kind of set in motion would be around that
14 training environment and doing the DME/IME up or down in
15 that bucket.

16 We could acknowledge the importance of tweaking
17 the speciality and mix. I think already legislation in
18 health reform is doing this, generally in the direction we'd
19 like to see.

20 I would say in that section one bias is that
21 splitting this up into all kinds of different settings is
22 kind of counter to our integration strategy. So I worry a

1 little bit about having this free-standing entity have money
2 and this -- when we're trying to create systems of care.

3 So I think we need to think about if we make all
4 of these other people eligible for directly getting dollars,
5 is it counter towards the integrated systems of care serving
6 a community or not? It's just a concept.

7 But anyway, that's how I kind of think about the
8 chapter and I think we really can make some directional good
9 contributions in these areas.

10 MR. HACKBARTH: Thanks for the framework. That's
11 helpful.

12 MS. BEHROOZI: It's really to pick up on George's
13 point about disparities, though Peter also mentioned it as
14 an issue that we should keep in mind. I would just urge
15 you, maybe for the 21st report or the 22nd report -- since
16 you'll be around for that -- to be actually more aggressive,
17 I think, in looking at disparity of treatment and outcomes
18 than just sort of cultural competency and recruiting more of
19 the others who are currently not populating the medical
20 profession, bring more of those others in.

21 I think it's really about focusing on who the
22 professionals are and will be and will continue to be,

1 because medical school is going to continue to be expensive
2 and the tests are going to be hard, all of those things.
3 Because there is emerging data -- and actually the staff
4 presented some to us this summer -- that disparities really
5 come out most strongly when you're talking about a non-
6 minority person -- I guess that would be a white person --
7 treating particularly -- in that case, I think it was
8 evidenced with respect to African-American treatment
9 outcomes.

10 And the African-American doctors were not
11 responsible for disparities in the treatment of their
12 patients by race.

13 So it's not just sensitivity and awareness. It's
14 like really confrontation with that evidence and those facts
15 and making it a very conscious part of training people who
16 are going to be the providers, not just bringing additional
17 people in to be the providers.

18 DR. ROBERTSON: Just a quick comment. To the
19 AAMC's credit, they had a program that was called 3,000 by
20 2000. It was an aggressive effort to recruit minority
21 medical students to medical school. They didn't quite hit
22 the threshold but it was a very substantial activity that

1 they undertook and I think is very much aligned with what
2 you're referencing. We need to do more of it and more of
3 the same.

4 DR. DEAN: Thank you very much. This is obviously
5 an area that is of great interest to me. I'm a family
6 doctor who has practiced in a small rural community for 30
7 years.

8 It seems to me what I find very frustrating, and I
9 appreciate your comments and I suspect that you may have
10 some of the same feelings, is that where Medicare has
11 leverage and where your mandate lies is at the end of the
12 process. And it seems to me that where our problems lie is
13 at the beginning of the process.

14 And you mentioned the problem with medical school
15 admissions structures, which I've seen data -- probably some
16 of the same data you've seen -- which show changes in the
17 demographics of the people that are coming into medical
18 school which don't fit with what we know we need, or don't
19 predict very positively the kind of mix of specialists that
20 we need to come out of.

21 I was very troubled by what you said about the
22 national boards. I, too, just had a son who just graduated

1 from medical school and I was struck by what a negative
2 influence that process is and how when I complained to
3 medical school faculty that he was involved with, they tell
4 me -- and I believe they're honest -- that their hands are
5 tied basically because their students have to perform well
6 on that board. And yet, it totally crowds out the kind of
7 experiences that we would like to have students have to say
8 there's a very positive future in primary care.

9 But instead, they have to learn the PKAs of every
10 amino acid, which is totally useless, quite frankly.

11 [Laughter.]

12 DR. ROBERTSON: I couldn't agree with you more.

13 DR. DEAN: And then to deal with the things that
14 you mentioned about the sort of negative influence that all
15 too many students experience, with regard especially to
16 primary care as they move through the specialty dominated
17 inpatient experience that they have in medical school.

18 All of that, I guess the question, to get to the
19 question, do you have -- does COGME or in your discussions
20 or do you have any thoughts as to ways that Medicare could
21 have an impact on the early phases of education which I see
22 where our real problems lie.

1 Sure, there's a lot of things we can do to improve
2 graduate education, but we still have lots of primary care
3 slots that are going unfilled. And when you argue to the
4 policymakers that we need to pour more money into graduate
5 education, they say look, you're not even filling the slots
6 you've got. And that's a fairly potent argument, even
7 though it's obviously much more complex than that.

8 But it seems to me, in my career, I entered family
9 medicine when there was a great deal of enthusiasm, right in
10 the very beginning of the specialty. A lot of enthusiasm, a
11 lot of very motivated, talented people coming into family --
12 then there was another burst of enthusiasm, like you said,
13 in the mid-'90s. Now we hit a sort of a nadir. I think
14 we're headed back up and I think the future is bright. But
15 how do we communicate that to incoming students? And how do
16 we create an environment early on that supports the choices
17 of the specialities we know we really need?

18 DR. ROBERTSON: I think that medical schools get
19 this. I don't think that they're an obstacle to what's
20 going on. I don't think there's a conscious decision for
21 medical schools to try to block people going into primary
22 care. I think they're sometimes kind of stuck with the

1 environment in which they find themselves and it takes a
2 long time to make a change.

3 Northwestern is in the process of completely
4 revising its curriculum. We had a curriculum retreat a week
5 ago today. One of the things that resonated throughout the
6 retreat is we've got to find a way to get our students out
7 of the medical center and into the community. That's where
8 departments of primary care can make a big difference. Part
9 of what I've done as chair is develop some really deep
10 relationships with federally qualified health centers that
11 are located in medically underserved communities and we're
12 trying to find a way to function as a conduit to get
13 students into those settings. And we have the support of
14 the medical school's administration in doing that.

15 So I think those kinds of realizations exist.

16 In terms of what you can do from a Medicare-
17 related policy, I think that again, in 1965 it made perfect
18 sense to have GME policy directly aligned to hospitalized
19 care because that's kind of where most of the care was being
20 provided. The GME policy has remained virtually unchanged
21 since 1965, and I think the challenge that you have and/or
22 the opportunity is to look for a way to begin that

1 transitioning process without necessarily throwing hospitals
2 into complete chaos.

3 I think this is something that can and should be
4 done in a reasonably sequential manner to allow institutions
5 to be able to plan. But we're also in a big hole right now.
6 And I think that's the big concern, regardless of whether
7 health care reform is passed, the numbers of physicians that
8 we're producing who want to be adult primary care providers
9 is still going in the wrong direction.

10 MR. HACKBARTH: I want to talk about Peters'
11 Chapter 6 related to the financing piece of this, and use
12 Mike's comment as a platform. So much of the discussion
13 seems to be focused on how we draw more people into primary
14 care as opposed to make the other alternatives less
15 attractive.

16 At least implicitly, our model here has been sort
17 of laissez faire, we'll be neutral in terms of what we fund
18 and we'll let the system decide how many specialists we need
19 of different types. That's not working, I think
20 demonstrably it's not working.

21 So I'm fixated on Medicare and Medicare payment
22 policy, and I know there are a lot of other very important

1 aspects of that, so forgive me for my fixation.

2 In Medicare, broadly speaking, we've got two types
3 of levers. We've got our physician payment policy and
4 broadly there's agreement that we have to increase the level
5 of payment and perhaps change the method of payment for
6 primary care. And correspondingly, we're going to have to
7 tamp down payment for some of the subspecialty services. We
8 may disagree on details but directionally I think we're all
9 on board with that.

10 Now the other bit lever, Medicare lever, is the
11 payment for graduate medical education. There we've had
12 this very neutral policy, you decide what and we'll pay for
13 it. We've got this situation where we know we need more
14 primary care physicians but we don't have enough people
15 wanting to go into them. So that's sort of pushing on a
16 string there.

17 That leads me to the other obvious alternative,
18 which is to say Medicare is not going to pay for as many
19 subspecialty training spots and we're going to clamp down on
20 that end.

21 Earlier I asked the question about whether the
22 spots over the cap suggest that they're self-financing. The

1 answer I got back was persuasive, no, they're not. So the
2 corollary of that is that, in fact, if Medicare squeezes on
3 the number of subspecialty spots that we'll fund, that may
4 have a significant effect. That lever may have power.

5 Reactions?

6 DR. ROBERTSON: Well, I think part of what happens
7 right now, in terms of -- depends on the motivational
8 direction that this ends up taking. Part of what I
9 referenced earlier and what we got from the Altarum Report
10 is that 17 percent of current students want to go into
11 primary care but 27 percent actually end up going into
12 primary care because they couldn't get the specialty slot
13 that they thought that they wanted.

14 If you look at the expansion of medical schools in
15 the U.S. right now, the COGME 15th Report I think projected
16 or recommended a 15 percent increase. We're already at 18
17 percent so we've -- both by medical school expansion and, as
18 well, as the creation of new medical schools. Central
19 Michigan University now is going to start a medical school.
20 Grand Rapids has now got a campus for Michigan State
21 University. So this expansion is continuing.

22 So part of kind of what's happening is the gap

1 that exists between the number of U.S. medical graduates --
2 both allopathic and osteopathic -- and residency positions
3 is beginning to shrink. And so by default, we'll end up
4 filling a lot more of the primary care slots with U.S.
5 medical students. And there's a brain drain issue that
6 comes up with that. So that's one thing that I think is
7 going to happen regardless, so long as the cap remains
8 intact.

9 From a payment related standpoint, rather than
10 looking at E&M codes, I'd rather see primary care physicians
11 paid for the stuff that we like to do, which is the care
12 coordination. I was the chair of the ethics committee at a
13 community hospital where I was on staff. We spent lots of
14 time with end-of-life issues. And 99 percent of the ethical
15 issues for the ethics committee had nothing to do with
16 medical ethics. It was all about the information that had
17 been communicated to a patient and his or her family. But
18 that takes two or three hours to do that. And right now
19 there's really no way for that to be funded.

20 So those are the kinds of things that you could do
21 that I think would make a difference. And these are the
22 things that I think people who went into primary care for

1 all of the right reasons, they like doing that. They enjoy
2 those conversations. They value the depth of the
3 relationships that they develop with their patients and
4 families.

5 MR. HACKBARTH: Thank you. As evidenced by the
6 number of questions and comments, it was a very valuable
7 presentation. We really appreciate the time.

8 DR. ROBERTSON: Thank you very much.

9 MR. HACKBARTH: Thanks, Russ.

10 Okay, we are substantially behind schedule but I'd
11 like to assure Commissioners that we will end on time. Don't
12 change your plane reservations.

13 So our next topic is comparative effectiveness and
14 some results we got from some research on physician
15 perspectives. And Joan and Nancy have graciously agreed to
16 accelerate their presentation so we can get through this.

17 DR. SOKOLOVSKY: You really should not ask two New
18 Yorkers to go fast.

19 [Laughter.]

20 MR. HACKBARTH: Right, right.

21 MS. RAY: Good morning. During this presentation
22 we intended to first review the Commission's previous work

1 on comparative effectiveness and then describe the Recovery
2 Act's funding for comparative effectiveness research
3 initiatives, \$1.1 billion to AHRQ, NIH, and the Secretary of
4 Health and Human Services, as well as it also creates a
5 Federal Advisory Council.

6 In the interest of time, I'm going to draw your
7 attention, however, to one aspect of the Recovery Act's
8 initiative, but I'm happy to take any questions that you may
9 have about the funding to AHRQ, NIH, and the Federal
10 Council.

11 The Recovery Act requested that the Secretary fund
12 an IOM study on national comparative effectiveness research
13 priorities. To fulfill this mandate, the IOM formed a 23-
14 member committee of individuals from academia, physicians,
15 payers, patient groups, and providers. Your mailing
16 materials list the members.

17 Partly based on topics suggested by the public,
18 the committee went through a three-round voting process to
19 identify the 100 highest-priority CER topics, and the IOM
20 released its report on June 30, 2009. The IOM committee
21 organized these 100 topics into quartiles.

22 Your briefing paper includes a chart that shows

1 the distribution of the 100 topics by research area, so this
2 is what I would like to draw to your attention, and it was a
3 bit surprising to some of us. About half of the topics
4 compare some aspect of the health care delivery system, such
5 as comparing the effectiveness of comprehensive care
6 coordination programs, such as the medical home and usual
7 care, and comparing the effectiveness of accountable care
8 systems and usual care on costs, processes of care, and
9 outcomes. A third of the top 100 topics address racial and
10 ethnic disparities, and about a fifth address patients'
11 functional limitations and disabilities.

12 So, again, that concludes my part of the
13 presentation at this point, but I am happy to take
14 questions.

15 DR. SOKOLOVSKY: As we talked about yesterday,
16 every year we conduct focus groups in different parts of the
17 country with beneficiaries and physicians to hear from them
18 about their recent experiences with the program. This year,
19 with researchers from NORC at the University of Chicago and
20 Georgetown University, we conducted six focus groups with
21 physicians in July and August. Groups were held in
22 Baltimore, Chicago, and Seattle, and participants came from

1 many different practice settings, including solo practice,
2 small groups, multi-specialty group practices, and hospital-
3 based physicians. About half were primary care physicians,
4 and participants were ethnically diverse and included both
5 men and women.

6 Although focus groups cannot have the precision or
7 comprehensiveness of quantitative findings, they do enable
8 us to gain more real-time knowledge of how the program is
9 working for those people who are most directly affected.
10 And they also supplement our knowledge by providing
11 information that cannot be explained through claims,
12 analysis, for example.

13 In 2007, as Nancy would have told you, the
14 Commission concluded that there wasn't enough information
15 for patients and providers to make many decisions about
16 alternative treatment options for many common conditions and
17 recommended more comparative effectiveness research. CER,
18 however, will only be useful if physicians know about it and
19 find it credible and easily accessible.

20 So this summer, we asked practicing physicians
21 what they thought about comparative effectiveness research,
22 and we found that physicians had a very diverse range of

1 opinions about comparative effectiveness. We found that, in
2 general, the current initiatives are not well understood by
3 practicing physicians. Some focus group participants
4 opposed any comparative effectiveness research. While the
5 majority welcomed more data, many had concerns about aspects
6 of the research, and they also had a number of ideas about
7 the best ways to disseminate CE information so that it would
8 be useful to them.

9 I'm going to focus mostly on the concerns of those
10 physicians who wanted more information but had some issues
11 about the research. But I'd like to talk first about those
12 focus group participants that opposed any comparative
13 effectiveness research.

14 Those who were most opposed said they got all the
15 information they needed from annual conferences, journals,
16 drug company representatives, and their own experience.
17 Some worried that CER would lead to mandatory guidelines
18 from both the government and private payers and, as one
19 said, "cookie-cutter medicine." They also worried that the
20 research would only show the most effective treatment, on
21 average, and ignore sub-populations. They believed that
22 personal experience with a treatment was enough for them to

1 make treatment decisions.

2 For example, one focus group participant said, "I
3 think the decision should be left up to us. We have our
4 judgment. If we like something, if it works, great. If it
5 doesn't, then we try something else."

6 On the other hand, those who were most supportive
7 of CE said it would give them more information to decide
8 best treatments for their patients. They said that despite
9 all the information they got on a daily basis, they had very
10 little access to head-to-head comparisons of drugs, devices,
11 or procedures. Several said that the current guidelines
12 from their specialty societies that they often consulted
13 were frequently based on consensus-based -- were consensus-
14 based because evidence enough simply did not exist.

15 Consensus-based guidelines could be shaped by
16 professional biases and conflicts of interest. One primary
17 care physician said, for example, "I take care of patients
18 with cardiovascular risk factors, and I try to determine
19 their risk with standard testing. And I get this consult,
20 and I've never even heard of the thousands of dollars' worth
21 of tests that they did. And I'm sure it's not evidence-
22 based. It's just what they learned at a conference. And

1 I'm spending \$30 of the patient's money, and they're
2 spending \$2,000 in this testing. Does it make a difference?
3 Well, that should be answered objectively and in a
4 centralized manner."

5 Although all participants said they would not use
6 a treatment that didn't work for their patients, most didn't
7 think personal experience was sufficient. For example, one
8 physician noted that there were some things that an
9 individual physician simply couldn't observe based only on
10 their patients. He said, "The other issue is risk reduction
11 or mortality rates. I can't see that in my practice. It's
12 just not large enough."

13 Now I want to address some of the specific
14 concerns mentioned by the focus group participants. They
15 wanted to be sure that studies took into account not only
16 outcomes but also the side effects of treatments, the
17 patient's quality of life, and differences among groups.
18 Some worried, on the other hand, that doing studies that
19 took all of these important factors into account could
20 require large sample sizes that would then make the studies
21 prohibitively expensive.

22 Some worried about the effect of CER on

1 innovation. Again, we got very different views. Some said
2 that manufacturers of drugs or devices that proved less
3 effective than alternatives could be driven out of business,
4 and that would slow innovations of new treatments; while
5 others thought it would lead the industry to develop more
6 innovative products because there would be a smaller market
7 for "me-too" products.

8 A number of physicians linked CER to liability
9 reform, one worrying that it could make them vulnerable to
10 lawsuits if they used alternative treatments, even if they
11 had good clinical reasons for doing so. But another
12 believed that, in fact, it could be used to protect them
13 from lawsuits if they were able to show that they used
14 evidence-based medicine in their treatment decisions. And a
15 few physicians said that this protection should be
16 explicitly recognized in any comparative effectiveness
17 program.

18 Physicians probably talked the most about how to
19 ensure the most objectivity in the evidence they used. For
20 example, nearly all physicians met with pharmaceutical
21 company representatives. They said it was a good way to
22 learn about new treatments, but that they had to take the

1 information they received with "a grain of salt." And if
2 they were interested in a particular new treatment, then
3 they would have to do more research to see if they were
4 really interested.

5 Specialty societies seemed to be a generally
6 trusted source of evidence, whether through conferences they
7 sponsored, journals, or regular e-mail communications.
8 People also cited NIH, FDA, and CDC as trusted sources.

9 In general, physicians believed that no source was
10 completely without bias. Even the government could be
11 biased towards less expensive treatments. So they
12 emphasized the importance of transparency. Not only should
13 researchers report any conflicts of interest, but also that
14 credible CER information has to be transparent. Researchers
15 must present their studies' research design, methodology,
16 and particularly report all of the results so others could
17 evaluate it for themselves.

18 Our focus group participants also discussed the
19 best ways to make the information useful to them. They
20 wanted CER findings to be concise and easy to read -- in
21 other words, something they could look at quickly to see if
22 it was relevant to their practice, and then dig deeper if

1 they were interested.

2 Results should be easily accessible. For example,
3 some suggested getting brief information about something on
4 their PDAs or through specialty society e-mails, which was a
5 source that many were already receiving.

6 Several said that the priority should be high-
7 priced new technologies with studies done before these
8 technologies became widely diffused in practice. Another
9 thought there should be an emphasis on studies that compared
10 medical management with procedures for a given condition.
11 Several also mentioned that, given the fast pace of medical
12 science, it would be important to update studies frequently
13 to take into account new evidence.

14 Well, I've discussed how the physicians who
15 participate in our focus groups view comparative
16 effectiveness research. To start your discussion, we'd like
17 to hear about dissemination techniques that in your
18 experience work best, and we're also interested in any other
19 comments you may have about the other concerns physician
20 express.

21 And, with that, I turn it over to you.

22 MR. HACKBARTH: Okay. Thank you, Joan and Nancy.

1 I would like to allot 10 to 15 minutes for
2 questions and comments, and we'll just do one round on this.

3 This was useful information on these focus groups.
4 It's pretty much what I would have expected, but, you know,
5 it's useful to sometimes have that confirmed. It would be
6 pretty much what I would expect both in the positive and
7 some of the concerns raised.

8 Let me start with a question. Was there anything
9 that really surprised you in the focus groups, anything that
10 really stood out for you?

11 DR. SOKOLOVSKY: I suppose it was somewhat
12 surprising to have people say, "We don't want any more
13 information." I mean, the concerns did not surprise me, but
14 the strength of the few people who were completely negative
15 did surprise me.

16 MR. HACKBARTH: So even though that was a small
17 number of people, that was surprising to you.

18 DR. SOKOLOVSKY: Yes.

19 DR. KANE: Did they all wear glasses?

20 [Laughter.]

21 DR. MARK MILLER: The only other thing I would
22 have added to that, which is a little bit off of the focus

1 groups, is the IOM's priorities, at least when we went
2 through them, we expected to see a lot more drug-drug,
3 device-device, medical treatment versus surgical, that type
4 of thing. And I was kind of curious as to what your
5 reactions were to that as well, in addition to whatever
6 happened in the focus groups.

7 MR. HACKBARTH: Okay. Let me see hands. Why
8 don't we start on this side this time.

9 MR. KUHN: Thank you. I'm like Glenn. The result
10 didn't surprise me. But I would just make the observation
11 that, you know, every physician I've ever worked with in one
12 way or the other attempts to practice evidence-based
13 medicine. They've done that since day one, and somehow this
14 issue has really taken on an interesting role because of the
15 government's role here one way or the other.

16 Two questions -- one about the data. I noticed
17 that you did these focus groups during a time of -- I think
18 it was July and August of this year. That obviously was the
19 same time when a lot of town hall meetings were going on
20 around the country. Was there any kind of spillover that
21 you could see from the activities that were going on and
22 reported in the national press and the results you were

1 getting in your focus groups at all?

2 DR. SOKOLOVSKY: Not in a bad way. These were
3 very kind of intellectually engaged, the people
4 participating. People said afterwards what a good time they
5 had discussing these issues. These were, in general, not
6 high-passion. They were really thoughtful discussions.

7 MR. KUHN: Good. That's good to hear. The only
8 observation I would just make on this is that obviously one
9 of the clear messages we're getting here is that, you know,
10 this issue of non-interference within the physician-patient
11 relationship is loud and clear when you look at this data
12 that's out there. And I think there will be some
13 portability or some opportunities for us to discuss this
14 further when we get into other topic areas in the future
15 Commission work, such as shared decisionmaking and things
16 like that. So I think it's one thing that -- there will be
17 a number of interdependencies here on other things that we
18 do. I just want to kind of point that out as we go forward.

19 MR. BERTKO: Just a quick question. On Slide 16
20 you mention here that they call for updates on new
21 procedures and such. Was there any discussion in the focus
22 group about using surveillance to see what happens after

1 procedures or devices get used a bunch of times?

2 DR. SOKOLOVSKY: They didn't talk about it. It
3 was kind of interesting. We didn't want to define what
4 these studies should look like, and it was very clear that
5 people defined them based on their own experience, so that
6 some people who were already engaged in clinical trials
7 assumed that every one of these studies would have to be a
8 clinical trial. Others did talk about meta-analysis.
9 Nobody specifically mentioned things like registries. But
10 others did talk about FDA, in fact, keeping track of what
11 happened.

12 DR. DEAN: Thank you. This was very interesting.
13 Obviously, this has been an interest of mine for some time.

14 In response to Mark's question, I had exactly the
15 same response to the IOM list. I was really surprised at
16 how vague or kind of non-focused some of the recommendations
17 were, and I certainly expected much more in the way of much
18 more specifics. At least from a clinical point of view,
19 that's what we would need to make clinical decisions. From
20 a policy point of view, maybe some of the other broader
21 things.

22 In response to the focus groups, I guess I would

1 just respond that personal experience can be highly
2 misleading, and I think that that's why the value of this.
3 The most striking thing, just a month ago in the New England
4 Journal there were two studies -- one from the Mayo Clinic
5 and one from Australia -- about the treatment using
6 vertebroplasty, which is a treatment for compression
7 fractures of the vertebra, which is a very painful
8 procedure, not a life-threatening procedure but the
9 procedure that has been used and has come into wide use.
10 They put a balloon into the collapsed vertebra, expand it,
11 and then put the cement in to stabilize it. And the belief
12 across, I think, the whole medical community is that that
13 improved the outcome and shortened the recovery time. And
14 in both studies -- one from the Mayo Clinic, one from a
15 university in Australia -- these were well-done studies with
16 sham procedures to compare for comparison. There was no
17 difference with placebo. I mean, one study showed a very
18 minor trend toward a shortened recovery time with the
19 procedure, one showed no difference at all.

20 So here is an expensive participation that
21 everybody believed worked, and when it was subjected to
22 really hard-nosed scientific evaluation, it's not nearly as

1 good -- maybe it's not any good at all, but it certainly is
2 nowhere near as good as people believed. That's why this
3 kind of research is so important.

4 And so I think the important challenge is, first
5 of all, we need to get the studies done. People fear how
6 this data could be misused. And it could be misused, but
7 any data can be misused. And I think we've got to get the
8 data first, and if the powers that be become too heavy-
9 handed in its applications, then that's a separate problem.
10 But we cannot make good decisions if we don't have good
11 data.

12 The dissemination is a challenge, and I guess my
13 thought would be it would be helpful if CMS or NIH, maybe --
14 I'm not sure who the vehicle should be -- would develop some
15 sort of a clearinghouse or website where you could
16 consolidate all this information and you could have one
17 source where, when we're looking for what really has worked,
18 what does the research show in a concise form, we could go
19 there and see what has been done.

20 We're never going to have perfect data. There's
21 always going to be patients who have unique situations, and
22 we have to make sure that our policies allow for that, and

1 that if we make good clinical decisions that don't entirely
2 follow that, there has to be allowance for that. But,
3 still, we need to figure out ways to make this data easily
4 available.

5 MS. BEHROOZI: Just on the topic of the IOM list,
6 it seems like a lot of the stuff is good stuff about public
7 health kinds of issues, but it's really not the kind of
8 thing where you would want there to be one answer. You
9 would maybe want there to be sort of a ranking or here are
10 alternative strategies or, you know, this works for 40
11 percent of the population and for the other 60 percent you
12 have to do these other six things that have proven
13 effective, as opposed to not even necessarily direct head-
14 to-head things, but, you know, a more limited set of choices
15 that a clinician might make among interventions. So they
16 really seem to be kind of two different lists, almost,
17 combined into one.

18 And just on the demographics, you know, the
19 eyeglasses, as Nancy raised it, of the participants in the
20 study, I imagine that the focus group is too small to really
21 do a demographic analysis or specialty analysis or whatever.
22 But maybe that is worth sort of at a next level of research

1 how do attitudes break out among specialties, you know,
2 among ages, regions, whatever. That would be the kind of
3 thing that I would think would inform the question of
4 effective dissemination strategies. Again, you'd probably
5 need multiple dissemination strategies to approach all the
6 different groups of people you're dealing with.

7 DR. CROSSON: Just one comment on the
8 dissemination strategy. I think you noted in the report
9 that in the focus groups, a number of physicians had sort of
10 a healthy skepticism towards all data that they use to make
11 judgments, and I think that's entirely appropriate,
12 particularly because I think there has been some concern in
13 recent years about bias in research and the like. And I
14 think in our own organization, our large medical groups, we
15 see the same thing even, you know, within our own
16 organization. And to the extent that we can generate
17 clinical information about what we think might be the best
18 direction or the other, sometimes we have physicians look at
19 it with healthy skepticism also.

20 What we have generally found is that physicians
21 tend to trust the judgments of individuals in their own
22 specialty who have strong reputations for quality,

1 excellence, and independence of judgment. And so what we've
2 tried to do over the years is to use those groups of
3 individuals not just to promulgate information about what
4 appears to be the best way to practice but actually to
5 develop that information.

6 So it seems to me that there's something to learn
7 from that in terms of the dissemination process, and that
8 is, to both involve the key physician leaders in particular
9 clinical areas in the development of these, which I'm sure
10 is the intention, but then also to use similar groups of
11 individuals -- expert panels, you might call them, or
12 whatever -- in standing behind the recommendations, as the
13 FDA does and other organizations do.

14 I think in the end it's very important. Often
15 physicians turn right to the back page and say, "Okay, whose
16 recommendation is this?" And they look for names that they
17 can trust and, you know, based on reputation and the like.

18 DR. KANE: Yes. Was there anything in there about
19 not just informing physicians, but also the patients and the
20 broader community on what might be done with respect to
21 informing, you know, the people who might really also like
22 to know more about clinical effectiveness from the

1 perspective of the patient, and media, how to train the
2 media on how to report on some of these kinds of things?
3 Because it's often not well reported in the media, or, you
4 know, people don't -- I know in public health risk ratios or
5 odds ratios are very poorly interpreted by people who aren't
6 trained to do that.

7 So is there any kind of thought about how to
8 invest in both more broadly disseminating and then on how to
9 train the media to talk about these things intelligently and
10 objectively?

11 DR. SOKOLOVSKY: In terms of the focus groups --

12 DR. KANE: No. More in terms of all these other
13 bodies talking about [off microphone.]

14 MS. RAY: Well, what I can speak to is that at
15 least -- in AHRQ's announcement on projects that -- in
16 AHRQ's general announcement on types of projects that it
17 intends to use some of the Recovery Act's money, some of
18 that will be on dissemination and translation initiatives.
19 They didn't get into anything more specific about that.

20 At an AHRQ conference I just attended this past
21 week, they noted that it is very difficult to try to
22 disseminate -- to try to find effective dissemination

1 strategies to reach patients. So I think we will just have
2 to watch and see how the Recovery Act's dollars are used to
3 further dissemination strategies.

4 DR. BERENSON: Two points. One, since we're
5 concerned about physician perspectives, I think it's
6 important to point out that there was a letter signed by, I
7 believe, 60 physician organizations that was very
8 specifically supportive of the whole CER enterprise. So I
9 think physicians are on board. I think we have to be
10 careful about some of the concerns raised, but this is not
11 an area where at least physicians are causing problems, so
12 that's very reassuring.

13 The second point, to Mark's issue, I actually was
14 the lead author on an article about a month ago in Health
15 Affairs on a new technology -- not brand-new, but tele-
16 health for ICUs, or the EICU, in which 10 percent of ICU
17 beds now in this country are monitored by people in an
18 external bunker. The people who have adopted this
19 technology believe it reduces mortality dramatically, is the
20 great thing since sliced bread -- not that sliced bread is
21 that great, but that's what we say. And then there's most
22 hospitals are quite skeptical. They don't think it's worth

1 the investment. They think their strategies make all the
2 difference. And there's no objective data one way or the
3 other.

4 So the whole hook to this article was that
5 comparative effectiveness should not just study devices,
6 procedures, and drugs, but that there should be some room
7 for studying a delivery system or work process improvement.

8 And when the IOM came out, the paper got accepted,
9 and we had to change it because there was the IOM saying
10 that almost all of comparative effectiveness should be about
11 delivery system and work process improvement.

12 I think probably there is a balance here that is
13 closer to the original vision, which is drugs, devices --
14 clinical interventions, but that there should be room in the
15 research agenda for the kinds of research that AHRQ does
16 more so than just NIH research, which is what I think some
17 of us were concerned that would tilt too far in that
18 direction.

19 DR. STUART: There is another perspective on this.
20 I, too, attended the AHRQ annual meeting just completed on
21 Wednesday, and I direct one of AHRQ's Decide Centers, which
22 is supposed to be preparing evidence on comparative

1 effectiveness. And one of the big deals that came out in
2 this last session is the fact that in many interventions
3 there is no particular reason to believe that the effect of
4 the intervention, whether it's drug, device, or even
5 behavioral, is going to be the same across different
6 population groups. So this whole issue of treatment
7 heterogeneity -- and Mitra focused on that -- is a real
8 concern because there aren't clear boundaries upon where the
9 heterogeneity goes and how close heterogeneity -- or what
10 the variance is around some mean treatment effect according
11 to different sub-populations.

12 So my question is: Is this reflected in part in
13 terms of what you found in your focus groups? In other
14 words, could it be that a physician says, "Oh, well, my
15 patients respond to this particular treatment, and if they
16 don't, I do something else," it really is a treatment
17 heterogeneity effect as opposed to ill-informed personal
18 opinion?

19 DR. SOKOLOVSKY: Certainly it was one of the
20 concerns of physicians who wanted more comparative
21 effectiveness research that we shouldn't assume that the
22 same treatment worked for all populations, and they were

1 pretty clear about it. But the first group that I was
2 talking about, in fact, didn't want any more information;
3 they only wanted -- and, remember, this is a small minority.
4 Most wanted more information but wanted to be careful that
5 it took into account the heterogeneity of the population.

6 DR. CHERNEW: I have two very quick questions.
7 The first one is: Do you have any sense of where the
8 physicians or the focus group participants were getting
9 their information about what comparative effectiveness
10 research was? How did they come to what they were actually
11 evaluating?

12 And my second question is: Is there anything that
13 came out of the focus groups that might lead you to an
14 opinion about where the detailed aspects of managing
15 comparative effectiveness research -- not the board areas,
16 but who decides I am going to study treatment A versus B
17 within the sub, you know, gets done? And one would think,
18 for example, that the system stuff might be best done in a
19 place like AHRQ or an AHRQ-like place, and maybe some of the
20 other ones might be done more at an NIH place. I know there
21 has been a lot of discussion of the quasi-independent, sort
22 of federal authorized whatever. And so any information

1 about how one might place all of parts of it would be
2 useful, if there was any information that came out of the
3 focus groups on that.

4 DR. SOKOLOVSKY: To your second question, I don't
5 think that the knowledge of the different initiatives was
6 clear enough that there was any useful information on that.
7 In terms of where they got their information now, as I was
8 saying, it seemed to be very much based upon their
9 background so that there were physicians there who either
10 now or in the past participated in clinical trials, and they
11 had an NIH model of what clinical trials should be, and
12 that's how they saw comparative effectiveness.

13 There were others -- and I want to say the primary
14 care physicians were more interested in kind of looking
15 across things and so talked more about meta-analysis. There
16 were people who were familiar with Cochrane reviews.

17 One thing that -- I guess to Glenn's original
18 question about was there anything surprising, one thing that
19 was quite surprising and impressive to me, really, was that
20 I am accustomed to hearing that physicians are overwhelmed
21 with information and don't have time to read, for example.
22 And we heard over and over again, we heard physicians

1 saying, "Well, if something's interesting to me, I want to
2 go back to the original study and look at it." And I found
3 that very both interesting and impressive.

4 MS. HANSEN: Great. I wonder, are there any plans
5 to do focus groups on beneficiaries? Because there is so
6 much -- you're talking about the climate of how people look
7 at what's called comparative effectiveness. Or is, you
8 know, AHRQ perhaps able to do that with some of the stimulus
9 funds? And I know some of this then relates to work you've
10 done on the informed decisionmaking that I think Herb
11 brought up that this is another dimension of, but just how
12 the beneficiary side gets represented.

13 DR. SOKOLOVSKY: Well, as you know every year we
14 have a number of issues that we go out and talk to
15 beneficiaries about. I have the feeling based on the lack
16 of familiarity with the current initiatives by physicians,
17 who were otherwise very kind of plugged in, that just going
18 out and talking about that now to beneficiaries might not be
19 the most useful thing we could talk to them about yet,
20 although certainly down the road it's going to be really
21 important.

22 MS. HANSEN: Sure. But is it something that we

1 can find out whether AHRQ is doing? Because, again, they
2 are a process of that dissemination, and so how well that
3 perhaps plugs into this side of the line of our working with
4 the physician community. So I think if we could just
5 somewhere, as we do some write-up on it, just to be able to
6 get a fuller side as to what's happening.

7 And I bring up the same thing with just the health
8 forums that have been going on, just the reaction, the idea
9 that people don't want that, and they see that, ironically,
10 as something coming between them and their physician. So
11 there is some way to just bring a balance to that picture on
12 the beneficiary perspective.

13 MS. RAY: You know, I don't have the details
14 exactly in my head, but a couple of years ago, a California
15 group conducted focus groups of patients and talked about, I
16 believe, comparative research, and that's something that we
17 could summarize and bring back to you at some point.

18 DR. CASTELLANOS: I'd like to take a little
19 different viewpoint than what's been discussed. I think we
20 all value the value of comparative effectiveness, so we're
21 not going to -- we're not arguing that. I'd like to look at
22 this issue, not just comparative effectiveness, but this

1 issue from 3,000 feet up or 10,000 feet up or however high
2 you want to go.

3 I think the real issue here is -- and I'm not
4 surprised by how the physician community reacted. Peter,
5 you've been at hospital board meetings. Here, you have.
6 George, you have. And this is not -- the physicians argue,
7 they bring up issues. I mean, this is part of the physician
8 mentality and education and intelligence.

9 What I think the point here is is that we need to
10 think about not just strategies for comparative
11 effectiveness, but strategies for all of the issues we've
12 talked about, whether it be comparative effectiveness,
13 whether it be, you know, design of a new -- dissemination of
14 what we have wanted to do. And we don't have these good
15 strategies for getting this useful information down to the
16 practicing physician level or, as Nancy said, to the general
17 public or to any of the communities.

18 I think, you know, with funding, I think we have
19 the opportunity to better communicate these principles that
20 we stand for and we've emulated. And I think as MedPAC we
21 have the opportunity to be able to perhaps recommend some
22 funding issues where we can get this information, not just

1 comparative effectiveness but other information that we
2 think is valuable, not just to the physician community but
3 into the general public.

4 MR. GEORGE MILLER: Thank you. Very interesting
5 work from my perspective. I've got a question, just a
6 technical question first, and you mentioned a little bit
7 about a small minority. But could you give me the
8 percentage of those who thought that CER shouldn't be done
9 versus the majority who felt it should be done? Is it 10 to
10 90? Is it 30 to 70?

11 DR. SOKOLOVSKY: I don't really want to do that.
12 I think it's hard to parse where the kind of line's drawn
13 of, yes, I want more information, but I have so many
14 concerns that, in fact, it's not possible to do it. So
15 where do we draw that line?

16 MR. GEORGE MILLER: Okay. And I'm wondering if
17 that line is because of the trust issue and what are the
18 parameters for that trust. We've often heard health care is
19 local, so where that information comes from -- and Ron just
20 hit it, I think, in that. What is the entity that should
21 effectively communicate for the physician community? And
22 can you have one organization communicate to the physician

1 community about CER? Or should it be different avenues?

2 I was struck by the comment that some physicians
3 relied on consensus versus CER, and I'm wondering what the
4 basis of the research -- or what the basis of their
5 consensus would have been. Or did they talk to you about
6 that?

7 DR. SOKOLOVSKY: What they actually said was that
8 the guidelines that their specialty societies use --

9 MR. GEORGE MILLER: Specialty societies, okay.

10 DR. SOKOLOVSKY: And, in fact, that seemed to be
11 the most trusted source, if I could characterize it, would
12 be the specialty societies. But some physicians said that,
13 in fact, they thought that many of those guidelines that
14 they relied upon were actually consensus-based not evidence-
15 based, because the evidence didn't exist.

16 MR. GEORGE MILLER: I think it goes to Tom's
17 discussion about the Kyphoplasty versus vertebroplasty. I
18 remember being a CEO, and one of the greatest food fights I
19 ever had was listening to that argument. And they would
20 quote what I believe was at that time consensus-based
21 information and not actual studies like you just quoted.
22 And for someone who's trying to decide what resources to

1 invest in either, both, or neither, there has to be a
2 repository of information.

3 So, again, my question centers around the
4 communication. Should we as MedPAC make a recommendation?
5 Should it be AHRQ or NIH? I think that's the challenge we
6 have, and it sounds like that's the challenge of the
7 physician community to deal with that issue. So it will be
8 interesting to follow this.

9 I'm probably going to be a little bit off the
10 subject, but I'm wondering if you had discussions in
11 addition to CER, if discussions were in the vein of which
12 specialty should do a procedure. Because, again, the food
13 fight was over should anesthesiologists be doing a procedure
14 or should it be a neurosurgeon, that type of thing. Did
15 that come -- was that not part of it?

16 DR. SOKOLOVSKY: No, that really never came up.

17 MR. GEORGE MILLER: Okay. All right. Thank you.

18 DR. BORMAN: Fairly quickly, I hope. This is very
19 nicely organized, and it's a nice juxtaposition of sort of
20 some objective and then some subjective.

21 I, too, do not find the focus group comments
22 surprising. I would hope that we do all remember that it is

1 a very small sampling of physicians, and while we all have a
2 gut sense that it's emblematic, I think we need to be just a
3 little bit careful about attaching too much weight in our
4 thinking of what we take forward to that. So just as a
5 caveat.

6 The second piece, just to comment on the linkage
7 to the professional liability reform, and I think that's
8 hugely important here for two reasons. One is that I think
9 you can see that this is a carrot for embracing a process
10 that we as a Commission have felt is important to take
11 overall quality of care to another level. So I think, you
12 know, it's a carrot; we need to understand the power of the
13 carrot.

14 And then the second piece is that even separate
15 from just the carrot of drawing people into it, as all
16 certainly the physicians at the table will tell you, there
17 will have to be a mechanism for peer review when guidelines
18 are not employed. And you will never get meaningful peer
19 review if you do not tie this in some way to professional
20 liability considerations.

21 So that while the devil will be in the details and
22 it will have to be appropriately crafted, that in order to

1 have this system have the downstream effect, there will have
2 to be a peer review component, and it will have to offer
3 protection to get that to happen.

4 Then, finally, in terms of what to focus on, with
5 all due respect to the IOM and with respect to the fact that
6 we do need to think about systems and processes, once again
7 I think we can go to the high-cost, high-volume diseases and
8 conditions, the high-cost drugs, some of the things we've
9 already talked about here, high-cost element of biologics
10 and, you know, what is going to be the appropriate use of
11 those in relative diseases. And so I think that coming up
12 with a list from the Medicare program's standpoint -- and
13 I'm sure analogously the Medicaid program's standpoint or
14 SCHIP in some combination -- could come up with the related
15 pediatric issues for the segment that Medicare doesn't
16 cover. I think identifying those will be a relatively easy
17 place for at least some up-front good things.

18 MR. HACKBARTH: Thanks, Karen. Okay. Thank you
19 very much, Joan and Nancy. Now we will move to our last
20 sessions, an analysis of episodes of care and Jennifer is
21 going to lead that.

22 So we are now at almost 11:40, so I'm going to be

1 shooting to wrap this up around 11:20 so we can allow 10
2 minutes for the public comment period. Jennifer has agreed
3 to help us with that.

4 Did I say 11:20? We're actually going to go
5 backwards, yes, and Jennifer is going to do that for us.

6 I meant to say we're going to finish at 12:20.

7 MS. PODULKA: And I'm going to try to go as
8 quickly as I can, but being a Texan and not a New Yorker,
9 it's going to be a little bit challenging for me.

10 I don't want to confuse people with the face and
11 the episodes name because my presentation is actually going
12 to take a look at the Medicare program in a way that the
13 Commission has not traditionally undertaken.

14 Several Commissioners have asked over time for a
15 cross-payment-silo perspective. Mike, you specifically
16 suggested that we use our episode database for this purpose.

17 So as I mentioned, cross-silo perspectives, we're
18 going to explore levels, growth and variation in Medicare
19 spending using the episode database. Just to reorient you
20 to that, the database is built using Medicare claims and the
21 episode treatment groups, from ETG software from Ingenix,
22 Inc.

1 Before I get into that, this is not an
2 endorsement. As you will recall from our June report, we
3 very strongly said that CMS needed to use an open, non-black
4 box Medicare-specific episode grouper. But we have this
5 data tool, and when we have a data tool we use it.

6 So the ETG software groups Medicare claims into
7 clinically distinct episodes of care. These include about
8 500 clinically related groups called ETG base classes.
9 These base classes are further split into more granular
10 ETGs, such as diabetes with and without complication or with
11 and without surgery, or some other smaller groups.

12 But for our purposes, we're using these as base
13 classes. Think of these as very high level. To be non-
14 confusing, I'm going to refer to these as episodes
15 throughout the presentation. Think of these, you'll see
16 soon, as diabetes, hypertension, things like that.

17 So basically, what we did was look at our usual
18 levels in growth, but in a slightly different way. Here,
19 the 20 clinical episodes that accounted for the greatest
20 share of total Medicare spending on episodes in 2005 --
21 that's the high level -- together, these accounted for
22 almost 60 percent of total Medicare spending on episodes.

1 I want to draw your attention the fact that our
2 denominator is spending on episodes, not the entire universe
3 of Medicare spending. That's consistent throughout. So
4 numbers, spending, everything is episodes.

5 Of these 20 high level episodes, only two are for
6 acute conditions: closed fracture of thigh, hip, and pelvis,
7 and bacterial lung infections. The rest are chronic
8 conditions.

9 Note, episode software splits all types of
10 episodes into either acute or chronic. Acute you might
11 think of as something short in duration, such as sinusitis.
12 Everything else is similar between acute and chronic. It's
13 all types of services -- doctor visits, hospitals. But
14 acute ends when that service grouping ends.

15 Whereas chronic conditions, such as diabetes, tend
16 to not go away in your lifetime. So for analytic purposes,
17 what the software does is it creates annual chronic
18 episodes.

19 Okay, the first set of numbers. Here you see the
20 first 10 of the top 20 high level episodes. To orient you
21 to the data, the first line, ischemic heart disease, ranks
22 first in total spending, accounts for 14 percent of total

1 Medicare spending on episodes, and about 20 out of every 100
2 beneficiaries with at least one episode has ischemic heart
3 disease.

4 If you look down those columns on the right-hand
5 side, you see that we have a mix of both common episodes
6 that are not so expensive, and rarer episodes that are
7 rather quite expensive.

8 And to fit everything in, here are the next 10 of
9 the top 20. Notice that these now account for about only 1
10 to 2 percent of total Medicare spending on episodes.

11 Moving from levels to growth, I'm going to show
12 you on the next couple of slides. About half, exactly half
13 of those 20 episodes that were high level are also high
14 growth. But we set our definition for growth a little
15 differently. We first limited our universe to those that
16 accounted for at least half a percentage point of total
17 spending on episodes. And in that universe, these 20
18 together accounted for almost 30 percent of total episode
19 spending in 2005.

20 Again, coincidentally, of the 20 fastest growing,
21 two are acute conditions, which are spinal trauma and then
22 the UTI and similar episodes. All the rest here are chronic

1 conditions again.

2 So data here, the yellow lines represent ones that
3 are both high level and high growth. Reading across, for
4 the first line, joint degeneration of the neck grew the
5 fastest. I want to note that that 19 percent growth rate is
6 average annual. It's not total growth over the multi-year
7 period.

8 Note, if you read down, that there were some
9 Medicare coverage decisions during this time period that, of
10 course, contributed to the growth. For example, coverage of
11 breast and prostate cancer screenings.

12 To spend a little time, the next 10 of the top 20.
13 Of course, when we talk about growth, the natural question
14 is what's driving growth rate? So to help answer that
15 question -- sorry, I tried to squeeze it all in so we could
16 look at it all together. It gets a little small.

17 But basically, what you can see is that we broke
18 out number of new cases and total change in spending
19 annually. You can see that in all instances, the total
20 spending -- the green bars -- grew faster each year than the
21 number of new episodes. So both are driving growth but it's
22 not all just new episodes.

1 Next, we ranked those high level and high growth
2 episodes by 10 geographic areas. You see them here on the
3 screen. Basically, they're a mix of high and low levels in
4 growth. So they're designed to be illustrative.

5 So I'm going to take you through the words first.
6 In each of these 10 geographic areas, the 10 episodes that
7 account for the greatest share of total Medicare spending on
8 episodes were pretty similar in rank -- rank in that local
9 area -- to the national rank. So if you read across that
10 first row for the most common condition, ischemic heart
11 disease, it was consistently in first place across all 10
12 areas.

13 However, I'm going to give you a secret. You
14 don't have to read anything. If you sort of unfocus your
15 eyes and look at this as a pretty picture, think of it as
16 mosaic, one -- the first level rank -- is the lightest
17 color. Ten, the opposite end of the ranking, is the darkest
18 color.

19 So if you kind of look at it, and of course, those
20 blue cells are blank so there's no overlap between national
21 and local, the pattern is a little mixed up by fairly
22 consistent. Which means that national and local is very

1 similar in terms of level.

2 Not so on growth rate. Here the results are quite
3 different. Again, maybe don't try to read if you're not
4 interested, because they do get kind of small. But if you
5 look at the picture, you can see that overlap between
6 national and local looks really different here. It ranges
7 from only one cell overlapping in Houston to six in
8 Minneapolis. You'll notice lots of blanks where there's
9 absolutely no overlap between national and local. And of
10 course, it's very mixed up.

11 So you can draw lots of conclusions from this, but
12 one that I offer is that any policy options that focus on
13 the high growth conditions are probably going to have some
14 differential impact by local area.

15 Next we took that local comparison and we looked
16 by type of service spending. Of course, type of service
17 spending differs by episodes. That's not a surprise. But
18 we found that there were significant differences in type of
19 service spending for the same episode in different
20 geographic areas.

21 In other words, the exact same condition is
22 treated quite differently in different cities. Of course,

1 if I really did this analysis it would be way to big to look
2 at compared to the last one. So we drew some illustrative
3 examples.

4 So if you look at this table, it shows notable or
5 largest type of service ranges for the first five of our 20.
6 You know that ischemic heart disease, the share of spending
7 for the episode devoted to inpatient services ranged from a
8 low of 49 percent in Miami to a high of 68 percent in
9 Minneapolis. And we have notable ranges in all of these.

10 Next, we repeated this not for level but those
11 high growth episodes. And note that this time we're
12 comparing the total change over time by type of service. So
13 let me interpret what that means. For a joint degeneration
14 of the neck, the share of total episode spending devoted to
15 post-acute care services declined by 4 percentage points in
16 Indianapolis and grew by 15 percentage points in Phoenix.

17 In some instances, when you look past the five --
18 and this was in your paper but not shown on the screen --
19 there were fewer differences. But remember again, those
20 fast growing -- we had fewer number of cells to draw from.
21 But even still, some significant differences.

22 I'm going to skip future analysis because it's

1 understood.

2 Discussion questions. I offer this for your
3 consideration. This analysis of fast growing episodes
4 especially raises questions about the underlying incidents
5 of disease. I grouped this into three possibilities. Does
6 this reflect growing disease burden in the Medicare
7 population? Or an increasing propensity among health care
8 professionals to diagnose and treat? Or third, an
9 increasing propensity among Medicare beneficiaries to seek
10 treatment?

11 Of course, the next big bullet there, are there
12 detailed analyses that you would like to see? It's a
13 powerful dataset. Virtually the only limitation is the
14 ability to present the information and our time to slog
15 through it here, of course. But if you have ideas, please
16 let me know.

17 And we've done top 20, top 10. But if you have an
18 illustrative episode or two that you would like to really
19 dig into, please suggest that, as well.

20 And thanks very much.

21 MR. HACKBARTH: Thank you, Jennifer. For a Texan,
22 you talked pretty quickly.

1 Let me just say a word about the context for this.
2 Mike has pointed out in the past that on the one hand we
3 lament the fact that so much of Medicare is focused on silos
4 and all that. But we fall into the trap of, in fact,
5 talking mostly about the silos. So Mike suggested it would
6 be good for us to spend some time looking at these things on
7 a different plane. So this is a first effort to do that.

8 So Mike, I'm going to give you the first
9 opportunity to react to this.

10 DR. CHERNEW: [off microphone.] I think this is
11 stunning work.

12 MR. HACKBARTH: Would you hit your mic?

13 DR. CHERNEW: I think it's stunningly even more
14 wonderful when I say it into the mic.

15 I guess -- I will just be very brief because I
16 know we don't have time. I think that as we move forward to
17 new sets of payment systems, it raises a whole bunch of ways
18 of what we want to do. I think the first thing people would
19 agree on is we'd like the Medicare system to be more than
20 just paying bills, but be a little more clinically oriented.
21 In order to do that, I believe we need data that's a little
22 more clinically oriented. I think this is a wonderful start

1 at doing that.

2 I think there's a number of specific questions
3 that arise. One of them which will come up, which we don't
4 need to talk about now, how good are the groupers? What do
5 we think about the episodes? There's a whole series of
6 technical things about groupers that matter that are more
7 than mundane questions in an era that might go towards some
8 sort of episode-based payment. The details of that will
9 matter.

10 Issues of how we would deal with updates, which is
11 something we deal with a lot, in a world that has episode-
12 based payments or under bundling, is crucial. So beginning
13 to look at what episodes look like matter.

14 I know that there are several people -- I'm
15 involved with a group at the Bureau of Economic Analysis and
16 there's a group at Harvard run by David Collier that's been
17 thinking about this a lot. So I think, as next steps, it
18 might be useful to talk with some of those folks as to
19 what's going on.

20 But I'll just stop by saying I'm thrilled that you
21 did this, so thank you. I think there's more to be done in
22 this area to make the health care policy questions focus

1 much less on how do we control spending in a silo and how do
2 we make sure we're caring for people in certain clinical
3 conditions better.

4 The data being oriented that way, I think, is one
5 step to do that.

6 DR. SCANLON: One observation about the issue of
7 looking at growth. I think that as I looked at this and I
8 saw that about half or slightly more than half of the
9 fastest growing episodes, in terms of share of spending,
10 were less than the lowest of the top 20. I think there's
11 this question that when something is small, a little bit of
12 growth can be a big percentage change.

13 So thinking about different ways of looking at
14 growth might be something that would be worth doing. What
15 contributes most to the share of growth? Or among the top
16 ones, which ones are growing the fastest? Because I think
17 that if we do do policy, we want to make sure we have the
18 biggest impact of the policy that we have.

19 MR. KUHN: Thanks. This is really fascinating
20 stuff. I really enjoyed reading it, and the presentation.

21 A quick thing in terms of the groupers -- and it's
22 been a while since I've looked in terms of the makeup of all

1 of the inputs into the groupers. But as MedPAC has opined
2 in the past and CMS has begun to implement a number of ways
3 to try to get pricing correct, MS-DRGs work in terms of some
4 of the activities. I know the RUC is going through right
5 now to look at procedures that are going up dramatically.
6 CMS has picked off the top 100 that they have asked the RUC
7 to look at.

8 So I'm curious about is there a way we can get a
9 relationship, in terms of the ones that are growing fast,
10 what part of the pricing of that particular procedure, of a
11 part of that grouper, is helping drive that on a go forward
12 basis.

13 So in a way we could group this together but then
14 also kind of disaggregate them a little bit so we can see
15 the relationship or the correlation between maybe mispriced
16 procedures or mispriced activity and how much that's
17 influencing the grouper, as well. Because as we try to
18 think about new payment policies as we go forward, we still
19 might have a foot in the old world and yet try to get a foot
20 in the new world. And how those two relate to one another
21 would be helpful for me as we continue to look at this.

22 MR. BERTKO: Again, good work, like everybody

1 said.

2 One of the things I guess I'd bring up here is the
3 question of bundling. Arnie, in an earlier meeting, forced
4 me to think about this yet some more. I think -- I noted
5 the caveat here that your percentages there were percentages
6 of episodes, which I assume is a subset of percentages of
7 spending but a large subset.

8 So it brings up the fact that perhaps limiting
9 ourselves on a practical basis to 10 episodes -- and I think
10 I counted them -- would be 45 percent of the episode costs
11 and somewhat -- a large percent of that. Because to
12 actually run this out would be very complicated and begin to
13 organize things.

14 The question I would ask as maybe a follow-up
15 might be throwing water balloons of bundled payments at
16 episodes might be different between the acute ones,
17 obviously, and the long-term ones, chronic ones -- diabetes
18 in particular. But are there ways, given the way the
19 episodes are structured, that you could see some of the
20 episodes being more practical than others? Diabetes being
21 lots of comorbidities. Maybe ischemic heart disease being a
22 little bit simpler. And the chronic ones, the fractures

1 being the simplest of all.

2 So it's more of a rhetorical question. Can you
3 come back to us at some point with some response?

4 And like Mike, I think, there are other people
5 working on the episode based types of stuff that you might
6 want to check with also. Prometheus, as being a key example
7 also.

8 MR. HACKBARTH: So a factor might be simply the
9 number of physicians typically involved in each episode.

10 DR. DEAN: Just a quick question, which might make
11 this even more impossibly complex. But the real question is
12 who has it right, in terms of the spending and resource use.
13 Is there any way to tie some of this data to outcome data?

14 I don't know if that's even possible. But with
15 the variation we see, it's not all right. And is the -- are
16 the high spending areas getting better outcomes? Or as
17 we've seen frequently, they don't. I guess that would be
18 what we'd need to decide the policy.

19 I don't want to try to construct the graph to
20 present that.

21 At any rate, thank you. It's very interesting
22 stuff.

1 MS. BEHROOZI: Yeah, it was great, and I
2 appreciate your struggle to figure out how to convey things
3 visually, because you've done such a great job with the
4 stuff that you've chosen, and the squinting and seeing how
5 the colors shape.

6 Can you turn it back to Slide 9? Because that was
7 actually my favorite chart in the paper. It shows the
8 difference between the growth in episodes and growth in
9 spending, number of episodes and spending. And I just -- I
10 don't know. I feel like there's a lot more to learn about
11 that. I mean, how do you have spinal trauma -- okay, it's
12 only responsible for 0.6 percent of spending. I looked that
13 up. But that's kind of amazing, more than a 5-percent
14 annual decline in number of episodes, yet over 3 years, if
15 that's an almost 10-percent average annual increase, a 30-
16 percent increase. You know, what explains that? Some of
17 what you were looking at in terms of the types of procedures
18 in various regions, some going up and some going down. But
19 I guess I just would love to know more about what's behind
20 consistently the costs are going up much faster than the
21 episodes are going up, that spinal trauma, one, just being
22 sort of the most -- the biggest spread or whatever.

1 MS. PODULKA: We can pick spinal trauma and a
2 couple others and dig down and see what's going on there.
3 I'm not prepared on any of them today, but we could
4 certainly try and break out new treatments, more treatments,
5 what's happening.

6 MS. BEHROOZI: Thanks.

7 MR. BUTLER: What I like about this is that
8 yesterday we tried to look at Medicare Advantage plans
9 versus fee-for-service, and this is the middle ground way of
10 looking at things where all the action is. And if we don't
11 make an impact here, we're not going to change the system.
12 So I think it's the right unit of analysis that we ought to
13 dive into.

14 Now, two suggestions on the additional analysis.
15 You gave the dollar numbers, and not up on the slides, but
16 the annual spending per episode, and I was shocked at how
17 low some of them were. Of course, being a hospital guy more
18 than others, you know, you quickly say, well, this is a mean
19 for annual spending. And then I come to, you know, you can
20 drown in a lake that is an average of 5 feet deep. And so I
21 want to know where the depths are, and the mean doesn't tell
22 me a lot in this. It doesn't tell me where to hunt.

1 The second is that the geographic variation is
2 interesting, but I think at the heart of this still is to
3 line up our silos and look at the variation across the
4 segment, as you did a little bit of, to say what communities
5 had high hospitalization use for an episode versus other
6 components of care. But if you can do some of your slick
7 magic on some of those charts that show the best in class
8 for the components of the care across the silos, that would
9 be very helpful.

10 DR. MILSTEIN: I think early on when I started at
11 MedPAC, I think I complained to Mark and Glenn saying, you
12 know, if you benchmark the information flow that we,
13 Congress, CMS, you know, GAO have to go on in figuring out
14 what we're getting for the money in the Medicare system, I
15 said, you know, we're not even close to what goes on in
16 other industries. And I said what we need is a -- you know,
17 so we have to move toward a value-based dashboard navigation
18 system so we can begin to, on a more timely basis,
19 understand where we're having the biggest fluctuations in
20 value -- that is, you know, quality, as Tom was referencing,
21 divided by total cost of care.

22 As I was looking at your mosaic, I realized this

1 is the beginning of movement in that direction. It's like a
2 glimpse into the future as to the kind of instrument panel
3 that all those parties I referenced, including us, you know,
4 need if we are going to better steer this big aircraft
5 called Medicare and, perhaps with respect to comment, the
6 health care system.

7 So this is for me -- and I think a lot of us were
8 sort of mouthing or have said the word "wonderful," and I
9 think that's right. Michael's comment is properly
10 cautionary. This is an early instrument panel, right? This
11 is like a vacuum tube. But this is at least a step in --
12 you know, a huge step in the right direction and I think,
13 you know, it invites all kinds of interesting questions,
14 like the potential utility of such a dashboard at different
15 units of analyses, whether it's plans, accountable care
16 organizations, health systems, provider -- physician groups,
17 individual physicians, individual hospitals. There are just
18 innumerable applications. But this is just a huge advance
19 and a wonderful presentation, and I think a real glimpse
20 into, you know, what could be a value-based navigation
21 system for us, for CMS, and for the people putting money
22 into these benefits.

1 DR. KANE: I think this is -- I am very excited as
2 well. I want to reinforce what Peter mentioned, that the
3 distribution of the variability within the episode would be
4 very useful as well. I think, you know, if everybody is
5 doing the same thing within even a highly occurring, highly
6 frequent episode, maybe that is less something we should
7 spend time on than something that has a lot of variability
8 in the way the spending is within. So, you know, maybe tell
9 us the standard deviation or the range as well as the
10 frequency and the rate of growth.

11 I'm going to do my broken record routine and ask
12 if drugs are in here.

13 MS. PODULKA: Unfortunately, this is an earlier
14 time period, so for these data we don't have them.

15 DR. KANE: Yes, so at some point, obviously, we
16 really want to see the drug piece be in here.

17 And then I wonder if -- so spending is one metric
18 of what's going on in an episode, but so is utilization.
19 And I'm not sure that spending, particularly for the
20 inpatient component, is a particularly good, you know, proxy
21 for utilization to what's going on inpatient, you know, the
22 number of tests, procedures. I don't know if we have a good

1 record. I mean, the DRG payment is one amount, but what
2 happens to the utilization within the hospital might be
3 useful information, even length of stay and -- I don't know.
4 But it might help understand what happens post-acute or help
5 explain some of the variation. And it may be impossible. I
6 don't know if we have good inpatient utilization types of
7 information.

8 But it would be, I think, trying to eventually
9 understand the variability within an episode, spending, you
10 might want to have some type of utilization as well as just
11 other spending data to understand that.

12 DR. MARK MILLER: I know we're behind on time, but
13 is this standardized?

14 MS. PODULKA: That's correct, so the payments are
15 standardized to remove geographic differences. So to an
16 extent, we are coming closer to like an RVU count with our
17 dollars. So the differences aren't differences in input
18 prices or something like that between the different cities.
19 It really is differences in utilization.

20 I hear what you're saying about disaggregating
21 what types of utilization. I'm not sure how much we can do
22 that within the inpatient. But I'll explore what we have as

1 options there.

2 DR. KANE: Yes, and my understanding also even
3 home health, isn't it episodes? We don't know how many
4 visits. Some of the breakdown of what's actually happening
5 inside that spending might be -- might or might not be
6 available, but at some level, it might become useful.

7 And then the last thing that I think would be
8 helpful and interesting and probably relevant and explain
9 the variability within an episode would be whether the
10 enrollee has supplemental coverage or not, or even if
11 they're LIS, non-LIS -- I mean, some sense of the
12 socioeconomic and coverage status of the beneficiaries, that
13 that could be also linked.

14 So look at the distribution within an episode of
15 spending and/or utilization, and then try to explain -- not
16 adjust, but explain why that variability might be in terms
17 of some of these basic things, and then the remainder might
18 be, you know, clinical variation that we would want to look
19 into and better understand. But I think it's great and I'm
20 very excited.

21 DR. BERENSON: I will join that sentiment, but let
22 me start with maybe a quibble and then ask a question. The

1 quibble has to do with my perception that everybody now is
2 so convinced that all spending is related to chronic care,
3 and that's the area that I work in, that I think people miss
4 that there's a lot of acute events that happen in people
5 with chronic conditions. And so when I see cerebral
6 vascular accident labeled as a chronic condition, I sort of
7 scratch my head. I mean, these are people with
8 atherosclerosis who then have an acute event. Ischemic
9 heart disease is a chronic condition. Acute myocardial
10 infarction is an acute event.

11 I guess my question is: Does this grouper permit
12 you to do it both ways? Can you -- well, you know the
13 question.

14 MS. PODULKA: Right. That was actually in my
15 expanded notes that got cut right before coming up here.

16 DR. MARK MILLER: [Off microphone] Why are you
17 looking at me?

18 [Laughter.]

19 MS. PODULKA: Yeah, blame it on Mark.

20 Okay. So basically anyone -- and this is true of
21 the software, but any researcher who is trying to split care
22 into acute and chronic, some are going to be clear cut, and

1 some are going to be gray areas that fall in between. The
2 way it works in the grouper, chronic conditions can
3 absolutely have acute flare-ups, so you can have
4 atherosclerosis and it can flare up into an event.

5 It seems to generally characterize it more as a
6 chronic than to separate it out into a separate acute, which
7 can be helpful from a research point of view to see the
8 related care and see when it flares up. And, again, as I
9 said at the beginning, these are the very aggregated base
10 classes. I keep referring to them as episodes, but the
11 actual episodes are much more granular than these so that
12 you would see a heart condition with AMI being a specific
13 episode; whereas, here you just see the heart condition.

14 So there is the ability to disaggregate these into
15 the more is it chronic with a flare-up or is it chronic
16 without the flare-up. And, again, these are the pros and
17 cons. You're trying to create a schema to understand this
18 without having everything completely disaggregated into
19 little individual bits, and there's a trade-off to that
20 schema.

21 DR. STUART: I agree with Bob, and I was
22 particularly interested in terms of the impact of flare-ups

1 on lower back pain.

2 I have a couple of substantive issues here. One
3 is when I look at this, it looks like we're focusing on all
4 of the increases. Whether it is through acute or chronic,
5 it's all looking at growth. And my guess is that some of
6 this growth is really additive, but some of it really
7 substitutes for other kinds of things. And so there may be
8 a certain artifactual side to this where, because of the way
9 certain procedures, maybe new technological interventions
10 come in, is that you'd really like to see in cases where you
11 see big increases, are these brand new or are they
12 substituting for something else. And so if you had
13 something to look both at increases and decreases, I think
14 that might help increase the -- or it might help make the
15 picture more holistic.

16 The second thing is -- and I think we have all
17 faced this in one sense or another, and it has to do with
18 how we interpret percentage change. Between last August and
19 this March, I lost about 50 percent on my stock portfolio,
20 and then between August and July, my stock portfolio
21 increased by 50 percent. So, therefore, I'm even, right?
22 Well, no. I'm down about a third.

1 So if you're looking at increases and decreases,
2 and particularly if you're looking at increases from small
3 bases, it would be useful to have an analytic technique that
4 standardizes that. And economists actually have come up
5 with one that looks at absolute change and then change in
6 absolute change, and it's associated with something called
7 arc elasticity. That's probably the most common application
8 of this thing.

9 And so I would suggest that you look at this and
10 think about how these things might change if you do them in
11 terms of absolute rather than relative changes.

12 Then the third thing -- and it's been mentioned
13 before -- I think this is potentially a way for putting the
14 clinical piece into the large Wennbergian view of
15 differences, geographic differences. And so I would really
16 encourage kind of some thinking about how we take this and
17 we marry it to what we see in the Dartmouth Atlas.

18 MR. GEORGE MILLER: Just a quick question. I'm
19 very thrilled with this work and very excited. I thought
20 that I would have a platform by looking at this information
21 to deal with one of my pet peeves or concerns, and that is,
22 if there was a correlation between specialty hospitals or

1 physician clinics. But I didn't see that correlation here.
2 At least I haven't been able to draw that conclusion. I
3 don't know if you plan to do that in any way, because these
4 are not all procedure driven. I was a little surprised by
5 that.

6 MR. HACKBARTH: George, you're looking at the part
7 that's related to particular markets and just sort of making
8 a guesstimate as to where --

9 MR. GEORGE MILLER: I'm just guesstimating, yes.

10 MR. HACKBARTH: -- physician-owned hospitals are
11 most prominent.

12 MR. GEORGE MILLER: Yeah, and also with the
13 previous slide, not only this slide but the previous slide,
14 which is just counterintuitive to me, but that may be
15 because I'm not a researcher at all. I'm just curious if
16 that's going to take that path, if you think the large
17 spending -- we've got a large increase in procedures in some
18 cases and referral by physicians to their own practices.
19 But I don't see that correlation here.

20 MR. HACKBARTH: Well, you know, in other data,
21 other analysis that we've done, we have found a relationship
22 between the advent of physician-owned specialty hospitals

1 and increased utilization with associated services.

2 MR. GEORGE MILLER: Right.

3 DR. BORMAN: Just to reiterate, great stuff. I
4 think it's starting to take us in a direction that we all
5 want to go. The question would be if we pick several things
6 to dig deeper into, would we want to see if we could
7 identify commonalities in fastest growing or in spending in
8 terms of types of services, because that -- and whether that
9 matches up with some of our other analyses about growth and
10 various types of services.

11 MR. HACKBARTH: Okay. Just one comment. I agree
12 with what everybody said about this being very interesting,
13 and thank you, Jennifer, for your work on it. And like
14 Mitra, I really liked the visual presentation. That was
15 very effective.

16 One other reaction that I have is that while I
17 don't really disagree with what Arnie said about the utility
18 of a dashboard that includes better measures -- a dashboard
19 for policymakers, CMS, et cetera -- my ideal world is where
20 we've changed the payment systems so that it's the providers
21 of care who are hungering for this data and trying to
22 perfect it and figure out what it means and what they can

1 learn from other places. To me, that is nirvana, not having
2 a bunch of feds pawing through it and trying to figure out
3 what's best but providers wanting it. We have a ways to go
4 before we get there.

5 MS. HANSEN: The one comment I would make -- first
6 of all, this is fantastic. I didn't get a chance to say
7 that. But I think to your point, Glenn, the ability to have
8 this -- this is where the HIT side of this comes into place,
9 and being able to use it at that local level so it's both,
10 you know, individual kind of pure comparative and benchmark,
11 the ability to constantly have that so that the evidence is
12 about you in terms of what you're doing on behalf of care,
13 but it's really framing it in terms of value from multiple
14 levels, clinical effectiveness per se as well as, you know,
15 whether there's a barrier so that only the administrative
16 side looks at it, so that it's not finances driving it but
17 the relativity at least gives you a sense.

18 MR. HACKBARTH: Thank you, Jennifer. Well done,
19 and also thank you for helping hasten things along.

20 Okay. Actually, we are right on time. It is
21 12:15, and we are ready to begin our public comment period.

22 Dr. Rich has, once again, proven quickest to the

1 mic.

2 DR. RICH: I've lost weight.

3 MR. HACKBARTH: Let me just repeat the ground
4 rules here. Number one, please identify yourself and your
5 organization. Number two, please limit yourself to comments
6 no more than two minutes. When this red light comes back
7 on, that means two minutes is up and I'd ask you to bring
8 your comment to a conclusion.

9 Once again, let me just emphasize, I know this is
10 a short public comment period, but it is not the only way,
11 or even the best way to communicate with the Commission.
12 The absolute best avenue is to communicate with our staff,
13 who will go to great lengths to listen to you and your
14 information.

15 As I mentioned yesterday, we are also looking at
16 ways that we might enhance opportunities for public comments
17 and we'll have some more information on that at the October
18 meeting.

19 With that, Dr. Rich?

20 DR. RICH: Thank you, Mr. Chairman.

21 My name is Bill Rich. I'm Medical Director of
22 Health Policy for the American Academy of Ophthalmology.

1 I would just comment that I was very impressed
2 with the last presentation, especially the slide showing the
3 20 areas of fastest growth. Frankly, the Commission should
4 take credit for a lot of the answers to those questions are
5 actually being answered now.

6 The Commission recommended that we look at area of
7 growth. CMS submitted the 100 fastest growing services.
8 The RUC actually put together four other screens: codes
9 presented together, growth, change in site of services, and
10 several others. Just looking at those, I can tell you, some
11 of them are expanded patient populations, new technology,
12 marginal technology, inappropriate coding. It's all over
13 the place.

14 But the explanations are actually there. The
15 granularity is there to explain those 20 -- this is a
16 different way of looking at it. This is aggregate data.
17 But looking at the subsets of growth, be it coding or volume
18 change or change in the patient population, almost all of
19 those things can be explained.

20 So I strongly encourage Jennifer to get in touch
21 with Barb Levy at the RUC now. Just look at the simple one
22 of rheumatoid arthritis. That's Enbrel. So that's a Part B

1 drug. So I mean, some of these things are very explicable
2 and the data is out there now and actually being sent back
3 to CMS. And a lot of them are explained by the 100 codes
4 that Herb sent forward last year.

5 So I think this was very interesting. We're the
6 little guys looking at the little pieces. But to see the
7 aggregate was really very enlightening.

8 Thank you.

9 DR. LURIE: Good morning. I'm Dr. Peter Lurie
10 with the Health Research Group at Public Citizens, an
11 advocacy group here in Washington.

12 I have no conflicts of interest to disclose.

13 In your June 2009 report -

14 MR. HACKBARTH: Sir, could you make sure you stand
15 close enough to the microphone. It's a little difficult to
16 hear you.

17 DR. LURIE: Let me see if I can raise this. Is
18 that a little better? Should I start again?

19 I am, again, I am still Peter Lurie, a physician
20 at Health Research Group at Public Citizen. We're an
21 advocacy group in Washington. I have no conflicts of
22 interest to disclose.

1 In the Commission's 2009 June Report, you observed
2 that "Medicare, with an enormous financial stake in health
3 care and graduate medical education, has never specifically
4 linked any of its direct GME or IME subsidies to promoting
5 or fostering important goals in medical education."

6 I want to suggest one area that you might consider
7 doing that in, one that did not come up at all in the COGME
8 presentation this morning. That would be resident work
9 hours.

10 You are helped here by a very recent report by the
11 Institute of Medicine that concludes that "a robust evidence
12 base links fatigue with decreased performance in both
13 research laboratory and clinical settings." They review all
14 the research in this area, including a randomized controlled
15 trial conducted at Harvard that shows a 36 percent decrease
16 in serious non-intercepted medical errors.

17 So I think that you're starting to have a
18 scientific base there that is just really getting stronger
19 with time.

20 Now all of you know that in 2003 the ACGME came up
21 with new guidelines on just this question. Guidelines are
22 well and good. Compliance is another matter all together.

1 Research looking at compliance objectively shows that it's
2 really been quite poor so far. 84 percent of interns and 91
3 percent of teaching facilities had a work hours-related
4 violation in the first year after implementation of these
5 guidelines.

6 So I think we should not assume that this problem
7 has been taken care of and certainly the IOM has made that
8 point, as well.

9 I also urge you to think about what the public
10 thinks of this question. It's easy for we physicians and
11 others in this room to think that it's so important a matter
12 that we can, ourselves, solve it. But actually, there's
13 limited information on what the public knows and thinks
14 about this. And what there is is very worrisome.

15 The public is very worried about this issue. In a
16 2002 national public opinion poll by the National Sleep
17 Foundation, 70 percent of respondents said that they were
18 either somewhat or very likely to request another doctor if
19 they knew that that doctor had been working for 24 hours.
20 Of course, the problem is they almost never know that. The
21 patients don't know that. They would prefer another doctor.
22 They simply aren't even offered the choice.

1 In a more recent survey by the Kaiser Family
2 Foundation, 66 percent agree that reducing work hours of
3 doctors to avoid fatigue would be a "very effective" way to
4 reduce medical errors.

5 So that all said, I want to come back to the
6 initial charge, really, to yourselves, the idea of linking
7 reimbursement policies to important goals in graduate
8 medical education. I'd like to suggest this is one for
9 initial consideration. A reimbursement formula that takes
10 into account compliance with the IOM report's
11 recommendations would be an important step forward.

12 Thank you.

13 MR. HACKBARTH: Any others?

14 Seeing none, we are adjourned. See you in
15 October.

16 [Whereupon, at 12:22 p.m., the meeting was
17 adjourned.]

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