MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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COMMISSIONERS PRESENT:

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P R O C E E D I N G S

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

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

DR. SOKOLOVSKY: I will.

MR. HACKBARTH: Okay. Thank you.

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

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

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

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

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

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

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

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

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

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

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

These research findings on knowledge and

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

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

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

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

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

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

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

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

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

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

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

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

So it seemed from our preliminary research and

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

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

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

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

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

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

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

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

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

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

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

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

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

to discuss it with the patient.

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

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

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

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

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

similar initiatives.

So we present the following questions for your discussion:

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

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

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

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

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

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

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

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

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

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

MR. GEORGE MILLER: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. SOKOLOVSKY: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

exactly the same thing, but it's sort of a close cousin. Could you remind me what percentage of care falls into that sort of patient preference-sensitive category? Does anybody know that? I think it is a pretty big hunk.

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

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

Okay. Any other round one questions? Ron?

DR. CASTELLANOS: Round two.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

really define what we're talking about.

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

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

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

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

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

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

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

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

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

Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Right.

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

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

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

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

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

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

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

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

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

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

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

I would love Karen to make some comments concerning that.

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

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

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

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

and have signed on for it.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And then the final thing, in the discussion I

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

[Laughter.]

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

Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In the middle are perhaps the preference-sensitive

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

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

Okay. Next up is the Impact of Physician Self-

Referral on Use of Imaging Services Within an Episode.

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

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

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

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

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

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

2006.

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

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

for more tests than other physicians.

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

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

We used Episode Treatment Groups, or ETGs, to

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

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

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

We compared self-referral with non-self-referral

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

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

Jeff will now present the results from our univariate analyses.

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

2005.

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

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

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

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

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

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

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

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

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

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

In addition, there are some older studies from the

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

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

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

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

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

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

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

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

hospital costs or length of stay during an admission.

And second, we examined 13 clinical conditions. The relationship between imaging and total spending may be different for other conditions, for example, use of CT scans for a suspected appendicitis.

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

Thanks, and we look forward to your discussion.

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

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

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

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

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

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

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

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

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

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

DR. CASTELLANOS: Great. And I think the second

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

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

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

overused.

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

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

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

MR. HACKBARTH: Okay. John?

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

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

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

MR. BERTKO: Okay.

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

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

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

MR. BERTKO: Okay.

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

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

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

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

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

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

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

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

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

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

MR. GEORGE MILLER: Right.

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

percent. So it was a broader group.

MR. GEORGE MILLER: Right.

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

MR. GEORGE MILLER: Right.

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

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

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

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

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

MR. GEORGE MILLER: Okay. Thank you.

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

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

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

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

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

DR. REISCHAUER: I am not sure.

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

[Laughter.]

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

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

into the patient severity calculation.

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

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

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

DR. CHERNEW: That is fascinating.

MR. WINTER: You seem surprised.

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

MR. WINTER: Correct.

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

MR. WINTER: So let me clarify --

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

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

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

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

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

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

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

MR. WINTER: So we have made two recommendations

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

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

MR. HACKBARTH: Round two questions or comments.

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

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

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

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

MR. GEORGE MILLER: Right.

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

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

MR. WINTER: I mean, so --

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

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

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

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

MR. GEORGE MILLER: Right. Right.

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

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

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

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

MR. GEORGE MILLER: But something's wrong.

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

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

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

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

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

[Laughter.]

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

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

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

procedures.

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

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

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

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

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

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

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

about a number of clinical conditions.

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

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

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

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

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

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

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

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

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

Thank you very much.

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

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

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

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

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

that are on specialty tiers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Although there are no follow-on versions of

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

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

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

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

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

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

products available in the same therapeutic class.

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

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

considerable administrative expense for the plans.

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

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

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

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

follow-ons.

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

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

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

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

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

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

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

That's it.

MR. HACKBARTH: Okay. Thank you.

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

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

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

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

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

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

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

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

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

cost-sharing is really not an option here.

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

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

MS. HANSEN: Great. Thank you very much.

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

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

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

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

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

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

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

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

DR. SOKOLOVSKY: Yes.

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

apples comparison.

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

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

happen.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

drugs or not?

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

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

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

substitutes.

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

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

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

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

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

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

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

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

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

The second one is conditional on having a follow-

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

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

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

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

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

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

payers.

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Okay. Thank you.

We will reconvene at 1:45.

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

AFTERNOON SESSION [1:50 p.m.]

MR. ZARABOZO: Good afternoon. We're here to discuss the report on Medicare Advantage payments mandated in Section 169 of the Medicare Improvements for Patients and Providers Act. We'll provide new information and we will continue our discussions from prior meetings.

As you may remember, our mandate involves three main tasks. The first task is to evaluate CMS's methodology for estimating fee-for-service expenditures at the county level. Today, we will present our findings on this topic.

Regarding the second task, we discussed the issue at the January meeting. As we reported then, we found a very high correlation between plan costs and fee-for-service spending.

The third task is to examine alternative payment approaches, which will be a continuation of last month's discussion, including some specific issues you brought up at the last meeting. We will also present new information related to the third task. The presentation includes a discussion of the goals of the Medicare Advantage program and transition issues. All of these issues are discussed in the mailing materials, which we have reorganized as

suggested last month.

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

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

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

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

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

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

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

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

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

[Laughter.]

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

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GLASS: Thank you, Scott.

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

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

Under current policy, Medicare retains 25 percent

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

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

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

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

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

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

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

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

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

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

MR. GLASS: Right.

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

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

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

MR. HACKBARTH: Yes.

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

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

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

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

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

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

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

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

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

of concern that you want us to address?

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

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

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

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

MR. HACKBARTH: Okay.

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

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

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

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

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

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

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

this.

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

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

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

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

DR. REISCHAUER: How much would it be?

MR. GLASS: You mean the $3?

DR. REISCHAUER: What?

MR. GLASS: Would the $3 be different?

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

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

DR. KANE: The MA people.

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

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

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

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

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

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

[Laughter.]

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

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

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

DR. REISCHAUER: They have less of something else.

MR. GLASS: Yes, so they --

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

MR. GLASS: That's an idea.

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

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

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

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

DR. KANE: That's another -

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

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

MR. GLASS: Oh, I see. Okay.

DR. KANE: I think it's --

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

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

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

DR. KANE: Even modify that, too.

MR. HACKBARTH: I have Mike and then John.

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

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

DR. HARRISON: No.

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

I know it was just yes/no --

[Laughter.]

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

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

MR. HACKBARTH: Any other clarifying questions?

Let me see hands for round two questions, comments.

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

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

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

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

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

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

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

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

DR. CHERNEW: By lowering the Part B premium.

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Puerto Rico is unique, right?

Let's see, I have Nancy and then Jay.

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

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

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

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

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

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

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

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

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

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

DR. MARK MILLER: And I was --

DR. KANE: Taxpayers are also --

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

DR. KANE: Right.

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

DR. KANE: The taxpayer.

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Could you restate your second goal?

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

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

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

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

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

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

DR. REISCHAUER: Nancy speaks with a forked tongue.

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

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

like it implies two different quality performance comparison processes.

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

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

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

MR. GLASS: That's correct.

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

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

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

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

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

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

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

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

DR. CASTELLANOS: I'm okay with that.

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

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

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

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

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

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

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

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

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

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

I will also say that we probably want to consider

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Okay. Sorry for the long discursion.

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

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

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

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

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

benchmarks and how will that fit with the assumptions?

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

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

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

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

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

[Laughter.]

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

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

happened with BIPA --

DR. CHERNEW: I think there's others.

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

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

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

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

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

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

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

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

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

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

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

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

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

previously been offering.

Now the second part --

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Well --

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

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

availability and a high level of average extra benefits.

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

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

DR. HARRISON: A lot more areas do.

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

MR. HACKBARTH: It's a tradeoff.

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

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

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

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

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

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

MR. HACKBARTH: Right.

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

[Laughter.]

MR. HACKBARTH: Right.

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

MR. HACKBARTH: A competitive bidding movie.

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Drug benefits. Drug benefits.

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

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

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

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

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

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

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

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

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

MR. GLASS: So, Glenn --

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

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

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

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

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

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

MR. HACKBARTH: Yes.

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

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

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

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

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

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

have to address and wrestle with those issues, also.

MR. HACKBARTH: Okay. Other thoughts on this?

Okay. Thank you very much.

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

MR. ZARABOZO: Good afternoon. John and I are here to discuss another report mandated by MIPPA, which is the report to the Congress on the topic of quality, as Glenn mentioned, and Medicare Advantage and the traditional fee-for-service sector.

The congressional mandate for this report is consistent with recommendations the Commission has made in the past to the effect that Medicare should collect information on quality that enables the comparison between the two sectors, Medicare Advantage and fee-for-service Medicare. The main subject of the report is an analysis of the methodology that should be used to compare MA with fee-for-service along with an examination of the methodology for making comparisons of quality across MA plans. The report is due in March of 2010.

The statute specifically directs the Commission to

address technical issues such as the implications of new data requirements and benchmarking performance measures. The report is to include any recommendations for legislative or administrative changes that the Commission finds appropriate.

Since presenting our work plan for the study to the Commission last fall, we've conducted about two dozen interviews with CMS staff and stakeholder groups representing health plans, providers, beneficiaries, quality measurement and reporting organizations, and health services researchers specializing in these issues.

As a result of what we're learning from these interviews and from our ongoing review of the literature, we've developed a draft framework for our analysis that John will go through in more detail after a discussion of some general issues.

I should mention, though, that one of the issues that John will highlight is the question of tradeoffs involved in going from the current systems of quality measurement to alternative systems, and to what extent any changes could strain the already limited administrative resources available to CMS, as well as impose new burdens on

plans and providers.

To begin the general discussion, this slide presents a high-level comparison of the major sources of data on quality currently in use in the two sectors, MA and fee-for-service. In fee-for-service Medicare on the lefthand side, quality for the most part is measured and reported at the provider level. That is, the results tell us how a specific provider performed for the patients that provider actually served. In contrast, MA quality for the most part is reported at the plan level. That is, the results tell us how the plan as a system of care perform for its entire enrolled population.

There's one important exception to these general rules, and that's the CAHPS MA and CAHPS fee-for-service surveys that I'll discuss after this slide. This slide shows that quality measurement in fee-for-service Medicare is structured around specific provider types, as shown in the first bullet of the lefthand box.

Setting aside physicians for a moment, for the other provider types, CMS gathers data for specified sets of quality measures, and then publicly reports the results on the Medicare website. CMS also has implemented incentives

for providers to report on measures.

Most of the quality measures currently used in fee-for-service are process measures that assess whether a specific service was performed for patients who met the inclusion criteria, but the skilled nursing facility, home health, and dialysis measure sets include more outcome measures, such as changes in functional status. CMS is also introducing outcome measures such as mortality and readmission rates into the hospital quality reporting system.

The Commission, in the past, has made recommendations for improved quality measures and fee-for-service. For example, in the case of measures that skilled nursing facilities should report on. For physicians in fee-for-service, the physician quality reporting initiative is used to gather data and provides bonus payments for physicians who meet the program's reporting criteria. CMS does not publish the performance rates on the PQRI measures, thought it recently added an indicator on the Medicare Physician Finder to inform users when a particular physician successfully participated in PQRI in the previous year.

The other quality measurement system in fee-for-

service is a version of the Consumer Assessment of Healthcare Providers and Systems, or CAHPS that was developed specifically to be fielded for the Medicare fee-for-service population.

Like all of the CAHPS instruments, the CAHPS fee-for-service survey measures respondents' perceptions of quality and access to care. Almost all of the questions in the fee-for-service version of CAHPS ask about the respondent's experience with ratings of his or her care providers.

In MA, the Healthcare Effectiveness Data and Information Set, or HEDIS, is used to measure plan-level performance on a number of process and intermediate outcome measures.

In the last round of published HEDIS measure results for Medicare, there were 48 indicators in total, 7 of which were intermediate outcome measures, such as maintaining a specific level of blood glucose or blood pressure control.

There are two beneficiary surveys in MA, CAHPS and the Health Outcome Survey. Like the fee-for-service version of CAHPS, the MA version, which actually was developed

first, asked respondents for their perceptions of the quality of and access to providers within their health plan, as well as the quality of health plan services, such as member services.

The Health Outcome Survey was developed specifically for the Medicare population and is designed to measure changes in respondents' self-reported physical and mental health status over a two-year period, as well as collecting information about other aspects of cares and interactions with healthcare providers.

Having briefly reviewed the available systems of quality measurement, we now consider some of the options for building on the current measurement systems to compare quality between MA and fee-for-service Medicare.

One option that has been used in the past is to compute HEDIS-like values for the fee-for-service program by applying HEDIS measures to fee-for-service claims data. This is how Fisher and colleagues for the Dartmouth Atlas Project have developed fee-for-service measures for the Robert Wood Johnson Foundation, aligning forces for quality program.

Technically, this is straightforward, but fee-for-

service scores on some of the HEDIS measures, particularly those that rely on data such as laboratory test results, pharmacy data, and intermediate outcomes that require medical record review would yield incomplete results if the fee-for-service results were based solely on claims data. Part D information could be combined with Part A and Part B claims information to obtain drug data in fee-for-service. Lab information would have to be obtained in fee-for-service, which is something the Commission recommended in 2005. Based on our discussions with provider representatives, purely claims-based approaches may not viewed as an accurate measure of quality in fee-for-service.

Another issue in such a comparison is defining the appropriate geographic unit. It is not clear what the appropriate geographic unit would be for a population-level comparison between MA and fee-for-service. There are other measure sets that currently exist that could provide more information on quality in each sector. These other measure listed on the bottom of the slide include outcome measures and measures of care management and care transitions.

There are also two beneficiary surveys in use that can be the basis of comparisons between MA and fee-for-

service, the CAHPS MA and fee-for-service surveys have been used on the past to compare MA and fee-for-service on a national, state, and in some areas, local level.

The Health Outcome Survey, or HOS, also offers a technically feasible method for comparing the results for MA and fee-for-service. In the past, researchers have used the equivalent of fee-for-service HOS results to compare fee-for-service and MA results on changes in beneficiary perceptions of their healthcare status over time.

For both these surveys, because they are population based, they may be less valuable for promoting improvements among fee-for-service providers versus their potential for promoting improvement within a system of care like MA.

John will now walk you through a draft framework for evaluating different approaches to quality measurement by looking at the tradeoffs among several criteria.

MR. RICHARDSON: The framework we have drafted is a matrix that we can use to compare the strengths and weaknesses of the various quality measurement systems in meeting a set of criteria. This tool can highlight the tradeoffs among these often-conflicting criteria when

deciding which quality measurement system could be used to compare quality between MA and fee-for-service and to improve quality comparisons within MA.

Our first cut of these criteria are listed in the rows that are visible in this slide. We selected these criteria based on the terms of the congressional mandate, earlier input from the Commission, and the results of our research and analysis to date. These criteria are also reflected in the discussion questions on pages 27 and 28 in your mailing materials. I will briefly touch on each of these in a moment when I walk through an example of using the framework, but first we need to finish building it out.

The next step in building it is to array each of the major quality measurement systems in the table's columns, including the provider-level measures used in Medicare fee-for-service, the HEDIS system, CAHPS, the Health Outcome Survey, a system that would use enhanced administrative data, which could include medical and pharmacy claims data, encounter data recorded by health plans, and other types of administrative data such as laboratory test results and hospital discharge records, and finally, a system that uses clinical data that are available

only in medical records, such as are used in the original ACOVE measure set.

With the skeleton of the framework in place, the next step would be to assign a value in each cell based on whether each measurement system meets each criterion.

In your copies, Commissioners' copies of this slide, we have filled in each cell with our preliminary assessments of these values, but to make this thought process more concrete, I'll walk through an illustrative example of using the tool.

In this illustrative example, we will use only the three measurement systems listed at the top of the table: current fee-for-service provider quality reporting, HEDIS, and an enhanced administrative data system. Also in this example, we have assessed whether or not each system meets each criterion simply with a binary yes or no indicator in most cases. These evaluations could be made more nuanced by assessing the degree to which each option meets the criteria and assigning a numeric value, say, on a scale of 1 to 5. But in this simplified example, we will use a straightforward yes or no assessment in most of the cells.

I also should emphasize that all of the entries

shown in this example are for illustrative purposes only.

So, the first two criteria assess whether the measurement approach is useful for meeting the two basic mandates set forth in the MIPPA provision: Is it useful for comparing MA and fee-for-service Medicare, and is it useful for comparing among MA plans? Now, the term useful here can be defined to encompass whether the performance measures in a given system would be broadly accepted by CMS plans, providers, and beneficiaries as valid measures of quality, whether the measures are technically capable of distinguishing differences between the units of analysis in a statistically valid and reliable way, which could include risk adjustment when appropriate, and whether they enhance our ability to measure and report on disparities in the quality of care among communities with certain demographic or socioeconomic characteristics.

Against these two criteria, we determine that the current fee-for-service provider quality reporting system would get Ns in both of the cells. Since it is currently designed, it is not useful for comparing MA to fee-for-service or for comparing among MA plans.

In contrast, HEDIS and an enhanced administrative

database system could potentially be used for both those purposes, so they get Ys in those cells.

Next, we would evaluate the potential increases relative to the status quo in the costs and the administrative burden for each approach. The cost and burden increases could be borne to varying degrees by CMS plans and providers, but at the risk of oversimplifying, we've reduced the question to one dimension. Overall, will the proposed change increase costs and administrative burdens for providers' plans in CMS or not?

Next, we would consider whether each system could provide actionable information to fee-for-service providers and MA plans such that they could design and implement activities to improve their quality. From the assignment of yeses and noes in this illustrative example, one could conclude that these criteria could be met separately by the fee-for-service provider and HEDIS systems respectively, or for both sectors by one system that incorporated enhanced administrative data.

Next, we would look at the unit of measurement supported by each system. Would the system accommodate measurement and reporting at the level of individual

providers or groups of providers, at the level of a plan for MA or population for fee-for-service, or both?

We should note here that the degree of disaggregation that would be feasible under a provider-level approach would depend heavily on the specifications of the quality measures and the availability and reliability of the administrative data used.

Next, we would assess the geographic area for which each system could measure and report quality. Different systems could allow for measurement and reporting from the national level all the way down to the level of individual hospital referral regions.

As with the preceding provider or plan unit of measurement discussion, the more granular one wishes to get with the geographic area, the greater the costs and administrative burdens one would place on the system.

Next, we would look at the types of quality measures used in each system, and here we could decide to put more or less emphasis on certain types of measures compared to others. For example, if one decided that outcome measures or patient experience measures should be priorities, that decision could guide you towards

measurement systems that included those types of measures.

And the final major element is an assessment of whether quality reporting under each system is useful for beneficiaries when they make decisions about which provider to seek care from, whether to enroll in MA, and if they do, which MA plan to select.

In this context, we propose to focus on the intent or potential of each system to inform beneficiaries, but we also fully acknowledge the information that's detained in the literature and conveyed to us personally by beneficiary stakeholders that many, if not most, beneficiaries currently make little use of the quality information that is available. In response to these concerns, this criterion could be defined to include whether a quality measurement system makes quality information more or less accessible to beneficiaries in practices as well as by design.

So, in summary, we are presented a draft framework for sorting through the interconnected tradeoffs involved in responding to the congressional mandate. To advance to the next phase of our work in actually filling in the matrix and evaluating specific courses of action to meet both aspects of the mandate, we seek your input, particularly on the

draft framework. Are there other criteria that should be factored into the analysis? Are there other measurement systems we should include? And more broadly, are there specific goals for a quality measurement system that can guide is in filling in the framework and evaluating the tradeoffs?

We're also interested in your views on the extent to which we might address improving quality reporting and measurement by capitalizing on the forthcoming investments in health information technology that were authorized by the recently enacted economic stimulus law.

Thank you, and we look forward to your questions and discussion.

MR. HACKBARTH: Okay. Round one questions.

DR. CROSSON: Just a technical question about the Health Outcome Survey. As I looked at that, or at least looked at a subset of the questions, the ones that are included in the Star survey, it occurred to me that it might be hard to differentiate in at least some of those questions between underlying health status and the impact of the care delivered by the providers or attributed to the plan or whatever unit.

Is that the case? Is there a way to mitigate that?

MR. ZARABOZO: I think that's the case. I'm not sure if they make some sort of an adjustment at the individual beneficiary level for the response.

MR. RICHARDSON: I believe that they do make an adjustment. We heard the same concern during our meetings with various stakeholders of whether the adjustment that is made in the instrument itself is sufficient to capture what you're getting at. So, there are really two different questions. One is, is there a technical adjustment made there, and I believe that there is, but we can certainly verify that for sure.

But I think another part of your question is, even if there is an adjustment, to what extent does that actually get at the differences in the underlying health status in people's responses to that.

DR. CROSSON: That's a better question than I asked.

MS. HANSEN: Just as a question of clarification on the data collection itself, are all of these tools built up in a way that they do collect race and ethnicity as part

of the question, just because I know there has been at least one study that has pointed out to some of the disparities, even though Medicare does have access?

MR. ZARABOZO: There has been a lot of work on CAHPS, in particular, to attempt to identify race and ethnicity. So, I would say that they are probably relatively good on a relative scale, because they have paid particular attention to that issue and how best to identify race and ethnicity, not exclusively using, for example, the Social Security information or Medicare-based information.

MS. HANSEN: But the CAHPS is more just the patient experience, but in terms of the actual clinical data itself.

MR. RICHARDSON: I think you've put your finger on one of the issue among many of using administrative claims data in particular, and we could certainly -- I don't want to read into what you're saying, but that could be one of the criterion we use to evaluate the quality of the data, if you'll pardon the expression, in using that, is that if it is important to be able to have good measures of disparities, but the data you're using aren't going to help you do that, then that's one of the things we need to

balance.

DR. CHERNEW: They're not powered for that often, either, which is a separate issue. The data, there's a power to be able to use.

MR. GEORGE MILLER: In this work is the comparison of the quality data between fee-for-service an the MA plans. Is the goal to have less or an equitable amount so that we're not creating more data gathering. I'm thinking of small, rural hospitals and rural hospitals, whether they're small or large, quite frankly, if we're not duplicating or making extra work. Quality measurement is very, very important. I'm not making light of that, but I'm wondering if we're setting a separate standard for an MA plan and a separate standard for the fee-for-service measurements.

MR. RICHARDSON: I think that's one of the critical issues that Congress is looking to us to help them trade off against the other goals one might have for quality measurement systems, but it is an explicit part of the mandate.

MR. GEORGE MILLER: So, in your work, you're talking about a coordinated effort and not a comparison.

MR. RICHARDSON: No, not necessarily. If one of

the criterion -- if a great amount of emphasis is put on the criterion of we need to be mindful of the cost and the burden placed on the providers and the system, CMS, as well, then that is going to help us figure out some other things that we might otherwise do if that wasn't a criterion. I'm not being very linear here.

If that is the predominant criterion and we recommend that that is a major one, then what we could do in the report is say these are the kinds of things you could do with that constraint in place, if you want to look at it that way.

MR. GEORGE MILLER: And just a quick follow-up: Have you talked to everyone that would be involved, rural providers, physicians, and all those folks who have respond to that gathering of data for measurements?

MR. RICHARDSON: We have spoken with some of the representatives. I'm not sure if we did with rural groups in particular, but we can certainly do that.

MR. GEORGE MILLER: That would be a good thing.

MS. KANE: Maybe I'm just overly influenced by Massachusetts, but don't most MA plans basically pay claims to fee-for-service type providers, and isn't there a way --

well, you're shaking your head, but we have three plans that pay claims and they're MA plans. I'm just saying, isn't there a robust number of MA plans that could reasonably be compared because they have claims. They are paying fee-for-service providers, or you could look at -- I guess one question is, when you're looking at hospital compare and nursing home compare, you're looking at the providers' experience in achieving infection or discharge instructions to the patient, and do we really think that they're different whether they're an MA patient or a traditional Medicare patient? So, wouldn't it be possible, even if the MA plans don't want to give you their claims data to say, well, which hospitals do you use in your network proportionally and then say, well, for these plans -- I'm just trying to think of ways you can use what's there and allocate them even to the plans if they don't want to give you their claims data.

It just seems like some of the stuff that we use for hospital compare, they're just using the same hospitals as everybody else, and you could compare the plan's particular network using the traditional Medicare data. I don't know what proportion it is, but I would guess it would

be a fairly large proportion.

MR. RICHARDSON: Well, in fact, hospital compare data are all adults in the hospital. It's a sample of --

MS. KANE: All payer.

MR. RICHARDSON: All payer, thank you. But the sample isn't large enough to distinguish between MA and fee-for-service. I know that's not what you're suggesting. You're saying you could use those results to reflect the --

MS. KANE: The provider profiles of who signed up in which MA plans.

MR. RICHARDSON: Right. Now, we have come across another study that researchers at AHRQ did where, if you aggregate up to a larger geographic area, say, a state, then you can start to see some differences between MA and fee-for-service, at least in the -- they didn't look at quality. I think they looked at the quality indicators that look at ambulatory care sensitive indicators, which is one of the things we talked about in the paper, but they were more concerned with utilization differences, and they were probably seeing differences in the plans networks versus fee-for-service.

My point being, it depends on the level of

geography. If you abstract it away from the provider-level measurement up to a higher level of geography, you could actually start to see differences between the two systems.

MR. BERTKO: Nancy, if I could just -- I was disagreeing only with your use of the adjective most and more in the physician side than in the hospital side there are a fair number of physician groups taking capitation where you'd have difficulty attributing to that. Perhaps on the hospital side it might work better.

MS. KANE: Most of the traditional -- I guess most fee-for-service reporting isn't physician-side anyway, it's institutional. If you look at hospital compare, nursing home compare, home health compare, dialysis facility care -- but the physician one just tells you whether they report or not. So, I'm not sure that that's the -- but of the four traditional measures, it seems like we could approximate what that network looks like and see if the network in the MA plan has better or worse performance than the more generic network in that state. It's a simple, cheap way to do a comparison early.

DR. MILSTEIN: Just a question about the form in which you're envisioning our recommendation would appear.

In some ways it can parallel to the prior conversation. I think there are a number of options.

Option 1 is we simply take all these measurement systems and show the positive and negative consequences of each measurement method, and we can rate that either in binary or on a Star-rating system. That's option a for how we answer Congress's question.

The second is we take a step further and we lay out that matrix, but we star the criteria we think are more important.

And then, the third option is it's the all things considered question. Well, in view of this analysis, all things considered, we think these are -- these are the measurement methods we should use to compare the two programs and perhaps augment that with some collateral suggestions that would make a difference.

So, my question is, which of those three outputs are you envisioning would be the form of our answer to the question Congress has asked?

MR. RICHARDSON: I think the most hopeful, anticipating -- based on the mandate is the last example, which is, some -- I think just giving them the matrix on the

one hand, on the other hand would be somewhat less helpful than saying, in the Commission's view, the priorities are the burden on providers, for example, if that was one, or the ability to report on ethnic and racial disparities, whatever those are, as you guys help us figure this out, then I think those would be the most helpful things, and there may be some specific administrative changes that may improve certain technical aspects of the way that the current systems work.

I don't know if you want to mention the plan.

MR. ZARABOZO: Yes, that was what we mentioned, for example, in the mailing material about the health plans and the level of reporting statewide versus a small area, the Tallahassee situation.

DR. MILSTEIN: If I understand correctly, then you're saying we would go to the second level but not the third level, the second level being, of the possible consequences of the different measurement methods, these are the consequences that we think should be most highly prioritized, but we would not recommend a set of measures.

Is that what you --

DR. MARK MILLER: What John was saying is that if

we thought we could get to recommending a specific path, we would, and then what I thought you were qualifying was, unless -- and putting it out in front view -- the concerns were, well, this doesn't quite get to my concern for disparities, burden, whatever the case may be, which then, as a Commission, we might have to take a step back. I think the objective is to try and give a fairly coherent plan of how we want -- use this instrument or don't use this instrument, use these measures or don't use these.

Now, having said all of that, we're going through a fairly complex and difficult process in trying to put this together, and all I want to say is that's the objective, is to try to get to the point where we can name what we think they ought to do, but this is very complicated going, here, in case that hasn't come across; I'm sure it has.

And so, as always, I'm the guy to bring everybody down and all of that. So, I want to just -- our objective is to get you to a recommendation, but --

DR. CHERNEW: I just wanted your thoughts on the comprehensiveness of some of these. So, say process of care, and sometimes these things -- oh, this measures process of care as if there's one outcome, but oftentimes

there are very limited measures within those categories.

And I think I can just Arnie about to say something, which is good, Arnie.

So, I'm not trying to argue that we shouldn't take one step because we can't take the best step, but I just want to be sure that we're clear that, because we have this set of measurements and we compare, say, MA and fee-for-service, it's possible that one of the systems or one plan versus another looks better on the measures we have that may or may not imply they're better overall.

MR. RICHARDSON: As if there' s some objective best. Yes, I think it is going to be -- and part of the difficulty Mark was alluding to is there will probably be some dissatisfaction with whatever -- in other words, there will be limitations to whatever we try to do, and I think -- and part of what we struggle with is how do we square all these circles, and we may just end up with a triangle.

DR. STUART: I fully concur that looking of the value of the measure compared to the burden that it places is important, although it strikes me that burden to CMS is really quite a different character than burden to the providers for the simple reason that if we thought that a

particular set of measures was valuable and it would require that CMS expend resources in order to get it, we could make the recommendation conditional on giving CMS the resources.

In fact, I think that's something that we should consider as a Commission in all of the things that we do. If we make a particular recommendation, I've heard over and over and over again about how constrained CMS is. Well, let's be proactive about that so when we come up with something like this, then let's say, okay, well, they need more resources to do it and this is what we think they should get.

MR. HACKBARTH: Other questions? Comments?

We have migrated from One to Two.

MS. KANE: So, it seems that this is saying, well, here's where we are today under current fee-for-service, and then here's some things that are out there today for the MA plans. But given hat all we've been talking about for the last couple of years in terms of strong recommendations involve some form of ACO or medical home or episode or some type of Part A/B bundling.

Couldn't we, instead of trying to fix what's not

working in the historic structure, try to go towards recommending quality measures that would work under ACO, medical home, Part A/B bundling and be more comparable, rather than trying to twist something that doesn't twist too well, on a traditional system that doesn't work so well? I'm just wondering if there's not a way to say, well, yes, maybe add as a criteria, anyway, that this could work if we had -- your biggest problem is you don't have a denominator for a lot of the fee-for-service measures. You don't know who's in there. But you would know who's in there for a medical home, you'd know who is in there for an ACO, you'd -- I don't know about episodes.

But anyway, just start thinking about it more in terms of where we hope the delivery system is going rather than just putting a huge infrastructure of quality reporting in something we're hoping will go away.

DR. CROSSON: As typical, I was going to make some similar comments. Nancy and I tend to think a lot alike.

Some of this is obvious, and I apologize, but I think some criteria that occurred to me is, as we look at these possible ways of doing it is we want whatever we recommend to be doable. There's no point in suggesting

something that's not practical.

It probably needs to be something or some process that's as accurate as possible, therefore is as objective as possible, and it should measure important stuff. There's a lot of things you can measure, and some things are more important than others in terms of their impact on health and impact on cost and the like, and I have a bias towards clinical information in that regard.

As was mentioned in the report, it should support improvement, in other words, be actionable, something that can actually -- it's interesting to compare things, and we may want to use comparisons to move money around, but ultimately it is most important if it actually changes care.

I think, and I don't know how to do this -- and this is sort of where Nancy was -- I think that what we should do should support or presage where we're going to be in the future. And in the future, where we're going to be, in part, is we're going to be in possession of a good deal more clinical information than we have now through clinical information technology. We don't have that now, except in some places, but we will, most likely. And therefore, whatever we put in place at least should not take us

marching off into a very different direction so that when that information is available we have to completely reverse course, tear everything up, and go in a different direction.

The issue that I find the hardest is this issue of level of attribution and the difference between Medicare Advantage and Medicare fee-for-service in terms of who you actually hold accountable, not just because it is what it is, which is, in one case, you have entities, and in the other case, you have individual practitioners, but because that difference also feeds back into what you can measure.

So, for example, and I'll say this because it's probably more complex than what I'm saying, but if you wanted to measure the mortality rate from coronary artery bypass surgery, let's say, a 48-hour mortality rate from coronary artery bypass surgery, you could do that pretty much equally in both settings. If you want to measure something as important as the long-term sequaelae from diabetes mellitus, it becomes -- that's something that an entity, whether it's a plan or integrated delivery system can be accountable for over time. It's much harder to understand in the fee-for-service environment how you would do that. Who would be held accountable for those results?

And therefore, that difference, in the end, limits those things that you can measure. So, I think trying to tackle -- and I think this is where Nancy was going -- either temporizing or trying to figure out how to tackle that issue may be among the most important.

MR. HACKBARTH: This is a conceptually appealing thing to do, but the more I think about it, the more difficult it sounds. This isn't a proposal but a question: Maybe we need to consider as a possible outcome that, no, this isn't worth the effort, with existing technology, that we'd end up spending too much doing backward-looking things and it's a task that's better tackled when we've got better information technology in place, whatever. Again, that's not a conclusion that I've reached, but sometimes that's the right --

DR. REISCHAUER: Arnie is ready to go after you.

MR. HACKBARTH: I know. I can see his jaw clenching.

Let me get back to my last before I give Arnie a chance to talk.

MR. BUTLER: He's going to be loaded for bear.

I tried to reorganize this in my simple mind and

see what might evolve realistically. On the positive side, if you look in, whether it's the hospital or the nursing home -- look in the various silos of services, and I think we have got some momentum on quality measures and also tying them to payment, if not now, more aggressively in the future. I think we can point to some successes in the components of care, and so we don't want to slow that down.

So, what are we trying to marry that with? We're trying to marry the added value of the assembler of care, the MA plans, and saying, okay, what's the difference. So, it's almost like if you could lay out -- this plan is using this nursing home, this hospital, this doctor, and you could somehow aggregate the score of the performance of those individual units, you'd get a sense of what the network of what the value is, and you'd continue with the HEDIS measures, which the individual components of care can't do at this time, but maybe in an ACO world they will if we wait a little bit. But right now, don't expect them to do that, because we're just not ready for it.

So, if there was a way to display it that way and -- I don't know, that's how I would organize it in my own mind.

DR. MARK MILLER: Can I just draw one other point out, as long as Peter is on point. This comes from a conversation that we had on the phone and then a couple of comments that have occurred here.

So, when you think about the notion that we're headed -- I think it was your comment somewhere along in here -- perhaps to more EMRs, the notion that some of these things depend more on medical records rather than claims, let's build for the future, not necessarily the past, those types of things -- all things considered, Arnie.

Then, you have this new HIT money that has kind of come into the process. And one wonders whether there's a leveraging there that would warrant comment here and perhaps elsewhere, but if we're trying to build something here for the future and we have some money at the moment that is directed towards the future -- Peter, this is stuff that you've brought up in conversations that we've had over the phone. And I don't expect people necessarily to react on point but listening to some of the - are we kind of working with what we have or are we thinking about what we could have if there's some leveraging there. There's still that big piece of the HIT money which is -- I always forget each

time -- meaningful use, which is still to be defined, and maybe there's an opportunity here to define what that might be.

MR. BERTKO: Glenn, I'm not going to throw my hands up on this. What I was going to say was maybe agreeing partly with Jay, having a starter set that we use. And Mark used the word "path." I had that written down earlier of where we get to. And I can see adding in at some point, even before HIT, lab values. A lot of people are using statewide reference labs which are now reporting back to health plans, and no reason that CMS wouldn't pull in that kind of data, too, as well as the Part D data which is, I think, very useful.

The comparison I might suggest -- I mean, Jay also gave a great comparison of -- was it CABG mortality? Yes, that's available everywhere. But I'll go beyond that and say, suppose we use the EHMS model to attribute to certain places.

Flagstaff Medical Center owns everybody over 65, and Flagstaff was not in a managed care plan. That one is simple. It's more complicated in other places, but there's no reason we couldn't use that and get what I would hope

would be pretty good results and pretty good comparisons, and I think that comparison, even on the starter set, would be worthwhile to people.

MR. HACKBARTH: Just for the record, because Arnie's coming up here, I'm not ready to throw up my hands, either. And I think it might be possible to do some initial steps that could be constructive, but I also am sensitive to what Bruce said about resources. If we lived in a world where CMS was rolling in resources as well as healthcare providers and didn't have a lot of other things on its plate, it might do one thing, but the tradeoffs look very different in a resource-constrained world.

Just one constructive thought, or hopefully constructive thought about this, I'm drawn to this idea of using existing data on institutional providers. Broadly speaking, a plan can improve care through two mechanisms: One is through network selection, and this addresses that specifically. The other is through care coordination and programs that sort of knit together independent providers; that's what HEDIS tends to measure.

And so, if you could say the network selection activity of the plan is doing well or doing poorly in terms

of quality, and then use its HEDIS measures -- maybe not to make a direct fee-for-service comparison, but say it's really good compared to other plans in terms of care coordination and HEDIS-type activity. That could be a significant step forward in terms of information for people. And so, that' s one type of path to crawl forward even if we can't run very fast.

MR. GEORGE MILLER: Well, before Arnie gets in I'll make a couple of brief comments.

I agree with Jay's comments about putting together a goal. And let me see if I can just frame it in just a very minor way. And again, speaking from a hospital perspective and having to pull all this data together -- and I appreciate, Glenn, your comment about the concern for resources to pull all this together. It is important to have, but one question I would have, what are we learning? What are we trying to learn? Where are we trying to go? And then, what can we let go of? After we learn something, is there something that can come off the table? And how can we improve the system?

It would seem to me that the quality improvement measures to help us take better care of our patients and the

delivery of care that we have to our patients. So, that should be one way to look at it, according to effort between both MA and fee-for-service.

And then, I think it was you, Glenn, that made the comment about technology and having the EMR, especially in rural areas, all of us don't have that, but we do have measures that we could use to improve. And again, I just wanted to emphasize again we want to make sure that, with the limited resources we have we're not adding an additional burden.

DR. MILSTEIN: A couple of comments.

First, I think it's important to remind ourselves that Congress hasn't asked us for a recommendation with respect to how we should measure performance in every facet of the healthcare system; they've asked us a narrower question, which is, how do we go about comparing fee-for-service with Medicare Advantage.

And if you think about that more global, analytic charge, many of the concerns expressed so far having to do with, well, how do we attribute to an individual doctor, diminish, because that's really not particularly relevant to the question we're being asked now.

Second comment is that I think this idea that we might frame our recommendations for what they would be with and without a world -- some day, EMRs are relatively universal. I think that makes a lot of sense, but there's also an opportunity to essentially also comment in relation to a more modest set of enhancements of our health information in Medicare that's far short of all doctors, or 95 percent of doctors, implementing EHR. And it's that subset of things we've periodically commented on, and this might be a great time to remind Congress about things like laboratory values being appended to laboratory bills, and a few of the other things that we've commented on, and we could actually expand and take a look at what the National Committee on Vital Health Statistics, which thought about this question. Short of EMRs, what would make a big difference in our ability to measure? They had some very thoughtful recommendations they made five years ago, and this might be a nice opportunity to point in that direction.

Third point is just, as we appropriately sweat adequacy of measures coming out of any particular system, I think it is really important to keep mindful of the lessons that have come from other industries within this country and

from the health industry in other countries. This noting that you, if you're going to make a performance judgment, you have to explain to the producer of the service what actionably they can do, that's not something that's honored in any other industry in the United States. Nobody ever said to the airline industry, listen, we're not going to judge you on customer complaints unless we can also explain to you what you should to correct a high-complaint level. That's a standard that is just not applied in any other aspect of public performance measurement.

And last but not least -- this is probably self-evident, but there is always an inclination on the part of me, and psychologists have said it's true of all people, to be towards what's called status quo bias, sort of accepting the status quo as pretty good and then there needing to be a pretty high standard for moving beyond it. And I would say the evidence suggests that the status quo, with respect to our quality, one contributant to which is relatively low transparency on quality -- our status quo is not very good and we should not be biased toward it and be so cautious, and therefore be too cautious about moving forward with measures, imperfect though they may be.

If you talk to people in the UK who first went forward with their public reporting of risk-adjusted hospital mortality, there were just a million methodologists that came out of the woodwork saying this is crazy, it's not good enough, wait ten years. They move forward, and as a result their measures on risk assessment mortality have moved up much more quickly than ours have.

MR. HACKBARTH: Other questions or comments?

Okay. More on this later.

And last for today is medical education and its relationship to delivery system reform. Whenever you're ready.

MR. LISK: Good afternoon. Cristina and I are back to discuss the chapter on Medical education in the United States, supporting long-term delivery system reform. Today we're going to review some additional information that has been included in the chapter in response to some of the questions you had at the last meeting. After we do that, we will start you off on a discussion of future work you can consider.

At the last meeting, the issue of diversity was raised, and we have no included some information on this in

the chapter. This chart shows the distribution of medical students according to family income levels expressed in quintiles. And as you can see, most medical students come from higher-income households. In 2005, 55 percent of students came from families in the top quintile of family income, as shown in the gray bars on this slide.

If we look at the lowest quintile, however, less than 5 percent of students came from the lowest quintile group, and only about 10 percent came from the lowest two income quintiles.

As you can also see, these trends in the distribution of medical students by family income have been fairly consistent for the past 20 years, although the portion coming from the top quintile has edged up five points between 2000 and 2005.

Although medical students are significantly more likely to come from higher-income families, many graduate from medical school with sizable student debt from medical school tuition and fees. In 2008, medical students reported an average debt load of $141,000, and almost a quarter carried educational debt of more than $200,000. Service on this debt currently averages 9 to 12 percent of after-tax

income once in practice.

This next chart shows the racial composition of the U.S. population, applicants to medical schools, and medical school entrants or matriculates in 2007. The racial composition of the medical schools is not representative of the population at large. For instance, African Americans accounted for 12 percent of the U.S. population but just 6 percent of students entering medical schools. Similarly, Latinos and Hispanics accounted for 15 percent of the U.S. population but just 7 percent of those entering. Asian Americans, on the other hand, make up just 4 percent of the U.S. population but account for 20 percent of entering students.

The racial composition of medical schools, however, roughly parallels the medical school applicant pool; therefore, enrollment in medical school is affected more by application rates than by acceptance and admission rates.

Similarly, rural students, also generally thought to be underrepresented in medical schools, have similar types of issues. Women, though, now account for about half of all entrants and graduates in medical school.

Efforts to diversify the socioeconomic and demographic make-up of the physician workforce are thus hampered by circumstances that affect students' eligibility or decisions to apply to medical schools, such as college graduation rates and financial status and debts after college. Thus, if we are concerned about the demographics of our physician workforce, this issue needs to be addressed at an earlier stage in the pipeline before we get to graduate medical education.

I want to next move on and discuss rules for Part B billing for supervising physicians, which was also brought up at the last meeting. Supervising physicians can bill for services provided by residents if they meet basically three criteria: They need to be physically present for the critical or key portion of service, or actually perform the service. They must also participate in the overall management of the patient and document their presence during the service, including who provided each portion of the service. So just a signature on the resident's medical record is insufficient for the physician to be reimbursed. They need to document their participation. And as you may recall from the past, there were the PATH audits --

physician and teaching hospital audits -- that caught many hospitals not having sufficiently documented their service, and they had to pay back substantial amounts of monies for being in violation there. So there has been a lot more focus on this.

Now, there are some exceptions on the present rules. There are some relaxed rules for lower-level E&M services in primary care centers, and there's also some stricter rules for more complex procedures such as many surgical procedures and stuff. And if you want me to go into those, I can go into those in more details in questions.

We have also included in the chapter a discussion of the economic costs and benefits of participating and teaching activities by hospitals and physicians. This discussion was summarized very well by Peter at the last meeting. Here on this slide we list some of the economic costs and benefits. In terms of costs, you have, of course, the compensation for residents and the faculty. You have program overhead expenses for running the program. You have the facility infrastructure costs. Because of having residents, it may mean more office space and things like

that and a more complex medical library.

There is also the natural inefficiencies associated with the teaching process that takes place in terms of residents ordering more services, for instance, and additional documentation that may need to occur. And also, teaching hospitals often and being associated with academic practices may attract a more complex mix of patients.

On the benefits side, hospitals will receive Medicare direct and indirect GME and IME payments. Residents also provide labor for the hospital or the practice, sometimes at lower costs, providing potentially more timely service delivery of certain services and on-call coverage.

There is also the prestige associated with being associated with teaching that may lead to higher patient volume and other benefits.

Another benefit is allowing physicians to keep current on research, the latest research and technologies because of being associated with these practices and training residents, and also the ability for physician recruitment. You have physicians that are in an apprentice type role, and you get to see them and observe them, and

that potentially has an advantage in terms of potential for future recruitment, both for the hospital and for a physician practice.

With that, Cristina will continue on.

MS. BOCCUTI: So from our discussion last month, we heard a consensus for us to move forward on our analysis of policy options to increase residency experience in non-hospital settings for certain specialties. So these approaches could include the first three bullets that we have on the slide. I'm sure that there's more, and we'd be happy to hear them. But for the sake of example, I'll just mention these three. So we'll look at relevant regulations and draw attention to any unnecessary regulatory barriers. For example, we can focus on the distinction in training between didactic and hands-on care for the purposes of direct GME payments. We can also examine ways to reduce the substantial financial disincentives that teaching hospitals face for residency training outside the hospital. So these would include the disincentives of the labor costs and the loss of GME revenue that they are getting when the residents train outside the hospital. We'll also assess the approach of establishing requirements for non-hospital training to

obtain direct and indirect GME.

Next on this slide you'll see -- you'll recall that the results from our RAND study showed many lapses in residency training on topics that are important for delivery system reform, such as multidisciplinary experience and quality measurement. So, again, I've listed three possible approaches we could look at for addressing this issue in future work, and, again, you can mention more.

We can analyze mechanisms to encourage accrediting organizations to focus more attention on specific items in their auditing process, and this can include continuing medical education, which many people brought up at the last meeting that physicians are life-long learners, so we could be looking at those objectives as well.

We can also look into ways that GME funding can be used to support research on best practices in training -- in other words, investing in training the trainer. And we can also examine requirements or financial incentives for sponsoring institutions, such as teaching hospitals, to ensure their residency programs include specific criteria. These could either be a condition of funding or a means for increasing or decreasing funding.

On this last slide, we've developed three main questions for discussion, and hearing your comments on this will help us move forward with additional work.

First, it seems that an important feature of medical education funding should be that it be distributed equitably and efficiently. And since Medicare is the largest contributor to graduate medical education, teaching hospitals with lower shares of Medicare caseloads receive proportionately less funding, and this occurs more often in low-income communities, as Nancy pointed out in the last meeting.

So how should all payers contribute? And what mechanisms should determine fund distribution? For example, some expert panels have suggested trust funds and independent boards for determining the allocation of graduate medical education funds.

Second, we could also focus our thinking on linking education subsidies to actually delivery system reforms. For institutional incentives, the teaching settings would be the leaders in delivery reform. So, for example, teaching hospitals with certain infrastructure, such as comprehensive health IT, could garner more favorable

medical education payments. And as Peter has mentioned, it is important here that the health IT be actively used rather than just purchased, and we can talk about more details on that. But I think we did a little bit in the last session.

Institutions can also be leaders in payment policy reforms, so, for example, teaching hospitals that agree to bundle Parts A and B payments could receive higher GME and IME payments. And here residents would learn the skills needed for delivery system reform by working in settings that actually do them.

We can also draw from our previous work on curricula and examine requirements and incentives regarding delivery system reforms. Here, in addition to items such as formal multidisciplinary care, we can also include incentives for training in the basics of geriatric care across all specialties to address the aging of the patient population.

Moving to the third question there, the Commission may also examine ways for medical education subsidies to help generate the most efficient mix of generalists and subspecialists. And by generalists, I mean primary care physicians and also general surgeons. Payment policies

around the number and type of residency slots that Medicare subsidizes could be a tool for balancing these specialties.

Adequate nursing and nurse training is also important for successful delivery system reform as many of their skills and care coordination are essential.

Some of the demographic information that Craig presented showed the importance of even attracting lower-income and minority students into the field of medicine. Loan forgiveness programs and other strategies to encourage applications to medical school could be important to increase the economic, racial, and geographic diversity of health professionals.

Finally, to improve patient access to care, all physicians could be required to conduct minimal public service in exchange for the subsidies that Medicare paid for on their behalf. For example, physicians could be required to provide occasional on-call services. Having an adequate panel of local physicians on call is a crucial component of our nation's health care, yet in recent years, fewer physicians are even agreeing to take call.

So these are some of the topics that we really look forward to your discussion at the end of the day, but

I'm sure it will be a good one.

MR. HACKBARTH: Thank you. Okay. First round, clarifying questions.

MR. GEORGE MILLER: Yes, on your last comment, I'm just curious. How do you propose that the social benefit for the subsidy of their residency program would work? Can you give me some examples of how that would work or you suggest it would work?

MS. BOCCUTI: Are you saying with the third bullet?

MR. GEORGE MILLER: The third bullet about that, because --

MS. BOCCUTI: We need to talk about this and work through those ideas. I think what you're getting to is how the money would go to the hospital and then ensure that the physician -- this is after the residency program --

MR. GEORGE MILLER: Right, right.

MS. BOCCUTI: -- fulfilled this public service. Isn't that what you're talking about?

MR. GEORGE MILLER: Yes.

MS. BOCCUTI: We need to go through those ideas. We're aware that it's going to take some logistical issues,

but I don't know that that should stop the examination of that option.

MR. GEORGE MILLER: And just to tease that out a little, if I'm in rural West Texas, in Fort Stockton, Texas, I would have the same -- an equal opportunity to get a physician who did his or her residency training in Chicago. Is that --

MS. BOCCUTI: Well, maybe we'll talk about that as future work comes forward, because we need to think where the people would come from and what they would be doing. I think these are great issues to bring up when we talk about that.

MS. HANSEN: Yes, just a request perhaps more for context. I think the last time we met, I learned that within GME there actually is funding dedicated for hospitals who train nurses. There are not that many left, but I just wondered if a background piece could be included as part of this GME piece.

MS. BOCCUTI: Sure, we'll put a little more information about that. And we're talking not just about what exists but maybe what could be expanded as well.

MS. HANSEN: Yes, that was going to be part two,

but yes, definitely. Thank you.

MR. BERTKO: I think I'm asking about the first of the three bullets on the last page under -- well, it's the residency subsidies one. I have a couple of things in my head, but I was curious what you thought was included in that. Does it include something to generate a larger number of generalists, or is it more confined than that?

MS. BOCCUTI: I think we need to talk about that.

[Laughter.]

MR. BERTKO: I've heard those words --

MS. BOCCUTI: I'm not going to answer this right now, but I think there are two ways that one could go. You know, there is the number of slots that you're talking about, and there could be a redistribution within the current number. So we could talk about that and what's paid for, you know, what parts of that is paid for. And then the other idea would be if there were just simply increases, say, for primary care, and that's where you're going. So this is a discussion that we can have.

MR. MARK MILLER: For myself, the way we have been thinking about this is, given the slots, do we want to discuss redistribution and how we support them. And then it

becomes the next question of how many slots.

DR. CASTELLANOS: Thank you, and good job. I had a unique experience last night. One of my partner's son is here today. He's a medical student. And we were talking a lot about medical school and the education they're getting towards a lot of these concepts. Then I had the opportunity to talk to Karen Fisher from the AAMC, and one of the things I noticed in our report and presentation today has been an absence of any discussion on the student education in medical school, and these concepts of delivery system reform need to be imprinted in their basic educational process.

Somehow these concepts, we are really missing, I think, an opportunity to try to change this culture -- and that's what we're really trying to change, this cultural approach.

So I guess my clarification question is: What levers of anything we have to make this happen in the medical school itself? Do we have any levers that we can use to make these things happen?

MS. BOCCUTI: Well, I'll say something about it. I'm sure Craig might want to come in, too. Two things.

One, we have looked a little at what is being

taught in medical schools, and the RAND researchers did look into that to some degree. For reasons of space and, you know, keeping the chapter at the length that it is, we focused more on the graduate medical education component primarily because that is where the levers are right now. But I don't think that means that the Commission needs to restrict itself to that when they're thinking about the whole medical education process. But it is where Medicare plays the biggest role right now.

So I think that we'll continue to try and talk about medical school, and we talked about it with the PATH to becoming a physician and what's required there and what accrediting components are there, and also the importance of applications and what's going on with medical school.

So I think we addressed it to some extent, but we need to determine what levers that we as taxpayers, you know, have with this in the sense that this is the health care for the United States, and Medicare is training a lot of those professionals.

MR. LISK: There is some course work that goes on in that aspect of things in medical schools, but the details behind it -- and we were trying to get at that -- are not as

certain and potentially inconsistent. And sometimes it's mandatory in some schools; sometimes it's optional in some schools, too.

DR. CASTELLANOS: You're are absolutely right. It is happening. But is there any way that we can encourage this, if nothing else, in our chapter on this?

MR. HACKBARTH: I very much agree with the premise of your statement, Ron. Being a non-physician who hangs around with a fair number of physicians, it sounds right to me that there's a certain imprinting that goes on very early in the educational process. And Tom has talked about how even in the selection for medical school, important statements are being made, in effect. So I agree with that.

I personally am struggling, though, where we ought to draw the line on what we can contribute to this very big and very complicated topic. I sort of think of the discussion we had earlier on biologics. You know, clearly, a pathway for follow-on biologics has huge implications for the Medicare program and the health care system more generally. But it seems to me that it is a complicated issue that's outside of our normal purview in the things that we study and have some reasonable competence about, and

I'm always worried about reaching way beyond the familiar to say, oh, we ought to change this, we ought to change that. I fear that we run the risk of appearing as dilettantes. There are a lot of people who spend a lot of time on these issues, and we are going to spend, you know, a few hours talking about them.

So I don't know exactly where that line ought to be that's within -- or at least reasonably close to our distinctive area of competence, but I think we need to be careful about just drawing this circle ever bigger and making it ever more inclusive.

DR. CHERNEW: I actually second the idea of having that point, which I agree with, outside of the circle of this report, and the reason I say that is I actually teach a class like that to the medical students, and the problem is that -- and I think it's a very good class, I should say.

[Laughter.]

DR. CHERNEW: I should say I teach in the class. It's absolutely not my class. It's Haiden Huskamp's class, largely, and she does a tremendous job. But a lot of these issues come up. But I will say, after having, you know, a semester of going through many of these issues, I'm not sure

anyone, any of the students' culture is changed because, honestly, no matter what you say to them, they tend to think, you know, endocrinology, or whatever the exam happens to be. And so I think your point is very well taken, but I think it is well beyond the type of things we can influence with these levers because I think it -- that might change if we change some of these levers. But to try and go at that directly I think is really very, very hard because -- I think someone said this when they were here before. They're all going after their boards, and as long as that's what they're going after, we have to worry about how to change the bigger picture and stick in there instead of getting to that micro level.

DR. DEAN: Just to respond to a couple, I agree completely with what Mike just said, that it has come up in my discussions with medical educators. We were talking about the whole issue of teaching professionalism, and I said, sure, you can have lots of lectures about it, but really it's determined by what people observe in their day-to-day experiences, and it only has meaning once they sort of get into practice and have to make some of those tough decisions. That's when you need to have the opportunity to

discuss some of these issues and have access to that sort of expertise.

I certainly am sympathetic, Glenn, with your concerns, but on the other side of it, we have set some goals and set some ideas, at least, of where we would like to see the system go. And if we can't get there without some of these changes, then it does, I think, become a real concern.

So it is a real tension, I agree. This is sort of outside of our realm, and yet unless we see some changes in this education system, we can't get to where we want to go. So, I mean, just in response to what you say. I guess I have one other thing, and I'll shut up --

realm

MR. HACKBARTH: Just on that narrow point, though, I agree that there is a long way to go, and all of these things that we have briefly mentioned are important, potentially important factors in shaping the health care delivery system of the future.

I would say, however, though, we shouldn't think that we're the only ones who have made that observation and had that insight. You know, the tiny little window on the

world that I have is through the work I do with the ABIM, and I hear a lot of the same themes and how, you know, the process of specialty certification and maintenance of certification needs to be improved so that, for example, there's a greater focus on systems-based practice and improvement and a lot of the themes that came up in this chapter. I feel way better them talking about how to do that and making constructive suggestions than about my ability to do it. So we have allies in this fight. We're not the only ones pulling levers.

DR. DEAN: The other comment that I would make is the other response that I've certainly gotten in talking about some of these issues is just what Mike brought up, too, that especially the curriculum, especially in the first two years, is just totally dominated by what's on the national boards. And they are such a powerful force that the faculty tell me that their hands are tied. They would like to introduce some of these issues, but they say, "We are so obligated to make sure our students do well on that test that we have no choice."

Now, I don't know. Maybe they're overstating it, but I have gotten that from faculty in several different

schools, so I don't think it's just ones -- actually, the original question I had, Slide 3, I had seen data that the percentage of students from high-income households had actually increased significantly over the last decade or so. I don't know. I'll have to go back and see where I got that data because this is AAMC. I assume they should know. But I had certainly seen some data that said that that had increased quite a lot. So I don't know.

MR. LISK: Well, if you look at the top two quintiles and you look at that orange bar, there's quite a bit of drop in that orange bar from 1999 to 2005, for instance. So there has been an increase in upper-income families, students coming from upper-income families.

MR. HACKBARTH: We have to get on to round two since we are already sort of lapsing into it.

DR. BORMAN: Yes, I'm going to structure these comments to try and come at your questions, which I think was the purpose here. But I'm going to ask your indulgence and go in from the bottom up, if we could, because I think -- for a lot of reasons.

Number one, I think the bottom question perhaps is the one that drives most of the others, because I'm not sure

that we've come to a conclusion about what it is that are the professionals we need. And I think by that, I think this discussion, because it tees off of GME, certainly focuses on the physician. But I think that we all could agree that we're looking for the most efficient provider level for various services, and I think we tend to default a little bit to a notion that the overwhelming majority of this is being provided by physicians. I think we need to -- I personally would like us to be a little bit careful about the terms "primary care" versus "primary care physician specialist," because I think that not all primary care requires a physician to deliver. It requires very high level primary care physician skill to do certain things about primary care and to manage a team of extenders or mid-level providers or whatever you want to call it. But I think that we really need to be a little bit careful about that, and I'm not sure that at all times we are.

So I'm not sure that we've defined that workforce, and it may, Glenn, be one of those issues, frankly, that is ultimately somewhat beyond our purview. Just how far we go down this road -- and in all fairness, so you don't think I'm just picking on primary care, I would agree that there

are some procedures that surgeons provide that every day are provided by other than surgeons, and particularly more in the minor procedure category, can be very credibly provided. And we need to identify those as well, but I just want to sort of de-link this notion maybe of physician and, you know, the professionals we need, that this is a broader conversation. We can't fix everything through manipulating GME, and, again, I think that is in part what I hear from you.

In terms of the part about loans and subsidies, I would say that there are great things to think about. I personally think they apply to way beyond physicians. There are people that struggle to go to nursing school, PA school, respiratory therapy school, da, da, da. And in terms of supporting a workforce, we should make opportunities for all those providers, again, trying to get to that mix, whatever that mix appropriately is.

Just a comment about public service. I think that is certainly a very rational road to go down, to explore, given the extent of the taxpayer commitment to this not just through the Medicare program, the Medicaid program, the NIH, the state contributions. I mean, they're just too numerous

to count. And I think it is a very reasonable exploration, and I would say that many residents certainly seek out opportunities for international rotations, and I can tell you that the Residency Review Committee for surgery, which is part of the ACGME, is certainly having active conversation about this, because there are so many applications from residencies to send residents for international experiences. Well, one might think if they're interested in international service experiences, maybe we can interest them in domestic service experiences, or at least say, you know, from whence the money comes links to where the service might be provided. And I think we may have to have a bit of that conversation.

The other piece embedded in the chapter is the part about the overlap, at least in the organizations that appoint to the accrediting bodies and so forth. And I would just like to say while I recognize that there is overlap to a significant degree, I would suggest that the actual appointees tend to be fairly diverse. And so it's not quite as incestuous as maybe seems to be implied by the chart that is in the chapter. And I would want to be a little bit careful from getting too far from the level of expertise,

and perhaps part of the answer is to increase the public representation, but I am not sure it's to impose a different level or to undo that whole appointment system.

With regards to linking to GME, I think this is the most rational direction we can go down, particularly the institutional incentive side I think is the most natural place for this to go down, because it fits best with the system that we have right now. It gives us more of an immediate starting point. The money goes to the teaching hospitals. It's rational to start moving through that process while we work on answering what's the mix and deciding the other things we need to do. And so to do this in a way that can be more immediately productive.

I have a lot of disquiet about curricular incentives. Medicine is a moving target. The world in which I practice is very different from the world in which I trained just in diseases. Peptic ulcer disease, for an example, has largely gone away as something we operate on other than acute perforations because of drugs. The same things ultimately will happen to other diseases. We need to be very careful about meddling with curriculum, and I think, Glenn -- and maybe you've inferred that -- there are some

pieces of this we do need to leave to the experts.

In order to answer some things Jennie has brought up, I hope you will be encouraged, at least it's my observation that we do an increasingly better job of addressing geriatric issues throughout medical school and residency. And, frankly, that's the way we need to do it as embedded throughout and not some little focused touchdown that you check a box and then answer a couple of questions on the test. So that's that.

The top one, I personally think the board just muddies the water even further, and, again, I would like to see us think about something better in the way of public representation to some of the other parts that govern the system rather than some super board that just gets caught up in a lot of rehash and perhaps is not empowered to do anything differently.

If I could just mention on the sites of education, I don't think you've implied this, but I'd want to be very careful that it's not what people infer. While certainly most people do not spend 100 percent of their post-residency practice lives in the hospital, I'd be very careful about any implication that it should be a one-on-one relationship;

that is, if 80 percent of your practice is outside the hospital, that 80 percent of your education should be accomplished in non-hospital settings, and that's for a couple of reasons.

Number one, in exposure per minute to diseases, it's going to be greater in the hospital setting, so there is an educational efficiency to that. It may not meet the entire spectrum, but you see a lot more things more quickly in a hospital setting. So the notion that if we transformer it to 80/20 the other way, we will have people who don't know enough about an awful lot of things. So we want to be careful about not implying that that should be the standard.

On the other hand, we should remove regulatory barriers, and we should get away from this very artificial language of didactic and hands-on. Residency by definition is experiential. It needs to be graded responsibility experiential, and we just need to be careful about that.

DR. DEAN: A couple things. First of all, just quickly, there was a comment in the chapter, something to the effect that people with bigger debts were more likely to go into specialties that had loan forgiveness or something. And I really, I guess, think we need to look at that a

little more carefully because I think, in fact, a lot of the places where loan forgiveness is available is primary care in underserved areas, and as debts have gone up, recruitment in those areas has gone down. So I think I have a problem with that statement. It needs to be looked at.

Secondly, in a broad sense -- and I agree with much of what Karen said -- I think we need to be careful about getting too specific with some of these things. The thing that bothers me about the public support for GME is there is no connection between what the needs of the public are and where the money is going. And I don't exactly know how to do this, but I think we need to try to look for some way that we can have sort of a self-correcting system that when a need evolves, there is support for a program to meet it rather than specifying -- you know, I'm all in favor of more support for primary care, obviously. But there's also other gaps in the system, as I think Karen has spoken to, that we need to meet. And we've got to be careful we don't lock ourselves into a specific structure because, as she just said, this is a changing field, and the needs are going to change, and we need to try to develop some kind of a responsive system that gets the resources to where the needs

are. That may be tricky. I don't have an answer on how to do that.

I guess I would quibble a little bit with your last comment.

DR. BORMAN: I would be disappointed if you didn't.

DR. DEAN: I think, yes, there are a lot of things to be learned in the hospital, but there is also a large body of knowledge, especially with the spectrum of disease we deal with now, that simply can't be learned in the hospital. The management of chronic disease is never going to be learned in the hospital. And, in fact, some of the things you learn in the hospital almost work against that. So I think as far as the time breakdown, I wouldn't argue with that, but there are --

DR. BORMAN: It's just not one of them.

DR. DEAN: Yes, I can accept that. But there are some things that you just will never learn in the hospital that needs to be done.

MR. BUTLER: Of course, I've given this a lot of thought -- which could be dangerous because most of the thinking is just on my own. But at the risk of getting out

there and making some fairly strong recommendations, I'll try. And I will come back and say to me it's all about the middle part of the chart there. You know, these other things are great, they're important, but we spent $9 billion a year between GME and IME, and I don't want to go through three or six years at MedPAC quibbling over whether it is 4.5 or 5.0 or 3.0. We can do better than that. We can help articulate what a good GME setting and a good GME environment ought to be, and I think we can move the ball forward. So that's kind of a little bit of the punchline. Let me describe how I think I'd start to do that.

First, in terms of the chapter itself, to get my negative comment out of the way, this last one, just the last one, the minimal public service, that one just doesn't make -- I know you said we can clarify and discuss. I just don't think that that one is going to work and not worth study. All of the other ones, if we want to at least leave them in the chapter for now as potential study, I think they're okay and understandable. But I'd make an argument that that one come out of the chapter at this point until we know it better. A small point.

I made some comments last month, and you did a

terrific job accommodating them, so let me comment on a couple of them. The title itself, where you said "Medical education - Supporting long-term delivery system reform," is much better, especially because you got the long term. We're training and looking at creating lifelong successful people, not trying to respond to this year's medical home or payment methodology that will change next year and we're going to whip dollars all over the place as a result of this year's thoughts. So I think you helped capture that in the title, and that's important.

Secondly, you continue and you did a good job of still saying addressing the regulatory barriers, and I think that is a contribution we can make sooner rather than later to CMS, as soon as next year, I think.

And, third, you lifted out and highlighted the ACGME competencies, which, if anybody had read those, you can even read like the sixth one, a system-based practice. If you read that language, it says coordinate care, it says quality and safety and cost -- we couldn't even write it better. The question is: Is the ACGME kind of pass-fail system strong enough, or whatever, to make sure that those things are happening? But the language in the accreditation

now isn't that far off of what we want. It's a question of -- you know, now the question is: How do we make that kind of happen more? Do you use some of the financial incentives or some of the mechanism to go right after the program itself? Or do you sit it in the institutional setting where the dollars are going now? And I think it is the latter, because I don't think we're going to send money suddenly strictly to programs. We're going to send them to institutional settings. And that kind of gets at the heart of this second bullet point.

At the risk of using "meaningful user" as a concept, it's such a -- but you can envision, I think, in let me say a negative setting, if you were at a medical school or a residency program and you say, boy, this hospital calls you and they say, you know, we really could use some coverage, do you have any residents, you know, we'll pay them and we'll get the IME, and you go into an environment, there's no IT, there's no coordination of care, there's just a focus on acute care episodes. You can imagine -- paint as bad a picture as you want. Would you really want to send your Medicare GME and IME dollars in that kind of setting because you're not going to -- no. So

that's a negative of saying it. But how would you begin to say what would be a progressive or a meaningful user? What would that environment look like? And short of trying to measure it today, what are the characteristics that would say if you go into that setting in that environment with the competencies in mind, you know you're going to get something out the other end that is going to perform at an extremely high level.

So if we could begin to articulate what that environment would look like and then eventually or at some point you take those IME dollars in particular and you say flex them up, flex them down, whatever the support is, you could potentially differentiate them out that you're paying on, depending on the environment that these residents are going into. And I think that general direction creates the kind of accountability that would look a lot different than right now you send -- it doesn't matter what the setting is, what they're doing, and that's just not good enough.

DR. KANE: First, I agree with everything Peter said, and also, just a couple things that, as I read the chapter, came to mind, which was -- one is the role of FMGs, and one of the things I notice is that they seem to be

filling all the geriatrician slots and a lot of the primary care slots. And I'm wondering if there isn't some way to evaluate whether that's the most efficient way to produce a primary care capacity in this country, or whether we want to think about Medicare supporting, if it isn't the FMG - if American medical students don't want to go into primary care or geriatrics, perhaps there's another level of people, U.S. or foreign, that want to go through training. I'm thinking, you know, physician extenders, nurse practitioners. A lot of the people from the military who learned to become medics often want to come back and be effective in the domestic side. Should we be looking for ways to expand our primary care capacity? And what are the implications that so much of it is currently being filled by FMGs? I don't have a good sense of that, except that I do notice that in the classes that I do that are like Mike's, the training at the medical school level is about 30 years behind ours in terms of acceptance of IT or oversight or accountability or team -- - I mean, maybe not all of them, but some of them are. And so I just wonder if there's anybody thinking about what does it cost to untrain and retrain an FMG into this capacity. And would it be, you know, maybe to try to just start people

into the primary care capacity at a different level and try to expand that capacity?

The only other thing I thought of is that -- I'm the one who's into the lifelong learning thing. Is there a way to bring into the P4P for physicians that they've covered certain kind of CME topics, that they've done things around care coordination or cost/benefit, you know, that they've achieved those and therefore they get a blip-up? As long as we're on a P4P kind of mentality, is there a way to bring in what kind of CME they -- or whether they hit certain types of CME that relate to the kind of goals that we have for the Medicare program?

DR. CASTELLANOS: Two points. Nancy, just to emphasize your point about the international medical graduate, 25 percent of the primary care people in Florida are international medical graduates.

Talking about the medical education subsidies to produce the professions we need, again, I'm going to talk a little bit about workforce. I think the Commission has done a great job with primary care. We have certainly emphasized a higher pay rate, pay scale. We've tried to boost the reputation, put them in more of a substantial role, and get

that primary care doctor to have more intellectual stimuli. So I think we've done a lot of things for primary care. And I think there are some other issues on workforce, and Karen may want to comment, but general surgery has a real low role.

You know, one of the ways we can at least try to solve this is by the caps, and perhaps we could even consider designating certain specialties, not all, on a trial basis to see if that works to fill some of these critical shortage areas.

DR. CROSSON: Thanks. I think my comments are rather similar to Peter's in this case. I think just based on what was presented and based on the discussion, I have a sense that we're at risk of overreaching a bit in this particular charge that we have.

I agree with the framing, as Peter did, that talking about, you know, how Medicare might use its leverage to improve the education, postgraduate education, anyway, of physicians to promote more effective delivery of care over time is probably the most comfortable framing. There are some broader framings in that that are possible, but that's the one that appeals to me also.

So, within that and at the risk of being minimalist here, I think, again, the issue of the apparent growing inadequacy of the physician manpower and primary care is certainly one. And then also the fact that we've noted during the discussion that residents often come out of training without any real knowledge about how to practice medicine in the office, and particularly how to practice medicine in a judicious and responsible manner with respect to the cost implications of practice patterns.

So, again, and I apologize for being reductionist, if that's what it is, but it seems to me that among all the things that we have to look at here, this issue of trying to move over time to support the separation of a significant portion of training from the in-hospital experience makes a lot of sense. It doesn't solve all problems. I think there are problems, having done it myself, obviously, with hospital training only and that it's limited in scope. It's not where most care is practiced anymore, and that's literally changed in the 30-some-odd years since I was in training.

There's an expensive bias to having training predominantly in the hospital setting compared with the way

other forms of medicine are practiced in offices and other kinds of group practice settings and the like. And the peer experience in the hospital setting is somewhat narrow. I think others have commented on this.

So whatever we could do, whether it is trying to act to remove barriers to support training programs being more in the non-hospital setting or, in fact, creating incentives, that is the area where I think we can get -- it's the closest to our charge, in my mind, and it's the area where I think we can get the most impact.

MS. HANSEN: Thank you. I'll mention four points, and some it has been covered. And, Cristina, when we talked about the graduate hospital nursing role, in many ways I think it has been addressed by a number of the Commissioners here, about thinking about that next level, which is your point about advanced nurse practitioners or physician assistants or post-military individuals.

The ability to think about what do we need -- and it ties to the chronicity of care, where sites are going to be, so I really would like to see that that area just be discussed. And it may be also to be cross-referenced to one of the recent IOM reports, "Retooling for an Aging America."

So I think referencing, again, where care is increasingly going to be received and have that aspect.

The second point has to do with -- and it probably falls under, Glenn, your area of other groups like the ABIM having domain over this, but I think as pointed out, people will learn what they're going to get tested on, and so it's not just the first two years, but all the annual recertification, if that is built into the testing side, not just the professional societies but the actual testing for competency, if it's build in there, then it would get taught.

But one kind of complexity with that is that if existing faculty haven't done this, it's really tough for students to be learning it. So something has to be done, and perhaps ABIM is working on that: How do you prepare faculty? And this is the same issue in nursing faculty, trying to have them focus a little bit more on geriatrics. Many people don't have that. So that's kind of a cross issue.

Then the final point, just to pick up on Jay's last point where having money flow to the sites where people are going to be practicing outside of the hospital, I think

this has been always a tension, just because the requirement for the GME and IME kind of going into the institutional hospital setting. But if practice is going to go elsewhere, there are many sites, whether they're the FQHC clinics where people are practicing or other outpatient types of settings where people are getting their chronic care. I know when I operated the PACE Project, we had residents come through. The whole question is, you know, were we able to get some bit of funding to offset our physicians who were doing the training. And, of course, at that point the answer was no. But it just seems like some kind of shift on that area has to be considered.

Thank you.

DR. MILSTEIN: I'll be very brief.

First of all, this is a point that a number of people have made. I'll just try to make it more explicitly, and that is, there are a number of potential problems with current medical education, and our challenge is to figure out what tools within the jurisdiction of the Medicare program are a fit for those problems. On primary care, specialty care mix, you know, this has been pointed out by others, but the tool that is the best fit to that is

Medicare physician reimbursement. It is not beginning to dictate who comes in and out, you know, who goes into programs or forgiveness or anything like that.

The second comment, the second potential objective is this issue of improving the equity of slot allocation, and that is a tough one to solve with Medicare reimbursement policy because the inflow so much depends on who gets into medical schools, and Medicare has no grip point, you know, on that. So I support that social objective. I just can't figure out how to use Medicare policy to effect it.

Then the third is this educational content dilemma, and I certainly agree with Karen that the federal government trying to dictate, track, and manage curriculum content would be very tough. But I think there are some interesting tools within the purview of the Medicare program that we could use. For example, the American Board of Medical Specialties and maybe their member boards are very anxious to have their board certification process be deemed equivalent to PQRI participation, and so that is, you know, a terrific level, I think, because it's something that the boards want. And we have something in turn we want from the boards. And my last comment on this is if I had to pick one

thing to focus on with them, I would go one level up, and it's really -- it's the ability to manage performance that is the generic -- you know, if I had to pick one thing that sort if you could correct it might make the biggest difference in improving all aspects of the Medicare program, it is performance improvement, because that then would require all the other content areas to pull geriatrics because it's the Medicare population, it would pull health care IT. Those are all sort of instrumental to that objective. So that's at least my attempt to sort of map these different shortfalls, consequent goals, and then things that are actually within the jurisdiction of the Medicare program.

MR. MARK MILLER: So in previous conversations, whenever we've talked about delivery reform, a number of people -- and you among them -- have said, you know, we need to get to looking at GME and the education process because it's part of it. And so I guess some of these -- you talked about there may be different tools like the primary care -- it's a physician reimbursement issue. I hear that.

Could I just get you to say the last point again? Because I tracked comments where people were saying, well,

focus your efforts here. It was your last point, I'm not sure I got quite the connection. And it feels a little different than -- you know, it almost feels like we're pulling back and saying this is not really the place to get, you know, delivery system change, so that also felt like a little different than I'd heard from you before.

DR. MILSTEIN: Absolutely, and probably I'm influenced by the discussion, which is appropriate. But I do --

MR. MARK MILLER: Don't let that happen.

DR. MILSTEIN: But I think that maybe to have this better fit with my comments before, you know, based on the help from people around the table, I thought about what's the best lever for changing educational content. I am persuaded that probably the number one choice would be to change what's on the boards that the physicians take. And now I see an avenue for achieving that having to do with the horse trade that, you know, the medical specialty boards are now -- you know, have been on the Hill lobbying to Medicare to achieve. I think it is a great opportunity for a trade if the trade can be -- you know, if the deal could be struck aggressively.

MR. MARK MILLER: And what is the trade? What are you --

DR. MILSTEIN: The trade is rather than as an alternative to participating in -- this is one of the things being discussed as we speak, as an alternative to participating in PQRI reporting. If a physician is participating in the performance, measurement, reporting, and improvement system that their specialty board is delivering, A, that would be the basis for any performance measures being reported to the public, if we get to that point; and, B, it also could be a means of satisfying whatever requirements likely to evolve from PQRI, which is not just performance reporting but performance improvement.

I want to make one last comment, and that is, my view is, in the spirit of Mark Miller, don't only offer one option. This is my preferred option for how to change content of medical education. But if this also turns out to be very objectionable, then I have a second objectionable option that I still support, which is not so much, you know, letting the GME money depend on curriculum, because I think that's very, very slippery to track and manage, but it's what I've said before: Let it depend on whether or not the

faculty FTE in the teaching program include a reasonable percentage of people whose primary focus is in these health reform domains. That's much easier to track than curricula, and it happens to personally reflect my experience in the unnamed teaching hospital and medical school that I'm affiliated with, which is that there's actually quite a bit of support for these new content areas, until you get to the point, well, you know, who do we have now within our current faculty who has the expertise to teach it? And that's the point at which it becomes clear to the department chairs that they would have to use some of their precious FTE slots to hire people with expertise in performance management and other things, and that's where things break down. That's why I think if you are going to focus on criteria for hospitals, it should be on faculty content, not on curriculum -- faculty mix, not curriculum content.

MR. HACKBARTH: Let me just test an idea here. What I've heard from some people over on this side, I think, is the idea that if you set up the payment system, used the dollars that Medicare puts into training as a lever to reward institutions that are leaders in innovation care delivery, if those institutions are rewarded for developing

the tools and the skills and applying those tools, that will pull along with it the whole training enterprise, and they'll start to think about things differently, the environment in which physicians, young physicians are trained will be a different environment than we've had in the past.

DR. MILSTEIN: [off microphone.] I like that idea better.

MR. HACKBARTH: Yes, and I think --

MR. BUTLER: You said it more simply than I did, and maybe too simply, but there is a menu or characteristics you call "infrastructure" up there that really the institution is spending those dollars to create that environment, and it could be -- your idea could be one indicator. You know, I wouldn't say it's X FTEs, but is there leadership available doing X? You could begin to create a list of the kinds of things that would be an innovative, progressive institution.

MS. BEHROOZI: But then you also have to deal with barriers. You are going to create an environment that will allow for the development of, you know, well-rounded, educated, and best practices physicians. But then I think

that you have to acknowledge the cost barrier as well as the specialty board certification exam barrier, which you identified in here, which I don't know -- and this is consistent with the conversation about what are the things that we have leverage over as payers. I don't know to what extent we have leverage over the exams. And I don't know to what extent we have leverage over the very last thing, the public service component, which I think is critical. You know, for all this taxpayer investment, taxpayers ought to get something explicitly back. But I don't know that we've got those levers.

But in terms of lowering the cost barrier, in the text box it says that, at least if I'm reading this right, for residency training programs begun before 1995, there is a 6-percent premium on GME for certain specialties, including family practice, general internal medicine, and geriatrics among them. And I imagine that is somewhat to offset the fact that the other specialties bring in more high-paying business to the hospitals, and I don't know whether that 6 percent is enough to change the balance in the hospital's view. But certainly that money is not getting down to the residents themselves.

So in terms of what Medicare is able to do, it looks like Medicare is able to base its payment decisions, at least to some extent, on what the specialty of the residency is. So why don't we not just accept things as they are, but, you know, think about shaking it up a little bit more and making big distinctions between how much we will support the specialties that the Medicare population needs the most or needs the most new doctors, not only to the extent that it incents the hospitals to develop those programs and hire the best teachers and invest in IT for care coordination and things like that, but also to the extent that we can make it apply to the students and whether that's in rewarding loan forgiveness program or tuition abatement programs or those kinds of things, it's really critical. Just back on whether it is Slide 3 or whatever -- you don't have to go back there, but just the distribution of quintiles, you know, the students of the upper quintile, remember, another factor that's not captured by that slide is that upper quintile's wealth has grown in that period of time, and that bottom two quintiles' wages have stagnated. I don't know how they have kept up as much as they have. And even the small decline, it is hard to tell on that

chart, but it looks like it's gone from maybe 18 to 15 percent. That's a bigger percentage drop, you know, proportionately in that group, and it's not just about who goes in, but obviously what they choose to do on the other end and where they choose to practice and things like that.

Sorry, just also on the top point, we have not talked about that because I guess it's the hardest one. And I know in states where insurance departments get to set the rules for how insurers pay rates, they -- in New York at least, there's a graduate medical education component to hospital rates. I have no idea what Medicare could recommend. I don't know. It seems like it might be worth more thinking and development.

MR. HACKBARTH: I think if you were to try to tackle that goal, it would have to be not through the payment rate per unit of service by private insurers but, rather, some sort of tax or levy a tax on premiums with the specific earmarking of it to help finance medical education.

MS. BOCCUTI: May I ask a clarifying --

MR. HACKBARTH: Sure.

MS. BOCCUTI: This is on something that Arnie brought up with the FTE example and I think what Mark was

getting at. What we were hearing, maybe in years, we've been trying to get to the GME because we've had such a tight agenda, and what we have been hearing is that, you know, students and residents are not learning, say, for example, quality measurement and how to make changes based on their own measurement of quality. And if they would learn this, this would help move the quality of care forward by -- you know, exponentially once they get into the pipeline.

But what you're saying, or maybe you could clarify, that maybe instead of trying to ensure that they are learning quality measurement, for example, we could ensure that they have faculty expertise in quality measurement, and that would be a way of measuring that they had access to these skills or that they were learning the skills. Is that the distinction you're making?

DR. MILSTEIN: Yes, is that it would be -- I'm trying to think of what would be easy and practical for Medicare to track or for -- that would be easy, practical, and a reasonably valid means of tracking and accountability, and I just am very -- because I thought about it, you know, worried about the ability to sort of track and quantify curriculum content; whereas, it's pretty straightforward

from looking at a faculty member's C.V. whether or not they do or do not primarily focus their teaching and research on any of these topics -- you know, performance management, information technology. You can tell that in an instant. And it also seems, at least in the hospital that I'm affiliated with, a major barrier to moving forward is the paucity of faculty that specialize in these topics.

MS. BOCCUTI: Do the faculty exist? What I'm worried about is that if they're not -- are they at some and not at others? I'm just worried, how do we get the expertise if it's not there?

MR. HACKBARTH: At the risk of really gross oversimplification, the point I hear Peter and others making is even leap a step beyond that. If the institution in which people are trained is paid in a way that causes it to really focus on quality improvement, then it will be part of the ethos of the institution, and they'll be recruiting people of all types, faculty and staff of all types that have these capabilities, and it becomes part of the culture of the institution. And that is way better than a course. You know, it's the way we do things here.

MS. BOCCUTI: Right. I hope we're capturing that

in our discussion and when we brought these topics up. That is exactly what we're trying to capture as sort of where we go from here. It may not be an either/or, if I'm hearing this discussion correctly. We may have an ideal and a perfect scenario, I think, as you're describing. But if we can't get there tomorrow, can we tackle other priorities, too?

I just want to make sure I'm hearing this correctly. Okay.

MR. BUTLER: It's not important that we capture it here. It's important you capture it in the chapter.

But the one point I would make is that -- a little bit short, I agree. It's a leap beyond, but it doesn't mean, you know, you've got to be a capitated system or you're not going to get GME. We're not going that far. And we're not going to have a checklist, if you are willing to do accountable care, you'll get it. But there ought to be a way we can describe what the characteristics of an organization, and that needs some careful -- and it needs a shelf life of more than a couple years, is the point. And we can do better, and I think it's worth a try.

MR. HACKBARTH: But I think you're putting your

finger on the challenge here. It's easier to say this than to do this. You know, how exactly do you link payment to this sort of high-performing, wonderful institution. How do you operationalize that notion? It's easier to say than it is to do?

MS. BOCCUTI: May I also just say, a lot of this is for future work, for future chapters. You know, we'll capture some of this in the chapter now, but the chapter that's coming for the June report is a little bit more introductory and won't go into major details on the --

MR. BUTLER: And it's a great start. It educates and it lays a foundation, and I think it's good.

MR. HACKBARTH: Okay. Craig?

MR. LISK: I have just one follow-up on Mitra's point. There are only a few states, there is only a small number of states that do have things like New York, and New York is the one that has the largest, because they have a lot of residents, too; there's a lot of interest there in having payments and the private payers. But it's a very small number of states where that is explicitly done for the private payers. So I just want to make sure that -- the impression is that it's not universal.

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

We will now have our public comment period, and Karen knows the ground rules.

MS. FISHER: I do. I am going to try to limit it to two minutes. I'm Karen Fisher with the AAMC, the Association of American Medical Colleges. We represent the allopathic medical schools and the major teaching hospitals in the country.

We support this Commission discussing this topic. It is important, it is timely, and, Glenn, you mentioned that other people are talking about these topics. I think if focused in the right way, this Commission has a lot to offer because of the varied perspectives that you bring to this topic, and not a lot of places have that. And so we support continued discussions on it.

I would say, though, that lots has occurred in medical education and in residency training over the past years, and more is going to occur. Our meetings are replete with discussions of GME leaders and others talking about how to look at the practice setting that future physicians are going into and how to make changes to that setting. So you

are not out there alone in having these discussions.

I also would point out, though, that the AAMC runs the Medical College Admission Test, the MCAT, and it is undergoing -- just so that you are aware of this, it is undergoing a review of the MCAT testing process with the same goal in mind: to look at what is the practice needs for the future, and is the MCAT doing its job to test on those measures to get the right applicants and get the right people matriculating into medical schools.

I think we'd agree, we love discussions. You could discuss a lot of these issues in further detail, but probably the best benefit for this Commission would be to focus more and probably more on the clinical setting where the GME dollars and where a lot of the training and the experiential training occurs. And don't forget that the third and fourth year of medical school mostly occurs in those clinical settings, so you're going to capture some of those experiences there.

We have a policy on all-payer funding. We'd love to have you discuss that in that arena.

Then, finally, what I would say on the public service arrangement, you know, there's a lot of that already

going on in medical schools and residency programs. A lot of residents are doing international rotations. They're spending time in schools. They're spending time in prisons and in other avenues. I will tell you the regulations don't allow any GME and IME funding to be paid for that. That's an issue.

But if the issue is that residents should pay back after they become physicians for the investment by the public in their education, it makes me a little bit nervous as a graduate of a state institution that maybe for all of the state money that went into my college education and for those going through that now, that if Congress would look at that, you might say, Well, shouldn't everybody who has had their education somewhat reimbursed through state and other mechanisms also do public service? Maybe that is a good thing, but it shouldn't be limited just to physicians.

Thank you.

MS. BURNS: Good afternoon. My name is Anne Burns, and I'm with the American Pharmacists Association. The American Pharmacists Association represents practicing pharmacists in all different practice settings. Thank you for a very informative discussion both today and at the

meeting in March.

As the Commission continues its deliberations, I would encourage you to consider including pharmacist-based residencies in your discussions and potentially in your report. Each year, over 1,500 pharmacist residents train in hospital, ambulatory care, and community pharmacy practice settings, provide medication therapy expertise as part of the health care team.

In hospital residencies, many of the programs are eligible for and receive GME funding, and I'd be happy to provide any additional information if so desired.

Thank you.

MR. CONNOLLY: Good afternoon. Jerry Connolly with the American Academy of Family Physicians. We really appreciate the rich discussion that you've had in terms of the global issues and even the specificity of how you might tackle graduate medical education and even, Glenn, how you might operationalize some of these ideas. In two minutes, just let me make three points, if you will.

There is a common adage, and that is, what you pay for is what is produced. And right now, with particular emphasis on primary care training, we're still training

essentially in a 1960s model. We're training in an inpatient hospital model when 95 percent of the care the primary care physicians deliver is in the outpatient, ambulatory, community-based setting. Since most primary care is delivered in that arena, we should incentivize the training so that that kind of education, that kind of care can be produced. In other words, we are talking about modernizing the graduate medical education system for primary care.

The second point, a couple of elements on the way to how to modernize this. Do we incentivize the institution to create more non-hospital setting opportunities? Or do you incentivize the residency programs that create those opportunities and train those physicians? We think perhaps the latter would be the better way to go about that. In other words, don't lock yourself into the mechanism of funding the institution when actually the residency program should be more responsive to the community needs and produce the primary care physician who is actually going to be a member of that community, practicing in that community, and delivering and serving the needs of that community. The residency program, the RRC, the accreditation body, can be

more responsive to the community needs; therefore, you create the physician who is a systems-based thinker, someone who can manage the care of a community, of a population.

You could also then incentivize through this mechanism means by which the necessary inpatient training can take place. It's just that the dynamic would be in the opposite direction. You fund the residency program who is responsive to the community needs, and then they take care of the necessary training to produce the kind of primary care physician you need not only for the current population but for the growing and changing demographic population that we have.

Lastly, let's just talk about the source of funding, and I'll follow up on what Karen said. Graduate medical education was linked originally to Medicare to make sure that we had enough physicians to handle the Medicare population in 1965. We're now not talking about just the Medicare population. I know this body does talk about Medicare. But times have changed. Health care delivery has changed. And we're no longer functioning predominantly in an inpatient hospital setting. We're now functioning in the community. So we need to talk about not only the Medicare

population, which I know you are more concerned with, but we need to talk about now the 47 million uninsured. And if, in fact, we are talking about a community that needs primary care, is it only then the Medicare and the Medicaid systems that should be responsible for funding this?

It can be argued that perhaps it is not just the Medicare program that should be funding it, that that is an argument for all payers to come to the table and contribute, particularly to producing the primary care physicians that are going to be needed in those community settings to take care of those uninsured.

Thank you very much.

MR. HACKBARTH: Thank you. We reconvene tomorrow at 9:00 a.m.

[Whereupon, at 5:27 p.m., the meeting was adjourned, to reconvene at 9:00 a.m., Thursday, April 9, 2009.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, April 9, 2009
9:04 a.m.

COMMISSIONERS PRESENT:

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

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-- Anne Mutti 78

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-- Rachel Schmidt 101

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P R O C E E D I N G S

MR. HACKBARTH: Our first presentation this morning is on accountable care organizations. David, are you starting?

MR. GLASS: Sure. This morning, this briefing is a follow-up to last month's discussion of ACOs. We're responding to your comments. We were going to attempt to more clearly define the basic concept and introduce two new variants, one somewhat simplified and one somewhat more complicated, but it results in patients actively enrolling in ACOs rather than being passively assigned.

First of all, let's start by trying to nail down what is an ACO. This seemed to frustrate everyone last month, so here is a concrete definition of what we mean when we say ACO. An ACO is a combination of a hospital and some primary care physicians. It could also include some specialists, although they would not be strictly necessary. ACO could be an integrated delivery system that was organized and included one or more hospitals and many kinds of physicians; or it could be a physician-hospital organization, or a hospital plus a multi-specialty group practice, or just a hospital and some independent practices.

It could be an academic medical center, however that was organized. Any of these arrangements could meet our definition. The other requirement is that there should be some defined population of patients associated with the ACO. And the final part of the definition is that the ACO be held accountable for the total Medicare spending and the quality of care delivered to the defined patient population.

Now, we realize there may not be total agreement with this definition, and we look forward to your questions at the end. But we wanted to start with something concrete to anchor the discussion.

The basic thrust of an ACO design is to give physicians and the hospital joint responsibility for the quality and cost of care delivered to a population of patients. It would provide bonuses for high quality and low cost growth. If a provider meets quality and cost targets, they will receive a bonus of some percentage of their base year fee-for-service payment rates. We are defining high quality as meeting some defined benchmarks, for example, perhaps low mortality or a lower rate of readmissions. We are defining an ACO's cost growth as the rate of increase in total Medicare spending per beneficiary assigned to the ACO.

Total spending would include Medicare services patients receive outside of the ACO. The spending growth in the ACO is compared to the target, and that is set nationwide. As we discussed last month, it would sharpen the incentives to also have a penalty for low quality and high cost growth.

Now that we know what an ACO is, let's review why we wanted them to begin with. Medicare needs a way to control cost growth. Current spending growth is unsustainable. Constraining fee-for-service rates in conjunction with other policies the Commission has recommended may improve quality and slow growth, but we don't think that will be sufficient to achieve sustainability. ACOs could provide the Congress an additional lever by tying bonuses and penalties directly to the rate of growth in overall Medicare spending, which is ultimately what we want to control. In the same way, ACOs can also help improve quality.

The objectives for an ACO policy are to move towards delivery system reform by improving care coordination and collaboration among providers, to tie physician and hospital payments to quality and resource use via a common set of incentives, to achieve a sustainable

rate of growth for Medicare spending, and, finally, to reduce regional variation by how we set the target for spending growth. It is a set dollar amount for all, which results in a more aggressive percentage target for high-growth areas, as we discussed last month.

The hope would be unnecessary services would be reduced and quality would be improved.

Last month, we talked about the two paths towards ACOs shown on the slide. First, let's review the voluntary model in the first column.

A hospital and some associated physicians would volunteer to be an ACO. CMS would assign the patients to the ACO based on the primary care physicians that the patients go to, and that's why there must be primary care physicians in the ACO, by definition.

Patients are still free to go to any Medicare provider they choose. There is no patient lock-in. The ACO would be subject to bonuses and penalties. They would be held accountable for cost and quality. And providers would need to be organized to volunteer.

In contrast, let's look at the mandatory model we discussed in column two. Under this model, all providers

are in. CMS assigned providers and their patients to a virtual ACO. There is still no patient lock-in, and there are bonuses and penalties. In this model, no prior organization is needed, but providers may decide to organize to have a better chance to succeed at meeting cost and quality targets.

Presumably, in both models, CMS would first tell all physicians what hospital they're affiliated with, the population of patients the ACO would be responsible for, and a few years of cost and quality history. This information would be crucial for physicians and hospitals to decide if they want to volunteer to be an ACO in the voluntary model, and in the mandatory model, it will help them to start organizing and know who to organize with to improve their chance of getting a bonus and avoiding a penalty.

Once again, the motivation for talking about ACOs is to find a way to slow the growth in Medicare spending. The basic equation for Medicare spending is price times volume, which means there is a trade-off between the two. Spending is the product of price, and price here is the fee-for-service rates, be they hospital DRGs or the physician fee schedule, or whatever, and volume. You have to

constrain on or the other or both to constrain spending.

Under the voluntary model, there are weaker incentives to control volume because the program has to attract volunteers, so penalties can't be too tough, and not all hospitals and physicians will join. Those that don't join will have no reason to constrain the volume growth. Without a strong incentive to restrain volume, there would need to be a stronger restraint on fee-for-service rates.

Mandatory ACOs, on the other hand, could have stronger incentives to control volume. Penalties could be made tougher, and all hospitals and physicians are included. So incentives for volume control will apply to everyone. This means there could be softer restraints on fee-for-service rates. Providers in the ACO are still paid fee-for-service rates less withholds, so what happens to rates is important to them, not to mention to everyone else.

Finally, it would be preferable to eliminate unnecessary care -- that is, control volume -- rather than use the blunt tool of low updates for everyone forever. Research on geographic variation shows there's plenty of care that does not contribute to patient welfare that could be eliminated.

The point is there is a trade-off between reducing volume and reducing rates, and mandatory ACOs could have a larger effect on volume. However, there would likely be greater resistance to the mandatory model by providers.

Because there seemed to be a preference for the voluntary path last month, we came up with two new variants that address some of your comments. One question was would a bonus-only model be feasible, and we look at that model in the first column. This is the voluntary model I just described, except in this case, instead of a bonus and withhold, there is only a bonus. This model has been proposed by others when they talk about ACOs.

You also wondered if there was a way to give physicians in an ACO more control over their patients' Medicare spending because now they would be held responsible for it.

In the second column we introduce a new model, which is a voluntary ACO paired with a Medigap SELECT plan. The key difference here is that patients choose to enroll in the ACO and buy an affiliated Medigap SELECT policy. Because a Medigap SELECT policy has higher cost-sharing for out-of-network providers, there is a soft lock-in. Patients

can still choose to go to any provider, but they have to pay more to go to providers outside the network.

Our motivation for creating this kind of strange-looking creature is that we wanted to get some lock-in that would be attractive to patients, but not get the ACO involved in insurance functions such as claims processing.

Now, Jeff will explain how these work in more detail as he walks you through the two new models, and he'll also explain how they compare to the broader spectrum of payment possibilities.

DR. STENSLAND: Now we look a bit more closely at the bonus-only ACO that David just outlined. Recall that the ACO concept is grounded in joint responsibility. In the bonus-only model, physicians that use a common hospital agree with the hospital to be held jointly responsible for cost and quality. These could be physicians that are employed by the hospital, or they could be independent community physicians that form a physician-hospital organization.

CMS assigns patients to that ACO based on which primary care physician the patients use for a plurality of their office visits. To be a viable ACO, the physicians

would need to serve at least 5,000 Medicare beneficiaries. As we said last month, we need at least 5,000 patients so we can differentiate between random variation in costs and quality and true improvements in performance.

The two key things to remember about this model are, first, that patients are assigned to the ACO, but they can still use any doctor they choose; and, second, the model is bonus only. If the ACO succeeds in consistently improving the value provided to Medicare beneficiaries, Medicare and the ACO will share in the savings. If the ACO fails and practice patterns do not change at all, providers will not face a penalty. In a sense, the status quo is accepted.

This is just a visual picture of how the bonus ACO would work. The physicians that use a common hospital volunteer to be held jointly responsible for the set of patients they serve. CMS would evaluate Medicare claims and assign each patient to the primary care physician -- these are the green circles in the slide -- that a patient sees for a plurality of their visits. Physicians in the hospitals would be members of some type of physician-hospital organization. As I said, this could be a loose PHO

or a formal integrated delivery system with common ownership. Medicare wouldn't prejudge which physician-hospital structure works best. Anyone that provides high-quality care at a low cost would be rewarded.

The new variant for today is a voluntary ACO teamed up with a Medigap SELECT supplemental insurance product. We bring up this option because some of you have expressed some concern about physicians being held responsible for all patient care, even when patients use providers outside of the ACO. The purpose of this option is to give patients an incentive to stay in the ACO for services.

Note that providers' obligations in this model are similar to the bonus-only ACO. The providers still need to form some type of physician-hospital organization and take responsibility for the patients; however, from the patient's perspective, things are very different.

In the ACO with the Medigap SELECT model, a patient must enroll in both the ACO and an affiliated Medigap SELECT supplemental insurance product. The patient acknowledges that if they go outside of the ACO network for care, they could face higher cost-sharing. A Medigap SELECT

insurance product will have a limited preferred provider network. The SELECT plan could cover Medicare cost-sharing for providers in the ACO's network, but the ACO network would consist of providers in the ACO and providers outside of the ACO that are needed to create a full complement of medical capabilities.

Providers may look at this and prefer this option because it could give them greater leverage to control utilization and where the patient goes for care. This may lead physicians to be more comfortable being responsible for the patient's overall cost of care. Some patients may prefer this option because it could end up giving them lower Medigap premiums. The restrictions on the network of providers that they would use could create some savings that could be passed on to them.

This is a picture of how the ACO SELECT option could work, and this is still just a preliminary idea we are sharing. There are two differences in this from the earlier picture.

First, note that the Medigap SELECT plan is affiliated with the ACO. Now, the ACO could operate the Medigap SELECT plan, or it could be provided by an

independent insurer.

Second, notice that the patient has to choose to join both the ACO and the affiliated Medigap plan. In this picture, the little arrows indicate patients who choose to buy this type of Medigap SELECT insurance and enroll in the ACO. In this example, patients 3 and 4 chose not to enroll in the ACO.

Now we just want to recap some of the benefits and challenges of the ACO SELECT model. The benefit of the ACO SELECT model is the patient commitment to the set of providers in the ACO. The weakness of the model is we need beneficiaries to actively switch from their current Medigap plan to a new ACO SELECT Medigap plan. Some would do so, but we expect that many would not.

Last month, we showed that an ACO requires 5,000 members to be stable enough to differentiate between real improvements in cost control and random variation in costs. If there are fewer patients per physician, then the number of physicians in the ACO would have to increase. Individual physicians would then have less of an incentive to change their practice patterns because more physicians are the ACO splitting the bonus. In addition, reaching joint decisions

to change practice patterns or capacity may be more difficult if you have a larger number of physicians, especially if those physicians are not part of a single practice or a single integrated delivery system.

As we have said in the past -- I think we said this last month -- to truly change practice patterns, it may be necessary to have a significant share of both Medicare and private payer patients in each physician panel under ACO-type incentives. This may require certain physicians to focus their practice on ACO patients. So maybe the ACO SELECT model would still be feasible if there was some physicians that focused on ACO patients and other physicians that focused on patients that chose not to join an ACO SELECT type plan.

Finally, if we complicate the ACO model by bringing a Medigap product into it, we would have to consider some of the complexities of Medigap insurance, including how to bring low-income beneficiaries into this type of ACO.

Now we just want to do a head-to-head comparison of the ACO variants we discussed today, just to recap some of the differences of the two models.

In the bonus-only variant, CMS assigns patients to the ACO where they go for primary care. In contrast, in the ACO SELECT option, the patient must sign up to be in the ACO, and there are several implications of this. In the bonus-only model, all Medicare patients would be assigned. In contrast, in the ACO SELECT model, many patients will choose not to switch Medigap plans. Hence, if a physician was to have a large panel of ACO patients, they may have to start limiting their practice to patients in the ACO.

In the bonus-only model, patients are free to choose any doctor. In the Medigap ACO model, patients would face higher cost-sharing for going outside the ACO.

Another key difference is how the top options are funded. Under the bonus-only option, shared savings may not fully fund the bonuses. Medicare may need to restrain fee-for-service rates. Under the ACO SELECT option, providers may be willing to accept withholds due to having greater control over patients. Incentives for volume control could be larger, and shared savings and withholds together may be sufficient to fund the bonuses.

In sum, we have yet to find the perfect ACO concept. The difficulty with the bonus-only variant is it

is not clear that fee-for-service rates could be constrained enough to create a meaningful bonus. The difficulty with the ACO SELECT option is we're not confident that many Medicare beneficiaries would select it.

Now we contrast the strengths of the ACO models with the MA plan. Starting at the left, the last time we talked about mandatory ACOs, the key benefit of mandatory ACOs is that a large share of each physician's patients will be in the ACO because it is mandatory, and there would be stronger incentives put in place under the mandatory model. The weakness is that physicians may resist being jointly responsible for care that is outside their individual control.

In the second column, the ACO bonus-only model wins some points for being the least disruptive. Physicians still get fee-for-service payments. Patients can still choose any doctor accepting Medicare patients. The weakness of this plan is that the bonus would have to be funded in part by constraining fee-for-service payments, and there is the question if we have the will to do that.

In the third column, the ACO with Medigap SELECT model wins points for having a stronger commitment from

providers and patients. Patients have to enroll and accept a restricted network of providers. Physicians will still have more control over patients and would have to accept a withhold. The withhold would create stronger incentives for behavioral chance and, hence, larger shared savings.

The difficulty here is that few patients may join, and even with a big incentive per patient, if only a small share of a practice's patients join an ACO, it may not have much of an effect on the practice's practice patterns.

Now, last, we show the MA plans for comparison. The MA plans have the most restrictions placed on patients and give providers the strongest incentives to control costs. However, providers have been reluctant to start their own MA plans due to difficulty in negotiating rates with other providers and difficulty absorbing insurance risk.

To kind of summarize, the objective of all four of these models is to give physicians and hospitals a greater incentive to keep people healthy. We want to avoid unnecessary services and counteract incentives in the fee-for-service system to grow volume. The ACO variants try to create incentives for efficiency without making the

providers take on the insurance risk or to pay claims or to have to negotiate rates with private payers, the kind of things that insurance companies do. So kind of the idea is, Can we get some of the benefits of the incentives of an MA plan without putting all the burdens of the MA plan on the providers?

Now, over the past couple of months, we have presented four different variants of ACOs, and now we want to hear some of your thoughts on which direction to take the ACO concept. We presented one mandatory option and three voluntary options. We'd like your thoughts on the relative merits of mandatory versus voluntary.

Second, we discussed a bonus-only option and three options that could have bonuses and withholds. For the bonus option, the key questions are: First, can the bonus be large enough to really change practice decisions? And, second, will fee-for-service rates be adequately constrained to fund the bonuses?

For the ACO SELECT option, the key question is whether enough people sign up for it to affect physician practice patterns. We're concerned that having 20 or 30 percent of a practice's Medicare patients in this type of

plan will not be enough for physicians to change practice patterns. In addition, there may be a need for some special provisions to allow low-income individuals into the Medigap plan who do not currently purchase Medigap plans.

For both options, a key question is how should bonuses be distributed, and this would hold for all the four options we've discussed. In the mailing, we suggested that each physician and hospital receive a set percentage add-on to their fee-for-service rates. Others have suggested that the ACO get a lump sum and then divide the payment.

There is a concern that if the PHO is giving a lump sum of money, the PHO members may spend a considerable amount of time deciding how to divide the funds among the hospital, the primary care doctors, and the specialists, and this could create some conflict when what we are trying to do is foster cooperation.

Another topic for discussion is which option would be most likely to induce private insurers to create their own plans with incentives to restrain volume and capacity. To make ACO incentives strong enough to overcome the fee-for-service incentives for capacity growth, physicians may need to face incentives for capacity constraint from both

Medicare and private payers. The idea is Medicare alone may not be enough.

Finally, we could discuss having our system of spending targets for ACOs be synchronized with a system of spending targets for MA plans.

I would like to hear your comments.

MR. HACKBARTH: Thank you. Before we start the round one questions, we're not going to have any votes on ACO, but as you know, there is a lot of interest in this idea in Congress. so I am striving for as much concreteness in what we say about it as possible.

Personally, I see the interest in Congress as a very good sign. It seems that there is a growing acceptance -- not unanimous acceptance by any stretch, but growing belief that more organization in the delivery of care is an important step in improving the health care system. And that is something that I believe personally and very strongly. And so the interest in this idea is, you know, how can we through Medicare foster, support that sort of organization, so it is a very important topic.

I want to thank Jeff and David and Mark for their patience in dealing with me on this issue. I have led them

down a number of alleys, more blind than rewarding, and so thank you for doing that.

Let me see hands of people with round one clarifying questions.

DR. REISCHAUER: Yes, do we envision that a primary care physician could be a member of more than one ACO? And do we envision ACOs that might consist of more than one hospital, a community one and a teaching one?

MR. GLASS: I would say no to the first question. We think that a primary physician would have an assignment to a particular and only one ACO. But, yes, we think that multiple hospitals could come together and form a larger ACO, and that would make particular sense.

DR. REISCHAUER: Do we have a distribution of physicians -- you know, if you did this virtually and we looked across all primary care physicians, do we have a distribution of how many, what fraction of their Medicare patients participated with one hospital?

MR. GLASS: Yes, I think we did. Jeff, do you remember the number? Seventy-five percent?

DR. STENSLAND: I don't remember the exact number. Maybe John remembers the number, but it's fairly high. I

think there is a possible benefit of the physician that uses two different hospitals or is a part of two different organizations. If indeed one does have higher quality scores and lower cost, then they would have an incentive to start admitting their patients over to that more efficient system, and more patients would be funneled into the more efficient system because they would get a bigger bonus if they affiliated themselves with the more efficient of the two systems.

DR. REISCHAUER: But the capacities of hospitals say within a metropolitan area vary, and you might have a physician like mine who would send you to one of the major teaching hospitals for major cardiac surgery, but to a community hospital for other kinds of things. And I'm just trying to figure out how that's going to work.

MR. GLASS: Yes, but Elliot Fisher has done work on this, and they have -- I think they call it loyalty to a particular hospital, and they also have to the next hospital up, so to speak, to the referring hospital from there.

DR. REISCHAUER: [off microphone] [inaudible] of the area which involves a 150,000-person metropolitan area versus a 2 or 3 million one, and I'm not sure that that

pattern might not exist in the large metropolitan areas to the extent that his data suggests.

MR. BERTKO: Two comments and the preface being that --

MR. HACKBARTH: [off microphone.] This is clarifying questions.

MR. BERTKO: I know. Yes, they are clarifying questions, but I -- thank you. As David noted, I want to identify myself as being on the Fisher team for ACOs so everybody recognizes that.

David, if you could turn to Slide 6, I think it is, where you're comparing spending. I would suggest -- and I'd look for you to see if you disagree with me on this, and this is on the borderline, Glenn, so I will ask your forgiveness. Because the first one where it is voluntary is subject to presumably big bonuses, I would suggest that the volume incentive here actually isn't weaker. It is actually stronger. The money comes, as Willie Sutton said, instead of from the banks, from the hospital. That is the first source of savings, and it is pretty high. And then, secondly, from controls on referrals to specialists. So the high pressure I wouldn't necessarily say is on fee-for-

service rates. It might be on fee-for-service intensity where you are substituting, for example, primary care services for lower back pain in place of orthopedic services for lower back pain. And so the rates per se don't necessarily have to be constrained, but I would suggest that the intensity and the utilization have a fairly high constraint in order to achieve the bonuses.

DR. STENSLAND: The basic idea we were coming from is whatever your bonus, a bonus plus a withhold is going to have a bigger incentive than just a bonus on itself.

MR. BERTKO: I agree with that.

DR. STENSLAND: And it is going to be much easier to get a bonus and withhold system in a mandatory than in a voluntary, was the idea. Under a voluntary system, it might be more difficult to get physicians to accept a withhold.

MR. BERTKO: I don't disagree with what you said. What I am suggesting here is you have weaker volume incentive. I don't think I agree with weaker volume incentive as that particular adjective.

MR. GLASS: The other aspect of that is not everyone will volunteer. So there will be a large population of providers out there who have no incentive to

control volume. So when you add them up, we think the volume incentive would be weaker in total.

MR. BERTKO: Okay. Well, I'll save that discussion for the second part. The other clarification question is -- and you guys I think did a very good and very clever job on setting out these. I'm going to only make it slightly more complicated and ask if you considered a soft enrollment version of the voluntary ACO. And by "soft enrollment," it means that CMS would attribute members to their physicians, and then send out a letter that says, "Dear Mrs. Jones, You seem to have gotten all of your care in the last two years from Dr. Smith, so you're in this particular ACO unless you decline. Sign the form on the bottom if you wish to decline. Otherwise, you're in."

MR. GLASS: Then what would you do? Meaning what? That they couldn't go to other providers or that they'd have higher copays or --

MR. BERTKO: Of course, they could go to other providers, but it would be an alert to them that they, in fact, were working with this particular doctor who is part of this particular ACO.

MR. GLASS: So it would be informative, not

particularly -- it wouldn't change their behavior in any way.

MR. BERTKO: Yes, there would be -- without changes to Medigap, there would be no penalties. But it would be informative in the sense that it confirms where they are and that they should be looking to have Dr. Smith as the usual source of care.

MR. HACKBARTH: Okay, let me see hands again on this side, and let's keep it to clarifying questions because, in fairness to the people who are waiting for round two, I want to make sure we get to round two. You have a clarifying question, Jennie?

MS. HANSEN: The clarifying question is assignment, and I guess it's built in that this is still choice on the part of Medicare beneficiaries, because I know this has been an issue of a Medicare beneficiary being told that they are in a place. So this is addressed in this issue?

MR. GLASS: Well, they are assigned -- depending on which variant we're talking about, but in most of them Medicare says they're assigned to that particular ACO. But the beneficiary still is free to go wherever they want.

DR. STENSLAND: The decider is the beneficiary. So the beneficiary goes wherever they want, whenever they want, at least except for the Medigap SELECT model, that aside. But in the basic models, they go to wherever they want whenever they want, and then CMS looks at where did the beneficiary choose to go. Oh, they choose to see Dr. X mostly? Okay. Then they'll be assigned to Dr. X. So the beneficiary is still in the driver's seat of complete choice.

MR. HACKBARTH: And even in the Medicare SELECT model, there they are making a choice to enroll or not, much as they make a choice in Medicare Advantage to enroll or not. So all of these designs in various ways strive to maximize choice for Medicare beneficiaries as opposed to force them into a particular delivery system.

DR. MARK MILLER: Even in the SELECT model, they can choose to go in and out of network.

MR. GEORGE MILLER: My question follows Bob, but only from a rural perspective. Can you describe to me how this would work in a town of 10,000, maybe five physicians, where two may send to one hospital X and the other three may send to hospital Y in different directions? I just can't

put my arms around how this would work in rural areas.

DR. STENSLAND: I think there would either have to be an exception for small towns to opt out or some special provision. I could envision a system where they may, especially in a bonus-only model, choose to band several hospitals together. For example, these larger rural systems that may have five different small hospitals, they could all be banded together and evaluate on the sum total of all their patients together. I think that would probably end up being their choice if they wanted to do that.

MR. GEORGE MILLER: To follow up, those who are independent are not part of a large system, they'd just opt out?

DR. STENSLAND: If they didn't want to sign up with other individuals and just be their own entity, it would be difficult. You might have to have some sort of exception because they would have such a small number of patients, there would be a big volatility in costs, and you really couldn't measure them adequately.

DR. SCANLON: The model you have on page two, I think it differs from what I had in mind that was an ACO and it seems like it's somewhere between a medical home and what

I used to have in mind as an ACO, so this is a question about selection or assignment sort of within this new definition and it goes to sort of what is this idea of a primary care physician, because I think, in thinking about an ACO that involves specialists, people with diabetes, heart disease, COPD, who use specialists as primary care physicians, they get included. And the question is here in this assignment model, is there a way that that can be taken into account?

And I guess the other part of the assignment is the issue of the non-users and sort of what happens to them in the system, even though they are likely to be low users. There is also the potential that they develop something after an assignment period and then they become more expensive for the rest of the --

MR. GLASS: Well, taking the second part first, I think the definition is, what, plurality of E&M visits, Jeff, or the -- for who is considered their principal provider. So I think that a cardiologist would still fit into that mode.

MR. STENSLAND: You could do it -- it's been done two different ways, and sometimes when the data has been

run, it's only looking at primary care physicians and assigning them that way, and sometimes it adds in specialists if that's where they got most of their care. And I think that's probably a detail that we'd have to work out. There's kind of some difficulties if we start assigning people based on primary care and how the data plays out in terms of if we start assigning people to the specialists and certain hospitals use more specialists than others, it affects the risk adjustment in the model. So maybe we'll leave that for a later discussion and a long footnote.

MR. GLASS: But in general, the idea would be primary care providers would be who you would design it to and you'd have to figure out what to do with the -- but the very low users would still, as long as they had one E&M visit in two years, I guess, would still work. So that's a pretty low bar.

MR. HACKBARTH: Let me see clarifying questions on this side.

DR. KANE: Yes. I guess I'm wondering why is it Medigap SELECT instead of Part B SELECT or some -- I don't know what the Medigap average premium is, but the Part B is

probably the more meaningful premium that you might want to lower. I mean, if one was trying to -- anyway, just did you say it should be a Medigap SELECT rather than a Part B SELECT --

MR. GLASS: You know, I mean, these things exist. The Medigap SELECT plans exist. I think about 10 percent of Medigap people are in them now. And so that's kind of the model we're building off of. It's the existing model. And I'm not quite sure why. I mean, if a lot of the savings would be from admissions or readmissions or whatever, I would think you'd want both A and B in there. But anyway, I think the current Medigap SELECT ones are -- it's both A and B. It's all Medicare.

DR. KANE: I'm just thinking about the amount of the premium that might go down if you choose it. Which one would be the bigger -- how much is an average Medigap premium?

MR. BERTKO: One-hundred-seventy-nine or $180.

DR. KANE: Okay, so that's -- and Part B can be anywhere from $100 to $700, depending on how your income is. And then the D is $30. So Medigap being the biggest premium to cut? In other words, the incentive to join the Medigap

SELECT would be you have a high Medigap premium and you want to lower it.

MR. STENSLAND: Yes, and I think we're kind of -- we're striving to find something out in nature that already exists that we could piggyback onto and that's kind of where the Medigap SELECT idea worked. If they're able to move 10 percent of beneficiaries already into Medigap SELECT plans by offering them a lower premium with a restricted network, we thought, okay, at least that shows that this is something that has proven to work to some degree.

DR. KANE: Just another minor question. If you're talking about physicians having admitting privileges to two hospitals and the one with better bonuses is the one they start sending patients to, how do you make sure that doesn't look like a kickback?

MR. STENSLAND: Well, I think that gets back to how do you set up the bonuses, and if everybody's bonus was just a flat add-on to their fee-for-service rates, so if I was an orthopedic surgeon and I was getting paid $1,000 for this surgery, I knew that if I was in a high-quality, low-cost area, I would get $1,100, or a 10 percent bonus, and that would happen no matter which of these high-quality,

low-cost things I went to.

The kickback problem would get to be more difficult if we just gave the physician hospital organization a lump sum and then we said, okay, you can decide how much the orthopedic surgeon gets for the patients that go to your hospital, that would be a concern.

DR. CROSSON: Yes. I had actually focused on the same sentence that John had, and I just want to clarify the clarification, if that fits. So could we go back to Slide 6 for a moment?

So I had the same sense that I couldn't understand necessarily how the voluntary model produced a weaker volume incentive, and I think what I heard was that the way you're defining the volume incentive is sort of in global dollar terms. In other words, the total amount of money, let's say, saved by the Medicare program would be less than a mandatory model because everybody wouldn't be in it, not that the dynamics inherent in the voluntary model would produce at the level of an individual provider or an institution a lower incentive. Is that correct?

DR. MARK MILLER: I think actually there were three parts to the answer. One is how many people do you

have in a voluntary model versus a mandatory model, the point you were making.

Two, in the exchange between Jeff and John, it was relative to a bonus plus withhold, this is a weaker incentive, and part of our conversations have included this notion of bonus and withhold, and I think part of the sentence is predicated, well, if you remove the withhold, you have somewhat weaker incentives.

The last piece in my mind, and I'm not sure how close we got to this point, is this model depends on what size of a bonus you can give, and that's kind of unclear. And part of our thinking is predicated on, well, you may have to pressure fee-for-service to produce a bonus that you can give to these people, to people who volunteer. And depending on that, that could be strong or weak, depending on how deep you go on your fee-for-service side.

So I think the complexity is there's three -- at least three concepts running around in that sentence.

DR. CROSSON: So this is a question between the two slides. The voluntary/mandatory distinction here, on the next slide, the voluntary option is blown up, if you could go to Slide 7, on the right, is blown up to include a

voluntary mechanism that, in fact, does include a withhold.

MR. GLASS: That's correct.

DR. MARK MILLER: On the select side --

DR. CROSSON: Right.

DR. MARK MILLER: -- versus the -- yes. So between those two, I think some of the argument would be that we would think that the incentive would be stronger on the right side than on the left side.

MR. HACKBARTH: Except for the fact that since you're on the right side, you might have fewer beneficiaries participating and a lower proportion --

DR. CROSSON: Because of the complex and double enrollment.

MR. HACKBARTH: Right. Okay. Let me see hands for round two comments, and we'll just go the other way. Bruce, and then Peter.

DR. STUART: I guess one of the problems I have is this looks like a bird that keeps getting heavier and heavier and I'm just not sure that it has wings to be able to take off, and part of that comes down to the issue of this is, after all, a fee-for-service system and we recognize the incentives that fee-for-service provides for

making more services available, and I just have trouble seeing how this is going to provide -- how conceivable bonuses under a system like this would offset the inherent incentive in fee-for-service to make more services available, particularly for non-primary care physicians.

I guess my thinking is that Medigap SELECT, we're pushing -- I think the reason that's there is that I think that this thing probably can only work if there is some kind of lock-in. Maybe it's a soft lock-in or something other than that, but it seems to me that unless the organization can be fairly well assured that it can control the members that are under its wings here, that it just isn't going to be able to take off.

This gets back to a point that Mike raised yesterday, is that we tend to look at these things in silos. We have had an opportunity to look at medical homes and now we're looking at ACOs and I can see how something might come together if you had a combination of a medical home and an ACO, but I sure have trouble seeing how just straight ACOs without something that keeps people together is going to work.

And Medigap SELECT, I just can't see it as being

the structure that's going to make this thing fly, because it's not going to affect anybody who's in a retiree program. It's not going to affect anybody who's in Medicaid. And it's going to be a small, presumably, subset of people who are in current Medigap policies. So --

MR. STENSLAND: Yes. You would have to hope that there would be some other people coming into the game, and I think this is the idea that maybe there would be a Medicare ACO or a Medigap SELECT. Maybe the employers could set up some parallel set of incentives in their own supplemental insurance plan, and the idea is that even private insurers could set up their own parallel system of incentives. And I think this is the kind of model that they're trying to come up with in Vermont right now, where you have the main private insurers and Medicaid and they're hoping Medicare, all getting involved with similar incentives where they're basically saying, your payment per unit of service will be higher if you have lower growth in your volume of fee-for-service.

DR. STUART: I agree, and nothing of that is here. I mean, that's the assumption. But what makes that happen?

MR. GLASS: Well, I don't think that's the

assumption. I think that's the hope, maybe.

MR. STENSLAND: Yes. We can go through that, but that kind of gets back to the detailed things we did last month on what is your actual incentive to buy an MRI machine? What's your incentive to build an extra bed? What's your incentive to hire a cardiologist? And do we think that the amount of money we're moving around here is sufficient to change those decisions?

MR. HACKBARTH: Let me just react to what Bruce said. I share your concern about the strength of the incentives, so long as the underlying payment is fee-for-service, and we discussed that at some length last month and I think that's a real issue. What that prompted me to focus on after the last meeting was thinking about, well, what about a model based on global capitation as opposed to fee-for-service with gain sharing? And I spent some time trying to think through what that model might look like. And you can conceive of that as sort of an extension of Medicare Advantage as opposed to building from fee-for-service. Let's approach it from the other direction.

The problems that I ran into on that particular journey was that you're going to have an enrollment decision

then with beneficiaries, and to the extent that you get lower enrollment, that is another way of reducing the incentive to change. You're only talking about influencing a small piece of the hospital's revenues or the ACO's revenues. So that's a challenge.

The second thing in talking to some hospital people about this was that I had thought the reason that they didn't do the MA-PSO thing was concern about risk, and I said, well, we can deal with that. We can attenuate the risk through risk corridors and various things to make it so it doesn't seem as risky. And they said, well, okay. That's nice. But it still means that we need to have insurance capabilities. We need to be able to pay claims and deal with providers and negotiate contracts. That's not the business that we're in. And so it's not just a matter of attenuating the risk. It's also lots of administrative functions that they don't have the capacity for.

So given that, I've sort of cooled on approaching this through global capitation and went back to basing it on fee-for-service. It doesn't alter the fact that you're right. The incentives, as we discussed last time, are attenuated. They're not as strong as I would like them to

be.

DR. MARK MILLER: Just one quick thing. I mean, the Medigap SELECT point here was in response to comments about, well, is there some way to get a soft lock-in with the beneficiary. These were questions you were raising, so we went out and tried to find something to do that.

The other way to think about the Medigap SELECT point is that maybe that concept needs to be blown up in order to make the ACO work. Maybe there needs to be a new Medigap product and maybe structure it in such a way that it isn't such a small part of the market. But we'd have to think through exactly how that works, the enrollment rules, the people being able to transfer from their current Medigap to this new product, that type of thing. But it would be a whole different exercise, or additional exercise.

DR. STUART: What do you think, though, about linking the medical home to this concept, because it strikes me that if you have a real medical home, then the physicians that are associated with that medical home are going to be in a much more powerful position to work with the hospitals.

MR. STENSLAND: That's -- several people have thought about that and have the idea of having the medical

home embedded in this thing. They start with the little building blocks of the medical home and then you can build an ACO around it. I think one of the key questions is do you have the hospital in there, also, and a lot of these models, they just have the primary care physicians and maybe some of the other specialists and they don't have the hospital in this ACO framework, where we have set it up so far that the hospital is in there, basically trying to respond to some of the comments we heard from all of you that you want to encourage more systemness and cooperation.

MR. HACKBARTH: You know, I would think that, certainly if I were setting up an ACO, I would want to have medical homes linked up. I'm not sure you need to require that. I think that's where -- if the medical home model works, they will gravitate towards that. You don't need to tell them to do it.

DR. STUART: Well, maybe it's a staging issue. I mean, all of the emphasis that I've heard over the last two years that I've been here on primary care, I mean, that is focused on the medical home model. So, I mean, if we said, okay, we've got a certain number of chits in terms of the kind of recommendations that we want to make, I would feel

much more comfortable in terms of really putting some strong recommendations on medical homes and then saying, look, if you can set up a system of medical homes, then it's going to lead -- it can lead naturally to these kinds of organizations as kind of a second tier in terms of the development strategy.

MR. BUTLER: Okay. I've got several comments here. I'd start by saying that my bottom line will be heavily in favor of the left-hand side, voluntary bonus model, with some clarifications, and I would say at the front end somewhat similar to what you said, Glenn, and that is there's a real beauty here in that not only are you eliminating the contracting, administrative, and billing functions, but you're locking in Medicare rates, which Medicare Advantage plans typically haven't been able to achieve. So you've got a baseline on the pricing side kind of solved. As much as hospitals and doctors may not like that, that's not unimportant in this model.

Second, and maybe the most important part, we're going to talk about episodes of care later and whether to bundle them and just the inpatient stay or the 30 days and now this is just another point on the continuum at the ACO

level. Now, I think we need to think about where do we want physicians and hospitals to spend their next energy in organizing to managed care, and where I come out heavily in favor of ACOs versus episodes or others is you've kind of got one shot. If you don't set it at a fairly high level that ultimately will handle the continuum of care, you're going to have a lot of short-term energy around bundled care that is going to create a lot of anxiety behind doctors and the juice-to-squeeze yield in the long term isn't going to be there and we're going to spend a lot of energy without a lot of the dollars.

So I think the important part of this concept relative to the others is that it gets us to organize at the right level in this next phase of health reform and I think that's a very important concept.

Now, the voluntary side, I think, is extremely important. I actually am not in favor at all of engaging the patients at this point. It's another disruption, another confusion, another -- I would rather have the data shown to me and how I'm doing, what it looks like, even if there's no bonus, it's kind of like showing your readmission rates. To show the data for an institution is very

powerful. I can tell you, CMS core measures came out, no payment tied to it. Guess what? It's improving. Readmission rates now are starting to -- we understand our readmission rates much more than we did a year ago. Simply getting that scorecard out in front will have some powerful, I think, implications.

So you can see I'm kind of headed towards definitely an ACO as a key model on a voluntary basis. Get the data flowing and we'll figure out through that data how to then get the bonuses aligned. But we will have set the right structure in place if we believe hospitals and doctors, which I think need to include the specialists, not just the primary care.

Now, why do I -- last comment on this. We do have a, what you would call a PHO. We have a community hospital, a big teaching hospital. We have private physicians. We have full-time faculty physicians. That organization right now does all of the contracting. We have some capitation arrangements. Granted, they are not enough -- while we handle the capitation and hand it out, it hasn't changed the fee-for-service culture, but it's there. We're a participant in PQRI. We have HEDIS measures, even though

we're not a health plan.

And so we kind of have the structure, and I think I said at the last meeting, bring it on. I'd love to see -- and it's physician-driven, even though hospitals are a partner, a physician chairs that board. We meet every month. We'll look at our PQRI results next Monday. So I kind of say, if you had that scorecard in front of me now, I'm kind of organized to be ready for that. And so that kind of model, not get into Medigap and, frankly, confuse the Medicare beneficiaries at this point in time, that's kind of the model that I'd favor.

DR. CASTELLANOS: You know, this is -- I think Peter said there's going to be a lot of anxiety in the medical community. Well, I think there's going to be a lot of anxiety among a lot of us. I think it's fair for me to say that we happen to be looking at this model and had made some inquiries because we recognize we need to change. We need to change the fee-for-service incentives. But then I look in my community and my doctors in the community look at me and say, why do you want to do this? Why do you want to move away from what we call a very robust, perhaps overly funded in some respects, less-risk program and to go into

something like this? You know, they say, well, what incentive do I have just to improve quality and resource use?

I kind of tell them, maybe it's going to be done to us unless we are part of the solution, but I really don't -- I would like to have explained to me a little bit better than you have, what's the incentive for the physician to give up this robust fee-for-service program with less risk and accepting risk on a financial and a quality on a patient that may leave my control and go somewhere else for three years and yet I'm still responsible?

I think a lot of this -- and Peter really put it nicely -- anxiety around the physician, but there's going to be a lot of anxiety around the hospital. There's going to be a lot of anxiety around the beneficiary.

MR. HACKBARTH: Do you want to take a crack at that? I have something I want to say on that.

MR. STENSLAND: Go ahead.

MR. HACKBARTH: I think that you gave them the right answer, because it's going to happen to you regardless. You can either organize and try and deal with the problems or you're going to get squeezed another way in

an unorganized system. To me, that's one of the central conclusions that I've reached about this.

I don't think you can require people to form ACOs. I think you've got to do a voluntary thing. This is a challenge. You're talking about redefining relationships among people who haven't worked together, and so I think it needs to be voluntary. But I think a corollary of that is that there needs to be pressure on traditional Medicare as a complementary force, and that strengthens the incentives to participate and to do well. So I think that's part of the puzzle, and so I think you gave them the right answer, Ron. It's going to happen on both traditional Medicare and here. These actually give you an upside opportunity to win, whereas the squeezing on traditional Medicare is all downside.

DR. CROSSON: Thank you, and thank you, Jeff and David, for the work. As Glenn does, I strongly support this. I think this is, as Glenn said, extremely important. Even if Congress weren't looking at it right now, it's still important because I think it represents the right direction.

In terms of the alternatives that we have been discussing, I think I agree with Peter. My general sense is

that a voluntary model probably of some sort probably makes more sense than a mandatory one. The nature of the change is going to be difficult enough for people to accept without necessarily right at the beginning feeling like there's a strong arm here.

I do think, on the other hand, that if it's going to work, specialists need to be part of it, as Peter said. Otherwise, you lose the strongest lever over the largest producer of the costs. And if you're trying to save costs and you don't have the specialist involved, and particularly if the primary care physician has no leverage over that, then I think you probably have created a weak system.

I think, in addition, the hospitals have to be part of it, as was part of the definition. I think the two weaknesses, parenthetically, of the medical home model are just those, that there is no particular mechanism for the primary care physician to influence, directly, anyway, influence specialty costs and there's a relatively weak relationship in most medical home models with the hospital.

I also think, as Peter said, that although probably in an analysis we're going to be forced to look at incentives in a relatively simple sort of manner, in fact,

the creation of these sorts of organizations is going to create a much more complex set of incentives. I hesitate to tread into the area of behavioral economics, but in fact, once you've created these sorts of models, you then develop other types of incentives.

For example, peer pressure, the influence of other physicians on physicians in terms of the welfare of the enterprise, the goal in the end, in the long term, that individuals have to see that the enterprise is maintained and the pride that can exist in an enterprise, in this case an ACO, that is, in fact, improving and does well. And those are subtle. They're soft and not measurable. They wouldn't be scored. But in the end, in many ways, they're at least as important for many, many professionals, perhaps not everyone.

The other thought is that we have to think about the nature of the change that we're talking about here, so kind of sort of envision this as a table with the vertical axis being payment methodology, for example, with pure fee-for-service at the bottom and, say, pure capitation at the top and the horizontal axis being the structure, which is completely disintegrated to completely organized with all

elements in there.

And what we're embarking on, I think, with this set of recommendations is the idea that we think the delivery system needs to move from the Southwest corner, if you will, to the Northeast corner, and I'm not sure how that works on the Dartmouth Atlas, but it seems to me that there's no way that that change is going to occur rapidly and there's probably no way that that change is going to occur linearly. It's going to occur most likely with step-wise changes, probably starting with payment changes, which then evoke changes in structure, where if, for example, physicians and hospitals come to work more closely together, and then that allows further changes in payment that move more towards the sort of prospective withhold partial capitation model, which creates then stronger incentives and the like.

And I think we need to realize that that kind of change, if that's the change we have in mind, and it certainly is what I have in mind, is going to take time. And what we ought to be thinking about is constructing how we speak about it in that way and then making recommendations for the first step or two in such a way that

it at least heads in the right direction and not think that we can solve every problem, or that we can even understand the evolution of the best model, or that the best model is going to be exactly the same in Manhattan as it is going to be in Minneapolis or as it's going to be in Miami or wherever.

The only last comment I'd make is with respect to the MSA, or the MA-PSO model, I think the question of the readiness or the willingness to develop the capabilities to utilize such a model, given a rethinking of Medicare around how it might share risk, might very and there might very well be -- I do believe, in fact, there are organizations and organizations that could form that would respond to that and could do that. There's no reason why we couldn't move in both directions, so that that model, it would seem to me, which already exists in law, I think, although it's not being implemented right now, could be made open and could be improved for those organizations that do have the capability and willingness to do that.

MR. HACKBARTH: It could be one of the evolutionary steps, developments, as you say, that occurs with time.

Okay. Let's just do a time check. We were scheduled to end at ten. It's ten after ten. I've got five people on my list -- John, Jennie, Arnie, Mike, and Karen. I think this is an important topic and so I'm going to extend on this. My apologies to Anne and Rachel, who are going to have to shorten those sessions correspondingly, but we need to cover this thoroughly. But please, those of you in the queue, keep in mind our time constraints.

MR. BERTKO: All right. Yes, sir, I'll be concise. So the first thing I'd like to do is say that some of the bonuses, and Jeff and David are correctly worried about how they're attenuated, would actually be leveraged. I'll take Peter's enthusiasm as an example and say that hospital plus primary care -- and I would suggest a subset of specialists -- would be where you derive the savings, and thus paying back to a smaller-than-everybody group makes the bonuses proportionately a little bigger. And Peter here, being an early doctor in my example, begins eating the lunch of his competing hospitals across the street and ten miles away. He has reduced utilization. He has reduced his variable cost and covered some of his fixed cost, so he still has a pretty good incentive there.

Secondly, I would say that I personally like the idea of the enrollment model, just as Glenn and others have worried about. But I would contrast it with what Bruce was worried about of what I'll call a population health-based model. And to the extent that you describe to a community, and I'll take my small community up in Flagstaff, you are now responsible for basically everybody in town and you get a bonus if you do it right, that this could actually be a reasonable incentive. Enrollment-based would work better, no doubt, but the population base and the stickiness of people has been demonstrated to be in that 80 percent range or so, even though you can migrate out to use the academic medical center that, Bob, you were describing earlier.

Again, I congratulate you two guys and Glenn, maybe, and Mark on thinking about this SELECT model, so I will propose one more variation of it, which is you get the big Medigap player in town, or in the State or a region, usually a Blue, and you say, let's convert everybody into a version of SELECT, and maybe it's a new product and maybe it's a rollover of everybody into it. That solves the problem. And to Jennie's worry about choice, again, it's an opt-out. It's like Part B as in Bravo. You get a form

which says you're now in this product. It's going to save you money. And if you want to go pay the old high premium, you can sign the form on the back.

The very last thing is I would be careful and maybe remove the idea of an ACO becoming a Medigap SELECT plan for all the reasons that we've talked about. It just didn't work in the past. I had some personal experience trying to bring up PSOs, and the moment hospitals and physicians begin saying, we've got to pay attention to all this stuff and we've got to deal with the DOI, it's like, we're done. Sorry.

MS. HANSEN: All right. Two comments and a question. The comment relates to the beneficiary, and I think perhaps another dimension. I think talking about why would doctors have any incentive to change, and then I was thinking from the beneficiary, what benefits the beneficiary. I think one view I would put is to have the beneficiary not feel that they're a walking bar code. In other words, you've got another test. You go in the hospital. You get some more medications. The idea of getting care that's right for their best benefit. So I just wanted to put that bit on the table. Why would the

beneficiary want to be in anything? It's transparent to them as to what it is. Choice is important, but bottom line is they would like to get probably the best and as little care as necessary so that they can basically live their lives.

The provider change is a second comment, and that is I'm struck by the physician piece. It takes -- having operated what is really probably closest to an MA-PSO in an integrated capitated system with Medicaid, as well, I notice that the physician behavior in order to do this culture change really takes time to knit together and really focus on the care coordination and the most efficient use of resources. When we went out and contracted with private fee-for-service physicians, that interface of culture was very different, and understanding what the motivation and the incentives were for the fee-for-service physician was something that our plan had to figure out -- and did -- in order to do that. But I must say that this culture change component that I think Jay alluded to takes a long time in order to have two different countries, so to speak, come together and figure out what that bridge really is. So I wouldn't give that part short shrift at all.

And then the last question that I have is when I heard about, thinking about the medical home vis-a-vis probably as one of the core possibilities of an ACO, not required, but it certainly seems like it would be an advantage, it would be one of the areas that made me think of all the different things that we study and write about, whether it's episodes of care, pay-for-performance, medical homes, ACOs. And I notice that they each generate conferences. But along the way, the silo approach and the fact that they're really related in some form, I wonder if we've ever thought about developing a schematic and seeing how some of these things really are kind of subsets or related to the other so that at the end of it, we're about care quality and volume control with the dollars associated, and just to see how they articulate and sometimes are synergistic and sometimes have a little bit of conflict so that we don't, as I think Peter said, get all the angst worked up with lots of people thinking about these models and getting consultants all into developing consultation when, in fact, some of these things could be thought through with these conceptual models that we're offering a little bit more logically.

DR. MILSTEIN: I'm very supportive of this line of development. I think it's important to reflect on the fact that the prize here is motivating the agent with the most authority in a health care system to continuously innovate and discovering better, less expensive ways of delivering care, and then using sort of the lessons from complex systems, trying to make sure that you have the fewest number of rules as you move forward.

I have to say that I'm very impressed with the incidence of failure in the Medicare demos, and for that matter, the incidence of failure in Medicare Advantage plans to essentially deliver on what they were after. It's caused me, among other things, to become more humble in my views as to what it is that would achieve -- that would sort of ignite American physicians to be much better and much faster at discovering better, less expensive ways of delivering care.

And so what I've tried to do is look at those delivery systems that are actually achieving what we're looking for and then studying what they're doing. And what I would extract from three years of such study relevant to this discussion is that there are two things that I think

it's very important that we get right. Number one is harmonizing physician incentives to improve value across all patients that a physician is seeing, or as many as possible as opposed to --

MR. HACKBARTH: Not just Medicare.

DR. MILSTEIN: Yes, and I think that's very important.

And then, secondly, giving physicians flexibility in terms of how they innovate, who their partners are, because there have been -- I saw a number of examples, for example, in which physicians were affiliated with a hospital, but over time, that hospital turned out not to be the best value. And it's the ability to switch that was very important to their ability to continuously deliver better.

So with those reflections in mind, I guess I would raise three questions for our consideration. Number one is since getting as many patients into -- I'm sorry, improving -- increasing the number of patients whom physicians regard as being in programs that are aimed at this objective, should we entertain as one of our options assigning all enrollees, all Medicare enrollees who don't -- I'm sorry,

all Medicare beneficiaries who don't connect with a voluntary ACO to a default involuntary ACO, so kind of we get all of the Medicare beneficiaries in, appreciating that the mandatory version has some disadvantages, but that way, at least, you have all Medicare beneficiaries -- the providers treating all Medicare beneficiaries aimed at the same objectives. So that would be one idea for consideration. So it is assignment of those beneficiaries that do not enroll in a so-called voluntary ACO to then be auto-assigned into a so-called mandatory. That's idea number one.

MR. HACKBARTH: Yes. Can I --

DR. MILSTEIN: Yes.

MR. HACKBARTH: -- just to make sure I understand that, Arnie. So when we talk about voluntary ACO, we're talking about voluntary to the provider.

DR. MILSTEIN: Correct.

MR. HACKBARTH: They can choose to be paid under these payment rules or traditional Medicare. So the voluntary is provider voluntary.

DR. MILSTEIN: Exactly.

MR. HACKBARTH: And the underlying concept is,

it's basically invisible to beneficiaries.

DR. MILSTEIN: Right.

MR. HACKBARTH: So now with that as the foundation, I'm trying to understand what it means to assign beneficiaries who are not in a voluntary ACO to an ACO.

DR. MILSTEIN: It's simply a way of enabling all providers serving Medicare beneficiaries in a given geography to mentally feel that they will -- they, the providers, will benefit if they discover higher-quality, less-expensive ways of taking care of the patients.

And so what I refer to is let's say in a given geography, 30 percent of Medicare beneficiaries are participating in ACOs that are provider voluntary. I'm suggesting that one way of synchronizing physician incentives would be to say for the other 70 percent, those enrollees are essentially -- then automatically participate -- participate in what we are calling a provider mandatory ACO.

What I'm trying to do is come up with a solution whereby --

MR. HACKBARTH: I think I understand.

DR. MILSTEIN: Okay. What's a little confusing is

the provider voluntary versus enrollee voluntary, and I'm trying to stick with the language we started out with, which is voluntary and mandatory applied to provider, not to enrollee. So that's idea number one.

The second idea is should we consider not requiring every ACO – physicians in every ACO to include a particular hospital, so that the physicians have the flexibility of switching hospitals if, over time, they find that a different hospital is going to better serve their innovation objectives. So that's idea two.

And idea three is, and I really -- well, I just have to say it. Let me go back to where I started, which is this works best if physicians are facing the same incentives over as many patients as possible. So idea number three is should we consider extending certain CMS benefits to commercial payers that agree to harmonize their ACO program with Medicare's? So we essentially have a world in which American physicians are facing a uniform set of goals of better, less-expensive health care.

Nancy is saying, well, for example, what do I have in mind? I'll put the least controversial and then I'll leave it to your imagination for the more controversial.

But the least controversial would be, for example, no balance billing rule. That's something that is attractive to -- would be attractive to many private payers. That is that if there is a dispute over how much is owed between the payer and the provider, the patient can't be leveraged through collection agencies. It's a minor problem for private payers.

And there are obviously other benefits. For example, probably on the more controversial end would be what happened in patient private fee-for-service, where the payers were allowed to pay Medicare rates. I realize on the commercial side that could be a problem. So maybe some 100-and-X percent of commercial rates. You fill in the blank. But I'll just put benefits for harmonization to commercial payers, and then the nature of those benefits, it's probably better that I not lay that out, because I think there are a lot of options.

And my last comment is that the demos and the Medicare Advantage plan show us the low probability that whatever we come up with is going to work. I mean, let's face it. The failure rate in terms of Medicare Advantage plans who are not saving the government money or improving

quality and the percentage of demos, that despite best design efforts and enthusiasm of the leaders were supposed to add a lot of value didn't.

And so my notion would be, again, is there an opportunity for us to study a little bit more of what's working. I mean, for example, take a subset of Medicare Advantage plans that even in relatively low-cost areas are below Medicare benchmarks and getting good quality. Can we take private sector exemplars, like the State of Minnesota Employees Health Plan, that have implemented their own variant of ACOs, and actually have positive results, lower spending, lower trend, so that as we make our bets, they can be maximally informed by what is working elsewhere?

DR. CHERNEW: Thank you. So my view of this loosely is there is probably a set of parameters that we could come up with which would make this a really good idea, and in reading the chapter, I'm not sure what that set of parameters are and what the details are.

So I've tried to do some math. I didn't do a good job. It's not surprising that my favorite parts of the chapter are Table 2 and Table 5, which are the tables that try and work through some of these exact examples. But I'd

like to ask a question relative to a benchmark that I have for ACOs. So here's how I see them, and John may correct me or you may correct me, but let me give you an example of a type of ACO program which is not what you're recommending and not what I'm advocating, and I'll say that again to be clear. This is not what I'm advocating and not what they're recommending, but at least it helps me as a benchmark.

Imagine a world in which every ACO, voluntary or not, was capitated, had a capitated target. If they conserved utilization so they were more efficient in a Bertko way of more efficient, they would get a really big bonus. They would get all of that bonus. That would be funded not by fee-for-service rate cuts. That would be funded by the savings associated with the cost, which is what I think John was pointing out, and that's how they get their bonus, and that's about as strong a bonus as I think you could get. If you wanted to do that in anything else that we talk about in terms of a bonus, I think it almost by definition has to be weaker than that.

The disadvantage of capitation, which is well known, of course, is if for reasons -- because they didn't do a good job or sort of reasons of no fault of their own --

their experience is higher than that capitation rate, they take the entire risk, which, of course, they hate. And so the idea is to have an ACO that in some sense mitigates that risk if they go over whatever this particular target is. And in your tables, like Table 5, I think, for example, you have this target, but it's not clear how the target's set and the numbers always kind of work out in the end so it looks like it's good. But I think if you told me the formulas, I could go through and give you some behaviors where it might not work out quite that good, depending what the actual parameters were.

So what I'm worried about or what I see in terms of the voluntary-mandatory and how this works is imagine you're a plan or an organization like Peter's and you're an ACO. So on one hand, you have some bonus if you do a good job by sending the person to watchful waiting instead of taking out their spleen or whatever it is you were going to do.

[Laughter.]

DR. CHERNEW: Do they do that?

[Laughter.]

DR. CHERNEW: I don't even know. Do people have

spleens?

[Laughter.]

DR. CHERNEW: But in any case, whatever they're going to do, they do something more efficient and then that helps them and they can save money. So that's sort of one option, which is never take an image of anybody.

The other option is, in sort of the Ron sense, to do whatever they are doing in the robust fee-for-service world. And the challenge is sort of to work out a set of parameters so the more conservative, hopefully higher quality -- and you have set it up with good and poor quality in your tables -- is more profitable than doing the not-so-right thing. Over time, that has to be the case, that the not-so-right thing becomes less profitable, because over time, if this is going to be effective, there has to be a growing gap between the profitability of just run with the system, whatever percentage per year, versus the sort of bonus model.

So when you weaken the bonus, make it weaker than the capitation bonus for doing the good thing -- in other words, in your models, I think you use 80 percent gain sharing. You picked some number. So you weaken the bonus

relative to capitation. So that says, you know, I don't get quite so much. I don't get to save all of the cost savings. I get 80 percent of it or whatever it is, relative to the profit if they do it.

And working out the math of that to understand what the alternative is, I think is the key thing to making this work, because I think relative -- Glenn made a comment, which I agree with completely, is the problem with putting everyone into an MA plan, which has this capitated risk feature to it, is that not all provider organizations want to take on all of that risk. And so I think we collectively are struggling with how much risk to give them. The more you fiddle with that, what happens if they get above how much fee-for-service, they're going to face some risk.

And so I think the challenge in going forward and the challenge in why it's hard for me to answer the questions right now is I still am not completely sure about exactly what's on the table and how we're going to walk that line between making it strong enough os it works but weak enough so not so many people have risk and stuff.

I guess my view is that I'm hesitant to do things that are mandatory until I know more. I like the idea of

doing things voluntarily. I like the idea of ways of exploring how to make what I believe is loosely a new type of MA sort of plan, which is what these big voluntary organizations would be, with some risk mitigation component.

So I think there is something positive in going in that direction and I think we have to think about what the exact incentives are, and I agree with Glenn's comment strongly, which is the voluntary/non-voluntary nature of this has a lot to do with what the alternative is. And so per the silo comment, we have to think about this not just in terms of medical home, but there should be a comprehensive sense of how we're going to face the quality problems that we want to improve and how we're going to deal with the fiscal challenges, how we're going to make sure providers have enough money to provide good quality care, that the country has enough money so we actually don't sink.

And so I think my final comment will be, I just think we need a little more work on exactly what the details we have in mind are of this before we can go say ACOs are good, because I think there's a certain type that probably is good and there's a certain type that's probably not and I'm not sure we're quite there yet.

DR. BORMAN: I certainly am not going to elucidate or articulate an elegant economic discussion. I do have a couple of comments that I think I can bring some expertise to bear on.

One is I, too, am a bit concerned, although perhaps in a different way, about the specialist piece of this model as presented, and I'm concerned for multiple reasons, but the most cogent, I think, probably are: Number one, I've heard several people espouse restricting access to specialists. I think that, frankly, that was one of the biggest backlash items of previous experiments in this area and I would be extraordinarily cautious about doing that.

On a less psycho-babble way of looking at it, perhaps, is the issue that for both my primary care colleagues and myself, I have great concern about setting somebody up to be an arbiter of a body of knowledge that is ever expanding while their own body of knowledge is ever expanding. I do think that an expectation that there will be a group of individuals who will have sufficient knowledge to make some of the judgments implicit here when the challenge of their own field is exploding on a regular basis may be a bit of a stretch.

And so for those two reasons, I'm a bit concerned about how the specialist piece of this plays out.

The second piece is that it's very clear that we need to constrain costs. Quite frankly, and I think Ron alluded to a little bit in his conversation, that is not an intrinsically obvious piece to many parts of our health care delivery system, including physicians and beneficiaries both, I would say. You know, a sense of a bigger picture that there's real bankruptcy and it's in our face is not something that's universally kind of on the table, like opening your Cheerios box is on your table in a very concrete way.

So I think that that being said, that I also think that at least the physician community, who along with the hospitals are the biggest chunks of the program spending -- one of the very natural reactions, however, is going to be there appear to be some other system pieces that hold some low- to medium-hanging fruit and I think that things like competitive drug pricing, durable medical equipment, some of those kinds of things where there are demonstrable savings, some of which have been the subject of conversation at this Commission, are very legitimately going to be push-back

kinds of comments that -- I think if we're all going to say, universally, we need to constrain costs, universally, there is going to be some pain and it will need to be shared pain, then it does truly need to be shared across the system, and leaving Part D or biologics or whatever it is out of this as sort of a piece of the puzzle, I think will make this more difficult to engage folks in. And so I do think that to engage physician colleagues, we are going to need to be able to show that there is a multi-pronged attack on cost constraint, not just the world of the physician.

MR. HACKBARTH: Okay. Let me just make a few comments. My apologies to Anne and Rachel.

I've been trying to figure out how to label these. My working label is ACO design principles, but "principles" somehow sounds too high-fallutin' for what will follow, so don't hold me to that.

Number one is I think that we can't afford to put all of our eggs in one basket, and I think this is similar to some of Arnie's thoughts. As much as I personally believe that more organization of care is the path out of the wilderness, I don't think, Peter, we can say, well, we're just going to do ACOs and we're not going to do

bundling, we're not going to do the other things. Your point is a very important one, that we run the risk of diffusion of energy and effort, not just among providers but CMS and the Congress -- I know that's an argument that Elliott and John and Mark McClellan have made, but at the end of the day, I just don't think we're confident enough in this particular basket that we want to put all of our eggs in it. There's just too much uncertainty about how it will develop. That's my view.

Second is I think it's very important to move in steps, as Jay has said, and I agree with Peter's point that the first step of feedback to people about how they're doing is potentially a powerful one in its own right. And rather than sort of rush through that, I think we should take some care to do that and do it well. I think there will be some benefit.

Second is that, for reasons I described earlier, I think participation as an ACO must be voluntary. We're talking about forging new relationships among actors, relationships that have evolved this way over decades. To say that everybody's going to do a certain thing quickly, I just think is unrealistic in that context.

I also agree with what several Commissioners have said that we need to be flexible about what an ACO is and what the exact form of the organization might be. I don't think that any individual physician should be required to participate with an ACO. I think that would actually be detrimental. I think you want people in who want to engage in this task and see some benefit in it. I can imagine that, over time, different varieties of ACOs might develop. Some might be managed by a hospital. Some might be a hospital-physician joint venture. Some might even eventually involve a private insurer and we should allow that evolution to occur over time and respect that we don't know the right answer at the front end.

Next is I don't believe that we should lock beneficiaries in. For beneficiaries who wish to go into a closed system, make an enrollment decision, we have Medicare Advantage, and I believe with a different pricing mechanism, we can get more productive organizations in Medicare Advantage, which offer truly meaningful choices to beneficiaries who are willing to lock themselves into closed delivery systems. This path is one for those beneficiaries who wish not to be locked in. That's what we're trying to

create here.

Next is I think ACO needs to be the place where we begin to address these equity issues that have been simmering beneath the surface and increasingly are bubbling up in very prominent ways, and there are two types of equity issues that I'm thinking about. One, the inequity for health care providers who have actually been engaged in trying to make health care better and more efficient and have received not only no reward from Medicare for doing that, they have actually been penalized for it.

And so when we set targets, one idea that's floated around has been, well, you set the target based on ACO's specific historic costs, which basically says to those organizations, thank you very much for all you've done. You're not going to get any reward for it. You've got to improve from your already low level while the providers who are at the other end of the continuum are going to get to reap a windfall. That's not right, it's not just, and I think it's counter to any principle of reform that I know.

Another equity issue is this regional inequity, and nobody's been more vocal than I in saying that Medicare Advantage is not the proper vehicle for addressing regional

inequity. It needs to be done in traditional Medicare. Here's the place that I think we need to try to make good on that. Where it comes in in my view of ACOs is I think ACOs need to be voluntary, because I said earlier that needs to be coupled with restraint on traditional Medicare so that we've got complementary forces there, and a restraint on traditional Medicare, I think, has to be higher for providers that have had high historical costs than for those who have had low historical costs. We've got to start to squeeze differentially in traditional Medicare.

Next is -- I'm trying to do this as quickly as possible -- next is that, as John and Arnie and a number of people have said, I believe that, ultimately, the success of this will hinge on private payers moving simultaneously in the same direction, and if the typical hospital-based ACO has 30 percent Medicare revenues and they're getting some share of their savings on 30 percent of the revenues and the underlying payment system is still fee-for-service, the incentives to make really important changes in how they organize and deliver care are just too weak. We need to get not 30 percent involved in this game, but as close to 100 percent as we can get.

Now, I don't think that there's any simple mechanistic solution to getting private insurers involved in this. At least I don't know of any. But I think the step of data disclosure at the front end is important in laying the groundwork for that, because that information will become available to private insurers eventually, as well, and they'll start to say, well, boy, this is where I want to try to steer my patients and here is the groundwork for a shared incentive system with those institutions. I can use Medicare's model as a starting point for that conversation. And I think the faster that happens, the more powerful this can be as a tool.

So there are my thoughts, and I think there's substantial overlap with what I've heard from other Commissioners, and that's probably because I've been informed by what I've heard from other people as we've worked through these issues. I guess that's all I have to say.

DR. KANE: Just as to your getting private payers to follow, perhaps we might want to consider recommending or looking into the recommendation of encouraging all-payer State Medicare waivers and thinking about what that means

and how to facilitate those.

MR. HACKBARTH: Thank you very much. Great work over a series of meetings on this.

Let's now turn to follow-up on previous discussions of bundling and episode payment organized around hospitalization.

Again, Anne, I apologize for using up so much of your time. Anne has graciously agreed to make some adjustments in her presentation, and much of this is informational, and it's important information. But we'll try to keep our discussion limited. Thank you.

MS. MUTTI: So a year ago we made recommendations on readmissions and bundling. In the interim, there has been increased interest in this, so we thought it was a good opportunity to come back and update you. To be clear, there is no June chapter in the 2009 report, and we're obviously not looking for recommendations.

Just to refresh you, we came at this issue because Commissioners were concerned that the health care delivery system is fragmented, care not coordinated. Commissioners expressed frustration with our siloed payment system in fee-for-service and the fact that it reinforces fragmentation

and drives volume.

We focused attention hospitalization episodes for a couple of reasons. First, it's a particularly vulnerable care juncture for our beneficiaries where a change in incentives could really improve the quality of their care. And, secondly, it is a costly episode of care with a lot of variation in practice patterns, and it suggested an opportunity to reduce unnecessary utilization.

This table we showed you a year, a year and a half ago. The point of it was to focus you on the fact that when we look at an episode of care around a hospitalization, a lot of the variation occurs around readmissions and post-acute care. I'm not going to go through it any more than that right now.

This is just to refresh you on what our recommendation was on readmissions: that the Secretary would reduce payment to hospitals with high readmission rates; it would be for select conditions only; as part of it, we would permit shared accountability, otherwise known as gain-sharing. We encouraged the Secretary to look into other approaches such as virtual bundling that may be a little broader, in effect; and that as part of this,

information about readmission rates and service use around a hospitalization episode should be made available first confidentially and then publicly. These policies, ideas, have been picked up both in the CBO budget options book as well as the President's budget.

MedPAC also recommended that the Secretary conduct a pilot to test the feasibility of bundled payment around a hospitalization episode, and, again, we're talking about the stay plus some time post-discharge, something like 30 days. Similarly, it was for select conditions. The pilot was to be voluntary only, and it was at a minimum to be budget neutral. So savings or budget neutrality was a requirement.

So in surveying the environment around the issue of bundled payment, we would just want to point out that right about the time that we came out with our recommendation on bundling, CMS announced its ACE demonstration, and that demonstration seeks to bundle payments for select cardiac and orthopedic inpatient stays. And it's the inpatient stay only. They're not bundling that post-discharge period that we talked about. And they were setting the price for the bundle based on competitive bidding.

Just real quickly, the sites have been selected. There was only one in each eligible market, so the degree of competition is a little limited. The kind of discounts they got were in the range of 1 to 6 percent, and it varied more by hospital rather than by condition. And that is supposed to be up and running at least for three of the sites in May.

Bundled payment proposals also appeared in the CBO budget book. A Commonwealth Fund commission has also recommended this approach, and it was also in the President's budget. I guess at this point I'd just say the bundling proposals vary a bit as to what they include and don't include, so in the next couple of slides, I'm just going to take a little time to illustrate how it can vary.

DR. MARK MILLER: Anne, can I just say one thing for the Commission and for the public? Another way to think about what is happening here is this idea the Commission had been talking about for a couple of years. We came out with recommendations, and now the environment appears to be quite fertile. People are now thinking about it in a number of different directions, and Anne is going to give you some more detail on that.

MS. MUTTI: Here I was just going to review what

some of the Part A and B care components are that could be subject to bundling around a hospitalization.

First, there is the admission, and that includes the hospital services, which in a sense are already bundled under the DRG and also include care delivered 72 hours prior to admission. So there is already a sense of bundling built into hospital services. And also there is the physician services that are delivered during the hospitalization, and that is in that left-hand side of the chart here.

Then there is the care that is delivered in the 30 days post-discharge, and that can include readmissions, post-acute care services, physician services, and other services like lab services. We don't have the Part D drugs on this chart, but we are aware that they exist out there. But we've been focusing our attention on bundling for Part A and B.

So currently all of these services are paid separately, sort of piecemeal, if you will. The ACE demonstration would bundle those services, and what we recommended as part of our pilot was to bundle the broader set of services.

In the CBO budget options book, there are two

other approaches to bundled payment. One is to bundle the inpatient stay plus post-acute care in 30 days post-discharge, and that doesn't include readmissions or physician services either during the stay or after the stay. Another option that they talked about was bundling the inpatient stay with those physician services during the stay. So what services are included in an episode is clearly a design issue that people are thinking about.

Another consideration is whether bundling is voluntary or mandatory, and in this first CBO option here, the stay plus the post-acute car component, it is mandatory, and the money would go to the hospital.

The Commission discussed a mandatory bundling option, but decided that voluntary was more appropriate, particularly when we were talking about our broader kind of episode of the stay plus 30 days. But given, you know, increased interest in this idea, we thought it might be helpful to explore some variations on bundling that could be possibly more palatable on a mandatory basis.

One is virtual bundling, and we discussed this last year, but ultimately recommended that CMS study it further. Under this, providers continue to be paid fee-for-

service but would be subject to a withhold. And so those who are on average part of high-cost risk-adjusted episodes would experience a payment penalty by not getting their withhold back. Bonuses could be awarded to providers with relatively low costs. So, again, everyone is paid fee-for-service in this piecemeal approach, but everyone's payment is adjusted based on overall average spending in the performance period, and I've indicated the performance period here with the dotted circle. The test for earning back the withhold then could be both efficiency or costs across the episode as well as quality measures.

There are several advantages to the virtual bundling approach. It holds a variety of providers accountable over an episode creating symmetrical alignment of incentives, and it should in that way spur conversations among care partners about coordination and reducing redundancy. It is a broader policy than our readmissions recommendation because it addresses variation in post-acute care spending, not just focusing on readmissions. And at the same time, it mitigates some of the concern with bundled payment that we intended to be addressed in the context of the pilot, and one of the concerns about bundling is that

without refined risk adjustment and solid quality measures, we risk creating an incentive to stint on care. The potential financial gain from withholding services can be substantial under bundling. Under virtual bundling, the gain from stinting is much less.

The disadvantages to virtual bundling is that in a sense, by continuing to pay providers fee-for-service, it doesn't allow for that payment flexibility, for that flexibility in creating incentives that bundled payment permits. For example, it doesn't allow Medicare payments to be used for e-mails or for nurse home visits or other things that Medicare does not explicitly pay for now, but under a bundle, providers could choose to cover it and be more innovative and perhaps stimulate greater efficiency.

Virtual bundling may also present some administrative challenges to implement, but we're not thinking that they are prohibitive. But we'd certainly like to give that a little more thought.

Another possible approach is something we call the hybrid approach, and the hybrid approach simply builds on the virtual bundling, overlaying bundled payment for the hospital stay onto virtual bundling. So this means that a

single bundled payment for all services during an admission would be made to a hospital-physician entity. So these services on the left-hand side would be bundled.

At the same time then, all these services across the entire episode would be subject, say, to a withhold, and it would be returned if you were a relatively efficient group of providers. So it's a mix of a bundled approach but for a more limited set of services than we've talked about, but then overall holding people accountable for the volume of services provided in an episode.

The advantages of the hybrid approach are that it could induce greater efficiencies, much like were realized in the bypass demonstration in the 1990s, where we saw some reduced consults and lower hospital costs in the area of ICU, lab costs, pharmacy costs. And it is a step toward more comprehensive bundling. It is, you know, one step in that direction, and it may be, therefore, a possible -- since it's a smaller scope of bundling, it may be more possible to be a mandatory program-wide kind of approach.

Among the disadvantages are that, like any bundling proposal where we're putting hospitals and physicians together, it could increase admissions, and

that's because hospitals and physician incentives would now be aligned, and they may be more inclined to admit relatively low-severity, high-margin patients. We have a couple of ideas to counteract that effect. I won't go into that now, but it might be possible to balance that out.

As with any bundled approach, it could create the incentive to stint on needed care. In this case, we're thinking mostly in inpatient physician visits. That could be mitigated by holding the providers accountable for service use in that post-discharge period like we're talking about as well as through quality measures. And the magnitude of potential savings in this approach is probably smaller than achieved by bundling payment across a longer episode because here we are not bundling for those services that we know have a lot of variability -- the readmissions and the post-acute care. We are attacking that with a virtual bundling approach, but it's not bundled, and so we may have less savings opportunities.

I'm just going to switch gears here to say a bit about looking at Medicare's quality infrastructure because, regardless of which bundling variation or readmission policy is adopted, an important consideration is how to support

learning of best practices and accelerate the pace of change in practice patterns, because ultimately we want to promote the success of providers in responding to these financial incentives, not just have the opportunity to take some of their payment. So we need to be mindful of the possibility of creating payment policies where providers that are ill-equipped to respond reduce services and in turn compromise access to care in the community or the quality of that care.

At the same time, we don't want to lower expectations on quality and affordability and not achieve what is possible. So we could think about promoting an effective quality infrastructure as a way to ensure that capable providers have the tools to succeed and that beneficiaries get that improved care. So as part of that, we're thinking that as staff we might want to evaluate the efficacy of Medicare's resources and regulatory requirements in promoting quality improvement and system-ness, and that would include taking a look at the QIOs, the accreditation and survey process, and conditions of participation and assess whether those resources are being maximized.

So, in conclusion, just talking about what staff next steps could be, we could perform some data analysis to

assess the variations of bundled payment that I mentioned here, also to look into some of the Part D issues, and also we could investigate ways to improve the Medicare quality of infrastructure along the lines I just mentioned.

MR. HACKBARTH: Thank you, Anne. As opposed to going through two rounds, let's just have a quick one round.

MR. GEORGE MILLER: Just quickly, has the Commission had the opportunity to do a deep dive to look at all of the regulatory and statutory issues around pulling all this together of civil monetary penalties, state statutes that may have effect on bundling?

MS. MUTTI: Not a deep dive.

MR. GEORGE MILLER: Okay, because I am concerned about whether we can all pull this off as a recommendation without first dealing with the regulatory and statutory issues around this issue.

DR. REISCHAUER: This is really a clarifying question on Chart 11, the hybrid approach. I'm just trying to figure out how this works. Everybody in the plus-30-day column has a withhold, so a hospital in a situation in which their readmission rate, because of good post-acute care and physician services, for those readmissions that do occur,

get a bonus. I mean, there is a withhold and then a payment. Their behavior --

MS. MUTTI: There could be --

DR. REISCHAUER: I'm just trying to figure out how it works. I can see, you know, on the physician services as opposed to acute care, what you have is fee-for-service payment with a withhold. And then if at the end of the year everything looks good, people get a dividend, in a sense.

MS. MUTTI: Right. And the withhold could be applied -- the way we're envisioning it, the withhold would also be applied to this new bundled payment, the inpatient stay plus the physician, so that they, too, would be on the hook for the volume of services in the entire episode.

Do you want me to say it again?

DR. REISCHAUER: No, I'm just thinking about the readmission portion, and if the withhold is applied to it -- or you're saying it will go into the circle to the left?

MS. MUTTI: So if a readmission -- do you want to jump in here?

DR. REISCHAUER: What if readmissions went to zero?

MS. MUTTI: For that particular group of

providers, they would look pretty good across -- their resource use would look pretty good across this larger episode --

DR. REISCHAUER: I know they would, but I'm wondering, does the hospital get any kick in that? And how does it work?

MS. MUTTI: They could if we included a bonus component to the program also.

DR. MARK MILLER: I think what she's saying is that the withhold applies to the left-hand side circle on that chart, and if everybody does well on readmissions, they get it back. And if it's a bonus situation, they would also experience the bonus. So, in other words, the hospital does get a benefit from the 30-day episode if readmissions are controlled. The hospital-physicians on the left --

MR. HACKBARTH: The withhold covers all of the right column services.

DR. REISCHAUER: [off microphone] I know, the right hand, but --

DR. MARK MILLER: [off microphone] It actually covers everything.

DR. REISCHAUER: He said it covers everything. I

didn't know that. I thought that it was just -- you know.

MR. HACKBARTH: I'm sorry. I meant --

DR. REISCHAUER: A bundled payment for the first -

MS. MUTTI: I'm sorry. I wasn't clear. There's the bundle but then it, too, is subject to the withhold.

DR. REISCHAUER: That is withheld, too. Okay.

DR. CROSSON: So, Anne, as I was listening to the presentation, and this is in relationship to the non-virtual bundling options or the part of the -- the non-virtual part of that one, in terms of where the money actually is paid to, at one point I heard you say hospital, and then at another point I heard you say hospital-physician entity. And I'd just like to stress that I think we should think about it in the latter term, for two reasons:

Number one, I think at least when I've discussed this notion with physicians, the biggest opposition isn't really to the incentives created or anything. It's just simply to the notion that the hospitals would receive all the money, and then the physicians would be sort of one down in that arrangement at the beginning. So that, you know, creating the payment to some third entity -- and this would not need to be complex. I'm not talking about creating a

structural entity like a PHO, but simply an agreement between the physicians and the hospitals to apply for this opportunity, if you will, or to receive the payment in this way, would then allow the physicians and the hospitals to work out how that would be done.

The second reason is I think that that discourse, that dialogue, which could be easy or quite contentious in the end, would create the basis for a dialogue between groups that don't necessarily talk with each other all that much.

So for those reasons, I think we might want to think a little bit more about how we describe who gets the money and what we mean, you know, when we're saying physician-hospital entity.

MS. MUTTI: Just to be clear, as I've tried to reflect what you all have said, we have always talked about provider entities, joint provider entities, hospital-physician entities. When I mentioned the hospital-only approach of giving the bundle that way, I was just referring to CBO's proposal, not ours.

DR. SCANLON: Just a comment on the idea of trying to improve the quality infrastructure. We did about 30 or

so reports at GAO looking at sort of oversight on quality, nursing homes, home health, dialysis centers, hospitals. And I think one of the strongest messages coming out of that is not so much that the methods that we have are deficient, but that we never applied them. We've never given CMS and the states the resources to actually go out and check conditions of participation on a timely basis, and so you don't know if the conditions are deficient or if it's just the fact that agencies could -- we found home health agencies that could go five or ten years without getting an inspection, the same thing for dialysis centers. Nursing homes are looked at more frequently, but not necessarily frequently enough.

So there is a real issue here about whether we need to think about using the methods that we've got correctly as opposed to developing new methods, because there is no issue that we need to improve the quality considerably among some of the organizations participating in Medicare.

MS. HANSEN: Thank you, Anne, on covering this again and bringing it back. I was struck by a comment you made on Slide 10 about some of the pros and cons of virtual

bundling, and the first one is the flexibility issue. It just basically keeps the same structure, but it doesn't allow perhaps more innovative or economic ways to achieve the results that everybody would benefit from. And this ties back to both George's comment about some of the regulations that do exist, both on the federal and the state level, and then Nancy's comment in the last section about is there some kind of broader Medicare waiver that would allow for this kind of flexibility.

So at some point, it's not just moving the existing structures. It may call for other ways to do it in terms of the efficiency of e-mail, you know, technology, perhaps another kind of workforce that would help bring down the cost but produce some of the results. So I do want to highlight that that is -- whether it is just virtual bundling or it's a broader concept that we have to keep in mind.

MS. MUTTI: Right. I think that point is one of the reasons why we have been so interested in bundled payment, because it does allow that flexibility for providers who are on the ground to make those kinds of decisions.

DR. CHERNEW: First, to clarify -- and I think this is right -- the bundled rate would include -- would essentially reflect the average readmission rate, or whatever it is, average resource use now.

MS. MUTTI: It could, right.

DR. CHERNEW: Okay, so something like that. And then my question is: How do you envision the bundled rate getting updated over time? And if organizations like Peter are lowering their readmission rates anyway right now because they're so shamed by -- not Peter's organization. In a bundled payment rate, that savings gets captured by Peter, and in the non-bundled payment, that savings gets captured by the program. So it's just an arithmetic question.

MS. MUTTI: Right, although you could design bundling so that the program did get part of the savings. One reason why I say it could, when you asked me is it just the average, well, you could say we're going to assume that you're going to do better, and so we're not going to give you the average, we are going to go for the 40th percentile or something like that.

DR. CHERNEW: And you could deal with Glenn's

issue that she was mentioned earlier on the ACO, which is you don't want everyone -- so a bundled rate that's based on the average penalizes the high readmissions rate and -- I'm just trying to understand --

MS. MUTTI: But it doesn't necessarily get us savings.

DR. CHERNEW: Right. So my only comment would be at some point -- I don't know when -- knowing some of the details about exactly what is put on the table for how the bundling does work I think would be useful. But I agree, there's a lot of possibilities to how to do it, and I think conceptually it is a good idea to begin to move in this way. But, again, if you're not careful how you do these ways, and depending on what you assume is going on in the future, you might actually not save -- you might actually save less money than you thought you otherwise would have saved, depending on what you think is going to happen.

MS. MUTTI: Right, and we did have some of that conversation in our 2008 chapter on bundling.

DR. MARK MILLER: I'm going to summarize at least one point that you have made very quickly here, which is, you know, Anne has also in previous conversations talked

about the notion that you start with a readmission policy, let that run for a few years, telling people that bundling is coming. Medicare takes those savings. Then you build the new bundle around a more efficient bundle. And she has made that point in previous meetings.

MR. HACKBARTH: Any others?

MR. BUTLER: All right, we won't put all our eggs in one basket, even though it's Easter on Sunday. Maybe we will on Sunday. I am just saying there's more yield out of the ACO than this level for me, and I think at this level you also create some potentially toxic effect among physician and physician relationships, more likely than ACO level.

Okay. I have a couple specific recommendations because my thinking around this has changed in the last year.

I'm less excited about addressing episode than I am the readmission rates head on, and a year ago, I would have said, well, you know, doctors admit and discharge patients, not hospitals. And nursing homes, you know, offload their sick into the -- and there's not compliance and all these other things. And I said, well, that's not

good enough. Hospitals can do a leadership role in here. We recommended a year ago that we take three years to kind of gradually publicly disclose. I would say today publicly disclose the hospital readmission rates. It would get everybody focused, and I don't -- you know, get on with it.

And then, second -- and this is maybe a stupid idea, but in my simple mind, I'd say if you could have a risk-adjusted rate -- so let's say you're 23 percent and risk-adjusted -- and you're average. If you could give a carrot and say, you know, you get down to 20 percent next year, hospital, you keep the savings or half the savings or a quarter of the savings. If you had a simple thing, it would very clearly kind of align things, and you wouldn't even necessarily have to have the physicians, you know, in all these payment gyrations along with it, and suddenly we have another scorecard and a carrot opportunity below a capitated level, and I don't know, it just might -- that's my crazy idea for this morning, but it would -- I think of all the health reform buckets where they're looking at the $634 billion or whatever the number is up to, I think this is a ripe opportunity, and I think there may be quicker ways to get to it than the kinds of episode of illness things

we've got on the table.

MR. HACKBARTH: That's a very helpful comment. As I said earlier, I don't think it's a good idea to put all our eggs in one basket, but having said that, it's important to look for the most streamlined way to deal with particular issues, and straightforward readmissions, reward/penalty opportunity is a lot easier to operationalize, I think, than bundling, virtual or real. And the reason for looking at bundling was the concerns that you mentioned, that, well, the hospital doesn't have all the control, blah, blah, blah. And, you know, it's helpful to hear it from somebody who lives in that world to say --

MR. BUTLER: I say tough. It will force us to look at all these relationships head on; particularly if there is a carrot aspect of it, I think we could make a difference. And these are the medical cases particularly that are coming -- frankly, they aren't as profitable as other ones, anyway. And you can grind down the rates and say we will only pay you half for those, but you'd still then say, well, their contribution -- you go through all this rigmarole, then rather than having a flat-out incentive, I think would be helpful.

MR. HACKBARTH: My understanding -- the striking thing to me about the readmission date is the variation. There's enormous variation, which always says to me if you really are motivated, there are lessons to be learned. You can find out what other people are doing to have much better rates, and there are organizations like IHI and others that are working with hospitals to try to identify what those best practices are and the things that you can do And so a simple incentive that says go for that and it's done in a streamlined way is very appealing to me.

Thank you, Anne. I appreciate it.

Thanks to you also, Rachel, for your willingness to streamline and put up with my poor time management.

DR. SCHMIDT: So last month, Chris Hogan presented his analysis of the relationship between secondary coverage that wraps around the fee-for-service benefit and higher Medicare spending. Today, I'm going to step back from the weeds and try to put his analysis into the broader context of traditional Medicare's benefit design.

So just a quick review, Chris provided evidence that when elderly beneficiaries are insured against Medicare's cost sharing, they use more care and Medicare

spends more on them. I'm not going to go over his results again, but his analysis suggests that if supplemental coverage didn't fill in much or all of Medicare's cost sharing, Medicare could use the design of its fee-for-service cost sharing as a tool to encourage certain types of care and discourage care that may be less appropriate.

In the interest of time, I'm going to skip over this slide for now, but I'm happy to go back to this if we have time later.

So just to review, remember that about 11 percent of fee-for-service beneficiaries do not have supplemental coverage, and that's kind of an orangish color in the top of this pie chart. And about a third have individually-purchased Medigap policies, and here I'm combining the dark red and bright yellow areas to say that. About a third have -- a little more than a third have employer-sponsored retiree coverage, the area in green. And about 17 percent have Medicaid, in light blue. And another 2 percent have other sources, like VA. There are some very important differences in these sources of supplemental coverage that your mailing materials cover in detail.

In the past, we've talked a lot about why so many

beneficiaries have secondary coverage and it has to do partly with fee-for-service Medicare's benefit design. It's complex and there's no out-of-pocket cap on spending. Beneficiaries can't predict what services they will need or what their providers are going to charge, and they dislike having to navigate through paperwork and any bills that they might be receiving from providers for their cost sharing. With many types of secondary coverage, the insurance is billed automatically for that cost sharing.

Let's take a minute to remember what health insurance is supposed to do and ask ourselves whether the fee-for-service benefit accomplishes this. One important function is to reduce an individual's exposure to financial risk and very high out-of-pocket spending. And at the same time, insurance shields people from seeing the cost of care, so many insurers and payers believe that insurance should deter beneficiaries from using lower-value services by leaving some portion of covered services unreimbursed.

All of you know it's really hard to figure out which services are a higher or lower value and for which subpopulations of patients. A more solid base of evidence on comparative effectiveness of therapies is really

important for figuring this out.

Right now, our current way of doing things doesn't really accomplish the overall goals of insurance. Fee-for-service Medicare doesn't cap out-of-pocket spending, and the widespread use of secondary coverage doesn't leave much unreimbursed, which leads us more generally to some problems with the status quo.

The fee-for-service benefit design itself leads to relatively few beneficiaries owing Medicare for most of aggregate cost sharing, and one reason is because it does not have an out-of-pocket cap. In 2007, about 22 percent of fee-for-service beneficiaries incurred about two-thirds of the combined $50 billion in cost sharing owed for Part A and Part B services. A typical retiree plan through a large employer or the BlueCross-BlueShield option in FEHBP used caps and also used combined inpatient-outpatient deductibles that spread cost sharing around a little more easily. My comparison, the fee-for-service method, puts more cost sharing on the sickest beneficiaries through a relatively high inpatient deductible and relatively low outpatient deductible.

Beneficiaries also have unequal access to sources

of supplemental coverage due to differences where large employers are located, differences across States, and the rules about whether disabled Medicare beneficiaries under age 65 can get a Medigap policy, differences in State eligibility rules for Medicaid and the degree of outreach they undertake, and also the wide variation in the price of premiums for supplemental coverage.

Chris Hogan highlighted another problem with the status quo with his analysis, namely that when beneficiaries have secondary coverage, Medicare tends to spend more on them. And since so many forms of supplementary coverage fill in all or most of fee-for-service cost sharing, that effectively means that Medicare can't use benefit design as a policy tool. We can't use cost sharing to try to steer beneficiaries in the way that private insurers do or even in the way that Medicare Advantage plans and Part D plans can do.

An outcome of the current way of doing things is wide variation in financing burden for hospital spending. Along the horizontal axis here, we've ranked all fee-for-service beneficiaries by their level of Medicare spending. This is taken from the 2005 MCBS. So the blocks of bars on

the farthest left show people who fell into the lowest 25 percent of individuals ranked by their fee-for-service spending and the farthest right shows the highest spending, 25 percent. And then each color of bar shows a grouping of beneficiaries with the same type of supplemental coverage. So orange bars are beneficiaries with no secondary coverage on the farthest left, and then moving right, the red shows people with Medigaps. Yellow shows people with Medigaps and retiree coverage. A green shows retiree coverage, and blue is Medicaid. The height of the bars shows the median percent of income devoted to the combination of out-of-pocket spending and premiums for health care. And in each case, the denominator is income, beneficiaries' income.

So looking left to right, you can see the beneficiaries with Medicaid as their secondary coverage spend the smallest percent of their incomes on health, even after taking their low income into account.

Individuals who are fortunate to have retiree coverage tend to have higher incomes and often have their employer helping pay for their supplemental premium, too. So their percent of incomes that they're paying for health is also relatively low.

Notice how the red bars, the people with Medigaps, tend to pay a high share of income if they've got low use of Medicare services, and that's largely because of their relatively high premiums for Medigap policies.

But as you move to the right, you can see the people without supplemental coverage and higher use of Medicare services quickly end up spending the largest percentage of their incomes on health. So there's wide variation, as you can see, from less than 5 percent of income for those with Medicaid as their secondary coverage to about 35 percent of income.

For the rest of the session, I'd like to start a conversation among you about the goals that we might want to pursue for the future if there were changes to the fee-for-service benefit design and to secondary coverage. I've listed four here and will go over each in turn.

So one goal could be to reshape the fee-for-service benefit to be more in line with the usual design elements of insurance, again, to reduce beneficiaries' exposure to financial risk and yet leave some spending unreimbursed to deter use of lower-value services. A direct way to do this would be to add an out-of-pocket cap to the

fee-for-service benefit, but this would be very expensive for the Medicare program, and in order to keep Medicare spending budget neutral, we'd need to spread out cost sharing more evenly across beneficiaries, for example, by using a combined deductible. Putting limits on what supplemental coverage could cover, for example, not being able to cover a deductible, could also make adding an out-of-pocket cap more affordable.

This is a big change from the status quo, as I'm sure you know, and so there will be objections. Still, this may be an important goal given how uneven the financial burden is across beneficiaries today.

A second goal could be to use fee-for-service cost sharing to help to begin to address Medicare's financial sustainability, and one way to do this would be to simply raise cost sharing requirements for all beneficiaries, which is essentially the same thing as reducing Medicare's benefit obligation. This approach could improve Medicare sustainability, but measures to do this would have to be balanced against concerns about raising barriers to care for low-income beneficiaries.

Another path could be to set limits on what

supplemental insurance may cover, for example, not filling in the Part B deductible, or as Bob brought up last time, one could charge an excise tax on premiums for supplemental insurance policies with the revenues dedicated toward Medicare. I describe in your mailing materials some CBO budget options along those lines.

A third way is to set priorities on what Medicare will pay for. In the past, Ron has mentioned the example of intraocular lenses with cataract surgery, where the beneficiary must pay out-of-pocket to have vision-correcting lenses implanted rather than conventional ones.

A third goal is to approach fee-for-service cost sharing much in the way that Mike Chernew and Mark Fendrick have talked about in a presentation to you a few years ago about value-based insurance design. And the basic idea is to use a more targeted approach to cost sharing, charging different amounts depending on the therapy's clinical value to the patient. In one approach, for example, you could charge lower cost sharing for an entire class of therapies, such as anti-diabetic drugs, in order to encourage diabetic patients to adhere to the therapy. This works well for classes of therapies that are only useful to the targeted

patients, but not as well for therapies that are used more widely.

A somewhat different version would be to charge lower cost sharing for certain therapies that we want to encourage high-risk patients to use, for example, some lower copays for anti-diabetic medicines only for diabetics whose blood sugar isn't under control.

Some private payers have had success at improving adherence with this approach and so it holds particular promise for raising quality of care. But unless you use a very targeted approach, value-based insurance design could also increase costs. To help offset this, you might want to also charge higher cost sharing for therapies that are of lower value.

The last goal I'll talk about is using fee-for-service cost sharing to help reinforce other changes underway in provider payment systems. For example, you spent a lot of time discussing ways to use differential payments to providers, for example, paying them more if they deliver higher-quality care and have lower resource use. Over time, we might want to use fee-for-service cost sharing to help steer beneficiaries towards those providers. So in

addition to being paid more by Medicare, the program could use tiered copays to encourage beneficiaries to go to those providers.

We could also use lower copays to steer beneficiaries toward providers who are designated care managers, for example, medical homes, while charging higher copays for other providers. Or if there's documented overuse of certain Medicare services, higher copays could be used to deter some of that use.

In each of these examples, we'd also need to keep supplemental coverage from filling in that differential cost sharing in order to make the strategy work.

So at this point, I'll leave this to your discussion. You might want to consider whether some of these ideas, some of these goals should take priority over others. And I'd especially appreciate it if those of you who have given a lot of thought to value-based insurance design would talk a bit more -- yes, Mike, that means you -- about whether and how it could fit into the context of fee-for-service Medicare.

MR. HACKBARTH: Somehow, I don't think Mike required an invitation.

[Laughter.]

DR. CHERNEW: I think this is wonderful and I'm not sure I have a ton to add.

MR. HACKBARTH: Let me just, if I might, quickly offer reaction to your questions. On page eight, you list the potential goals, and I don't disagree with any of those, but I think the one that has the broadest potential political support and appeal is the first, which is focused on the equity of the current system and assuring -- using a restructuring to assure better protection for the sickest people. That means more cost sharing for some other people and that's never popular, I know. But of them, I think more people can rally around number one than trying to use restructuring to improve Medicare sustainability or steering people to particular providers. I do think that the third bullet of encouraging use of high-value services maybe has some appeal, but it's also the most complex of these to operationalize. So I'm sort of drawn to the first one as the priority focus.

I have Arnie, John, Mitra, and Bruce.

DR. MILSTEIN: Rachel, one of the things that struck me in the prior presentation on this was the impact

on service use of having supplemental insurance. It was quite profound. Have we attempted to model how much higher Part B premiums are for beneficiaries who don't have supplemental insurance as a result of the well-demonstrated increased demand for Part B services that occur as a result of other beneficiaries that do have supplemental insurance? What is the unintended disequity or unfairness that we are imposing on people without supplementary Med Supp coverage simply due to the higher service volume associated with other beneficiaries that do have it? What's the percentage? Have we attempted to, order of magnitude, estimate the incremental price tag to the beneficiaries without supplemental insurance?

DR. SCHMIDT: No, we haven't. Last year, we did some simulations along those lines and I think we're trying to gear up to a state where we might be able to do similar sorts of things in the future. But no, we haven't yet. Last year, in some of the simulations, we were seeing, I think, lower Medicare spending on the order of 10 percent, if memory serves, but a lot depends on what estimate one was -- what assumption one was making about elasticities and that kind of thing.

DR. REISCHAUER: But also, since that would disproportionately fall on only 11 percent of beneficiaries, that could have a very substantial impact on the small number in terms of increased cost to those who -- anyway, you see where I'm going on that.

MR. HACKBARTH: You've got to remember, I mean, the induced utilization is Part A and Part B, and of Part B, it's only 25 percent that gets then translated into higher premiums. So what can be a huge number from the standpoint of public policy maybe isn't -- I mean, it's a significant number, to be sure, but it's not sort of an eye-popper --

DR. MILSTEIN: I was just following up on Glenn's point about the equity hook being the most powerful.

MR. BERTKO: So first, Rachel, thanks for a very thoughtful and comprehensive presentation on this. A couple of comments here.

The first is, and this addresses somewhat of what, Glenn, you brought up. If we were to require some amount of minimum cost sharing, one of the paybacks here is there is more of a tradeoff as opposed to a take-away because we are wanting to reduce from 100 percent of everything to, say, 95 percent of everything. That money theoretically would flow

back to beneficiaries in terms of lower Medigap premiums. And so I would make at least that argument.

Number two, and I would perhaps think about -- you might think about adding this, is that my experience designing benefit plans is that beneficiary seniors like predictable things, and so taking both the $135 Part B premium and the coinsurance being very unpredictable and having a minimum level of, say, and I'll use this $5 for primary care specialties, $20 or $25 for specialists, and a $100 emergency room copay known at the start, possibly indexed -- it doesn't even have to be indexed -- you get the, at least in my experience, the biggest pick-up in reduction of demand from having anything coming off of zero. So it could still work out reasonably well that way.

And then the third comment here is, and this goes to your comments, Glenn, about the goals here, I think at least three of them, counting my tradeoff argument, are closely aligned in terms of spreading the risk in a better way; secondly, protecting Medicare's solvency; and then thirdly, giving us incentives to use these redesigned systems. And so it could fit together pretty nicely.

MS. BEHROOZI: This is really great ,Rachel,

putting it all together and having there be a flow to all of these ideas. I don't think I'm going to be able to be so smooth in my flow of responses, so just picking out, starting with the goals, as you say, Glenn, I actually think the second goal doesn't belong on a list of goals for cost sharing. Benefit design overall, maybe, but not cost sharing.

And I think that what you're seeing out in the private payer world is a recognition by employers -- I was actually just watching Nancy-Ann DeParle yesterday with one of those roundtables and there were a couple of small business people at the table saying, I don't want to shift costs onto my employees. I don't want to do that. There's nothing of benefit to me in that. It's a bad thing to do. It's just about I can't afford it so I'm going to make them pay. So I don't think that that's what Medicare should be doing -- should be thinking of when it's thinking of cost -- cost shifting is not purposeful. It's just we're not paying it. Somebody else is going to pay it.

And the somebody elses, I think it's really significant -- you said this in your paper. We had heard this, I think, last year from Evan that half of Medicare

beneficiaries' incomes are at 200 percent of the poverty level or less. They do not qualify for AMB status or whatever. But they aren't rich people. The two lowest quintiles that we were looking at yesterday in Craig and Cristina's -- well, Craig and somebody's presentation -- sorry -- that distribution, those two lowest quintiles are below 200 percent of the poverty level. That's not like the general population.

So I think we have to be that much more cognizant when we're talking about cost shifting that it's going to have a dramatic impact. It's not a progressive thing. It's a regressive thing to take the same cost, whether it's 20 percent of the doctor's bill or whether it's a $25 copay to see a specialist. It's going to have a widely different effect on the people who retire quite comfortably in that probably upper quintile, right, and just about everybody else.

As I said, at that lower end of the income spectrum, it's going to have a really big effect, and I think that's demonstrated somewhat, I think, on page 27 of the paper when you say there was some evidence that relative to individuals without supplemental coverage, the presence

of secondary insurance had a proportionately higher effect on Medicare spending. So I think that means that if they didn't have supplementary insurance, they were that much less likely to seek care, is that right?

DR. SCHMIDT: Right. That's actually part of the slide that I skipped over --

MS. BEHROOZI: Right --

DR. SCHMIDT: -- in the interest of time. But yes, when Chris did his analysis, he did find that there was somewhat more responsiveness. The same amount of supplemental coverage, the same dollar amount was dearer to lower-income people, but it was not as large an effect as you might imagine. I would characterize it as a moderate effect.

MS. BEHROOZI: But I think we also haven't seen the effect of not having supplemental coverage on higher-income people, because they're the ones who are buying the supplemental coverage, you know, to be responsible for a share of the costs. They could also be less sensitive because they can afford, especially if you go to things like a $5 or $25 copayment. So I think it really comes down to the third bullet, which is encouraging use of high-value and

discouraging use of low-value services. That moves up, and I would even actually -- I would rephrase the first one a little bit. Not distributing cost sharing more evenly, but more equitably. And Glenn, you used the word equity, but you were talking about protecting sicker people.

This isn't what I think, but there are some people who would say the sicker people are the users, like the people who pay tolls to cross bridges, they are the users, right. It doesn't matter. They need to get to work. They have to cross the bridge. They've got to pay the toll. That's not necessarily what I'm advocating, but I think there's another view of equity which says if it hurts you more because you've got less money, you might be deterred from necessary care whether you're really sick or whether you're not so sick yet and we want to prevent you from getting sick.

So I really think that you have to take income into account and you have to take the efficacy of treatment into account if we're moving forward, not just sort of moving the pieces around on the board but trying to move the board ahead. I think those concepts have to come into play.

MR. HACKBARTH: I have Bruce, Bob, Nancy, Jennie,

and Mike. Bruce?

DR. STUART: I like this chapter a lot. I think putting all of these things together makes for a much more cogent set of arguments that we can use then to help improve the structure of these benefits and I'm a real fan for improving the structure of the benefits, both from an equity standpoint -- I think that Arnie's point is very well taken that, in fact, people that don't have coverage are forced to pay more because of the Part B premium, and Mike and I have also talked about this in terms of we share, I think, the same view that there is a more rational way to make -- to design drug benefits -- not just drug benefits, but A and B benefits that would, in fact, promote efficiency and quality of care.

So there are two issues that I have. One is a technical issue. Well, maybe three issues. One is a technical issue, which is the question about, well, how much do you save if you actually were to impose cost sharing on people who don't have it now, which is essentially Arnie's point, which is their utilization would go down if they faced cost sharing. There is no question about that. I think every economist believes that there is moral hazard in

this market. So it really becomes a question of, well, how big is it? How big is the number there? And in this particular case, I think that Hogan has actually overestimated the savings that could be obtained if, in fact, you were to take away the secondary coverage of Medicare cost sharing.

And most economists that have looked at this think, in fact, that there is some active selection into these programs that's over and above what you can control for with observable Medicare expenditures. And so I think that that's something that you really do need to pay some attention to, and if you were to try to put a number on Arnie's question, well, how big is the premium increase going to be, you really have to be pretty precise about that. So I think that's an issue.

The second thing is, and this is really political and I'm just going to leave it at that, if people have something, it's going to be damn hard to take it away, and so you have to think about how you're going to structure the process. If you come to the conclusion that there is too much -- that there's not enough cost sharing of whatever type, then I think there really needs to be some thought

given to the mechanism by which you get from here to there.

And then the third part is -- and this gets to the population who are both poor and/or have high Medicare cost relative to their income, and the assumption that I see in here, and correct me if I'm wrong, is that you really want to give the -- you don't use this term, but kind of a free pass on the cost sharing side. You really don't want to impose cost sharing on those individuals. But I think that if you had a more rational way of establishing cost sharing benefit design, then, in fact, you might well want to do that.

And by saying, okay, well -- and I'll use drugs as an example because it's a lot easier than the A and B side, but I think there are analogs on A and B -- so on the drug side, if you have a generic product that's available, then you have a low cost share on that product. If you've got a substitute for that, a branded product that is demonstrably better, then for these people, you'll probably have a low cost share, too, because you want to steer use into that particular product. But if you've got substitutes that compete with each other and are expensive branded products, then for those other substitutes, you could pick a preferred

product and then have other non-preferred products or have other, you know, the Medigap insurers and the employer-sponsored plans putting in those kinds of tiered arrangements. And I think those could apply just as easily to people that are low-income and high-spenders as to everybody else.

DR. REISCHAUER: I think I'm next. I think this is a terrific chapter, Rachel, and a lot of interesting data and analysis. But I was wondering if we wouldn't want for completeness here to have at least a box about Medicare Advantage, because there is a way that people can -- big smile here. There's obviously been some kind of a conspiracy. Is there?

DR. SCHMIDT: There is one.

DR. REISCHAUER: What the average was?

DR. SCHMIDT: It's towards the back. There's a section that discusses it.

DR. MARK MILLER: I just want to point out how fast we reacted.

[Laughter.]

DR. REISCHAUER: Very responsive. Just to build on John's comment with respect to if we had an out-of-pocket

cap, a lot of this is redistribution as opposed to additional cost because now many employer systems are requiring premiums, and those could go down. Medigap premiums could go down. And then there's a shift from Medicaid to Medicare that would occur with this. And so the actual sort of amount of new resources, I think it would be modest.

DR. KANE: Yes. I'm still trying to sort out what I -- I mean, I'm responding a little bit to your comment that the most politically popular aspect of this is actually not the one I would have said I'm the most interested in, which is the bottom one, about how can we get cost sharing to reinforce payment reform. I kind of think that's why we got into it, as a discussion of how do you get people into medical homes? How do you get people into ACOs?

I guess on the first one, I guess one question is rather than tell people -- well, let me show you how poor an economist I am. My recollection of the RAND study was that the cost sharing really affected low-income people more than anybody else. They made really bad choices and their health was more at risk than anybody else, but that higher-income people, I guess, were able to better mitigate the effects.

So one of the questions is, is the distribution and then the subsequent poor behavior choices on health more disproportionately a problem for low-income people, and wouldn't that suggest, rather than affecting the people who have Medigap coverage, trying to get more low-income people into either Medicaid or LIS or -- I'm just trying to understand why you want to necessarily take away from Medigap and give to low-income people when there's other mechanisms for dealing with low income. For the first goal, I just think that's kind of -- there's more than one way to improve the equity of cost sharing, particularly for low-income people.

And I was looking also at Slide 7 and trying to get a sense of, for the highest 25 percent and those who have no supplemental coverage, is that because they're really low income and so the premium and copays put them in there, or because they lack catastrophic, because if it's lacking -- I think you have different conclusions as to what you want to do about it. If the reason you're in that highest 25 percent is that you have really low income and therefore the copays and premiums and deductibles puts you in there, or is that mostly people who are going through

some kind of catastrophic, they have gone through all the --

DR. SCHMIDT: About 20 percent of fee-for-service benes have a hospitalization in any year. So at least part of this is kind of a Part A deductible kind of a thing, which gets your spending up pretty high. They do have very low incomes. That's for sure. I can't off the cuff say they've absolutely hit what one might call a catastrophic range, but I would say that their cost sharing is pretty darn high.

DR. KANE: Relative to their income?

DR. SCHMIDT: Yes.

DR. KANE: Yes. So to me, I guess part of what I'm trying to sort out is some of the problem of the equity or the lack of protection has to do with low-income people and how do we protect them. It doesn't really have to do with shall we make other people cost share more to protect them. I don't think that's the -- I don't translate that well. I'm happier sort of thinking, how do we create better incentives to reinforce payment system reform and use cost sharing to encourage people to buy better -- you know, use the right services, but not to subsidize low-income people because it seems to me we already have other ways to try to

do that.

DR. SCANLON: Well, it is, I mean --

DR. KANE: And I might just be confused about what's really going on here.

DR. SCANLON: At one point, this is a long time ago, we did some analysis at GAO and we looked at not incomes, but just at the amount of cost sharing, and there were, I think, 600,000 people that maybe were spending more than $10,000 on cost sharing for Medicare-covered services. So $10,000, even if you've got a $40,000 income, is a very significant cost share. So that's in contrast with a private insurance plan that would usually have a $1,000 cap at that time, and it's probably much higher today.

DR. KANE: Doesn't that say that the $40,000 person perhaps should be eligible for some type of -- okay. So I guess, which problem are we trying to solve here? One is how do we get everybody to be vulnerable to incentives to get them into better, higher-value plans and higher-value formulas.

I think there's a different set of tools to address the first problem of the financial protection issue, and maybe we just need to get people who go in with $40,000

of income who hit $10,000 get into Medicaid or get into a LIS.

DR. SCANLON: That's a fundamental philosophical issue, which is do you want Medicare to be a good insurance program, and most people would say good insurance puts a catastrophic limit on it, or do you want it to be a poor insurance program supplemented by means-tested programs --

MS. BEHROOZI: Just because I'm thinking that maybe what you're saying is a little bit in response to what I was saying about equity having something to do with income, I just want to make the point that I feel like, yes, it's three and four -- they're not up there now -- driving appropriate behavior is the most important thing, but by having just a fixed dollar amount that you charge for a service drives behavior differently at different ends of the income spectrum.

MR. HACKBARTH: And just one reaction, Nancy. On the fourth one, reinforced payment system reforms, in the abstract, that's appealing to me, too, but most of our models for payment system reform involve voluntary arrangements and we're talking here about base Medicare benefit design and how you use that to reinforce movement

into some things that some people are going into, some aren't even available anywhere. It's just sort of a complex interaction, number one, and number two, one of the most difficult things for the Congress is to use benefits to steer people towards particular providers and away from others. That's one of the most difficult political sells to make. So that was my --

DR. KANE: I think it's when you start to bring in the supplemental coverage and how do you want to regulate it that I start to get confused as to what our goals are here.

MS. HANSEN: I think this issue of confounding elements is probably here, except that I love the chapter because it does bring in the complexity. I was just thinking that with the last quartile, the lower income, and the fact that 35 -- I think it was on page seven -- that it can go up to 35 percent, I was just wondering about -- this is where it does confound to another issue of shifting it possibly back to Medicaid, because if we look at the bar, the orange bar as compared to the light blue bar, the light blue is the Medicaid population, right? So it doesn't take much more perhaps if you're earning $15,000 a year as a low-income individual, $20,000, to tip quickly into Medicaid and

I just wonder whether we've looked into kind of that shift that occurs, even though Part D comes back into Medicare.

So it's, A, complex, but I do also think that the payment reform option, I know we're working on, but I can't help thinking as a clinician, and bear with me with this example, how we would sort it out in this benefit design. Let's just say many people now have five chronic diseases and what happens as a result is you see ten to 14 doctors a year. I mean, these are the numbers that have been coming out. And you have 50 prescriptions a year. So when you look at that kind of live experience that people have, how do we do the coordination in some way to address the delivery system reform to mitigate some of those expenses, because oftentimes you don't have to take that many medications. You don't go into the hospital because you're not on 14 medications. There's kind of a cascade effect that comes into play with that.

So it's possible through delivery system reforms, which is alluded to in the fourth bullet, could mitigate actually the spend for whether you're poor or not on this. I don't know how that gets captured in -- because I think this is a reflection of what is, but what could be would be

as a result of reform.

But my first point was just that it sort of seems like it would make it reasonably easy for people to qualify for Medicaid after you pay so much out of pocket over time, that many States have a medically needy-only benefit that goes into a QMB/SLMB relationship.

So as I say, there are many moving parts to this which make it very textually interesting, but I'm not sure how to fully sort it out to make it effective and bring it back to Medigap policies.

DR. SCHMIDT: Yes, and just one technical point. The far right side of the bars, I'm showing you median percent of income and it's actually higher for mean because of the medically needy for those who don't have supplemental coverage. I mean, some would end up being medically needy and going into Medicaid.

I think there are differences across States, though, in how they treat the medically needy, though, so that may be some complexity we need to look into further.

DR. CHERNEW: As you know, I think this is tremendous and I can hardly contain my exuberance.

[Laughter.]

DR. CHERNEW: But let me just make a few points. The first one is, in your chart of the distribution of supplemental coverage, that's the distribution of supplemental coverage as of a few years ago. That's not the distribution of supplemental coverage we're going to see in the future, certainly not if costs grow the way they've been growing. We're going to see employers dropping a lot of supplemental coverage. Premiums are going to be rising. We're going to be worried about access for a lot of care to individuals, and the discussion that I think we're going to have in the future is going to be a discussion about we want a -- we're worried about this lack of financial access to services that people have and this financial burden that people are facing, particularly the low-income individuals, and we want to improve their benefit, but that's really expensive and we're not sure how to do that.

My view about how to think about all of this hinges tremendously on how successful I think all of the payment reform things are. So if I shut my eyes, imagine a world with accountable care organizations or a well-functioning anything, then I have a completely different view about how I feel about this than if I don't.

So while I agree with Mitra's comment about using cost shifting just so Medicare saves money and beneficiaries pay more is really unappealing, I don't like that at all, as opposed to using cost shifting to make the system more efficient. I just think we can't ignore the financial impact of what's going to happen and I think we have to prepare ourselves for a world in which the beneficiaries, particularly those on sort of the side of that graph, have dramatically less coverage for a whole range of things.

And if technology continues to progress, there will be dramatically more things that they're going to want to have access to and we're going to have to worry about that, which raises a broad complicated philosophical issue which I'm scared to talk about in public session, but which is how we deal with the equity of access to care for everybody, which I think is absolutely crucial and cost sharing has a tendency, because economists as a profession don't worry about equity, to cause inequities. It is a policy situation we just really don't like.

And so I think we're going to have to face the issue of cost sharing, whether we like it or not, not because we're going to try and find ways to make people pay

more to do whatever we want, because we're going to have to try and figure out what we're going to subsidize as they lose some of those other sources of care. So that's the first point.

The second point is, related to the other comments, cost sharing does interact with other aspects of the system so we need to figure out what happens if you have someone in an Accountable Care Organization or on an episode-based payment or some other system where now the physicians are trying to get people to do various things, but the people want more and more stuff because they don't have to pay. You know, the problem, I think you would say, happened in the past, or at least I would say, there was a tension between what the patients demanded and the financial incentives the physicians were under and that created a lot of problems in the patient-physician relationship that I don't think should be ignored.

I think it's also important to think about aspects of care. Many of the things that Peter might do or Arnie might do or I might do to prevent readmissions or to prevent management of folks to chronic disease is to get them to follow certain types of care. Make sure if they have

diabetes, they take their blood pressure medication. Medicines are hard to deal with because of the Part D design split, and I will finesse that for a minute and say the issue is, in a world where there's a lot of cost sharing, we need to think about encouraging -- and you could debate the magnitude, but I think there's reasonable evidence now that there's some offset, that if you spend more on some services, I don't think you get that all back, but you get some of that back through better health, and even if you don't get a lot of it back, at least you're healthier.

So I think figuring out how cost sharing interacts with other aspects of the system and supports preventive care, supports physicians if we move to another type of system, I think is absolutely crucial in doing this.

I'm very worried about the -- not very worried, but I worry a lot about having a catastrophic cap, in part because I think the economic theory would suggest that you want to have the cost sharing in the place where you want to have the efficiency occurring, and I know I don't know that, and so please don't tell me that I don't know that. I realize. And I know that's hard to do.

But there's an issue, for example, in this country

right now, for many people, if you have a heart attack, if you get cancer or something bad happens to you, you get taxed a certain amount of money. You just have a heart attack, here's the money. There's no beneficial incentive effect. There's no moral hazard reduction, to use an economic term. You're just taxed. Sorry, you had a heart attack. Pay whatever you have to pay. And then once you've paid that, there's no incentive to be efficient at the higher spending levels.

So my mother, who has a situation right now where she is spending a lot of the taxpayers' money and getting a lot of expensive imaging done on her has no incentive to think about that imaging at all because she's paid her tax and now she's just getting CT scans every six month, which is actually -- well, I think she's now to yearly. But the point is so a cap is fine in a standard model, but I think if you were to think about medical conditions, we would be a little smarter.

And I think there's two big challenges, neither of which I can speak to authoritatively. The first one is the politics befuddle me completely, so I have nothing to say about that.

And the second one is the complexity of how to implement this. You know, it's easy to point out particular situations where a reasonable person would say, in this situation, you shouldn't do this. But to figure out how to make that systematic across the board is harder, and I realize it's harder. My only plea would be that we don't get in a situation where the inability to do everything exactly the way we would want comprehensively prevents us from making policies which we think would actually improve the world, and I do think there are situations where people with certain clinical conditions, where people in certain income categories, where if the person were standing there in the public comment and explained to you the situation of what happened to them and what they have to pay and asked why the system was set up, you would have a hard time to answer except saying, you know, we designed the system in aggregate. We didn't design it for you. So I'm sorry, and then you just go on your way.

I think we could probably do a bit better. I'm not yet ready to say exactly how, but I'm thrilled that there's some thought to this because I do think this is the one area where bringing the Medicare beneficiaries into the

system, both in terms of their responsibilities and in terms of their choices, matters, and I think that whether we like it or not, we're going to have to deal with it.

DR. CASTELLANOS: I really like this chapter, for a lot of reasons. What we're really talking about is utilization here, if you really think about it. And what we're looking at, not for the first time but from a different approach, is that it's really multifactoral. There's a tremendous shift from Part A to Part B because of taking things out of the hospital and you're going to increase utilization from that. There's no question physicians have a real role in utilization and over-utilization.

But this is one of the first times, again, that we're talking about the beneficiary and the beneficiary's responsibility. What we're trying to do is change the beneficiary's behavior or incentivize the patient or the beneficiary. As Mike said, the landscape is dramatically changing. We need to make sure they have access, but we need to make sure it's appropriate, what they get, and the care they get is appropriate.

Whether you like it or not, first-dollar coverage

does make a difference. Cost sharing does make a difference. We have a lot of behavioral things where we have patients, we call them frequent flyers. They show up wherever they want, whenever they want, in the middle of the night and get readmitted to the hospital for no reasons, and they get readmitted because there's nobody else there to take them home or do something.

So what we're doing here really, and I know I'm not talking about insurance as much as patient, beneficiary responsibility, incentivizing a better behavior, but making sure they do have access.

DR. BORMAN: In respect to your comment, Glenn, about what is the most hot-button political implication and how we deal with that, I happen to find a certain amount of appeal in part of this equity discussion. Sort of the flip side of it is the part that you have on one of the slides about moving more of these people into designated care managers. And I'm not sure how we phrase that to get around a little bit about the politically-charged piece of that, but I think that is a fair tradeoff in that as we attempt to support you better, recognizing your burden of disease, your piece of this is that we hope you do it in the way that's

most efficient for the system.

And so my recollection, and it could be my ignorance, is that many States have certainly on the Medicaid side required certain kinds of folks to go into designated managers, and I wonder if we have any data to bring from that experience in terms of what really has been the success of that in terms of health outcomes, in terms of spending pattern changes, any unintended or unanticipated consequences for good or for ill that could help inform or sustain a good quality recommendation that there are certain groups of people that for them, it is a win to do this, and for the system, it's a win to do this. And then it starts to fold into, for example, the ACOs. Is this potentially a mandated population, if you will, and some of those kinds of considerations, but maybe there are some data out there that could help us inform that recommendation.

DR. MILSTEIN: Reflecting on this, what you realize is that asking any beneficiary to pay more is just a form of political poison. And so the question is, what is the least toxic variant? And I think the options -- I'm trying to make sort of a summary comment -- option A is the beneficiaries pay more if they don't enroll in an efficient

delivery system, whether it's a Medicare Advantage delivery system or a medical home delivery system or an ACO delivery system. That's option A, and I personally believe that is probably least toxic.

Next toxic is beneficiaries pay more if they don't select a more efficient provider, and Glenn, you commented on that --

DR. CHERNEW: They pay less if they do. They pay less if they do select.

DR. MILSTEIN: Yes. You can frame it -- framing it is --

DR. CHERNEW: The ability --

DR. MILSTEIN: It's always six of one, half a dozen of the other. The opponents will frame it negatively, so anyway, that's it.

And then C is pay more -- beneficiaries pay more if they don't select an efficient treatment option. That's sort of the most granular.

And those are really the three, I think, primary choices. Each of them varies in terms of their political toxicity and their likely impact -- their implementation difficulty and their likely impact on spending. And

modeling that is the best we're going to be able to do.

Michael points out the dynamic things that are happening concurrently, such as the evolution of biologics that will cause some treatments to be much more expensive than others. The large molecule phenomenon will actually make the last option, penalizing people who don't select the most efficient treatment option, in some ways more toxic, more of a problem than it has been in the past. So those are the choices.

MR. HACKBARTH: I don't disagree with that framing. I do think how it's present, you know, whether it's pay more or pay less is, in the real world, very, very important. And the way I think about this, and it may be that I need to get out of this rut, is that the step here is to define a base Medicare benefit package, and most people are not in these things yet because they don't exist yet, and so what I would want to do -- I think the existing Medicare benefit package is irrational in a lot of ways and doesn't fairly distribute the cost sharing burden. And so I'd set, as I said, a top priority, let's get it looking more like what a real insurance program ought to look like.

I don't disagree with Mike's notion that complete

coverage after a low threshold has some problems, and some creativity about how to deal with that, I think would be appropriate. But I think we do need to do a little bit better job of protecting the people who are sickest and charge a little bit more for people who aren't incurring big bills than the current benefit design does. And so I think of it in terms of equity and creating a sound insurance design.

Then from there, as we develop some care manager system that really works and we know it reduces cost, we can say, oh, we'll reduce your cost sharing or your Part B premium or both if you voluntarily commit to do that. It's your choice. You can stay in the other program, but we think this is good for you and good for us and we're willing to share the savings with you. I think that politically feels a lot better than, oh, we're going to do the Medicaid thing, which is require you to go to a certain care manager organization. I think that would be very hard to do in Medicare given the politics around Medicare.

So I don't think we're saying different things. It's really the framing of it and the package. I do believe that in the area of value-based benefit design, given the

growing importance of drugs in effective treatment, this design of having separate insurance pools for Part D private insurers versus traditional Medicare and having this fissure in the system is a big problem.

Okay. Thank you, Rachel. Very good job.

We will now have a public comment period.

[No response.]

MR. HACKBARTH: Okay. Thank you very much. We are adjourned.

[Whereupon, at 12:08 p.m., the meeting was adjourned.]