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 1, 2010
9:41 a.m.

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

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

2 MR. HACKBARTH: Okay, take your seats please.

3 Welcome to those of you in the audience. We have a number

4 of interesting topics for the next couple days, and we will

5 be voting on recommendations on one of those topics,

6 graduate medical education.

7 Let me just say a word about the context.

8 Obviously, since our last meeting, the health reform

9 legislation has passed. A number of the topics that we will

10 be talking about over the next two days relate to issues

11 that are also addressed in health reform, for example,

12 graduate medical education and enhancing Medicare's ability

13 to innovate, the first item on our agenda. Both of those

14 are addressed in some ways in health reform.

15 Those of you in the audience who follow MedPAC's

16 work closely know that we have actually been talking about

17 these topics for some time, in the case of GME in particular

18 for many months, long before the fate of health reform

19 legislation was clear one way or the other. In some ways,

20 our take on these issues that overlap with health reform may

21 be very similar to what is included in the recently enacted

22 legislation. In other cases, our take is a little bit

1 different.

2 Our goal here is not to critique health reform.

3 Where our take is a little bit different, those of you who

4 are reporters, I don't think it's appropriate to frame

5 stories as, oh, MedPAC is critiquing health reform or

6 proposing amendments to health reform. This is simply the

7 culmination of work that we've been engaged in for many

8 months, and don't over interpret the message.

9 Likewise, where our take is very similar to what's

10 in the legislation, that shouldn't be framed as, oh, MedPAC

11 is endorsing these provisions in health reform. Again,

12 we've been working on this stuff quite independently for an

13 extensive period of time, and our goal here is simply to

14 bring that work to conclusion.

15 So the first item on our agenda is "Enhancing

16 Medicare's Ability to Innovate." Nancy?

17 MS. RAY: Good morning. John and I are going to

18 review a draft June chapter that focuses on giving Medicare

19 flexibility to innovate. The chapter is a concatenation of

20 material that I discussed at last month's meeting on

21 innovative polices, including reference pricing, and that

22 John discussed on Medicare's research and demonstration

1 capacity. This chapter is informational only; we have no
2 recommendations. But we are looking for your comments about
3 the chapter and input about next steps for future work. We
4 hope to come back with more research about these issues in
5 the fall, and we are looking forward to hearing your ideas
6 about that.
7 All right. So the chapter is divided into -- the
8 draft chapter is divided into three sections. The first
9 part of the chapter discusses the issues associated with
10 giving Medicare more flexibility to maintain existing
11 payment methods in a budget-neutral manner. Next, the
12 chapter reviews issues associated with using innovative
13 strategies, which we discussed last month. The chapter
14 concludes with a discussion on enhancing Medicare's research
15 and demonstration capacity.
16 So recall last month we discussed these three
17 innovative strategies. From last month's discussion, there
18 seems to be consensus that we continue to study these
19 policies.
20 Reference pricing sets a service's payment based
21 on the rate of the least costly clinically comparative
22 service -- the least costly alternative. Performance-based

1 risk-sharing strategies links payment to a service's
2 effectiveness or appropriate use, and coverage with evidence
3 development links payment to the collection of clinical
4 evidence. Recall last month Peter Neumann and Sean Tunis
5 discussed these issues and their implications for Medicare.
6 Medicare law affects the program's ability to
7 adopt these strategies. For reference pricing and coverage
8 with evidence development, the statutory language does not
9 clearly lay out Medicare's authority. For reference
10 pricing, two recent court decisions have stymied future use.
11 For coverage with evidence development, the lack of clear
12 authority has prevented Medicare to implement a well-
13 articulated program that identifies potential services and
14 includes deadlines to re-evaluate the effectiveness of the
15 studied services. For performance-based risk strategies,
16 Medicare cannot implement these strategies without a change
17 in the law.
18 We have selected these three policies because
19 their application could improve price accuracy and decrease
20 knowledge gaps. Of course, these are not the only
21 strategies that have the potential to improve program
22 efficiency. They do, however, complement the federal focus

1 on comparative effectiveness. Reference pricing and
2 performance-based risk-sharing strategies consider
3 comparative clinical effectiveness information. And
4 comparative effectiveness research and coverage with
5 evidence development complement each other by focusing on
6 the collection of real-world clinical evidence that
7 patients, providers, and policymakers need to reach better
8 decisions about the effectiveness of services. Also,
9 coverage with evidence development has the potential to
10 complement post-marketing surveillance efforts that the FDA
11 and product developers conduct.
12 In addition to the material on reference pricing
13 and coverage with evidence development, we have added new
14 material on Medicare's flexibility to maintain current
15 payment methods in a budget-neutral manner. Medicare law
16 affects the program's ability to maintain existing payment
17 methods. In some instances, the statutory language does not
18 give Medicare the authority to maintain payment methods by,
19 for example, updating the wage index and the case mix index.
20 Your paper gives a couple of examples. One example is the
21 ESRD, end-stage renal disease, area where until the MMA came
22 along Medicare used an outdated wage index in its payment

1 method. And in the SNF area, Medicare lacks the flexibility
2 to implement an outlier policy to defray the exceptionally
3 high cost of some patients.
4 So the issue that we've raised in the draft
5 chapter is whether to give Medicare flexibility to make
6 modifications that would improve payment accuracy in a
7 budget-neutral manner.
8 In other instances, the statute is so detailed
9 that Medicare cannot implement it. One example is the
10 mandate, the legislative mandate created in 1993, that
11 Medicare use three compendia for determining medically
12 accepted indications for off-label use of drugs. Herb,
13 thank you for bringing up that example at last month's
14 meeting. Over time, two of the three compendia stopped
15 operating or were acquired by other companies.
16 Subsequently, Congress had to give the agency the
17 flexibility in the DRA to use other compendia. Based on the
18 DRA authority, CMS developed an annual process with a
19 predictable timeline for seeking changes to the list of
20 compendia used to determine medically accepted indications
21 for cancer drugs.
22 In this new material, we also discuss an item that

1 the Commission has addressed before. The law does not
2 permit Medicare to pay providers based on their quality. A
3 statutory change is necessary for Medicare to do so. Thus,
4 the issue here is whether the Congress should clarify and
5 strengthen Medicare's statutory authority to pay providers
6 according to the quality they furnish or whether the status
7 quo of the Congress mandating changes on a case-by-case
8 basis should continue. For example, it took MIPPA to
9 implement P4P in the first payment method -- outpatient
10 dialysis services -- and that will begin in 2012. Without a
11 change in the statute, Medicare lacks the flexibility to
12 apply P4P in other payment areas. And I do want to make the
13 point that in their recently passed legislation, there is
14 some additional P4P provisions that we would be happy to
15 take on Q&A. But the point is it again took legislative
16 change for Medicare to proceed with the policy.
17 MR. RICHARDSON: At the March meeting, the
18 Commission discussed a number of issues related to
19 increasing the pace with which Medicare tests and
20 disseminates policy innovations through research and
21 demonstrations. We sorted these issues into overarching
22 three categories: funding, flexibility, and accountability.

1 I am going to briefly recap the issues I presented
2 in March and, as I do that, I'll try and touch on specific
3 items that individual Commissioners raised during the
4 discussion and where we stand at this point in our research
5 on those issue. I'll then go over the main provisions of
6 the recently enacted health reform law that will
7 significantly affect Medicare demonstrations activity.
8 In our discussion last month, there seemed to be a
9 general consensus that funding for the design,
10 implementation, and evaluation of Medicare demonstrations
11 should be increased and stabilized. Bob, Bill, and Herb
12 specifically commented on using mandatory funding from the
13 Medicare trust funds for research and demonstrations. As
14 I'll describe in a moment, the health care reform law
15 authorizes the mandatory appropriation of a significant
16 amount of new funds for testing of payment and delivery
17 system models.
18 Arnie and Jay suggested looking at what other
19 federal agencies and private corporations, respectively,
20 spend on research and development as a way to benchmark an
21 appropriate level for Medicare. We started to research both
22 of those potential comparisons since the last meeting and

1 hope to have something useful to say about it in the June
2 report chapter. It is a little bit difficult to isolate or
3 disentangle R&D spending on payment policy and delivery
4 system reform from traditional scientific and manufacturing
5 R&D, but we are going to keep at it and see if we can come
6 up with some quantification of that.
7 Herb, you asked if I could get information about
8 the estimated return on investment for Medicare
9 demonstrations in the past, and that was included in the
10 mailing materials you got for this meeting.
11 Bruce, you raised the issue of whether CMS also
12 should be provided with more resources -- both funding and
13 staff -- specifically allocated to support basic health
14 services research, both in-house and by external
15 researchers. You and Mike also raised the issue of
16 improving access to Medicare data, including regular program
17 data from Parts A, B, and D, and data generated from
18 demonstration projects, for instance, for use in conducting
19 external evaluations of the projects. You also raised the
20 issue of CMS funding to upgrade its aging data
21 infrastructure to support research and for running
22 demonstrations, and to handle and analyze the new data

1 streams that are going to be coming out like MA plan
2 encounter data. I touched on these issues in the mailing
3 materials for the meeting. We're also analyzing provisions
4 of the new law that will affect these policies, and we look
5 forward to further comments from you and the other
6 Commissioners as we prepare the final June report chapter,
7 and beyond that.
8 Under the topic of flexibility, last month we
9 discussed options that could at least somewhat expedite the
10 process by which demonstration projects are reviewed and
11 approved within the executive branch, that make preliminary
12 and final results from project evaluations more transparent,
13 and that allow the Secretary to expand successful policy
14 innovations from a demonstration to program-wide
15 implementation without further congressional action if
16 certain cost and quality criteria are met.
17 Bob, you specifically raised the issue of the
18 history and use of budget neutrality analysis by OMB during
19 the demonstration review process, and I want you to know we
20 did follow up with the contact that you suggested to confirm
21 that the budget neutrality requirement is not required by
22 law but evolved over time starting with an executive order

1 or similar administrative directive during the Carter
2 administration and has been enforced by subsequent
3 administrations through the OMB. Regardless of where the
4 policy came from, in its current use -- I will come back to
5 this, but I wanted to note now that the new law prohibits
6 the application of budget neutrality prior to launching a
7 demonstration -- certain types of demonstrations under the
8 Secretary's new authority. The new law also exempts
9 demonstrations and their evaluations from the Paperwork
10 Reduction Act, which we discussed last time. And Peter
11 asked if we could estimate how much time eliminating these
12 administrative hurdles might shave off the demonstration
13 process. As I noted in the mailing materials, information
14 from CMS staff suggests that eliminating the Paperwork
15 Reduction Act review alone could cut six to nine months off
16 the demonstration process, and I will continue working with
17 the ORDI staff to quantify the impact of eliminating the
18 budget neutrality test. I want to mention right here,
19 though, that the ORDI staff have been very helpful and very
20 forthcoming with information as we have been working on this
21 project.
22 Mike, we also discuss in the mailing materials the

1 issue that you raised about increasing the availability of
2 data to external researchers for conducting evaluations
3 outside the CMS process. In the paper, I cited something I
4 couldn't remember last time, the Hospital Quality Incentive
5 Demonstration, where there have been at least three
6 published papers looking at that from an external
7 perspective.

8 On the expansion flexibility point, Glenn, you
9 commented that we should look at recommending that the
10 Congress grant a generic delegation of authority to the
11 Secretary to implement successful innovations, with
12 reasonable constraints on the authority, for example, not
13 altering the basic Medicare benefit package or denying
14 beneficiaries free choice of providers. That seems to be
15 the approach the Congress has taken in the new law, and we
16 can talk about that a little bit more.

17 You also raised an interesting point about making
18 a clear distinction in the amount of evidence needed to move
19 forward when evaluating the effects of a new payment policy
20 or delivery system model, on the one hand, and evaluating
21 the operational feasibility of implementing a proven
22 concept. Bob, Herb, and John also addressed the question of

1 what degree of certainty should guide demonstration
2 evaluations and implementation decisions, and we will make
3 sure all those issues in the June report chapter.
4 Last in our three buckets, on accountability, we
5 discussed whether Medicare should consult with external
6 stakeholders, such as the private sector and the Commission,
7 for ideas on research and demonstration activities and for
8 reactions to the program's innovation agenda. We also
9 considered an option suggested by outside experts that the
10 Secretary periodically submit a formal report to the
11 Congress on the program's research agenda, on ongoing
12 demonstrations, and on preliminary and final evaluation
13 results. The Commission could submit comments on this
14 report in addition to the ongoing consultation discussed in
15 the first bullet.
16 So since the March meeting, as Glenn noted, the
17 Patient Protection and Affordable Care Act has become law.
18 The new law directs the Secretary to create a Center for
19 Medicare and Medicaid Innovation within CMS by January 1,
20 2011. The law makes several significant changes to
21 Medicare's flexibility to test and adopt policy innovations,
22 some of which I've already alluded to. I would now like to

1 briefly go through the major changes in the law, with the
2 expectation that we will come back during the upcoming
3 discussion to discuss any questions you have about how
4 specific provisions relate to the issues we have been
5 discussing thus far.

6 First, on funding, the new law authorizes the
7 appropriation of $5 million in the current fiscal year for
8 the "design, implementation, and evaluation of models" under
9 the new center, and then it appropriates $10 billion for
10 fiscal years 2011 through 2019 and for each decade
11 thereafter to cover, we assume, any new provider payment and
12 benefit costs under the demonstration models, as well as
13 CMS' and HHS' costs to design, implement, and evaluate those
14 models. The law specifies that not less than $25 million in
15 each fiscal year shall be available for designing,
16 implementing, and evaluating the models that are being
17 tested. This $25 million minimum appropriation, just to put
18 it in the context of the current appropriation for this
19 activity, is about $10 million more than the roughly $15
20 million we estimate is available to CMS in the current
21 fiscal year for demonstration operational activities.

22 On flexibility, the new law includes a provision

1 exempting from Paperwork Reduction Act review all
2 demonstrations and evaluations. It also prohibits the
3 Secretary -- and presumably the rest of the executive
4 branch, that is, OMB -- from requiring, as a condition of
5 testing any model, that a demonstration design be budget
6 neutral during its initial implementation phase.
7 The law also, however, requires the Secretary to
8 monitor the cost and quality impacts of demonstrations once
9 they are implemented and terminate or modify a demonstration
10 unless the Secretary determines that it is expected to
11 improve quality while reducing or at least not increasing
12 Medicare spending, or to reduce spending without decreasing
13 quality. The Medicare actuary must certify the spending
14 impact determinations. The statute allows the Secretary to
15 terminate a demonstration on the basis of its cost or
16 quality impacts at any time after it's implemented and
17 before its scheduled completion date.
18 On evaluations, the Secretary must perform an
19 evaluation of each model tested under the innovation center,
20 and the evaluation must analyze the demonstration's impacts
21 on costs and quality, which must, on the quality piece,
22 specifically include patient outcomes. It further directs

1 the Secretary to make each evaluation publicly available in
2 "a timely fashion."
3 On the expansion flexibility, the law allows the
4 Secretary to use the rulemaking process to expand the scope
5 of any model tested under the innovation center if the
6 Secretary determines that such an expansion is expected to
7 reduce program spending without reducing the quality of
8 care, or to improve quality without increasing net spending.
9 The Secretary must also determine that an expansion would
10 not deny or limit the coverage of Medicare benefits to
11 beneficiaries. The provision again, similar to the earlier
12 one I mentioned, requires the Medicare actuary to certify
13 that the expansion would reduce or not result in a net
14 increase in program spending.
15 Now, because the statute requires the Secretary to
16 use the formal rulemaking process to implement expansions,
17 there will obviously be an opportunity for external
18 stakeholders to comment on proposed expansions through the
19 usual notice-and-comment period. The Congress also will
20 maintain a degree of oversight on these expansion decisions
21 if they are considered to be "major" regulations, through
22 the requirement under the Congressional Review Act of 1996

1 that all regulations are subject to a 60-day review period
2 during which the Congress may intervene before a regulation
3 can go into effect.
4 Lastly, on accountability, the new law requires
5 the Secretary to consult with representatives of relevant
6 federal agencies and clinical and analytical experts with
7 expertise in medicine and health care management through the
8 use of open-door forums or other mechanisms to be decided by
9 the Secretary.
10 It also requires the Secretary to submit a report
11 to the Congress on the activities of the innovation center
12 beginning in 2012 and at least every other year thereafter.
13 The law lays out the minimum content of the report and
14 directs the Secretary to make any recommendations for
15 legislative action to facilitate the development and
16 expansion of successful models.
17 MS. RAY: So we are looking forward to your input
18 about the draft June chapter, and to conclude, we tried to
19 address your comments from last month in the chapter. And
20 please let us know if you have any additional comments.
21 We also seek suggestions about future work on the
22 strategies discussed in the chapter.

1 MR. HACKBARTH: Okay, thank you. Well done. We
2 will, as usual, begin with round one clarifying questions,
3 and I'd ask people to take that quite literally. Any
4 clarifying questions?
5 MR. BERTKO: I think, John and Nancy, this is in
6 your background paper, but did you mention there about the
7 gain-sharing exemptions from some of the current
8 requirements that make those kind of innovations more
9 flexible? And could you walk through those just quickly
10 once more?
11 MR. RICHARDSON: Sure. I did mention that in the
12 mailing materials. The Center for Medicare and Medicaid
13 Innovation provision specifically allows the Secretary to
14 waive the requirements of Title 11 of the Social Security
15 Act, which is where the gain-sharing federal anti-kickback
16 statute is codified, and yes, so that is an important -- I
17 didn't mention it in my remarks here, but it is going to be
18 in the chapter. I think that is a very important piece of
19 this that will -- for things like accountable care
20 organizations and other issues, where there will be
21 relationships between physicians and hospitals that those
22 stringent requirements can be waived in the course of doing

1 the demonstrations. And then, of course, during the
2 expansion -- actually, that will be an interesting question
3 to see whether through regulation the Secretary, if she
4 wanted to expand those demonstrations, that might be an area
5 where they would have to have some specific further
6 statutory work -- I'll have to think about that a little bit
7 -- during the expansion. But certainly for the purposes of
8 testing the models, those can be waived.
9 DR. CASTELLANOS: First of all, great job. Nancy,
10 concerning reference pricing, I live in the LCA world. On
11 page 13, you made a comment that the medical contractors
12 could make an exception and that the beneficiaries could pay
13 an additional sum if the physician chose and the beneficiary
14 chose to elect the more expensive. I didn't think that was
15 possible.
16 MS. RAY: I believe it is. I can follow up with
17 you with the --
18 DR. CASTELLANOS: Could you please do that? That
19 would be the simplest way. Thank you.
20 MS. RAY: Yeah, okay.
21 MR. KUHN: On that, Nancy, it might be through an
22 ABN, an advance beneficiary notice, and the activities

1 related to that, and I suspect that is what that reference
2 is.
3 MS. RAY: Yes.
4 DR. STUART: I, too, want to thank you for putting
5 this together. This is obviously a real challenge given the
6 fact that much of what you've discussed here is affected
7 directly by the new law.
8 But my question is, when we talk about the Center
9 for Medicare and Medicaid Innovation, do you have a sense of
10 how much overlap there is between what the new law requires
11 for this center and what ORDI is currently funding or is
12 currently obligated to do?
13 MR. RICHARDSON: Well, there is a significant
14 amount of overlap. I think the implementation of it in
15 terms of both administratively how the agency does it and
16 then in terms of what projects will be covered under the
17 Center for Innovation, there obviously are some what we call
18 legacy projects that have already started that will
19 presumably continue down the road.
20 This provision does not repeal the Secretary's
21 existing authority under the Social Security Amendments of
22 1967, which we talked about in the paper a little bit, so

1 technically that demonstration authority still exists, and
2 if for some reason the Secretary decided that that was a way
3 that she wanted to do a demonstration, theoretically still
4 could. So in terms of how the projects are going to roll
5 out, it remains to be seen.
6 My initial reaction would be that most of it is
7 going to be done under the Center for Medicare and Medicaid
8 Innovation, so just in terms of the projects. The other
9 piece that's significant is the budget and the additional
10 funding that was authorized and appropriated under the act,
11 which, as I noted, is $10 billion not quite over the first
12 decade, but then every decade after that. And a couple
13 things I'd say about that.
14 One is there is no requirement in the law that
15 that be $1 billion per year, so there's obviously a sense
16 that, you know, during the start-up period or even during
17 any particular decade, depending on the flow of the
18 projects, that money could be moved across different fiscal
19 years. The one thing that does -- that the law mentions
20 specifically to fiscal years is that $25 million minimum
21 funding for the testing, I'll call it the operations, you
22 know, the administrative costs of running the center,

1 specifically to test the models, so it's not all overhead.
2 But the law, when it says the $25 million minimum, does
3 specifically say it's related to the testing of the models.
4 DR. STUART: The reason I raised that is that
5 there is a pie chart in the chapter that shows how CMS
6 funding is currently allocated, and it might be useful from
7 a relativistic standpoint to see how that might change under
8 the new provision.
9 MR. RICHARDSON: Yeah, I'm sorry. I'll clarify my
10 response, which is that under the current year's funding we
11 estimate there's about $15 million in ORDI's budget for
12 roughly the equivalent of what would be funded at a minimum
13 of $25 million under the center. So it's roughly a $10
14 million increase.
15 MR. HACKBARTH: Other clarifying questions?
16 DR. KANE: Yeah, on slide 8, actually two
17 questions. One is the word "expand" -- the last bullet
18 point gives the Secretary authority to "expand innovations."
19 Does that mean they could make them program-wide without any
20 further -- and can they mandate versus make it -- I mean, I
21 guess how broad is that authority, and that is question one.
22 Then the second question is: Do the requirements

1 to establish ACO and medical home and bundled payments fall
2 under the innovation center or are they separate? Or how do
3 they link up? So two questions. Sorry.
4 MR. RICHARDSON: Sure. I'll do the easy one
5 first. The expansion authority is up to program-wide, so
6 you could expand it from the current sites and just have
7 some -- which would be organized around geographic areas,
8 presumably, and you could expand it to other geographic
9 areas, or you could expand it program-wide. But -- and this
10 picks up on something that relates to my answer to John's
11 question. If the expansion requires, say, the waiver of
12 Title 11 requirements on gain-sharing arrangements and that
13 would require a change in law, the way that the law is
14 written, as I'm interpreting it right now, is that since the
15 Secretary does that through rulemaking, the statutory
16 prohibitions would still be in effect for the expansion.
17 There may be something I'm missing. I'm not a
18 lawyer, so we'll have to work that out, and I'm sure that's
19 one of the things we'll be looking at carefully during the
20 implementation of the center.
21 MR. HACKBARTH: Let me ask a follow-up question
22 about the expansion authority. If I'm not mistaken, I think

1 the bundling is characterized as a voluntary bundling
2 project in the legislation. So does the expansion authority
3 -- let's assume bundling is determined to have worked,
4 lowered cost and/or improve quality. Does the Secretary
5 have the authority to make it mandatory nationwide or just
6 to take it voluntary nationwide?

7 MR. RICHARDSON: Right. I honestly don't know the
8 answer to that, and so the other -- I mean, I'll have to see
9 how these provisions relate to one another. Maybe some of
10 my colleagues at CMS can help me figure that out. But the
11 point, Nancy, you are raising is an important one. There
12 are also some separate pilot -- in the case of the bundling
13 -- and demonstrations in the law, and, you know, technically
14 those are separate, stand-alone, sort of the more
15 traditional way that Congress has said we want to see a
16 pilot or a demonstration on this. But I don't know whether
17 it's an option for the administration to say that those
18 could be done under the center. I honestly don't know, and
19 I'll try and get with my colleagues there to see if we can
20 figure out how those would work together or, in fact, be
21 separate and run their separate tracks.

22 DR. KANE: So the $25 million, for instance, might

1 end up applying to including these other -- the bundling and
2 the ACO and the medical home as well, or whatever.
3 MR. RICHARDSON: Well, technically --
4 DR. KANE: Or it may not.
5 MR. RICHARDSON: Well, the law says that it's
6 specifically for the implementation and evaluation of
7 projects being operated through the center. But if the
8 center includes those projects -- there are creative ways
9 that they can do that, yeah.
10 DR. BERENSON: Let me follow up on that one a
11 little more specifically, and then I have another question.
12 The section where ACO shows up is actually called shared
13 savings, and then it refers -- and so my interpretation was
14 they have to at least test that shared savings model of an
15 ACO, but there would be no reason they couldn't use the
16 broader authority under the innovation center to test other
17 models of supporting ACOs. Is that generally correct?
18 MR. RICHARDSON: Yes.
19 DR. BERENSON: Okay. And then following up on the
20 budget neutrality issue, I'm a little confused because up
21 there you say exempts from budget neutrality, but you said
22 prohibits, and so -- in the writeup you say prohibits budget

1 neutrality in early implementation phase, but later in that
2 paragraph it says the Secretary can terminate a
3 demonstration for cost or quality reasons at any time. So
4 I'm a little confused about what the early implementation
5 phase -- is there a prohibition on the Secretary's
6 prerogatives, I guess?
7 MR. RICHARDSON: That was poorly worded, I would
8 say. The prohibition is on pre-implementation. So in order
9 to authorize a demonstration to go forward, that's when the
10 budget neutrality test can no longer be applied in making
11 that determination pre-implementation. But the Congress was
12 concerned that once it started, if something like -- the
13 Medicare health support would be a good example. It is so
14 far not budget neutral giving the Secretary clear authority
15 to stop that before its scheduled termination date. So I'll
16 clarify that in the chapter.
17 MR. HACKBARTH: Other clarifying questions?
18 DR. CROSSON: Just two -- one on the funding and
19 one on the expansion authority again. And I have to
20 compliment you already because we're asking you not only to
21 divine the meaning of language that's just recently been
22 written, but also guess what the regulations are going to

1 be. You're doing a pretty good job.

2 MR. RICHARDSON: Thank you

3 DR. CROSSON: With respect to the funding, though,
4 I am still confused about whether the $10 billion over 10
5 years is sort of sacrosanct in the sense that that money is
6 supposed to be paid out as part of the projects or whether
7 some of that money, if it needs to be, can be used by CMS to
8 actually construct and run the projects. So I don't know
9 whether that's, you know, building infrastructure or what,
10 because it seems like perhaps if this really got going, the
11 $25 million might not be adequate. So do you have a sense
12 of that?

13 MR. RICHARDSON: My sense, and subject to -- and
14 this is April Fool's Day, so I'll just point that out -- is
15 that it's for both. And so the notion is what I'm calling
16 administrative costs, but it's specifically for running and
17 evaluating the demonstrations, the models, is included in
18 that $10 billion, and say that you had a demonstration where
19 you wanted to test the provision of a new benefit, a care
20 coordination fee, for example, those costs would also be
21 covered by that $10 billion.

22 MR. HACKBARTH: Okay, let me -- I was just going

1 to follow up on that specific point. So would all of the
2 benefit payments for the services used by Medicare
3 beneficiaries be counted, or is it just the incremental
4 cost? Or is that to be determined?
5 MR. RICHARDSON: To be determined. To be
6 determined. Let me just say something about the $25 million
7 because that is important. The law says that that's the
8 minimum amount that needs to be allocated every fiscal year.
9 CMS and the Secretary and OMB could put more into it than
10 the $25 million. So, in other words, that's a floor for
11 that. But, I mean, I think it is something that bears
12 watching, which is whether that becomes the number -- I
13 mean, once you put a number like that out there, that sort
14 of becomes the number, and if there are other demands on the
15 funding, it becomes more difficult to increase that even
16 though the demands on the ORDI staff, for example, may be
17 greater than can be supported by that. So that's something
18 to keep an eye on, I think, as we implement this.
19 DR. CROSSON: So then the second question has to
20 do with the trigger for the Secretary being able to expand
21 the demo, and it relates to the cost and quality question,
22 because I thought I heard you say that even though the

1 language says cost and quality, you believe it may be
2 interpreted to mean that if a demonstration proved that a
3 particular model of delivery was cost neutral but improved
4 quality, that that would qualify for expansion, as opposed
5 to needing to do both, reduce cost and improve quality or
6 keep -- no, reduce cost and improve quality. So it's the
7 question of whether it's "and" or "or," and I realize we're
8 getting into the definition of participles, which is
9 probably beyond our scope. But do you have a sense of the
10 intent there?
11 MR. RICHARDSON: Yeah, and partly you may be
12 confused because I wrote the mailing materials one way and
13 then read a little bit more about the law and realized that
14 I had a little bit mischaracterized it in the mailing
15 materials.
16 This is correct, which is that the --
17 DR. CROSSON: So it's not just me.
18 MR. RICHARDSON: Not just you, no, no. It's me.
19 The law as amended by the managers' amendment clarified that
20 -- the original way it was drafted was that the models had
21 to save money. That was amended in the managers' amendment
22 to say at least cost neutral and improve quality, or not

1 decrease quality and save money.

2 DR. CROSSON: Thanks.

3 DR. MARK MILLER: I just do want to remind
4 everybody this is a very fluid situation, because I've got
5 to tell you, I mean, this point I think is not widely
6 understood, and I've heard a couple of different -- I
7 believe that we've read the law, and this is our best
8 interpretation of it. But lawyers will get involved and
9 eventually define it.

10 MR. HACKBARTH: [Off microphone.]

11 DR. CHERNEW: Actually, it is, though, on this
12 point. If there was a -- or at least one of the points that
13 Jay raised. If there was a demonstration which required an
14 extra fee for something, are there any funds other than the
15 funds we've been talking about to pay for that extra fee?
16 Or, by necessity, must -- the only way to pay for some new
17 fee for coordination or whatever has to come from this set
18 of funding that we've spoken of?

19 MR. RICHARDSON: Under the way that the center is
20 set up, it would have to come out of that $10 billion
21 appropriation. Glenn's question is still a good one. What
22 about all the other services that the beneficiaries

1 participating would be using?

2 DR. CHERNEW: But they couldn't, for example,

3 assume -- and this is really my question. Imagine they

4 assume there was an offset because they're now going to

5 prevent -- they can't use any actuarial notion that that's

6 going to pay for this. It has to be an accounting sense

7 coming from this money which is going to take from other

8 things.

9 MR. RICHARDSON: I don't know. I'll follow up. I

10 think that's a good question to look at during the

11 implementation. Related to that is the requirement that the

12 Secretary and the actuary, when they look at the cost impact

13 before they make an expansion decision, the law specifically

14 says they have to look at the net costs. So to your point,

15 if, you know, an expanded benefit of some kind would offset

16 costs in other places and that was determined to be at least

17 neutral, if not save money, that would work for the

18 expansion. In the context of the demonstration itself is

19 where I'm not sure what the answer is.

20 MR. HACKBARTH: [off microphone] Clarifying

21 questions?

22 DR. MILSTEIN: John, are any of the accountability

1 provisions, either in the law or in our draft
2 recommendations, do they address -- you know, one thing that
3 I found emerged clearly in our last discussion of this,
4 another that maybe didn't emerge as clearly but I think is
5 important in view of OMB's rating of a certain amount of
6 cost savings from this greater rate of innovation, the first
7 is cycle time. You know, there's a problem here with cycle
8 time. In other words, in no other context would you see
9 like, you know, five-, six-, seven-year cycle times to get
10 to the answer. And it's clearly not dictated by the content
11 of what's going on. So my question is: Is there any --
12 either in the legislation or the recommendation for
13 accountability, are we going to -- or do we get at -- does
14 either get at this issue of cycle time? And I'll trim this
15 down. And then my second question about accountability,
16 does either, you know, give us what -- let's say people
17 investing in, let's say, a venture capital firm -- this is
18 kind of like a venture capital firm, except the return would
19 be quality and accessibility in addition to cost savings.
20 But is there any report on kind of -- for the people who are
21 running this, how are their bets working out? Are they
22 betting on good things? Are we getting a good societal

1 return? And what relationship does the current distribution
2 of bets and returns bear, for example, to OMB's estimate of
3 what, you know, when they scored this as a cost-saving item
4 what we're likely to get back? In other words, these are
5 two dimensions of accountability, return on investment and
6 cycle time, and are they reasonably addressed in one or the
7 other document?
8 MR. RICHARDSON: The cycle time question is
9 addressed more during the pre-implementation phase, first of
10 all, which is -- there's another piece of it that I'll come
11 back to for a second. Just so everybody's clear, that's the
12 budget neutrality and the Paper Reduction Act. Okay?
13 Relatively small.
14 The other element that at least in the legislation
15 talks about is something that we talked about about a year
16 ago with this idea of having some kind of practice-based
17 research network or some -- and I can draw it out a little
18 bit more in the chapter, where the -- and this is both in
19 the innovation center and I think AHRQ also has some funding
20 or some direction in the law to do this, to develop practice
21 research networks that can more quickly incubate ideas and
22 figure out if there are innovations that are being developed

1 at the practice level that then could be brought back into
2 the innovation center. But it really doesn't deal with the
3 fundamental issue of whether these innovation -- I mean,
4 there is still an expectation that there will be a three- to
5 five-year period during which these models are running.
6 Now, having said that, I mean, and that's sort of
7 like the entire model. There is funding, and I think this
8 is an area where the Commission could talk about more
9 explicitly, to go to your second venue, which is in this
10 report, the extent to which interim evaluations or, you
11 know, grappling with this idea of how maybe it's different
12 for operational feasibility versus testing a particular
13 policy's impact on cost and quality, what should the level
14 of evidence and the standard be for the expansion decision
15 or for the program to be implemented -- I'm sorry, the
16 policy be implemented program-wide.
17 So to answer your question specifically, the law
18 doesn't really deal with that. It does say that there will
19 be more money for evaluations, and there must be an
20 evaluation for every project that's tested, but it doesn't
21 really address this issue of what happens in the interim,
22 and I think that's an area where we could comment.

1 MR. HACKBARTH: So let me build on that. So there
2 are the pre-implementation steps to accelerate the process.
3 After implementation, the grant of authority to the
4 Secretary to make a judgment is potentially a way that cuts
5 through the now almost 10-year cycle, the Secretary --
6 MR. RICHARDSON: Presumably there's some --
7 MR. HACKBARTH: -- partway through could say, you
8 know, the evidence is so clear that, you know, we're not
9 going to wait for another two years and an evaluation --
10 MR. RICHARDSON: Right
11 MR. HACKBARTH: -- we're going to go ahead.
12 However, that's constrained by the need to get the
13 chief actuary to certify the same conclusion, and so, you
14 know, you can imagine circumstances where there will be, you
15 know, discussion within the Department about how much
16 evidence is good enough, what constitutes appropriate
17 evidence to warrant the actuarial certification.
18 This process seems to me to be a very significant
19 step forward, but it is different than what I imagine to be
20 the innovation process in a corporate situation, which
21 doesn't have formal certification requirements by
22 independent actuaries that will in this environment take on

1 political significance. It's more I can make a judgment and
2 I'll be held accountable over the long run for how good my
3 judgment has been in managing the innovation process. Here
4 it's still project-by-project, independent certification.
5 It's a little bit slower model still, I think.

6 DR. MILSTEIN: I think the thrust of my question -
7 - first of all, your answer was, nonetheless, very helpful,
8 but it was they have to do cycle time with respect to
9 transparency and reporting on how it's going, because there
10 were examples we raised last time where it's been we're five
11 years into it, and the only people who have a clue as to
12 what's going on are, you know, inside HHS, it's unclear
13 whether you could use FOI to get at it.

14 You know, I suspect that for some of these demos,
15 this Commission, for example, and some of the other
16 commissions that are now being launched would like the
17 ability to make a reasonable judgment based on the same
18 information that's flowing into ORDI.

19 MR. HACKBARTH: Okay, let's move on officially to
20 round two and begin on this side over here. Round two
21 comments or questions.

22 DR. CHERNEW: So I have two quick comments. The

1 first one is there are places in here where I think
2 eventually we could add recommendations, and although I
3 don't think it's appropriate for this June report, I think
4 in terms of next steps, moving this to recommendations is
5 something that really should be done. And we can talk about
6 specific ones, but that's the general comment.
7 The second one is per the comment that I think Ron
8 made earlier, there are really important potential ties
9 between some of the things that are going here and payment
10 design changes so would people be charged more, for example,
11 if there was a least costly alternative-type thing. And
12 that ties into the chapter on benefit design, so I think
13 that connection is useful to point out. And in a related
14 sense, there's a connection between some of the things you
15 talk about and others that aren't really brought together.
16 So, for example, if we moved to a bundled payment
17 or an ACO or any of these other type of innovative models,
18 that has real ramifications for how you think about least
19 costly alternative. So you give examples about wound
20 therapy and stuff. How you think about that in a fee-for-
21 service world is very different than how you think about
22 that in a bundled payment world. And those things connect.

1 How all the different demonstrations are running, you know,
2 I want to be -- I don't think an organization could be in a
3 bundled payment world and in, you know, a least costly
4 alternative payment world because of the way in which that
5 all interacts. And I think that's important, and it is
6 worth some notion.
7 The final point that I'll make -- and this is a
8 minor one, but I think it's really important because it came
9 up several times about the return on investment to
10 demonstrations. I think we learn a lot from failed
11 demonstrations, and so some of the discussions that you have
12 in here that are good about how some of the things that are
13 really important now as far as demonstrations, that's
14 important, I agree. But I think it's really important that
15 demonstrations that -- if we knew that everyone we wanted to
16 do was going to work and it's just the way to start things,
17 we knew we're good, we would have much less cycle time, and
18 we would just go and do it. But we don't. So a lot of the
19 return on investment might be to stop us from doing things
20 that might not be so great, and I think that's important
21 DR. MARK MILLER: I was going to make this point
22 when Arnie was talking. I'll be very brief. The other way

1 I also try and think about it is there are often real
2 complaints about how long Medicare's cycle time is, and
3 there's examples of real long ones -- some good ones, some
4 long ones. But also in the private insurance industry,
5 we've had discussions where the private insurance industry
6 will kind of jump to trends, even though they don't
7 necessarily have evidence, and then abandon those trends,
8 which in some ways you can learn from what you abandon.
9 But, you know, sometimes there's faster cycle time, but not
10 with a lot of information driving that, and I think that's a
11 balance to keep in mind.
12 MR. BUTLER: So this may be something that ends up
13 in a couple sentences in the chapter and maybe could be
14 quickly dismissed, but when we began talking about this a
15 year ago at a summer retreat, you know, part of it is the
16 authority of CMS and then the second part was the budget to
17 do all this. And I think the chapter does a good job of
18 articulating the budget, and we've had other discussions of
19 dollar support here this morning emerging from health
20 reform.
21 As I look out from outside the Beltway, the amount
22 of activity that both CMS has to do, the new councils,

1 commissions, even outside of the government, support for
2 these things, the search for talent is going to be
3 tremendous. The limited -- so I'm a little bit less worried
4 about the amount of the budget, now thinking about what is
5 it that could make sure that the appropriate talent can be
6 recruited and retained within CMS, which is the hub of
7 making sure implementation occurs. And are there any
8 comments that -- you know, we've got ex-CMS people around
9 here -- where we want to make a statement that it's not just
10 about the budget but the ability to recruit and retain the
11 talent necessary to pull all of this off? You know, I would
12 defer to my CMS -- if there's something that could be said
13 along that just to convey the importance of it.
14 MR. HACKBARTH: Is there anything in the
15 legislation itself about hiring authority, special roles for
16 hiring authority?
17 MR. RICHARDSON: I don't think so. I mean, I
18 haven't looked through the whole bill, believe it or not,
19 but I don't know.
20 MR. HACKBARTH: Herb, do you have any --
21 MR. KUHN: Yeah, a couple thoughts on that, Peter.
22 One is the real key here is that as the new people come in

1 and they recruit the new talent in there, that's an ability
2 to retain and keep that new talent in the agency as it comes
3 forward. One of the things that we saw with the Medicare
4 Modernization Act is after we saw this influx of people to
5 come in and do implementation, it reverted back to a level
6 of FTEs pre-MMA. And so there was this new workload but not
7 the people there to maintain continuity of operations of the
8 workload. So part of the thought process could be that when
9 they have the new workload, there is sufficient staffing to
10 deal with that.

11 Another way on the recruitment -- and believe me,
12 I'm sure they've got a lot of talented people who are dying
13 to come in to help implement this thing as they come
14 forward. But one of the things that was talked a little bit
15 about at the last meeting and a little bit to Arnie's
16 suggestion is this notion of innovation networks or
17 innovation labs where there can be some connectivity with
18 universities, foundations, others around the country that
19 could be part of the innovation network that CMS could put
20 together here as part of the intake for information. So
21 intake not only of good ideas, but also intake for talent as
22 well. So I think that's something that we might want to

1 explore and maybe even opine on a little bit in this report.

2 Those would be my two thoughts on that.

3 DR. SCANLON: Two comments. The first is

4 triggered by what Mark said about sort of the differences

5 between Medicare and the private sector. I think one of

6 sort of the miracles of the market is that it is brought

7 about by -- that it works through trial and error, and

8 there's just countless number of trials that are tested, the

9 successes remain, the failures disappear, and we forget

10 about the failures. I mentioned this before. You know,

11 government, and Medicare in particular, sort of in some

12 respects has one chance. It puts something into place, it

13 works out to be unsatisfactory, and then it's very difficult

14 to change it. And we've heard in meetings before about sort

15 of complaints about Medicare being a bad business partner

16 because it changed its mind. It was getting not what it

17 wanted, paying too much, but it wasn't supposed to be

18 allowed to change its mind.

19 And so I think that there's a certain amount of

20 that mind-set that needs to be changed, and at the same

21 time, we know that it's going to be difficult to do that, so

22 this notion of, you know, moving to demos -- and this will

1 relate to my second point -- moving to demos quickly and
2 then sort of potentially making them program-wide causes me
3 some concern because we can potentially be locking in the
4 wrong thing and have very great difficulty in trying to
5 change that.
6 My second point was one I wanted to say that a lot
7 of attention has been focused on R&D, but really most of the
8 discussion has been about the D part, the demonstration
9 part. And I think we should give more attention to the
10 research part because we could have better demonstrations if
11 we had sort of more research. And that goes, though, to
12 kind of maybe a third point, which is to do research, the
13 prerequisite is data. And that's where we have significant
14 limitations, but we also have the potential, I think, at
15 this moment to think about how do we change that for the
16 future.
17 We have a recommendation from -- I can't remember
18 when exactly we did it, but about sort of the idea of taking
19 the investment in electronic health records and HIT and
20 making meaningful use more meaningful by getting data to
21 flow to the program so the program could be sort of more
22 thoughtful about what its policies were, be able to

1 implement sort of more options more readily. I think coming
2 back to that sort of as we talk about this in the future,
3 the Commission talks about this in the future, is one thing
4 that's important to do.

5 A second thing that's in the bill is there's more
6 attention being devoted to administrative simplification.
7 This is kind of a follow-on to HIPAA, which had sort of, I
8 think, a very valid premise, which is if we could specify
9 sort of what kinds of information we want from providers in
10 a very consistent way that would make their lives easier,
11 enhance our ability as purchasers to sort of understand what
12 it is we've been paying for, we -- you know, there's real
13 sort of -- it's kind of like a win-win situation, okay? In
14 the Commission earlier, in earlier years, we've talked
15 about, when we were dealing with pay for performance, how if
16 I'm a hospital -- and Ralph Miller was here then. He was
17 talking about -- he asked for the same sort of conceptual
18 measure in 12 different forms, and so I have to tailor it
19 for each one of those different payers.

20 We can eliminate that if we get the basic data
21 elements from every provider, and then if I want to
22 configure a measure my way and you want to configure a

1 measure your way, you each can do it. So I think moving
2 sort of -- having the Commission focus on both the
3 meaningful use and administrative simplification issues that
4 relate to kind of underlying goals of how do we innovate,
5 sort of how do we have a basis for innovation would be a
6 very important thing to do.
7 MR. HACKBARTH: [off microphone] Round two.
8 DR. KANE: I think some of the concerns that I
9 think -- or things that we might want to have evaluated
10 besides the impact on Medicare's cost efficiency and value
11 is the broader impact on the market and particularly the
12 private sector. I recall we had a couple examples where it
13 was clear we found these great providers from a Medicare
14 perspective, but they weren't great providers from the
15 private sector perspective.
16 I think we have to start changing this mentality
17 that Medicare, you know, can do things for itself and not
18 have an impact on the other payers. So I really would like
19 to see us try to expand the evaluation criteria to include
20 impact not only on Medicare cost and quality but also on the
21 impact of the other payers that are working with that
22 provider.

1 Also, on how it affects competition, if you start
2 to favor and pour lots of money into one institution, what
3 happens to those who are competing with that institution in
4 the marketplace? You know, you're plunking some -- we're
5 plunking some big bucks into very -- some markets that are
6 quite competitive, and I just wonder what the impact will be
7 and whether we're paying attention to that, and then there
8 may be some point where it doesn't make sense to have these
9 markets remain the way they are in the competitive mind-set
10 if it turns out that collaboration, cooperation, and, you
11 know, integration is the way it needs to go. So impact on
12 the whole market, impact on competition, impact on private
13 payers.
14 And then the other piece that kind of makes me
15 think we -- I mean, somebody needs to pay attention to it in
16 setting it up and demonstrating and evaluating is the
17 provider ability to deal with sustainability of any big
18 investment. If you put a big infrastructure investment in
19 to creating an accountable care organization or a medical
20 home -- I mean, I've been asked this by a lot of providers
21 when I walk around Massachusetts talking about this. You
22 know, what if I do that and then everybody decides, oh, this

1 is a bad idea? That could put places out of business.

2 So I guess something like how do you make sure

3 that that doesn't -- or, you know, how do you make sure that

4 that doesn't happen? How do you create incentives or

5 gradual changes? Or, you know, how do you make these things

6 not such high risk that people don't want to do them?

7 MR. HACKBARTH: Those are good points. Let me

8 pick up on the first one and ask a question. At one point,

9 I think in the House bill, there was language added calling

10 on the Secretary to look for opportunities to work with

11 private payers. Is that language still in the legislation?

12 MR. RICHARDSON: Yeah. It's not mandatory by

13 definitely a directive to do that.

14 MR. HACKBARTH: Yeah. Okay.

15 DR. KANE: It looks like a provision for the

16 accountable care organizations but not for the other

17 demonstration --

18 MR. RICHARDSON: No. In the center as well.

19 MR. HACKBARTH: Okay.

20 DR. MILSTEIN: Following up on my not really

21 question in the first round, but, you know, I think -- first

22 of all, I think the comments of the prior Commissioners were

1 very helpful to me in kind of honing what I'm about to
2 suggest we consider in our recommendation, because I agree
3 with many of the points made by Bill and Mark and others.
4 But, you know, I would ask that maybe we consider increasing
5 our accountability recommendation specifically with respect
6 to speed of transparency of interim evaluation results, not
7 in implementation. I completely agree that prudence is
8 indicated given some of the comments that Bill made and that
9 very important point. But it's this idea that no one --
10 when interim results become available that they're not
11 publicly available. That does not make sense. I don't
12 think it stands up to much defense. It's very hard to
13 defend that. I realize there are some defenses, but I just
14 think this is government, it's taxpayer money, so it's that
15 facet of accountability, that facet of cycle time we'd like
16 to see perhaps addressed in our accountability
17 recommendations.
18 And then, secondly, I also agree with Mike's point
19 about sometimes there's tremendous value in failure. But
20 that being said, I think it would -- I still would like to
21 have us -- hope that we would consider in our accountability
22 recommendation that there be some periodic tracking at least

1 against the OMB savings estimate essentially so that people
2 who are managing these programs have some sense of how
3 they're doing and the public has some sense of how they're
4 doing versus at least OMB's forecast of what might be
5 reasonable given the context.

6 MR. HACKBARTH: On your first point, the
7 availability of data, Mike raised at the last meeting the
8 same point in a somewhat different way. Mike framed it as
9 when it's complete, when the demonstration is complete, data
10 ought to be made readily available for anybody who wishes to
11 evaluate the data and it shouldn't just go to a single
12 designated government contract evaluator.

13 You're taking that one step further and saying not
14 only should that be true at the end, but to the extent
15 possible, data should be available as the project runs on an
16 interim basis.

17 DR. CROSSON: Just on that point, I don't know the
18 full panoply of what has gone on, but the one project I've
19 been watching for some time is the Group Practice demo, and
20 I think -- and I don't know whether that's an exception or
21 not, but I think, unless I'm wrong, every year or every two
22 years, at least, there has been a release of information at

1 a summary level in terms of which groups were able to save
2 money, what the quality results have been. So, I mean, I
3 don't know whether that's an exception or is a model or
4 what, but it's --
5 DR. MILSTEIN: It's a model.
6 MR. HACKBARTH: It maybe doesn't go as far as Mike
7 would like to see.
8 DR. CHERNEW: Right, exactly. I obviously would
9 like data as soon as Arnie would. The thing I think is
10 important is the group practice demonstration project is a
11 really good example because of the MedPAC, which is sort of
12 an external evaluation, has a somewhat different take on the
13 results of that, and they had access to, I think, different
14 and better data. So I think it's really important.
15 What's missing in here and where I would go in the
16 recommendations is to include more not only internal stuff
17 but, like, external data with NIH-funded, AHRQ-funded
18 evaluations, where people in the scientific community can
19 hash out what the results are. And I think John did a good
20 example, showed a good example of how other independent
21 evaluations in the chapter can come up with different -- we
22 don't learn, oh, yes, we did it, here's the answer. That's

1 just not the right model of learning. And the more data and
2 the more people that can get access to that data, it will
3 help us. For example, if there's a failure, we might learn
4 -- someone else might learn why, and we might be able to
5 resurrect it, as opposed to, oh, we tried that, we're never
6 going to do that ever again. And I think you need that
7 process [off microphone].

8 DR. MARK MILLER: I know we've got to move. I
9 just want to parse a couple of comments and then say one
10 other things. I don't reject any of this, but there is sort
11 of the notion of summary reporting. I periodically come
12 along, this is what we know about the demonstration. And I
13 would suggest that we also parse that thought to think
14 separately about versus release of information and when,
15 okay? Because there are two different thoughts, I think,
16 included in there. They both could be valid, but I think
17 they both should be thought about.

18 I think you're absolutely right that the more
19 people involved, you know, I, too, believe that that gets
20 you closer to the truth in the long run, but you also both
21 have talked about, you know, cycle time, and the more people
22 involved, the more likely you're going to get different

1 results. And I don't know whether that speeds the cycle or
2 slows the cycle, and it's something to think about when you
3 think about release of data and the timing of that release
4 of data.

5 I want to be very clear. I am not saying do not
6 hand out data. I think transparency is an important point.
7 But that's why I'm parsing the notion of summary reporting
8 on where it stands versus when do you release data to the
9 world.

10 DR. DEAN: Just a brief comment. I just wanted to
11 make a pitch to really support the three purchasing
12 strategies that you mentioned early on, especially the
13 coverage with evidence development, because it just seems
14 like time and again we see a promising intervention, a
15 promising therapy; it immediately gets implemented, and then
16 a year or two later, we find maybe it wasn't quite as good
17 as we thought it was. At that point, it's almost impossible
18 to do a randomized trial because it's become standard of
19 care, and we're stuck with an intervention that we know very
20 little about in terms of whether it's really as good as we
21 thought it was. And it's a very difficult situation to be
22 in from a clinical point of view because especially then you

1 throw in the liability issues. If we as clinicians decide,
2 well, that isn't nearly as good as it was initially proposed
3 and we decide not to do it, and then something goes wrong,
4 well, then we're out on a limb from a liability point of
5 view.
6 So I think anything that we can do -- and like you
7 say, the coverage with evidence development appeals to me
8 the most. But anything we can do to be sure that as we
9 introduce new clinical innovations that we have some sort of
10 mechanism to monitor those as we go along. And it would
11 seem to me that that mechanism is relatively inexpensive --
12 it's not totally cost free, but relatively inexpensive --
13 and could at least give us a foundation to make some
14 judgments down the line if this is something that we need to
15 say, whoa, we really do need a randomized trial and there is
16 justification for a randomized trial, or, you know, whatever
17 the case may be.
18 So I would really urge that we develop a
19 recommendation around those issues. Thank you.
20 MR. KUHN: One issue I want to come back and
21 revisit is the one when Peter asked a real good question
22 about recruitment of talent, and my response had to deal

1 with the innovation networks or innovation labs. I think
2 there's a dual opportunity for that kind of model to help us
3 in terms of the acceleration of innovation in this area, so
4 I think we could look at it in both spots that are there.
5 My experience now in Missouri but also in watching
6 things in the federal government, depending on how these
7 were set up, you know, there is an opportunity through
8 certain terms and conditions to contract with entities out
9 there, and then they don't get so bogged down in the federal
10 procurement rules and all those kind of activities. So I
11 think that could be a model to help accelerate the process,
12 is something that we ought to look at in that regard.
13 The other issue in terms of accelerating the
14 process -- and a lot has already been said on this, but
15 there is a bit of a distinction here that we ought to think
16 about, is that we've talked a lot about the traditional
17 demonstrations that are out there that have to go through
18 the development process, running the demonstration, and then
19 the full evaluation contractor to come in and run that. But
20 there has been introduced over the last several years these
21 notions of pilots, and the distinction on the pilot is that
22 if CMS sees some real value with the project as it moves

1 forward, they then have the authority to go ahead and launch
2 that if it's scalable more nationally or move it out without
3 having to go back to Congress for a "Mother, may I?" if they
4 can move this thing forward. One good example, as I think
5 you mentioned earlier, was the Medicare health support
6 program which was a pilot per se that could have been
7 expanded if the evidence was there.

8 So I think the real issue here is what is the
9 level of evidence that we're all seeking before a pilot
10 ultimately can be expanded. Right now it's almost a 100-
11 percent certainty that it's going to get there, but I think
12 we need to think about, as some people have suggested, you
13 know, is 80 percent, is 75 percent good enough as we go
14 forward, and the transparency of that data to make sure that
15 the CMS researchers or people doing it think it's good
16 enough to launch forward. So I think another kind of aspect
17 we'd want to think about that.

18 DR. STUART: A question and a comment. We have
19 been referring to this law in kind of generic terms. Is
20 there an official moniker? Is this P-PACA? I won't go
21 further than that.

22 [Laughter.]

1 MR. RICHARDSON: I don't know.

2 MR. HACKBARTH: It's a consensus process. People
3 try different pronunciations, and then they sort of stumble
4 into the right answer.

5 MR. RICHARDSON: Public Law No. 111-148.

6 DR. STUART: Yeah, well, the reason I asked is you
7 remember when the MMA passed, some of us thought that that
8 had something to do with prescription drug coverage, but
9 that never made it into the moniker.

10 I wanted to just say a word, following up on what
11 Bill said, about the research and data. I'm not going to
12 talk about the research side. We've had that conversation
13 before. But there are two parts of this law that might well
14 facilitate the development on the data side. One is the
15 provision that requires that data be made available to
16 private entities in order to evaluate, you know, the quality
17 of providers. Well, in order to do that, you'd also have to
18 be able to develop the data -- or you could develop the data
19 that would be used for research. So I think that there is
20 some compatibility there.

21 Then the second thing is -- and this hasn't been
22 mentioned. I don't know whether it's an appropriation

1 specifically, but it refers to CMS computer system upgrades.
2 And so obviously the extent to which you can get the
3 throughput through faster, then that would also facilitate
4 the development of research.
5 MR. HACKBARTH: Okay. This has been a good
6 discussion. Here is how I would summarize where we are.
7 This topic is actually a multifaceted topic or
8 several different topics put under one heading. You know,
9 today most of our conversation focused on the research
10 demos, pilots piece of this. The other big part of it is
11 the changes in payment policies, least costly alternative
12 and all that stuff. Based on prior conversations, I think
13 we've got a lot of interest in both segments of this and
14 potentially some recommendations to make. And so we'll
15 think about that and come back with a plan on how to proceed
16 from here.
17 The other comment that I would make is that what
18 today's discussion highlights for me is just how complicated
19 the decisions are that still need to be made about how to
20 accelerate the process of innovation within Medicare. In
21 pretty short order, we came up with lots of things to
22 wrestle with and think about.

1 I wouldn't want the message to our audience to be
2 that, oh, we're just focused on the problems or the
3 unanswered questions. This is a huge step forward in terms
4 of a much larger investment which we've often called for
5 more flexibility, which we've called for in various ways,
6 and I think it needs to be emphasized that a big step
7 forward is under way. That said, there are lots of really
8 challenging questions to be addressed to make sure it
9 fulfills its potential.
10 So thank you, John and Nancy. Nice job, and we
11 look forward to hearing more about it.
12 Our next topic is medical malpractice.
13 MR. WINTER: Today I'll be discussing the
14 following issues related to the malpractice system. We'll
15 be talking about the goals of the system; whether it's been
16 successful in achieving these goals, and its other effects
17 on the health care system; and efforts to change the system,
18 based on a review conducted by two experts on behalf of the
19 Commission which looked at state tort reforms and a set of
20 more innovative reforms. Although reform of the entire
21 malpractice system is beyond the scope of the Commission's
22 work, the Commission may want to consider narrow changes

1 within the Medicare program.

2 So first we'll explore why Medicare has a stake in
3 the malpractice system. First, Medicare's payments to
4 physicians, hospitals, and other providers include
5 reimbursement for their liability costs. Although liability
6 expenses account for a relatively small share of Medicare's
7 payment rates, the program also incurs the costs of
8 additional, unnecessary services that are ordered by
9 physicians due to defensive medicine.

10 Medicare also has a strong interest in improving
11 the quality and safety of care for beneficiaries, which is
12 one of the goals of the malpractice system. In addition,
13 medical liability is an issue of great concern to
14 physicians.

15 The first goal of the malpractice system is to
16 compensate patients who are harmed by medical negligence.
17 Injured patients who want to receive compensation must prove
18 to a court that their injury was caused by a provider who
19 failed to adhere to a standard of care.

20 The second goal is to deter medical errors and
21 negligence through the threat of litigation and financial
22 penalties. However, the system appears to perform poorly in

1 both areas and has had other effects on the health care
2 system, which we will briefly review.
3 The evidence is that the malpractice system does
4 not do a good job at compensating injured patients
5 equitably, rapidly, and efficiently. It also does not
6 appear to be effective in reducing medical errors. In fact,
7 the adversarial and punitive nature of the malpractice
8 system may hamper efforts to improve patient safety by
9 discouraging transparency around errors.
10 Another issue is that periodic spikes in
11 malpractice premiums have led to reductions in affordability
12 and availability of coverage. And, finally, the system is
13 associated with direct and indirect costs, which we'll
14 explore in a little bit more detail.
15 Direct costs refer to malpractice premiums and
16 legal costs. CBO estimates that $35 billion was spent on
17 premiums and spending by self-insured providers in 2009,,
18 which is about 2 percent of total health care spending.
19 Indirect costs refer to the additional services ordered by
20 physicians in response to their liability risk, which is
21 also known as defensive medicine.
22 It is difficult to quantify defensive medicine

1 because it is hard to determine whether physicians order a
2 test or a treatment due to legal concerns or for other
3 reasons. Studies have produced varying estimates of the
4 impact of malpractice risk on the use of services, ranging
5 from no effect to a modest increase, depending on the
6 population examined, the types of services studied, and the
7 methodology. Most studies focus on specific conditions and
8 populations and, therefore, their results may not be
9 generalizable to the entire health care system.
10 Several policies have been implemented or proposed
11 to reform the malpractice system. We contracted with two
12 experts in the field -- Michelle Mello and Allen Kachalia --
13 to review and synthesize the evidence of several of these
14 ideas. They looked at two groups: state tort reforms and a
15 set of innovative reforms. They evaluated the effects of
16 each reform on the frequency and costs of malpractice
17 claims; administrative costs, which refers to litigation
18 expenses and insurance overhead; malpractice premiums;
19 defensive medicine; the supply of services and physicians;
20 and quality of care and patient safety.
21 Here's a list of the state tort reforms they
22 reviewed. The evidence base for most of these reforms is

1 substantial. However, it indicates that they generally do
2 not have a significant effect on the key outcomes they
3 examined, with the exception of caps on non-economic
4 damages. So we'll take a closer look at that.
5 There is evidence in the literature that caps
6 reduce average payments per malpractice claim, in the range
7 of 20 to 30 percent; that they modestly constrain the growth
8 of premiums over time; that they modestly improve physician
9 supply; and that they reduce defensive medicine for some
10 services, such as the rate of Caesarean section births.
11 Caps on damages also have implications for the
12 vertical and horizontal equity of awards. Vertical equity
13 relates to whether the size of an award increases along with
14 the severity of the injury, while horizontal equity refers
15 to whether similar types of injuries receive similar awards.
16 Depending on the dollar level of the cap, a cap may
17 undermine vertical equity by equalizing awards for higher-
18 severity and lower-severity injuries. On the other hand,
19 caps could improve horizontal equity for the highest-
20 severity awards because these payouts will tend to be more
21 uniform.
22 We're not going to have time to discuss the other

1 state tort reforms that these experts reviewed, but they are
2 described in your paper, and I'd be happy to take them on
3 question. We'll focus most of the rest of our time
4 discussing the innovative malpractice reforms that they
5 examined.

6 These approaches have had limited or no
7 implementation in U.S. and, therefore, there's a very small
8 evidence base. However, based on the limited evidence and
9 theoretical predictions, the authors of the report concluded
10 that many of these reforms appear promising and may merit
11 further experimentation. Each idea has its pros and cons
12 and key design issues, which I can address during your
13 discussion, and they're also described in the paper.

14 We've organized the list of innovative reforms
15 based on whether they modify the current malpractice system
16 or represent alternative compensation approaches.

17 The first one we'll look at is a schedule of non-
18 economic damages. This involves creating a tiered system of
19 medical injuries ranked by severity and assigning a dollar
20 value for non-economic damages to each tier. A schedule
21 could be used by judges and juries as an advisory document
22 or as a binding guideline.

1 No state malpractice system currently uses a
2 schedule, but other types of compensation systems do, such
3 as Social Security disability insurance and worker's
4 compensation programs.
5 The next idea is a safe harbor for physicians who
6 adhere to evidence-based guidelines. The goal of this
7 approach is to strengthen the weight of clinical guidelines
8 during litigation. It could help prevent or lead to the
9 dismissal of claims that lack merit. It could also reduce
10 defensive medicine because providers would have more
11 confidence about the legal standard of care.
12 This concept was tested in a limited way in
13 Florida and Maine in the 1990s, but there is not much
14 evidence about the impact of these programs.
15 Next we'll talk about government-subsidized
16 malpractice reinsurance for providers. The concept here is
17 that providers who meet certain conditions, such as
18 improving patient safety, would receive subsidized
19 reinsurance or stop-loss coverage on claims that exceed a
20 certain threshold. The appeal is it could offer an
21 additional incentive to providers to improve quality and
22 safety.

1 There is a limited precedent for this approach.
2 Ten states currently run patient compensation funds that
3 cover claims in excess of the providers' primary coverage.
4 But participation in these programs is not conditioned on
5 achieving patient safety goals. The evidence does not
6 suggest that subsidized reinsurance reduces claims frequency
7 or costs. But it could reduce the cost burden on providers,
8 depending on how it is financed, whether through a surcharge
9 on providers or out of general revenues.
10 The next idea is enterprise medical liability,
11 which really refers to two related ideas. The first one is
12 a legal concept which proposes that hospitals or other
13 health care organization should be required to bear full or
14 almost full liability for all injuries that occur in their
15 facilities. This is currently not the legal standard in any
16 state.
17 A related idea is a concept in which organizations
18 voluntarily provide malpractice coverage for their employed
19 physicians, which is known as channeling. Examples include
20 self-insured academic medical centers and integrated
21 delivery system like Kaiser Permanente. Physicians in these
22 organizations can be sued, but the organization is

1 financially responsible. This approach could create an
2 incentive for a hospital to work with its physicians to
3 reduce errors and improve safety because the hospital is
4 responsible for the liability of its physicians.
5 Now we'll shift gears and talk about ideas that
6 represent alternative compensation approaches. The first
7 one is a health court or administrative compensation system.
8 This breaks down to two models. In the health court model,
9 the jury is replaced by a specially trained judge -- usually
10 a physician -- who determines negligence; in other respects,
11 it is similar to the current system. It has the potential
12 to improve the accuracy and efficiency of decisions.
13 In an administrative model, the courts are
14 replaced by an administrative agency that decides the
15 claims; the agency acts as neutral fact finder and
16 adjudicator. This model may use a broader compensation
17 standard than negligence, such as avoidability, which means
18 that the injury would not ordinarily occur in the hands of
19 the best specialist or optimal system of care.
20 Relative to the current system, an administrative
21 model could resolve claims faster with lower overhead costs.
22 It could also lead to generating more claims because it

1 would be easier for patients to file claims. There is
2 limited experience with administrative compensation systems
3 in the U.S. Two states -- Florida and Virginia -- have such
4 programs for birth-related neurological injuries. There is
5 also a national program that compensates patients for
6 injuries related to vaccines.
7 And the final idea we'll talk about is disclosure
8 and offer programs These programs vary, but this is how
9 they generally work. When a medical error occurs,
10 clinicians report it to their institution and disclose the
11 error to the patient and apologize. The institution
12 conducts a rapid investigation into the cause of the error
13 and decides whether to offer compensation to the patient.
14 The compensation may be limited to medical costs or may also
15 include lost wages or non-economic damages. If the patient
16 refuses the compensation offer, they may file a malpractice
17 claim in the traditional process.
18 The experience with these programs is limited to a
19 handful of self-insured hospitals and malpractice insurers.
20 Therefore, there is a very small evidence base. Some of
21 these programs report a decline in the number of malpractice
22 claims, total payouts, and administrative costs, along with

1 an improved culture of safety. For example, the University
2 of Michigan's hospital system experienced a 50-percent
3 decline in the number of claims in the first five years of
4 its program.
5 We'll conclude by outlining some ideas that have
6 been proposed for changes within Medicare. The first one is
7 to provide reinsurance organizations that meet certain
8 requirements, such as reducing errors or disclosing errors
9 to Medicare patients with an offer of fair compensation.
10 This idea could be linked to a demonstration of ACOs. A
11 similar idea was proposed by the Institute of Medicine in
12 2003.
13 A second idea would be to create an administrative
14 compensation system for beneficiaries. This could improve
15 the speed and equity of compensation and reduce the risk of
16 large claims for providers. Similar ideas have been
17 proposed by PPRC and by a law professor named William Sage.
18 So we'll conclude with some suggestions for your
19 discussion. We'd be happy to take any questions about
20 reform strategies that we've talked about today, and we'd be
21 interested in your thoughts on whether Medicare should play
22 a role in malpractice reform.

1 MR. HACKBARTH: Thanks, Ariel.

2 Let me just add to what Ariel just said about what
3 we're trying to accomplish here. This is our first
4 discussion on malpractice, and exactly where we go obviously
5 will depend on today's discussion and future discussions.
6 At this point I wouldn't think that our contribution would
7 be to, you know, discuss, evaluate, recommend specific
8 reforms. We've got a lot of different competing ideas out
9 there. I'm not sure that that necessarily plays to our
10 strength.

11 On the other hand, discussing the effect of the
12 malpractice system on the Medicare program, the effect on
13 the ability of Medicare beneficiaries to have access to
14 high-quality care at reasonable cost clearly is within our
15 domain and something where I think we can contribute.

16 We also may wish to go the additional step of
17 talking about some specific Medicare links, as Ariel
18 concluded with a couple of ideas in that vein. So we will
19 have to shape as we go along.

20 Let me see hands over here for round one
21 clarifying questions.

22 DR. CHERNEW: I may have missed it, but is the

1 review that Michelle -- is that available separately?
2 MR. WINTER: We are going to be posting that soon
3 after the meeting. Yes, that will be on the website.
4 MR. BUTLER: Ariel, could you clarify, if not now,
5 later on? You make a statement in the beginning, Medicare
6 covers its share of liability costs for hospitals and
7 physicians, which is a little misleading in the sense that
8 it's not a carve-out in most cases, and then they say -- but
9 it's also not simply -- so talk a little bit about how, in
10 fact -- what you mean by that statement and where, in fact,
11 it is somewhat true but not exactly true, because it's
12 folded into other payments in most respects.
13 MR. WINTER: It's built into the -- it's part of
14 the cost that Medicare is at least trying to reimburse
15 providers for. So for hospitals the share is roughly 2
16 percent, and that's determined from hospital cost reports.
17 For the physician fee schedule, there's a separate -- there
18 are the three competencies --
19 MR. BUTLER: It doesn't mean it automatically gets
20 paid for. It's just part of the DRG payments that we
21 receive --
22 MR. WINTER: Correct. It's not a --

1 MR. BUTLER: -- a cost trend, but it is not
2 separately identified in the paper. I am just trying to
3 clarify that. And then on the physician side, it works a
4 little bit differently.
5 MR. WINTER: Where it is separately identified
6 through the payment system, there are the three components:
7 the work, practice expense, and professional liability
8 insurance, which is the smallest components, about 4 percent
9 on average. But that varies by specialty and by service.
10 At higher specialties and services, it's a much higher share
11 of the total payment than on average across all physicians.
12 MR. HACKBARTH: In the physician context, it's the
13 measurements used to determine the rate of increase in the
14 rates and then the allocation, the relative values across
15 different services.
16 MR. BUTLER: It has a much more specific input
17 into the physician payment system than it does in the
18 hospital side. Not that it's not a factor on the hospital
19 side.
20 MR. HACKBARTH: Yeah, although there on the
21 physician side, as with the hospital, it isn't a cost
22 reimbursement system.

1 MR. BUTLER: Exactly.

2 MR. GEORGE MILLER: Well, Peter just said my
3 point, and that's the point I was going to make. It's in
4 the DRG payment. It's not a reimbursement issue for the
5 hospital.

6 DR. SCANLON: Not being a lawyer, I may be
7 misinterpreting non-economic damages, but I think of them as
8 pain and suffering compensation, and so I guess I'm
9 wondering sort of how SSDI and workmen's comp -- because I
10 think of them as income replacement programs. And so how
11 they would fit under this -- this is page 12.

12 MR. HACKBARTH: [off microphone] Page 12?

13 DR. SCANLON: 12, how they fit under sort of the
14 idea of a schedule for non-economic damages, because I see
15 the idea of coming up with a schedule as much more
16 challenging than coming up with an SSDI or a workmen's comp
17 or even a VA disability sort of schedule for payments.

18 MR. WINTER: That's a fair point. I'm not exactly
19 sure how they factor in non-economic damages. The authors
20 talk about -- do mention that these programs -- they do have
21 schedules, and it's unclear -- and I'll go back and look at
22 this -- whether and to what extent they're compensating for,

1 you know, income loss and medical costs versus pain and
2 suffering.
3 MS. BEHROOZI: I think because it's all in, you
4 know, whatever it is, economic or non-economic, that's
5 effectively a schedule of non-economic -- you know, it's a
6 schedule of damages, and so that includes measurable
7 economic and non-economic. It's all -- there's no other way
8 to get non-economic damages when you have a workers' comp
9 claim.
10 MR. HACKBARTH: Jay, let me ask a question about
11 the Kaiser Permanente system. As I understand it, the first
12 step for a KP member that has an issue is to go through an
13 administrative process. Does that process address non-
14 economic losses? And how is it done in KP?
15 DR. CROSSON: Well, it does. I mean, it's an
16 administrative process -- well, first of all, we have the
17 disclose -- I forget the term we were using -- disclose and
18 offer process also, which is a more recent addition. I
19 wouldn't say it's fully rolled out in the organization. But
20 we have been doing that, and it has been quite successful.
21 Failing that, either because we didn't do it or
22 because it was rejected, we have a process that uses a panel

1 of three individuals, usually former judges -- one of whom
2 is selected by the person who is bringing the concern, one
3 by us, and then the third by the two who have been selected.
4 Non-economic damages are considered. Most of our program,
5 as you know, is in California, and in California we have the
6 cap. We've got a cap for nearly 30 years on non-economic
7 damages under the MICRA legislation, Medical Injury
8 Compensation Reform Act. And so, you know, it takes place
9 under the framework of MICRA.

10 MR. HACKBARTH: Beneath the MICRA cap, is there
11 sort of a schedule, as this describes, a schedule of non-
12 economic --

13 DR. CROSSON: There is not. There is not.

14 MR. HACKBARTH: So it's a case-by-case judgment.

15 DR. CROSSON: Yes.

16 MR. WINTER: Foreign malpractice systems like
17 those in Scandinavia or New Zealand that do have
18 administrative compensation do have a schedule of damage for
19 non-economic losses.

20 DR. BERENSON: My comment was actually related to
21 that same topic. This is an excellent summary, and you and
22 your authors should be congratulated. I actually spent four

1 years running a malpractice reform project for Robert Wood
2 Johnson, and it's hard to summarize all this stuff.
3 The one thing that's not here which did get a lot
4 of attention and may be implicit in your description of
5 administrative, but alternative dispute resolution as a
6 category, anywhere from voluntary to mandatory mediation,
7 court-ordered mediation, has been tested. And then I think
8 we would call the Kaiser Permanent binding arbitration, and
9 that has been subject to controversy. And so I'm just
10 wondering whether your authors had a discussion of the
11 evidence around those or not.
12 MR. WINTER: We didn't ask them to look at that as
13 a separate topic. We requested that they look at certain
14 reforms that had been proposed based on our review of the
15 environment and the literature. We can certainly -- you
16 know, if we take a next step here, we can drill down and
17 take a closer look at alternative dispute resolution --
18 DR. BERENSON: I don't want to make your life much
19 tougher, but one of the value's of MedPAC work is to provide
20 good authoritative reviews of literature and things like
21 that. So to the extent that we would see this being used
22 for that purpose, then unfortunately we would make your life

1 more difficult by wanting to make it more comprehensive and
2 make sure we haven't left anything out and all that kind of
3 stuff. I don't know if we want to go in that direction or
4 not.

5 DR. DEAN: I would just echo what Bob said.
6 Having lived with this stuff for all of my professional
7 life, this is probably the best summary of the alternatives
8 that I've seen, and, really, it was very helpful.

9 Just a very small point on the issue of enterprise
10 liability, the people that have proposed that or advocated
11 that, certainly a lot of cases originate outside of
12 institutions. I mean, failure to diagnose is one of the
13 biggest causes of -- and so is there a way to deal with that
14 under this mechanism?

15 MR. WINTER: A really tough design decision is how
16 you deal with those situations. One idea that's been
17 proposed is that you sort of link clinicians to a hospital
18 based on where they, you know, admit their patients or
19 generally practice, sort of like, you know, a virtual ACO
20 kind of idea. I don't know very much about it. That's
21 pretty much the extent of it. But it's something that's
22 been thought about and would clearly be an important design

1 issue, is how you deal with that.

2 MR. HACKBARTH: Although it would seem to me in
3 some ways that that's inconsistent with the basic notion of
4 enterprise liability. Enterprise liability is based on the
5 idea that it's not one actor, it's a system, and what you
6 want to do is hold accountable the people who control the
7 problem, fix the problem. If you're talking about a
8 physician out in solo practice making a mistake in his or
9 her solo practice, that's really not within the hospital's
10 domain of control.

11 DR. DEAN: It really depends on what kind of a
12 structure you're dealing with, what kind of an organization.

13 MR. HACKBARTH: Right.

14 DR. BERENSON: Well, I think that is right,
15 although I guess I'd make two points. This came out of, was
16 a recommendation from Harvard Law School folks about 20
17 years ago, and it's not actually inconsistent with the
18 Elliott Fisher notion of assigning physicians to the
19 hospital and then -- I mean, I'm not particularly -- I mean,
20 I'm sort of with you. But one of the purposes of enterprise
21 liability other than sort of the basic one of having a
22 system be accountable is to decrease all of the various

1 defendants, all with their own individual behaviors. And so
2 part of the rationale that these Harvard folks came up with
3 is to just make it a lot simpler, have a single defendant to
4 move towards easier settlements, and sort of -- they did
5 say, well, we're going to assign docs to the hospital. This
6 was before, you know, the hospitalist movement where most
7 doctors actually did walk into the hospital. And one of
8 their goals was actually to decrease all the noise in the
9 system with different strategic behavior by a whole bunch of
10 different sets of defendants.
11 [off microphone] So [inaudible] there's pros and
12 cons.
13 MR. KUHN: One area -- again, I'll say what others
14 have said. This really was a very good paper, and I
15 appreciate the hard work on that.
16 Just on the notion of the dispute resolution that
17 Bob talked about earlier, Johns Hopkins has a really
18 interesting project, and when I was at CMS, we looked very
19 hard at that one. So that's one we probably ought to look
20 at as well.
21 But the question I had was on access, particularly
22 in the cyclical premium increase section of the paper, and

1 access from two parts, if there was any information that we
2 had or saw during the research. One is there's always been
3 these reports of flight, that is, physicians leaving one
4 state to go to another state when premiums moved up. And
5 mostly you see that maybe more closely aligned where there
6 is a metropolitan area that crosses two borders of states.
7 But if there's any information on that, and did that impact
8 access, flight of physicians from one state to another?
9 And the other aspect on access is the loss of
10 services, not necessarily a Medicare service per se, but I
11 know at least in rural parts of Missouri, when they saw at
12 one time a large spike of premium increases, primary care
13 physicians in those rural areas just stopped delivering
14 babies. And so a lot of rural hospitals stopped their OB
15 services altogether, and so you lost access in those areas,
16 and there were long drive times for delivery of children as
17 a result.
18 And so any evidence on those two or things that we
19 could ultimately augment this paper with?
20 MR. WINTER: Sure. The studies that I've looked
21 at and also have been looked at by other researchers
22 concluded that the evidence is sort of mixed, the

1 relationship between growth of premiums and problem with
2 access to services or physician supply. GAO looked at this
3 issue, I think in 2003, in seven states, and they found
4 there were localized access problems like access to
5 emergency care in rural areas, but they didn't find
6 widespread access problems in areas like spinal surgery and
7 mammography.
8 There was another study by Dranov and Groan
9 [phonetic], I think in 2006, where they looked at Florida in
10 the case of brain surgeries, and they found that there were
11 -- patients were traveling longer distances to get brain
12 surgery, but there was over -- and some neurosurgeons had
13 reduced their provision of brain surgery, but overall there
14 was volume growth in that time period, so sort of, you know,
15 mixed findings.
16 Then Michelle Mello did a study of co-authors in
17 2007 looking at Pennsylvania, which was identified as a
18 crisis state by the AMA in terms of high premium growth, and
19 they looked at whether there was a change in high-risk
20 specialists either reducing the scope of practice or exiting
21 practice. And they really found no changes in this period
22 with the exception of OB-GYN.

1 So those are three studies that are out there that
2 I could investigate as well.
3 MR. BERTKO: So going to Slide 18 again, my
4 questions, I think clarification, making no assumptions
5 about what states would do in their environment, can
6 Medicare take these actions alone or with some change in
7 only Medicare law? Is that something you're going to look
8 into?
9 MR. WINTER: That's a huge issue. There are very
10 significant constitutional issues at the federal level and
11 the state level in terms of Medicare entering this arena.
12 One way to perhaps avoid or deal with some of these issues
13 is to create a voluntary approach where, you know, if
14 providers do X, then the program will do Y in terms of
15 providing subsidies for malpractice premiums or some kind of
16 incentive like that. And even with an administrative
17 compensation system, the ideas that have been talked about
18 are demonstrations that would be voluntary. Perhaps this
19 could be required as the first forum or the first, you know,
20 level if a Medicare beneficiary has a claim, they'd bring it
21 through the administrative compensation process. And then
22 if they're not satisfied, they can still go to, you know,

1 federal court or state court. And that's sort of similar to
2 how the administrative appeals process works, is that there
3 is a system, a process within the agency that beneficiaries
4 have to go through, but if they're not satisfied, they can
5 take it to a federal court.
6 But we have not spent much time looking at these
7 issues. The articles that have talked about them, like
8 William Sage's piece, they spend a lot of time discussing --
9 noting the significant constitutional issues, and there's
10 not -- you know I don't have ideas for resolving those, but
11 it's clearly an important issue.
12 I'll stop there.
13 DR. MARK MILLER: I will just reinforce that
14 because I knew this question was going to come up at some
15 point. You know, it took us -- it was a fair amount of
16 heavy lift just to get to this point. I think Ariel has
17 been doing work just to get us to here, what are we talking
18 about.
19 I think one place that we could focus -- because
20 if you talk about constitutional issues or state issues, a
21 different way of focus is there are things that
22 organizations can do voluntarily. You know, the disclosure

1 and offer is something that within your context you can take
2 on. It doesn't necessarily mitigate the rights of the
3 person to go and, you know, seek redress through the courts.
4 And we may want to focus our efforts there as a way to what
5 could be done voluntarily without changes in law just to
6 organize our thinking. We could still even talk about
7 changes in law, but that might be one way to focus our
8 efforts.
9 MR. HACKBARTH: But even voluntary systems have to
10 be constructed within state law.
11 DR. MARK MILLER: Right
12 MR. HACKBARTH: And so Kaiser Permanente's system
13 is one -- I don't know what the relevant California statutes
14 are, but it's an acceptable mechanism for resolving these
15 disputes under the rubric of California state law. The
16 problem with doing it through Medicare is you are cutting
17 across all these jurisdictional boundaries, and it just adds
18 complexity to it.
19 DR. STUART: This refers to Slide 16, and it's
20 building in part on a point that Bill raised about the
21 relevance of SSDI and worker comp for this administrative
22 model. And I'm less concerned with the nature of the

1 decision than I am with the idea about if the decision is
2 made by an administrative law judge, just as an example,
3 there's a lot of history and controversy about
4 administrative law judges under eligibility determination,
5 particularly during the Reagan years, and how this might be
6 politicized. And my question is: Was that experience --
7 because I think that experience might be relevant here, and
8 I'm wondering whether that was brought up by your authors.
9 MR. WINTER: Yeah, the notion of how appeals are
10 handled and the process for doing that, yeah. So the
11 existing administrative compensation systems do have an
12 appeals process. The authors of the report found that the
13 rates of appeal were fairly low, something in the range of
14 15 to 20 percent.
15 DR. STUART: I was thinking in a larger sense of
16 decision making regarding how administrative law judges are
17 to make their decisions, and, again, I'll bring up the
18 Reagan years in which the eligibility for SSDI was really
19 choked off, and so there are obviously possibilities for
20 that if you have this structure in place. That was my
21 question.
22 MR. WINTER: Right, and I don't think the report

1 got into that. That is something we could consider for
2 future work.
3 DR. CASTELLANOS: Ariel, I think first of all this
4 is great work, and I really appreciate you bringing this up.
5 I think it's a good start in the discussion of this issue.
6 I guess my clarification question was: During the
7 health care debate, President Obama mentioned demonstration
8 projects, and I haven't heard anything more about that, and
9 I didn't see anything discussed yet. Do you know where we
10 stand with that?
11 MR. WINTER: AHRQ has put out a Request for
12 Proposal to award grants to programs, organizations that
13 want to test alternatives to the current system. They have
14 not yet announced as of Monday awardees of these grants, so
15 it's unclear. But they have laid out a process, and
16 applications have been submitted, is my understanding. And
17 the goal of that demonstration is -- I think there are four
18 goals. One is to improve patient safety and quality,
19 improve communication between physicians and patients,
20 improve affordability of liability coverage, and improve
21 compensation to patients in a fair and rapid way. But
22 awards have not been made yet.

1 MR. HACKBARTH: Ron, in view of your longstanding
2 interest in this, we'll even give you the opportunity to
3 kick off round two.
4 DR. CASTELLANOS: I really meant what I said,
5 Ariel. It's a great presentation. Throughout the paper
6 fairness permeates, and I think that's where we need to go.
7 You know, just on this subject here, on Slide 16,
8 since you have it there, two states administer a program on
9 birth-related neurologic industries, one of them is Florida.
10 I happen to be very involved in that. It's a NICA program.
11 It's the Florida birth-related neurologic injuries. For
12 most of the people here, you've never heard of that, but it
13 works in the State of Florida. It is totally funded by the
14 hospitals and physicians. We have to pay a fee every time
15 we renew our license and send to the hospitals.
16 But the whole -- and if you know these people that
17 are running it, and I have talked to them, they're really
18 passionate about being fair to the patient and to the
19 family. It's not an issue -- in a lot of these birth-
20 related injuries, it's really not a malpractice issue. It's
21 a matter of these are sick kids who have multiple problems,
22 and it's difficult to point out malpractice or liability.

1 And they don't do that. They say they're going to make this
2 patient fair and they're going to try to make the patient
3 whole. So it's a fairness issue, and it really does work.
4 I'd like you to maybe look at that.
5 Another issue is an issue we have in Florida
6 called sovereign immunity, and that's a special issue, and
7 that really works, especially for the public hospitals.
8 I guess my feeling where we should go with this,
9 our real goal on MedPAC should be an educational thing, and
10 that hasn't been said. I think we really need to educate
11 not just the physician community but hopefully the whole
12 medical community.
13 I think fairness is an issue we need to do, and we
14 need to stress on innovations, and I'd really like to have
15 that looked at and perhaps those three goals.
16 DR. BORMAN: Round two. Just a comment and then a
17 couple of suggestions about direction. And, Ariel, this is
18 really super, as everybody else has said.
19 One of the things that strikes me in the materials
20 -- and it's in the literatures -- we are somewhat imprecise
21 in how we sling around terminology. And so we talk about
22 injury, we talk about error, we talk about disclosure, we

1 talk about malpractice. I mean, it's just -- negligence.
2 And at least on the legal side -- and my lawyer colleagues
3 here can correct me if I misstate this, but there are some
4 relatively precise meanings to some of those terms, and I
5 think we just need to be very careful about that.
6 I personally prefer "professional liability" to
7 "malpractice" just because I think there is a connotation,
8 particularly of the "mal" part, that immediately leads us to
9 start assigning blame, and part of the problem we have in
10 our process is that it is -- seems to be mostly about
11 assigning blame as opposed to getting to a fair outcome for
12 patients and getting an improvement to the system. And so
13 to the extent that we can choose our terminology to be
14 accurate and consistent and perhaps as neutral as possible,
15 I think that would be a really positive thing, and
16 particularly the other thing that I find in the world of
17 surgery relates to the term "complication." You do need to
18 remember that this is not about widgets coming off an
19 assembly line. This is about a biologic population. A
20 biologic population, by definition, there will be some
21 things that we might term "bad outcomes" or "complications."
22 That does not necessarily mean that something was done or

1 failed to get done that did that. A certain number of
2 people are going to experience an adverse outcome in today's
3 world, and I think it's probably important to remember that.
4 Moving past those and trying to get to Slide 19 to
5 say, you know, where might we go with this, it would appear
6 to me that we get back to what we said initially, you know,
7 what's the point of the system, what are the goals, and
8 actually setting compensations for injury and rules systems
9 for doing that, I'm just not sure that's a place where we
10 belong, although obviously I'd defer to you all's
11 interpretation. But I think that other than to the extent
12 that some of these scales or systems might be examples of
13 places that could be reform strategies, I otherwise would
14 try to be pretty light on that part. I just think that
15 starts to take us down a road that we don't have expertise
16 and needs to be left to other communities.
17 I do think that, you know, where the linkage does
18 come and why it is appropriate for Medicare to play a role
19 relates to the ongoing big strategic effort of the
20 Commission to move toward a high-performance, high-
21 efficiency, high-value system. And this particular topic
22 does have so many overlaps. There's linkages here to the

1 comparative effectiveness piece, particularly in terms of
2 the safe harbor considerations. There's linkages here to
3 shared decision making and to the extent that that will help
4 make a better relationship, that at least in a lot of
5 studies, particularly, for example, the American College of
6 Surgeons has done a very large closed claim analysis,
7 communication errors end up being so important at some of
8 the base of this, and maybe that's where shared decision
9 making and clear decisions about advance directives or other
10 things may, in fact, be helpful.
11 I think those would be the two biggest places that
12 I see them spilling over. We might want to just happen to
13 just maybe a compilation of the efforts that some groups,
14 either medical associations and/or consumer associations,
15 have brought to bear in thinking about this, you know,
16 strategies they've done for their membership and just,
17 again, for example, from this closed claim analysis, the ACS
18 has structured a lot of educational programs both at
19 national meetings, but also producing a DVD that's called
20 "Disclosing Surgical Error" that is a very fine thing that
21 helps to bring people to a level of proficiency and
22 competency, if you will, for the practitioner, and also it's

1 a great tool in a residency program.

2 And then just one last little comment, in a very
3 anecdotal sliding scale across states, some states have, in
4 fact, been pretty effective, and I will say that in
5 Mississippi there actually was -- it was a crisis state, and
6 lots of things were undertaken, and not only did premiums go
7 down, but practitioners of certain disciplines did, in fact,
8 come back to the state. For example, OB-GYN availability,
9 particularly on the high-risk side, and neurosurgery are
10 things that the state became more capable about. And so I
11 think that at least there's one state where that was true.

12 And I will say that in educational conference
13 discussion with residents and students, which I think is an
14 important piece of the downstream of this, we much less
15 often talked about order this to protect yourself than we
16 did about similar cases in either Florida or now
17 Pennsylvania. And so I just -- my only point being that
18 measured by what we're conveying to the next generation of
19 physicians on a very anecdotal, non-randomized, biopsy basis
20 that states that have reputations as more difficult states,
21 it is -- we're building defensive medicine at the medical
22 student level and going forward, not just at the graduate

1 practitioner level.

2 DR. CHERNEW: I first want to throw my hat in the
3 ring behind everyone that said this was really very
4 interesting and behind Ron's comment that education is
5 really an important component of this.

6 I think I may have read this slightly different
7 than some people in general -- maybe not -- in the following
8 sense. Here's what I took from it, and I just want to know
9 if this is the right message.

10 There are isolated situations where the system is
11 very broken and bad things happen, so there's particular
12 places where there are problems that could lead to some
13 costs and it could lead to -- there's unfairness, and it
14 could lead to lack of access and those things occur. But on
15 the grand spectrum of all the problems that face Medicare
16 one way or another, this didn't strike me, after I read
17 through it, as being as big as one might have thought it
18 would if every time one tries to give a cost about a health
19 care system or health care reform, there's three people that
20 are in the front screaming about malpractice.

21 So I read this to say that without defending the
22 malpractice system, which I want to be clear I don't want to

1 do, or claiming that we couldn't do better, which I'm sure
2 we could do and which I think we should try and encourage,
3 in the grand scheme of problems, when I read the evidence or
4 the review -- the summary of the review of the evidence
5 relative to the anecdote or the general view, I felt that
6 the problems might not be as big as I otherwise might have
7 thought, although they might be big in isolated places, and
8 even more problematic, the solutions to those problems don't
9 seem to be as effective as one might think the solutions to
10 the problems were. There's a whole list of things, and you
11 basically say, well, here's one that works on a small set of
12 outcomes. But in terms of the grand scheme of things, if we
13 were to get it exactly -- I didn't see as much there.
14 So I don't know if I misread that, but that was my
15 read.
16 MR. HACKBARTH: Rather than engage on whether your
17 reading is the accurate one or not, what I'd suggest is
18 that's a topic that we ought to come back to and discuss
19 later on in a focused sort of way because that goes to the
20 impact of the malpractice system on Medicare, which I think
21 is something that we surely ought to address in our future
22 work on this.

1 MS. BEHROOZI: I'm not fully understanding, you
2 know, all of what you meant by saying that, Mike, but first
3 I should also add my kudos, Ariel, and as the token rank-
4 and-file lawyer member of the Commission, I had fun reading
5 this, actually. But to me, you know, there's this
6 quantification $35 billion of premiums and legal costs.
7 That's money that's being spent that ought to be spent on
8 health care, and also there ought to be ways of achieving
9 better safety outcomes or better results that don't cost so
10 much relative to what we get for them. So, you know, to me
11 that's a reason to pursue it.
12 Just two comments, I guess, one somewhat related,
13 I think, to what Bruce brought up. You mentioned the
14 workers' compensation programs, different programs by
15 different states, obviously, as being places to look for
16 examples with respect to alternative compensation systems,
17 particularly administrative ones, and schedules of damages.
18 But I would -- and so in the studies that were done, they
19 looked at malpractice programs, programs to address medical
20 malpractice or, as Karen says, professional liability
21 issues. But I would suggest in future work to actually look
22 at workers' compensation systems.

1 Bruce brought up some of the complaints about the
2 SSDI adjudication, but you'll find a whole treasure trove of
3 analysis of workers' comp problems and benefits. I mean,
4 clearly it protects employers. Clearly, it's quicker for
5 workers to receive some kind of compensation, but employers
6 will complain about how high their premium costs are, and
7 workers' advocates, having been one, will complain long and
8 loud about how workers really don't get very fair
9 compensation on the non-economic side, you know? There's a
10 schedule for if you lose a finger it's this much; if you
11 lose three fingers, it's this much -- neither of which, you
12 know, necessarily is related to whether you can work or not.
13 It's a value on body parts kind of thing. And, yeah, what
14 all the thinking was that went into that happened a long
15 time ago, and there's certainly been a lot of work -- not
16 necessarily of the MedPAC analytical nature, a lot of
17 complaining about how that has worked out. But most
18 importantly, as far as workplace safety goes, that system
19 hasn't been the one that's done a whole lot about workplace
20 safety. We still need an OSHA. We still need state labor
21 laws and labor departments and enforcement in all kinds of
22 other ways. So I think that's an important area to look at

1 for lessons, not necessarily about why it wouldn't work to
2 do things that way, but what you would have to take into
3 consideration in a design.
4 On the question of voluntariness of something like
5 that, I think there's a whole big issue about at what point
6 and with whom you get that voluntary consent, and then what
7 impact that will have, because if it's at the point, say,
8 that someone has a claim when you can voluntarily decide to
9 go into an administrative adjudication route, I don't know
10 that malpractice insurers are going to discount their
11 premiums very much knowing that the provider is still
12 subject to, you know, a massive damages award, whatever, if
13 a particular patient at a particular point in time makes a
14 different decision if it's always an option to go down the
15 other path. So I think we really need to look at at what
16 point and by whom, if we're going to talk about voluntary
17 systems, that decision should be made, like in the
18 employment context, you know, many people when they're
19 signing an employment contract sign away, waive the right to
20 bring lawsuits about all kinds of things. I mean, you know,
21 you can't sue your broker; you have to go through an
22 administrative adjudication process. But that's because

1 when you enter into the relationship, you sign away that
2 right. And I don't know how you could construct that in
3 this setting.
4 And then the final thing I just wanted to mention
5 -- Karen brought it up -- the connection to shared decision
6 making, it's noted in the paper -- thank you, Joan and
7 Hannah -- that in the Washington State statute there is
8 protection for physicians who engage in shared decision
9 making. And I know it's too soon to look at any results
10 from that, but I wondered what they looked at and what they
11 decided -- what was the evidence base for their decision to
12 do that, and, you know, what other lessons we can learn to
13 illuminate how we might go forward with respect to all of
14 Medicare.
15 Thank you.
16 MR. BUTLER: One editorial and then two
17 suggestions. The editorial is somebody once told me the
18 reason there's a lot of malpractice is because there's a lot
19 of malpractice. I said okay. And the problem is that there
20 is -- well, there is a lot of errors, and the problem is the
21 amount of money, and who receives the money is out of line
22 with it, for sure. More people should be getting money, and

1 they should be getting it quicker, and some people are
2 getting too much and even the legal system is getting too
3 much. But the paper reinforces that, but I think the
4 administrative compensation system actually probably has the
5 greatest -- for me, on paper, has the greatest promise of
6 perhaps helping align the money available with the errors
7 that are continuing, unfortunately, to be made in
8 organizations. So that's one comment.
9 The second is that -- and this is just -- I don't
10 know if you can do it. You've got such a nice description
11 of all the interventions. I'm a visual kind of guy that if
12 you could somehow graph -- you know, this is the kind of
13 thing where you could -- it would be great -- speaking of an
14 educational tool, I'm not sure what the X and Y axis are
15 yet, but there's a way you could kind of plot these in a way
16 that would say this is the range of options on a page and
17 their impacts might be or not, or a continuum. I think it
18 could be a powerful educational tool.
19 The third comment relates to a little bit picking
20 up on Mike's words, say, well, you know, this is where you
21 drown in a lake that's an average of five feet deep, maybe.
22 You know, I'm sitting in Cook County in Illinois, and so I'm

1 at one end of the spectrum. But I think when you talk about
2 the direct costs versus the indirect and the premium
3 variations, two of your categories, this is an enormous -- I
4 think we need a little bit more data on the variation in
5 costs and coverage in a kind of, you know, numerical sense,
6 as well as, you know, the fluctuations over time. So that
7 would help bring to light some of why this is a big issue in
8 terms of the direct cost. Let me just give you a couple
9 data points.
10 Around 2002 -- I might have my year wrong -- we
11 suddenly were not able to access insurance the way -- and
12 this was true of major providers in Cook County. All of us
13 were subjected to virtually a $20 million deductible, if you
14 will, self-insured retention. So the first $20 million of
15 every claim, with no aggregate, we were self-insured
16 overnight virtually. Okay? And then even for the coverage
17 above the $20 million, it was almost $10 million in premium
18 for the excess coverage. So we suddenly escalated to, on
19 about a $1 billion budget, a $60 million-a-year expense that
20 we have to record on our P&L. Right? And it was not 2
21 percent of the cost. It was a million -- and so when you
22 look at your -- and then what you have to fund on that,

1 according to accountants, suddenly the cash, you know,
2 almost overnight you had to save for funding liabilities
3 associated with -- now, Cook County is an extreme example,
4 but the major players in Cook County, the advocates, the
5 Northwesterns, the Rushes of the world, were subject to the
6 same kinds of things.
7 Now, since that time, it's come down dramatically,
8 and so now I could say we're higher quality. I think we
9 are. We have a very effective mediation process. Now the
10 expense on our books is about half that in 2009. Okay?
11 These are big swings in a bottom line if you think about it,
12 and so, yes, in the aggregate across organizations, in the
13 system overall, but in a marketplace it can have a dramatic
14 impact. And this was the time where OB groups in Cook
15 County were literally relocating over the Wisconsin border
16 and so forth.
17 So this is one of those big swings within
18 organizations that, you know, if we had a little more
19 appreciation for the geographic variation in coverage and
20 cost as well as the spikes up and down over time, I think it
21 would help highlight a little bit more about how important
22 the issue is.

1 MR. WINTER: And on your suggestion of having a
2 chart that displays the evidence for different reforms,
3 there's a very good chart that's in the researchers' report,
4 which you'll see once we put it out. I didn't duplicate it
5 for the paper, but it does summarize the evidence along each
6 of the outcomes they looked at for each reform option.
7 MR. HACKBARTH: In that sort of table assessment,
8 it seems to me that another important dimension of this is
9 what is your goal. You know, the malpractice system has
10 multiple goals. You know, one is to punish bad behavior,
11 poor performance. Second is to compensate victims for bad
12 outcomes. A third might be to stimulate improvement. And
13 which reforms you like depends in part on which of those
14 goals you think ought to take priority, because they can
15 lead you in different directions in terms of how you
16 structure the system.
17 MS. HANSEN: Thank you, Ariel, for doing this
18 whole topic. I think so much of it is an emotional
19 reaction, let alone the pure financial implications here.
20 One of the things that was cited in the report was
21 the fact that Medicare beneficiaries do disproportionately
22 suffer the injuries from this, but then have fewer episodes

1 of claims relative to the private sector here. I know that
2 it was alluded to, but I wonder if we could get a little bit
3 more in the future about describing that process.

4 The second request is relative to what's been
5 happening with the caps across the different states. I
6 think in the report there are, you know, some states right
7 now that are overturning the caps, and so the ability to put
8 some context as to what that means and what's behind this
9 kind of direction while we're talking about perhaps this
10 being an effective way to consider -- basically keeping some
11 control, but there is a movement afoot in the states now to
12 overturn the caps.

13 And then, finally, the third aspect would be
14 relative to especially the people who are a little bit more
15 vulnerable and having these caps on, whether or not that's
16 one of the factors that comes into play when you have
17 Medicare beneficiaries or people who are in more public
18 systems who are vulnerable who aren't able to speak to this
19 issue.

20 So I wonder if there's been any sub-study or
21 people who are oftentimes, you know, more in the disparities
22 group as to how they show up in any of this system at all.

1 MR. WINTER: We could look into that.

2 MS. HANSEN: Thank you.

3 MR. GEORGE MILLER: I also want to add my thanks,
4 Ariel. Excellent job.

5 I want to follow up on Peter's first point and one
6 of Jennie's points as well. In rural hospitals, we found
7 the same problem as Peter described in Cook County,
8 obviously not to the magnitude of Cook County because of the
9 high payments, but it still had the same overall effect,
10 except for those, when I was in Texas, public hospitals that
11 had a cap by the state of Texas, if I remember correctly,
12 either $100,000 or $150,000, because they were part of the
13 state system. So they had a strategic advantage as far as
14 the costs for malpractice because of that. So that created
15 an equitable situation, as Peter has described. I wonder if
16 we can find out a little bit more about that and see that
17 impact, because, again, as Peter already stated it, Medicare
18 -- the reimbursement is in the Medicare DRG payment, so
19 we're not getting compensated for the additional costs of
20 malpractice.

21 And then to Jennie's point about Medicare
22 beneficiaries overall, it said in the paper, did not bring

1 suits, do you know why they don't bring the suits as the
2 rest of the other payers or non-beneficiary payers? Does it
3 have anything to do with the impact of -- well, I'm not sure
4 what it is. I want to ask that. But I'll ask a different
5 question. Do you know the impact of physicians and
6 hospitals who offer apologies, who say, "We made a mistake,"
7 and how that impacts malpractice in any way at all?
8 MR. WINTER: So I'll try to address both
9 questions. A couple of reasons have been posited for why
10 beneficiaries are less likely to file claims and when they
11 do receive -- and receive compensation, and that when they
12 do receive compensation it tends to be much lower than
13 privately insured individuals.
14 MR. GEORGE MILLER: Private insurers.
15 MR. WINTER: One could be that because they tend
16 to be a sicker population, it might be more difficult to
17 relate an adverse event to an error or an act of negligence
18 by a provider. They may be less willing to -- they may be
19 very loyal to their hospitals and physicians and, therefore,
20 less willing to bring them to court.
21 Another issue is that attorneys -- because their
22 expected damages are going to be less because they tend not

1 to be working, they have shorter life expectancy, therefore
2 the expected damages are going to be less, and, therefore
3 attorneys may be less likely to take those cases because
4 they work on a contingent fee basis.
5 So those are some reasons that have been posited.
6 I'm not aware of empirical evidence explaining why they're
7 less likely to sue.
8 And then the second question was about -- just
9 remind me, about the --
10 MR. GEORGE MILLER: [off microphone] [inaudible].
11 MR. WINTER: The impact of disclosure and offer
12 programs, right. So we only have -- results for only two
13 programs have been published, so it's, you know, very thin
14 evidence, very anecdotal. Those two programs, one is the
15 University of Michigan. I believe the other one is a
16 program run by a Colorado malpractice insurer. They report
17 reductions in claims, number of claims, reductions in total
18 payouts, and reduced administrative costs, as well as an
19 improved culture of safety within the institution.
20 DR. CROSSON: Yeah, I would like to talk a little
21 bit to the issue of linkage of this topic to the Medicare
22 program and to the work of the Commission. I realize I have

1 a tremendous opportunity here as an outgoing Commissioner to
2 suggest a lot of work for you and then not have to bear any
3 of the burden of dealing with it.
4 [Laughter.]
5 DR. MARK MILLER: Can we cut that microphone off?
6 MR. HACKBARTH: You wouldn't --
7 DR. CROSSON: I'm actually going to speak a little
8 bit in the other direction, I think, and that has to do
9 with, I think, some of the complexity of the issue and the
10 legal issues that Glenn talked about, even constitutional
11 issues here with respect to at least at the moment where the
12 malpractice process is regulated.
13 I do think that it's a worthy topic for the
14 Commission, and a lot of this is just my own sense, having
15 been a physician for 40 years, kind of talking to Mike's
16 topic, that there really is more here to the notion of
17 defensive medicine than the evidence is able to show. And I
18 don't know how to explain that except that I know that in
19 the dialogue that exists within the profession, dialogue,
20 you know, that should go on, that does go on, for example,
21 about the overuse of services and whether, for example,
22 every person who comes into an emergency room who bumped

1 their head should have a CT scan, you know, and get the
2 equivalent of 150 chest X-rays directed to their brain is
3 the right thing to do. Those kinds of discussions tend to
4 get diverted quickly by the notion of the risk inherent in
5 our current malpractice system.
6 And, similarly, I think, and perhaps a little more
7 controversial, I think there's an interplay between the
8 malpractice situation, defensive medicine, and some of the
9 overuse of diagnostic services that we've talked about here,
10 particularly in imaging and other things, where the dialogue
11 about, you know, the use of equipment and how often it ought
12 to be used or not used in the diagnosis, the potential for
13 coronary events, for example, again tend to be obfuscated by
14 the malpractice liability and the risk of potentially
15 missing a heart attack and like that.
16 So there's a complex interplay here, I think,
17 which is lumped under the term of "defensive medicine." But
18 I think as a physician I'm aware of it, and I think most
19 physicians are aware of it and perceive a difference between
20 what the data shows and what the experience is from day to
21 day in practice.
22 Now, what does that say about what we should do?

1 I completely agree with Karen's remarks. I think of all the
2 things that are on the table here, if we're trying to
3 connect this with work that we've done and ideas we've
4 brought forward before, it is in the area of the use of
5 evidence-based medicine and shared decision making. And I'm
6 not sure that's an area that outside of this context is
7 getting as much play as some of the technical areas of how
8 to correct the settlement process and the like. And if we
9 actually could spend some time on that and to broaden the
10 dialogue -- and it's complex dialogue -- about, you know,
11 how it might work if you exercise decision making according
12 to evidence-based guidelines or you join with your patients
13 to exercise decision making through the shared decision-
14 making process, you know, how that gets documented and all
15 the rest of that and what types of protections might take
16 place. Nevertheless, I do think there's something there. I
17 think it is connected to, again, ideas we've talked about
18 before. And if we were going to focus this work, that might
19 be a suggestion as to where to focus it.
20 MR. HACKBARTH: Let me see hands on this side.
21 Okay. We're at noon now, so you're standing between us and
22 lunch. Keep that in mind.

1 [Laughter.]

2 DR. BERENSON: On that note, first let me
3 associate myself a little more with Peter and Jay, rather
4 than Mike, in terms of the importance of this issue, but I
5 may be coming out to the same place, which is urging extreme
6 caution in getting into what would be a swamp of difficulty.
7 If we this afternoon it looks like we've achieved consensus
8 on graduate medical education, this is infinitely more
9 complex. Substantively, every time you come up with a new
10 idea, there is a trade-off. There's no -- I mean real
11 trade-offs, not just political trade-offs. And that's the
12 second point. The politics of this are intense. So I think
13 we just have to be very strategic -- I'm not saying we
14 should not go down the road, but I would be very strategic
15 about what road to go down. It could be the shared
16 decision-making area. I'm not so sure I'd pick that one. I
17 think quality and safety would be the hook, and I like the
18 administrative alternative to the existing legal system as
19 at least potentially the way to promote an environment where
20 safety matters more, but even that one is difficult. So I
21 think we have to -- my basic point is we have to be really
22 sure of what we're going to accomplish before we go much

1 further. I think there's a lot of value in providing an
2 educational document, but I'm not sure how much beyond that
3 I would go.
4 DR. KANE: Yeah, I guess I agree, I think it's a
5 very big issue, and I think even my primary care doctor
6 lectures to me about it. So, you know, it's pervasive.
7 But I just wonder, in looking at -- first of all,
8 I see our new act that we haven't come up with a new acronym
9 for does have under miscellaneous, program integrity, the
10 Secretary should award demonstration grants to states that
11 can evaluate alternatives to the current tort reform. So I
12 think, you know, there is some pressure already. But I'm
13 wondering if we can't think about ideas for Medicare to
14 reward rather than providers or organizations, but to reward
15 states that adopt model legislation that, once this is done,
16 shows evidence that it does reduce inappropriate behavior,
17 either on the part of filing poor lawsuits or improves the
18 quality and outcomes of care. But rather than focusing on
19 organizations and providers, which we already do a lot
20 through payment for better quality -- or trying to do a lot,
21 I would just say, you know, if we want states to have better
22 tort reform, reward the states for passing better tort

1 reform, but don't get engaged in saying what it should be or
2 in trying to create just special reforms that only apply to
3 Medicare patients, because I don't see how you can do that
4 anyway. But why not focus on how to reward states in some
5 way that do try to do model things that have been proven to
6 work.

7 DR. MILSTEIN: I think, you know, first I think
8 Nancy's suggestion is terrific and I endorse it.

9 Secondly, I want to bring up one other idea that
10 might be also considered, although it's more complex and
11 suffers some disadvantages relative to Nancy's idea. That
12 is, Medicare-provided reinsurance, which is one of the
13 linkage options we're considering, is a potentially --
14 precisely because malpractice is so, you know,
15 psychologically powerful for providers, is a potential sort
16 of lower-cost way that Medicare might induce greater
17 provider interest in performance improvement, both quality
18 and efficiency. And it also has the nice characteristic of
19 not bumping up against state law. I mean, if Medicare
20 offers reinsurance, I don't think that --

21 MR. HACKBARTH: Can you say just a little bit
22 more, Arnie, about how federally provided reinsurance would

1 increase interest in improvement?

2 DR. MILSTEIN: Well, I think it is -- I mean, for

3 example -- I'll give a concrete -- for example, if the

4 availability to a provider or a provider organization of

5 some form of Medicare-provided reinsurance, maybe not 100

6 percent reinsurance but some -- you know, was contingent on

7 providers scoring very favorably on Medicare's current

8 systems for comparing providers on value, quality, and cost,

9 it might be a potentially low-cost, compared to other ways

10 of inducing it, you know, boost for getting providers more

11 interested in innovating in ways that would improve value of

12 health care.

13 The second thing that's attractive about it is it

14 doesn't -- compared to other options, it doesn't get

15 anywhere near as entangled with state laws. You know, it is

16 essentially -- so when you think about this as, you know, a

17 form of reinsurance that would simply reduce what physicians

18 are paying irrespective of what they're paying or

19 organizations, I don't think there's any state law, at least

20 on the obvious violations or issues.

21 And so, accordingly, one of the things I guess I'm

22 suggesting we may want to reconsider is whether or not we

1 think of this as sort of one element in our overall Medicare
2 strategy for inducing greater provider interest in attaining
3 benchmark levels of performance on value.

4 MR. HACKBARTH: That's an interesting thought,
5 again, this linkage to our other initiatives.

6 DR. DEAN: I think this is a big issue. I
7 certainly accept Mike's comments that when you really look
8 at it objectively, the actual at least identifiable costs
9 are probably not as big as they're sometimes made out to be,
10 and actually in the recent discussion and debate, you know,
11 some of the arguments you heard, you would have thought this
12 was the only driver of health care costs, and it obviously
13 isn't.

14 But I guess I would make the point that the
15 indirect forces are very powerful and that fear which
16 pervades the physician community is not a rational response,
17 oftentimes. I mean, I'm in a low-risk specialty in a low-
18 risk state, I haven't been sued, and it still affects my
19 practice. To make it even more so, I work for a community
20 health center. I'm covered under the Federal Tort Claims
21 Act, so I don't even have to worry about buying insurance.
22 But it still affects my practice. So it's a powerful force

1 even though from an objective measure of the actual dollar
2 cost it isn't as big.
3 Just a couple comments. I guess I would say, I
4 think as several people have said, I think Medicare's role
5 is probably best not -- for the reasons Bob stated, not to
6 get specific, but I think to raise the issue and to try and
7 clarify what a force it is. The issue of guidelines and
8 safe harbors is an appealing one on the surface, but I would
9 caution that establishing guidelines that are reliable
10 enough across a broad enough spectrum that they could be
11 used in this kind of a context is extremely difficult to do.
12 You know, I could get into that, but we really don't have
13 time, but especially in a Medicare population where you're
14 dealing with multiple chronic diseases, oftentimes where you
15 have conflicting guidelines and you have to violate some of
16 them just by virtue of the fact you've got multiple
17 different problems.
18 So I guess, you know, there are lots of things we
19 could say, but I really think it is a useful thing to
20 pursue. But I would certainly agree, we don't want to get
21 too specific.
22 MR. HACKBARTH: Okay, I think this has been a good

1 initial discussion, so here is where I think we are. For
2 sure, we can review the evidence about the impact on
3 Medicare, and we've got more conversation to be had on that
4 topic. We've got some different perspectives, Mike's versus
5 what we've heard from some of the --
6 DR. CHERNEW: [off microphone] [inaudible].
7 [Laughter.]
8 MR. HACKBARTH: -- some of the physicians. And so
9 we will come back to that.
10 I think I also hear agreement that we can perform
11 a useful function with a good, high-quality summary of the
12 different types of reforms that had been proposed without
13 trying to identify what the best approach is, just as Bob
14 characterized it, more an authoritative summary, and I think
15 an important part of that discussion is, you know, what are
16 your goals? Whoever said there are trade-offs, trade-offs,
17 trade-offs I agree with wholeheartedly, and how you make
18 those trade-offs is a function of what priority you give to
19 different goals.
20 And then the third thing is that we can talk about
21 how this links up to other topics of interest to MedPAC,
22 promoting value, evidence-based medicine, shared decision

1 making, and see if there might be some policy options that
2 can advance our primary goal in promoting value, et cetera,
3 but could also have some at least secondary benefit on the
4 malpractice front. So I think that's the plan from here.
5 Thank you, Ariel.
6 We'll now have a brief public comment period.
7 Let me just do the ground rules before you begin.
8 Start by identifying yourself and your organization and
9 limit yourself to no more than two minutes. When this light
10 comes back on, that will signify the end of the two minutes.
11 I would remind everybody that this is not your
12 only opportunity to provide input on the Commission's work.
13 Of course, the first place to do it is by interacting with
14 the staff. But in addition, we do have an opportunity on
15 our website now to make comments and submit information.
16 MR. JOHNSON: Thank you. Tim Johnson from the
17 Greater New York Hospital Association.
18 Just on the topic of med mal, which I felt this
19 was a terrific discussion, I would just encourage the
20 Commissioners -- and I can share this with Ariel also -- in
21 New York state we are actually looking very closely at a
22 model of what's called active case conferencing that has

1 been demonstrated, it has been working through the Office of
2 Court Administration in the state. And the public hospital
3 system has been using it and has shown some reductions in
4 their costs of medical malpractice over some years. And we
5 are looking to expand that to other hospitals within the
6 state.
7 It is actually part of the AHRQ proposal also that
8 was discussed and that was submitted by New York state. We
9 are going to be having a conference on that and I will share
10 it with Ariel if he might want to share it with the
11 Commissioners.
12 The other thing, just on Medicare's role, I'm not
13 sure about this but I believe that medical malpractice
14 expenses or costs on the Medicare Cost Report are collapsed
15 into A&G, administrative and general. And one of the
16 difficulties that we have had in looking at the whole issue
17 of med mal for hospitals is the fact that it's very
18 difficult to tease out exactly what the costs are to
19 hospitals on an annual basis for medical malpractice because
20 of all of the complexities of how they use the carriers, the
21 self-insured. There's no identifiable item on the cost
22 report for med mal.

1 So to the extent that MedPAC may want to look at
2 that and make a recommendation about perhaps making some
3 modifications to the cost report where something like that
4 could really be captured, I think it would really help with
5 the data analysis.
6 MR. HACKBARTH: okay, we will adjourn for lunch
7 and reconvene at 1:15.
8 [Whereupon, at 12:12 p.m., the meeting was
9 recessed, to reconvene at 1:15 p.m., this same day.]
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1 AFTERNOON SESSION [1:23 p.m.]

2 MR. HACKBARTH: Okay, would everybody take their
3 seats please.

4 It's a little bit cold in here this afternoon.
5 It's like they turned down the air conditioning while we
6 were at lunch. We've asked to see if we can get it
7 moderated just a little bit. Lots of hot air coming out
8 here in just a minute.

9 In fact, let me contribute to the hot air and
10 introduce the topic for our first session this afternoon,
11 which is graduate medical education.

12 For those of you in the audience who follow our
13 work closely, you know that this is a topic that we have
14 been discussing now for quite a few months. I can't
15 remember exactly when we began but it goes back a ways.
16 We're trying to bring that piece of work to a conclusion, at
17 least for now, with this meeting and a series of
18 recommendations which will go in our June Report to
19 Congress. More on the recommendations in just a minute.

20 But I wanted to begin by providing sort of an
21 overall picture of the assessment that we've made as a
22 Commission of GME. This is an assessment that I think

1 reflects a broad consensus of the members of the Commission.
2 And later on, they will have an opportunity to chime in on
3 this subject. But I thought that the broad assessment is
4 important in setting the context for our individual
5 recommendations.
6 I think the first point that I would make is that
7 as a group I think there's a feeling that, in some respects,
8 the country's system of GME -- graduate medical education --
9 is outstanding. And I know from work that I've done with
10 the American Board of Internal Medicine, I hear about
11 foreign countries wanting to learn about our system of
12 graduate medical education and board certification. These
13 are views are models around the world.
14 The output of the system is, in some respects,
15 truly extraordinary, thousands of new clinicians come out
16 each year superbly skilled in advanced technology and
17 techniques. And that bears emphasis.
18 On the other hand, through our work, we have
19 uncovered what we see as some deficits in what the system is
20 producing, deficits looked at in the perspective of what the
21 long-term needs are for our health care system to achieve
22 the goal of a health care delivery system that produces high

1 quality care, high value care, very efficiently for Medicare
2 beneficiaries and for the broader population.
3 The deficits that we have seen and discussed in
4 prior meetings are two broad types. One, there is concern
5 about the mix of physicians being produced by our system of
6 graduate medical education. Mix, for example, in terms of
7 specialty. And also mix in terms of socioeconomic
8 diversity, locations that they're drawn from, which are
9 important because they may influence the willingness of a
10 newly trained physician to serve underserved areas of the
11 country, whether they be rural areas or inner cities. So
12 there are issues in terms of the physician mix being
13 produced by the system.
14 Looking beyond physicians, we've also talked often
15 about the need for other types of health professionals to be
16 trained so that we can more effectively and efficiently
17 deploy our physician resources.
18 The second major type of deficit that we've talked
19 about is in terms of the content of the training. The way I
20 look at it, and I think this is a view broadly shared in the
21 Commission, is that well, the training is exceptional in
22 terms of technical skill and expertise. We are concerned

1 that there are some deficits in terms of the skills and
2 perspectives necessary to support the development of an
3 efficient, high quality, high value delivery system. These
4 are skills in things like evidence-based medicine,
5 practicing teams, coordinated care, shared decision making,
6 and the like.
7 Those are topics that we are aware are touched on
8 but they may not be given the primacy that we think is
9 necessary for the development of a really high value,
10 efficient delivery system in the future.
11 Now the fact that there are these deficits, should
12 not be construed as our criticizing the GME system and the
13 institutions and the people involved in that for the
14 deficits. In fact, Medicare has played a very important
15 role in how the system has evolved. Medicare's influence is
16 not just in how we pay for graduate medical education but
17 how we pay for services.
18 The signals, the price signals if you will,
19 embedded in our payment systems and the GME payment systems
20 which, in at least some cases, are percentage add-ons to our
21 underlying payments for services, they are sending out
22 signals about what Medicare values. Understandably, not

1 just the institutions engaged in GME, but also individual
2 physicians-in-training choosing their specialty for the
3 future, they're influenced by the signals that are being
4 sent by the Medicare program and often reinforced by private
5 payers, as well.

6 This is not just a Medicare payment problem but
7 one that public and private insurers share together.

8 So how do we get to a better place. Obviously,
9 our focus is principally on Medicare's role in GME reform.
10 Let's talk about our role in terms of the two broad areas of
11 deficit, the mix of clinicians being produced, first, and
12 then secondarily the content of the training.

13 With regard to the mix of the physicians being
14 produced, I think there's a broad consensus within the
15 Commission that the single most important thing that
16 Medicare could do to influence the mix would be to change
17 how Medicare pays for services and the signals that we send
18 out in that way, so that a medical student starting to think
19 about do I want to follow in Tom's footsteps in family
20 practice, or do I want to become a urologist like Ron or a
21 general surgeon like Karen, or an interventional
22 cardiologist, one of the things that they take into account

1 -- not the only factor, as Karen has often cautioned us --
2 but one of the factors is what is my future income potential
3 for paying off all these loans that I've taken out? What is
4 my practice life going to be like? And how Medicare pays
5 for services delivered, that long-term income potential and
6 lifestyle potential, is the single biggest influence we
7 think Medicare has on clinician choice of specialty.

8 With regard to the content of training, that's a
9 little bit more challenging. I think there's a broad
10 consensus in the group that it would not be appropriate for
11 the federal government, and certainly not appropriate for
12 MedPAC to prescribe the curriculum, if you will, that
13 physicians-in-training ought to experience. We don't have
14 the necessary expertise. HHS doesn't have the necessary
15 expertise.

16 What we want to do is engage those who do have
17 relevant experience in helping to shape that curriculum.
18 And here, as Karen has often said, we're using curriculum
19 here in a broad sense. Much of the training of physicians
20 is not in classrooms but is in their experience in helping
21 to deliver care to patients.

22 So the consensus of the group, I think, is that we

1 ought to try to use Medicare GME payments -- or at least a
2 portion of them -- as a lever for change, to help foster
3 change in how physicians are trained, so that they might be
4 trained in a way that better supports the long-term delivery
5 needs of the country and focus on again -- and I'm going to
6 say this over, and over, and over again -- efficient, high
7 quality, high value care.

8 In just a few minutes we'll go into the specific
9 recommendation on how that might be accomplished but let me
10 just say one more word about the spirit of it.

11 The idea, in my mind, is to use Medicare payment
12 for GME as a lever, a way to support people within the GME
13 system who know that we need to do a better job in preparing
14 physicians for the health care delivery system of tomorrow
15 and give them a lever to achieve the sort of reform and
16 change that we think is necessary.

17 We'd like the participants in that conversation to
18 be not just the people involved in the discussion today,
19 people involved in academic medicine or teaching hospitals,
20 but a broad group that includes representatives of patients,
21 representatives of purchasers, people who have expertise on
22 the broader issue of what sort of health care delivery

1 system do we need for tomorrow.

2 We've talked about a number of other questions
3 that we're not going to address explicitly in
4 recommendations. We had a discussion at our last meeting
5 about the financing of GME and whether it ought to be
6 financed solely through Medicare or whether there ought to
7 be a broader tax base. For reasons I won't go into now,
8 we've decided not to make a recommendation on the financing
9 of GME or changing the financing of GME.

10 With regard to how much should be spent on GME, I
11 think there's a consensus in the group that, given the
12 fiscal problems and challenges facing not just Medicare but
13 the federal government as a whole, that rather than thinking
14 about increasing the amount, we ought to be thinking about
15 how to better use the funds that exist within the GME
16 system.

17 I guess the last point I'd make as part of this
18 summary assessment is that I think there was a broad
19 consensus within the group that if we really want the
20 pipeline to produce the mix of clinicians that we need for
21 the future, some consideration needs to be given to
22 intervening before students are in residency and reach back

1 and trying to influence the people who go to medical school
2 and how they finance their medical school and the like.
3 There are a number of programs in the Public Health Service
4 that have that as an end.

5 The objectives of those programs seem quite
6 reasonable to us as a group. There have been some questions
7 about their effectiveness, and we'll try to address that in
8 a recommendation.

9 To sum up, shortly Cristina and Craig will present
10 the recommendations. At a high level I see them as this,
11 there is one recommendation which is directed at trying to
12 take a piece of the current Medicare expenditure for GME and
13 use that as a lever for change and establish new standards
14 of accountability for how the federal funds are used.

15 We have a second recommendation related to the
16 transparency, making it clear to the participants in the
17 system how much Medicare money is going to individual
18 institutions.

19 And then we have three recommendations for
20 studies, of questions that we repeatedly bumped up against
21 and, frankly, didn't know the answers to and think it would
22 be worthwhile to invest in some systematic analysis of those

1 questions.

2 So that’s the basic framework.

3 I’ll stop there and turn it over to Cristina and

4 Craig. They will present the recommendations and then we

5 will come back and, as I said earlier, Commissioners will

6 have a chance to reflect on what I just said.

7 Cristina?

8 MS. BOCCUTI: Okay, thank you.

9 So we’ll start here with a diagram that you’ve

10 seen earlier this year. It depicts Medicare's payments to

11 teaching hospitals for graduate medical education.

12 These payments total $9.5 billion for 2008 and

13 average to about $100,000 per resident in a year.

14 To take a minute to orient you, the top yellow

15 boxes represent Medicare's IME payments to teaching

16 hospitals. These are intended for Medicare's share of the

17 higher patient care costs associated with teaching.

18 The green box on the bottom represents Medicare's

19 direct GME payments, DGME. These payments are intended for

20 Medicare's share of resident stipends, faculty salaries, and

21 program administration.

22 Repeated MedPAC data analysis has shown that a

1 significant portion of Medicare's IME payments -- that is at
2 the top row -- is not attributable to higher patient care
3 costs. Therefore, we have depicted them in two boxes. The
4 left one represents the amount that can be empirically
5 justified. The right box, which is marked extra, represents
6 the amount Medicare pays in IME that's above the empirically
7 justified amount. For 2008, this came to $3.5 billion.
8 A side note that I'd like to make while we're on
9 the slide that tallies Medicare's spending on GME is that
10 during some site visits that Craig and I have done, it's
11 become apparent that many residents are completely unaware
12 that Medicare is subsidizing a lot of the expenses, the
13 educational programs, their hospitals expenses for them, and
14 their own stipends.
15 So I think it is important to keep in mind that it
16 doesn't seem the hospitals are actively telling the
17 residents that they're receiving Medicare dollars on behalf
18 of them and for their education.
19 On the next slide, an on that note, despite this
20 $9.5 billion Medicare is paying for medical education, it
21 really demands very little accountability. Medicare's major
22 requirement is simply that residency programs be accredited.

1 Medicare makes no distinction in its payments for
2 low or high performing programs and institutions -- to
3 reflect -- there's no distinguishing to reflect high
4 performance/low performance for both the programs and the
5 institutions.
6 The Commission has discussed a need for Medicare
7 payments to take a stronger role for for encouraging
8 delivery system reform. And that is where we are starting
9 to pair this.
10 Because it is calling now for incentive-based
11 payments for graduate medical education which should evolve
12 through consultation with representatives from educational,
13 insurer, patient and provider communities. This is what
14 Glenn was just talking about.
15 They should include ambitious targets to meet the
16 needs of high-value health care delivery systems.
17 Thinking about that, I would mention that the
18 research conducted by RAND that we presented last year found
19 that although the ACGME is striving for more outcomes-based
20 competencies, residency programs have been slow to achieve
21 these goals. That is what we were reporting on last year.
22 Moreover, this research found that a leading factor in

1 programs' ability to move towards these goals was really the
2 level of their institutional support.
3 So, incentive-based payments to those that are
4 receiving the money should be scaled to reflect performance
5 levels of residency programs and the supporting
6 institutions. And they should be funded through a reduction
7 in IME payments which go down to the empirically justified
8 level.
9 So with that statement, we come to this first
10 recommendation, which I will read for the record: the
11 Congress should authorize the Secretary to change Medicare's
12 funding of graduate medical education to support the
13 workforce skills needed in a delivery system that reduces
14 cost growth while maintaining or improving quality.
15 The Secretary should establish the standards for
16 distributing funds after consultation with representatives
17 of accrediting organizations, training programs, health care
18 organizations, and health care purchasers.
19 The standards established by the Secretary -- I
20 think in that first bullet, there was patients at one --
21 there was patients. So we will add that.
22 The standards established by the Secretary should,

1 in particular, specify ambitious goals for practice-based
2 learning and improvement, interpersonal and communication
3 skills, professionalism and systems-based practice,
4 including integration of community-based care with hospital
5 care.

6 Performance-based GME funding under the new system
7 should be allocated to an institution sponsoring GME
8 programs only if that institution met the new standards
9 established by the Secretary and the level of funding would
10 be tied to the institution's performance on the standards.

11 For the final bullet, the indirect medical
12 education (IME) payments above the empirically justified
13 amount should be removed from the IME adjustment and that
14 sum would be used to fund the new performance-based GME
15 program.

16 To allow time for the development of standards,
17 the new performance-based GME program should begin in three
18 years.

19 To discuss the spending implications of this,
20 there should be no Medicare spending increase. We thought
21 with the IME portion that potentially, based on provider
22 performance, either all of it could be given out, some of

1 it, or none of it.

2 For provider and beneficiary implications, it
3 would, therefore, increase or decrease payments to
4 individual teaching hospitals, depending on their
5 performance. There would be no direct impact on
6 beneficiaries.

7 MR. LISK: Now I am going to move on and talk
8 about transparency.

9 Medicare DGME and IME payments are made to
10 hospitals to help support residency programs. While
11 hospitals provide funds to help support residency programs,
12 residency programs often report that hospitals' budgeting
13 decisions for supporting GME activities are often obscured
14 from educators. Better communication between hospitals and
15 residency programs on GME financing potentially could help
16 programs and hospitals to work together to improve overall
17 educational quality and goals.

18 Publicly publishing data on Medicare's financial
19 support for GME could help to facilitate these discussions.

20 To address these concerns, the Chairman proposes
21 the following draft recommendation for your consideration.
22 It reads: The Secretary should annually publish a report

1 that shows Medicare medical education payments received by
2 each hospital and each hospital’s associated costs. This
3 report should publicly accessible and clearly identify each
4 hospital, the direct and indirect payments received, the
5 number of residents and other health professionals that
6 Medicare supports, and Medicare’s share of direct and
7 indirect teaching costs incurred.

8 The report would include the following
9 information: It would include DGME revenues from Medicare,
10 DGME costs allocated to Medicare, number of residents
11 counted for Medicare DGME payments, IME revenues from
12 Medicare, IME costs from Medicare. And that would be based
13 on a nationally justified empirical percentage -- that would
14 be just a share of basically the IME payments, recognizing a
15 certain portion of those are costs -- as well as the number
16 of residents counted by Medicare for IME.

17 The report should also include some caveats
18 explaining, both caveats about what direct GME payments are
19 as they are reported by the hospital -- I mean DGME costs -
20 and also with the IME cost issue, based on a national
21 percentage share.

22 MS. BOCCUTI: Okay. The Commission has been asked

1 about the numbers of residents Medicare supports. We have
2 not conducted analysis on this question directly. As you
3 know, different studies conducted that try to project U.S.
4 healthcare workforce needs, have drawn very different
5 conclusions.
6 In part, these varying projections are based on
7 different assumptions about future health care needs and the
8 health system needs.
9 The Commission finds that before considering
10 changes in the numbers of residents that Medicare
11 subsidizes: analysis must be conducted to determine
12 workforce needs of improved high quality, affordable
13 delivery systems.
14 The number of residents subsidized, in total and
15 by specialty, should not exceed reformed delivery system
16 needs. An analysis should incorporate optimal contribution
17 from other health professionals, including advance practice
18 nurses and physician assistants
19 So for this third recommendation, the Secretary
20 should conduct workforce analysis to determine the number of
21 residency positions needed in the U.S. in total and by
22 specialty. In addition, analysis should examine and

1 consider the optimal level and mix of other health
2 professionals. This work should be based on the workforce
3 requirements of health care delivery systems that provide
4 high quality, high value, and affordable care.
5 As this is a study, we have written that the
6 spending implications are none and provider and beneficiary
7 implications are none.
8 MR. LISK: Next, we're going to turn to talking
9 about how residency programs may affect the financial
10 performance of hospitals and sponsoring institutions.
11 Medicare payments for GME do not consider how costs of
12 training may differ by specialty. Medicare direct GME
13 payments are based on historical hospital-specific costs
14 trended forward.
15 While Medicare does pay less for subspecialty
16 residents for GME, there is no distinction made for IME, as
17 all residents count the same. Medicare payment policies do
18 not consider the net costs of residency training programs,
19 the cost and financial benefits of the program to the
20 provider, and whether these differ across specialty.
21 The net costs may differ for a number of reasons:
22 differences in supervisory and infrastructure requirements

1 for different specialties; residents impact on hospitals'
2 and physicians' productivity, which could both be positive
3 or negative, depending upon the specialty and the residents'
4 experience; and residents' contributions to hospitals'
5 revenues, which also may differ particularly if we consider
6 the value of resident services provided to the hospital. A
7 resident in the hospital may be of more value to the
8 hospital than a resident outside of the hospital, who does
9 their training outside of the hospital, for example.
10 Certain types of residencies may also help attract
11 physicians to those hospitals, increasing patient volume and
12 hospital revenues.
13 Given these considerations, the Chairman offers
14 the following draft recommendation which reads: the
15 Secretary should report to the Congress on how residency
16 programs affect the financial performance of sponsoring
17 institutions; whether residency programs in all specialties
18 should be supported equally; and whether certain residency
19 programs are sustainable without federal support.
20 Again, because this is a study, the spending
21 implications is none and the provider and beneficiary
22 implications is none.

1 MS. BOCCUTI: Last year's chapter showed that
2 multiple studies have found that greater diversity in
3 physician workforce is associated with better access and
4 quality improvements.
5 Nevertheless, there is significant under
6 representation in medical schools, and practicing physician
7 community, of certain minorities such as African Americans
8 and Hispanics, people from lower income families, and people
9 from rural home towns.
10 Several federal grant programs, many of which are
11 sponsored by HRSA, are designed to achieve greater diversity
12 among physicians, nurses, and other health professionals,
13 particularly in primary care.
14 Many of these programs reach to individuals far
15 earlier in their career decision-making process than their
16 graduate residencies. But because of: limited data
17 collection; fluctuating funding levels; and other grant
18 requirements, rigorous assessment about the impacts of these
19 programs is scarce. GAO and others have called for more
20 analysis on the effectiveness of these programs.
21 The goal for improving such analysis is to develop
22 strategies to ensure that federal subsidies are spent in the

1 most effective way for achieving these pipeline goals.

2 So with that, we go to the final recommendation,
3 which is that the Secretary should study strategies for
4 increasing the diversity of our health professional
5 workforce; for example, increasing the shares from under
6 represented rural, lower income, and minority communities,
7 and report on what strategies are most effective to achieve
8 this pipeline goal.

9 Again, because of a study, we have spending
10 implications and provider and beneficiary implications as
11 none.

12 Thank you.

13 MR. HACKBARTH: Okay. Thank you.

14 The first thing I would like to do is offer
15 Commissioners an opportunity to comment on my initial
16 summary assessment. Just so the folks in the audience are
17 aware, I circulated a written document last week that people
18 have had a chance to look at and think about.

19 I want to give everybody an opportunity to react
20 to it, but in the interest of time I hope people will be
21 careful in using that. Having 17 statements is probably
22 more than we can fit into the schedule at this point.

1 So the ground rule is this: if you don’t comment,
2 I’ll assume that means that you generally concur with the
3 statement.
4 With that preface, let me ask for a show of hands
5 of people who would like to comment on my summary
6 assessment. We’ll start with Karen, Jennie, and then Bob
7 and Arnie.
8 DR. BORMAN: I just want to first say that I
9 generally support the statement and I certainly, personally,
10 want to express appreciation to the Chair for all the work
11 that he has done to lead us through this topic. It is a
12 complex one and dear to my heart.
13 Just a couple of things. First, Glenn, you
14 briefly alluded to in the statement, although it’s not real
15 explicit there, that medical education is certainly a
16 continuum that includes undergraduate medical education as
17 well as GME, and then plays on through lifelong learning
18 through CME. And that some of the things that we touch upon
19 in the statement and, to some degree underlying the
20 recommendations, do relate to other than GME. I just want
21 to acknowledge that and think that’s an important thing to
22 make sure we all remember.

1 A second thing would be that while we use the
2 terminology excess IME, and I understand what we imply by
3 that, I would want to note that at least some portion of
4 that money in recommendation two about transparency
5 certainly applies here, is going to underwrite the several
6 thousand residents who are over the counted funding cap and
7 that we should understand that while it may be excess IME
8 money in the way that we define it, that it is indeed -- a
9 fair amount of it is probably indeed being invested in GME
10 as we currently know it.
11 The second area to touch on would be that we
12 identify that Medicare importantly impacts this process
13 through the signals that it sends primarily through the fee
14 schedule and pricing and other ways that it manages the
15 fiscal pieces of the program. And I would like to just
16 iterate and thank you for mentioning that I have previously
17 pointed out that there are some other factors, most notably
18 the nature of the work. And multiple specialties, including
19 my own of general surgery, have realized this. And I think
20 the educator community has certainly identified this.
21 And for the benefit of all practitioners, primary
22 care as well as non-primary care, we need to make sure that

1 physician work is truly physician work and that, in and of
2 itself, will lead to better recruiting into primary care,
3 more efficient and higher quality delivery of primary care
4 physicians are not quite so much tied up with doing
5 administrative work and perhaps quite so occupied with
6 regulatory burden and some other things.
7 So I think the Medicare program can influence this
8 topic a bit, perhaps indirectly, by the things it does to
9 reduce regulatory burden in its support of comparative
10 effectiveness and IT, and proper use of those things.
11 Also relatedly, I think that the recommendation
12 particularly about transparency is a contribution the
13 Medicare program can make by, to some degree, enabling and
14 empowering the educator community to have a better
15 understanding of the resources and to bring the world into
16 comment about the investment of the resources and perhaps
17 make that a more open process, which I think the statement
18 espouses.
19 And then my last piece would be that I think it’s
20 important, all the things we’ve said about workforce. I
21 personally remain somewhat insecure about knowing exactly
22 what the right mix of different kinds of health care

1 professionals, much less the mix across just physician
2 specialities is a relatively narrow part, what that should
3 like and if we're really forward thinking in allowing for
4 the fact that sometimes advances in medicine lead a sharp
5 turnaround in our world and its needs -- for example, if we
6 think about cardiac stents or cholesterol lowering agents or
7 things -- as they may play out over the future.
8 That would be it.
9 MS. HANSEN: Yes, thank you. And again, I so
10 appreciate -- just as Karen conveyed to you, Glenn, as well
11 as to our staff -- for this culmination after many areas of
12 discussion.
13 And so my comments are in the spirit of where are
14 we going with the function of where GME will be for a
15 Medicare program that will be responsive to the population
16 in the future. So I would say that certainly the
17 recommendations that have come out, I think I have shared
18 previously in some discussions that we have had recently,
19 these I really support.
20 But there is one area that is interesting because
21 as we are "modernizing" our GME look at this particular
22 point, there has been some historical factor that has been

1 interesting since we think about GME as all about physician
2 education. But there is a function within GME that's funded
3 currently that actually does train nurses -- primarily in
4 hospital systems still, although some programs I think are
5 in Baccalaureate programs -- primarily concentrated only in
6 about five states.
7 So there is, I think, an amount of money that is
8 about $300 million that currently is allocated for that. I
9 think it might be an opportunity to define that, I think in
10 the aspect of what Karen says, is to define what is going on
11 now. This is oftentimes not noticed. But it does speak to
12 how we use the funding that is allocated here, which is in
13 the amount I just cited, how to deploy that effectively for
14 the high value, the quality, the safety components that we
15 are needing for Medicare in the future.
16 So this is a point I bring up just as a place mark
17 because right now, in the midst of this particular time, the
18 Robert Wood Johnson Foundation, along with the Institute on
19 Medicine, are in the midst of an initiative on defining the
20 future of nursing. I sense that there will be some areas
21 there that may affect this component of the way nursing
22 money is spent in GME. So I hope that it will be tied

1 together, coupled with the third and final factor is that in
2 the new legislation that has just been passed there is a
3 workforce commission that is going to be established.
4 So along with Karen and the citations of say
5 physician assistants as well as nurse practitioners or
6 advanced nurse practice people, how we look at this
7 composite piece. Because that workforce commission is one
8 component.
9 And then with the subpiece of an experiment for
10 advanced nurse practices, having a pilot project that is in
11 the amount of $200 million over the course of five years.
12 So that's the reason I would say that the $300
13 million per year being spent in GME right now may be kind of
14 a rounding error number relative to the billions spent, but
15 it is for thinking about the Medicare population and how to
16 safely serve that population in the future.
17 So I just would like to have that noted.
18 Thank you.
19 DR. BERENSON: Yeah, I'm just going to briefly
20 pick up what Jennie just alluded to, was this new workforce
21 commission.
22 My conflict on this issue has been that, on the

1 one hand, I think a lot of the action in getting the
2 workforce we need for the delivery system as a whole and for
3 Medicare in particular relates to lots more than graduate
4 medical education, undergraduate education, post-residency,
5 loan forgiveness programs, just a whole range of programs.
6 I was frustrated that we kept talking -- we, our
7 jurisdiction has traditionally been graduate medical
8 education.

9 And at the same time, I was very concerned that we
10 not be taking on areas that we have no standing, we have no
11 particular expertise, although we may have some views.

12 So this workforce commission, I think, solves the
13 problem.

14 I guess my point would be that rather than be
15 passive and let the commission to come to us to sort of get
16 some information about Medicare, we have done a lot of good
17 work over months now sort of identifying issues that are
18 relevant for Medicare. And I think we should actively
19 engage such a commission. They will have the jurisdiction
20 and we would then be able to focus on graduate medical
21 education, where we are correctly focusing based on what
22 you've written up.

1 DR. MILSTEIN: My comment is simply to suggest
2 that we perhaps expand the assessment's findings with
3 respect to Medicare's role in GME reform, or in its role in
4 creating deficits in GME by noting -- importing content from
5 other reports -- that by overpaying IME we are
6 disincentivizing hospitals' motivation to think about how to
7 efficiently use residents in producing are.
8 MR. HACKBARTH: Okay. Let's move on then to the
9 recommendations. Inasmuch as we've talked about these
10 topics a lot, I think rather than doing our usual two rounds
11 of Commissioner comments, we'll collapse that into just one.
12 We'll go through the recommendations one by one, as opposed
13 to jumping around. I think that makes it easiest.
14 Let me just kick off with a couple of additional
15 words about the rationale for number one.
16 I think that there is important work underway in
17 terms of defining what the product should be from graduate
18 medical education, work that's been undertaken under the
19 auspices of ACGME but with many other organizations
20 involved.
21 Back in the early part of now the last decade,
22 ACGME took a major step of moving to what they referred to

1 as competency based education. As opposed to evaluating
2 programs on a certain number of hours, doing this and that,
3 they adopted a new format whereby physicians-in-training,
4 residents, would be expected to develop certain
5 competencies. That's how a residency program would be
6 accredited and evaluated in their performance. They
7 developed a framework of six competencies, which we have
8 included in our reports.
9 I think it's a good framework that encompasses
10 many of things that we think need to be emphasized to
11 support the development of a really high performance
12 delivery system.
13 Now some individual specialties are in the process
14 of taking that framework of six competencies and advancing
15 it to the next step, developing much more concrete
16 milestones within each of the competencies. For example, in
17 internal medicine, the ABIM staff, working with others, has
18 developed an initial product on milestones in internal
19 medicine training that again encompass many of things that
20 we think are important.
21 Karen, I think, is involved in comparable work for
22 general surgery. Family practice is another one of the

1 specialties going down that path. So important things are
2 happening. The way I see recommendation one is a way to
3 accelerate that process and provide an impetus for those
4 people who are trying to reform the system, help them get
5 more leverage to advance that agenda more quickly.
6 The basic construct here is to say, as Cristina
7 said, there's a pot of money, which is $3 billion, $3.5
8 billion. It is what we have referred to as the IME extra.
9 That would be available to support new, more aggressive
10 standards, more aggressive movement down this path.
11 All of the money could be paid out. A piece of it
12 could be paid out. Or none of it paid out, depending on the
13 Secretary's judgment about whether the new standards are
14 sufficiently rigorous and whether they've been, once in
15 place, adhered to.
16 My personal hope would be that all of it is paid
17 out and that would mean that we are really advancing the
18 agenda that we all care about.
19 So that's my comment on recommendation one.
20 Let me see hands. We'll start on this side, John
21 and then Tom.
22 MR. BERTKO: Just to keep it short, I would like

1 to say that I am strongly in support of recommendation one.
2 I think that the accountability that comes with the
3 performance-based GME funding is really important.
4 And then Glenn, I'm going to interpret that second
5 bullet there with practice-based learning and system-based
6 practice as leading to the kinds of physicians that we need
7 in the future that are team oriented that, in some cases,
8 may be re-engineering practices.
9 And as we come up on health care reform and the
10 demands for physician services, and particularly primary
11 care service from the new population, while Medicare doesn't
12 have as direct a role in fulfilling that, the demand for
13 those primary care services will have an indirect impact at
14 least among the Medicare population that we're concerned
15 about.
16 And so I think we really do need to go in this
17 direction.
18 DR. DEAN: I, too, strongly support the
19 recommendation. And maybe the comment I have is sort of
20 restating what's already in there, but just to make it more
21 explicit, we have assumed in the past and the graduate
22 medical education programs are all based in hospitals

1 because we assumed that if a young physician learns how to
2 take care of acute, complicated hospitalized patients then
3 they're prepared to do anything else.
4 I think what we've learned over the last few years
5 -- and actually I think the British probably learned this
6 even before we did, or at least they implemented it -- is
7 that there's a very different set of skills that's necessary
8 to take care of people in an outpatient setting.
9 And just as an example, you need one set of skills
10 when the patient comes to the emergency room with the acute
11 MI. You need a very different set of skills if you're going
12 to try and prevent that event from occurring in the first
13 place, and trying to bring about the behavior change and the
14 kinds of things you have to do to reduce the risk of that in
15 the first place. We're pretty good at the first one. We're
16 not very good at the latter, at least in our education
17 programs.
18 And so I think that we really need to -- this
19 recommendation, I think, very appropriately, could have some
20 very far reaching implications about where training takes
21 place, what the models are, what the techniques are, and so
22 forth. I think, I hope, that it has some far reaching

1 impact because we really need to recognize the value of
2 training for less acute problems that have really
3 significant importance over the long run, especially in the
4 Medicare population where we're dealing with chronic
5 disease, multiple chronic conditions and so forth. It's a
6 completely different set of skills.
7 DR. MILSTEIN: Is this time for questions or
8 questions and comments? Both?
9 MR. HACKBARTH: Both.
10 DR. MILSTEIN: Okay, I have one question and then
11 a comment that follows.
12 My question really relates to the linkage between
13 our recommendation here and what I would call inter-provider
14 equity, equity across provider categories in our payment
15 policies. In this circumstance we're deviating in two key
16 ways from the general principles that are evident in our
17 payment policy in relation to all other categories of
18 providers.
19 First, we have uncovered a substantial amount of
20 overpayment. And in most other provider categories, when
21 we've got overpayment, we bring it back into the program.
22 We are deciding implicitly, through this recommendation, not

1 to do that.

2 The second, I'll call it equity principle that I
3 see violated here is that when we move into a pay for
4 performance environment, it's always based on what I'll call
5 sort of a taxing of the base payment that we believe is
6 justified. And we're also varying that policy here.

7 So my question is what is the policy rationale for
8 this form of exceptionalism in the general principles that
9 we otherwise apply in our provider payment policy?

10 MR. HACKBARTH: Let me get to the precise answer
11 in just a second and just emphasize the redistribution that
12 this entails. The IME extra, which is the pool of money for
13 recommendation one, currently is paid out without regard to
14 the performance of the GME activity. It's rather paid out
15 as a percentage add-on to Medicare payments for hospital
16 admissions, and thus is a function of the number of
17 admissions, the case-mix, as well as the resident-to-bed
18 ratio.

19 So what's new about this is we're saying if we're
20 going to fund GME, let's use it as a way to achieve our
21 goals for producing the physicians of the future and not
22 just pay it out as an add-on for the delivery of services.

1 You've made the case often and well that all or a
2 piece of this ought to be returned to the Treasury. And
3 there are some other Commissioners who have at least made
4 comments to that effect. Of course, there are other
5 Commissioners on the other side of that question, as well.
6 Can I articulate the policy principle? I'm not
7 sure that I can. What I'm trying to do, as the chairperson,
8 is to find an approach that will advance our goals -- in
9 this case, reforming graduate medical education -- that wins
10 broad support.
11 In terms of the counter argument on returning
12 money to the Treasury, in fact some people have alluded to
13 this already. We have a payment system that is based on
14 Medicare's share. This is a major source of funding for
15 graduate medical education in the United States, but it's
16 all linked to Medicare's payment systems. Not all payers
17 are paying into it, and all of that.
18 From that perspective, the problem is too little
19 monies going into graduate medical education. We have
20 people being trained above the cap and all that. We don't
21 have everybody contributing. You know all of those
22 deficits.

1 I think there are reasonable arguments to be made
2 on both sides and, as I say, I'm trying to find a consensus
3 position in the middle that would actually make sure this
4 money is used for graduate medical education and used for a
5 reformed system of graduate medical education. I think
6 that's important for our future delivery system.
7 Not a great principle, but that's how I got where
8 I am.
9 DR. MILSTEIN: Can I make my comment now?
10 MR. HACKBARTH: Sure.
11 DR. MILSTEIN: I'd like us to at least consider a
12 modification of this recommendation. It's really out of a
13 sense of the history of thoughtful comments and critiques of
14 the U.S. medical education system that at this point date
15 back at least 100 years.
16 If one looks, in my opinion, at the
17 recommendations over the years, there have been a variety of
18 reports following Flexner. I think a fair case can be made
19 that both at the undergraduate and graduate medical
20 education -- and for that matter, continuing medical
21 education level -- that the system has not been quite as
22 societally responsive as we had hoped. Many of the

1 recommendations that occurred in reports 20 years ago recur
2 in the recent Carnegie Commission report.
3 And so if we're going to -- if the consensus of
4 the group is for this kind of exceptionalism in our
5 principles, I would like us to consider it being tied to a
6 relatively frequent periodic examination as to whether or
7 not the movement in medical education is brisk. For
8 example, every three years our decision to allocate this
9 extra $3.5 billion a year be linked to some evidence of
10 brisk movement along the lines of major advances in these
11 subsets of physician-based competencies that you've
12 outlined.
13 MR. HACKBARTH: That, in fact, is what I envision.
14 That's the significance of the comment that all of the money
15 could be paid out or none of it paid out or a piece of it
16 paid out. So what I envision is that the Secretary has to
17 make a series of decisions.
18 First of all, at the end of this three year
19 interval, she needs to decide whether the standards produced
20 are sufficiently aggressive and, if adhered to, would
21 advance the system towards producing the clinicians' need
22 for a higher performance system.

1 Second, I would envision that it would be a
2 graduated system of payments so that the programs that
3 perform highest on the new measures would receive larger
4 payments. Those who perform poorly would receive either
5 small payments or no payments. And to the extent that the
6 system isn't achieving the goals laid out, not all the money
7 would be paid out.
8 DR. KANE: Yeah, I guess I'm going to be even more
9 aggressive than Arnie in this issue of sane progress and
10 providing enough resource reallocation to ensure the
11 progress.
12 So partly, in the second -- page five, I guess --
13 I'm wondering if we can't -- the first one, both the first
14 and the second I had some comments.
15 It says performance-based GME funding under the
16 new system should be allocated to an institution sponsoring
17 GME programs. Can we make it clear that that could be new
18 institutions and they could be community-based institutions
19 as well as existing institutions? Just to make that a clear
20 point that you don't automatically get priority just because
21 you've had them in the past.
22 And then in the second bullet, where we said that

1 only the payments above -- I'm going to call it excess, only
2 because it's too long to say the rest -- that the excess IME
3 payments, right now that's the only amount of payments that
4 you would want to reallocate. But why can't we say that we
5 would eventually transition towards the full amount of GME,
6 both direct and IME should eventually -- within some time
7 period, five years, 10 years -- be allocated to support the
8 new performance-based -- I don't think we should just always
9 be playing with that $3.5 billion, that it should be the
10 whole amount.

11 Because this is really -- going along with Arnie's
12 point -- it's pretty vital. And I think without a change
13 and the mindset and skill sets of the provider population,
14 we can do all of the ACOs and medical homes and information
15 systems we want and we've still got the same human
16 conscience, the same human intelligence and mindsets working
17 it.

18 You're going to get -- you really have to change
19 this and you have to put a lot of money into changing it, I
20 think.

21 MR. HACKBARTH: I agree with both points and I see
22 both as consistent with the recommendation.

1 MS. BOCCUTI: Just for clarity, so that when we
2 vote, what was the first one specifically you wanted --
3 DR. KANE: That under "allocated to" it says an
4 institution sponsoring GME programs. But I think we should
5 say to new and existing institutions, including community-
6 based sites, that are sponsoring GME programs. So that it's
7 clear we don't mean just the ones that currently do GME now,
8 that it expands the eligibility for these funds to any party
9 that can meet these standards and produce those kind of
10 programs.
11 MS. BOCCUTI: So for clarity, are you introducing
12 an entity that isn't currently, under new law, able to
13 receive GME to now get these new payments? So you're
14 creating -- by this, you're creating another entity that
15 doesn't qualify for GME, they don't really sponsor a
16 residency program but now they're eligible. So that's
17 another entity?
18 MR. HACKBARTH: Yes. So the Health Reform law
19 changed the rules of the game a bit here and now what's come
20 to be known as teaching health centers -- I don't know if
21 that's the language actually used in the statute.
22 MS. BOCCUTI: Yes.

1 MR. HACKBARTH: They are now eligible to receive
2 GME payments. So that's a new non-traditional category.
3 What I would envision is that they would be eligible under
4 this system, as well.
5 If we just add an open-ended new institutions,
6 since it would be incumbent on us to define what those new
7 institutions are, and we're not prepared to do that, would
8 it suffice to address your issue to have in text that we
9 don't intend this to be only the existing, but we think that
10 those eligible to receive GME funds could be an evolving
11 group, an expanding group, as evidenced by what's happened
12 in health reform?
13 DR. KANE: Yes, I think that's the idea, that
14 we're not stuck with this fixed set of organizations.
15 MR. HACKBARTH: Good. And then on the second
16 issue, remind me what the second one was?
17 DR. KANE: Right now we're saying that only those
18 excess IME should be removed and then reallocated.
19 MR. HACKBARTH: Right.
20 DR. KANE: And I feel that over time we should say
21 the full GME, both BME and IME and excess, should eventually
22 be reallocated to support the -- whatever we're calling them

1 -- performance-based GME.

2 MR. HACKBARTH: And again, that's quite consistent
3 with what I envision. My notion was let's start with a
4 piece of it and try to develop the new standards and how
5 they're assessed. But I would envision if hey, we've got
6 great new standards, and they make sense, that they could
7 and should be applied more broadly in time. But let's start
8 with a piece. This is roughly a third of the dollars.

9 DR. KANE: The only thing is if two-thirds of the
10 dollars are going on to reinforce the traditional medical
11 education system, it could be very difficult. If it's not
12 clear that they're all going to go that way eventually, I
13 just think you get into kind of a gridlock situation. So I
14 would recommend -- I would suggest we discuss at least
15 saying within five, seven, x years that the entire GME
16 should be going towards performance-based GME.

17 Again, the whole idea -- we really need to change
18 the way people think. And it's got to be soon. If we wait
19 for 15 or 20 years, ACOs are going to be gone and so are
20 medical homes. They're all going to be "failures."

21 MS. BOCCUTI: Would it be helpful to mention that
22 in the text rather than in the recommendation? Is that

1 something we're discussing here?

2 DR. KANE: We could put something vague enough to

3 get the point across but not specific as to be contentious.

4 In the long run the goal would be to have all GME allocated

5 towards the new performance-based program, within 10 years,

6 some time frame.

7 DR. MARK MILLER: I do understand what you're

8 reaching for and it's consistent.

9 One thing to keep in mind is we're talking about

10 money that goes for the structure of the program and

11 improving curriculum. There's also a component of this

12 money that is for the incurred cost that goes along with it.

13 So in thinking about what a completely reformed system would

14 look like, you'd also want to keep your eye on that ball,

15 too, because there is sort of an indirect cost that just

16 kind of occurs in the hospital.

17 I think what brought us to this point is, thinking

18 through how to operationalize that thought, why don't you

19 just do it all this way? You'd have to have something that

20 sort of addresses the basic cost as well, indirect costs

21 that people run into in trying to support these programs.

22 DR. KANE: Maybe the right language is the

1 Secretary should study and make a recommendation for a
2 proper transition such that the entire GME, within 10 years,
3 is focused on performance-based GME.
4 DR. MILSTEIN: I think when Nancy says the whole
5 thing, she doesn't mean 100 percent of all medical education
6 payments be performance-based. I think what she's saying --
7 DR. KANE: No.
8 DR. MILSTEIN: That's the distinction here. She's
9 saying take a fraction of all three pools and allocate it to
10 performance-based pay. She's not saying take all Medicare
11 GME payments. Is that right?
12 DR. KANE: I'm simply saying to the extent that
13 two-thirds is continuing on to produce the same old
14 mindsets, we don't want that to continue on forever. We
15 need to change the mindsets.
16 I don't know whether you want to call it
17 performance-based, but the whole GME that we pay into should
18 eventually go towards producing the mindsets that will give
19 us the kind of people we need to motor the system.
20 MR. HACKBARTH: Yes, I think I understand your
21 point and I think you've made it well.
22 I see two possible courses. One is to add to the

1 bold-faced recommendation a sentence of the sort that you
2 described: the Secretary should also make recommendations on
3 whether and how performance-based GME payments might be
4 extended beyond this one-third. So that would be a bold-
5 faced recommendation.
6 The other path is to make that point in the text.
7 Is the text sufficient?
8 DR. KANE: I think that the whole thing should be
9 bold-faced because you're just stopping short --
10 MR. HACKBARTH: All right. I hear.
11 So now my next step is to ask for a show of hands.
12 I'm going to be guided by what most commissioners want to
13 do. Who would like to see an additional sentence added to
14 the bold-faced recommendation saying that the Secretary
15 should also report on how and whether an additional portion
16 of GME payments should be linked to this assessment? Who
17 would like to see that language.
18 I know it's vague. We'd actually work out
19 specific language before you vote. But I just want to see
20 who wants to add that element to the bold-faced -- hands up
21 higher. Five. So we don't have sufficient, but we'll
22 discuss -- we'll address the issue in the text, without

1 making a specific recommendation.

2 MR. BUTLER: Just a comment on this. Here's the

3 big problem I have on it. We have a system now that says

4 we're going to pay for the cost, whether the 2 percent or

5 the base. And the cost of entry is ACGME accreditation. So

6 there is a baseline standard now.

7 So if we were to say this even in the text, we're

8 essentially saying -- we're making a recommendation that

9 over time ACGME is not the mechanism that we would use,

10 which is a big statement. And I don't know that we're quite

11 there at this point in time; right? I think that's a very

12 different -- whereas what we're doing now is we're saying

13 the cost of entry is ACGME. Now we're adding on some new

14 standards that you will be required to meet to get your full

15 5.5.

16 So we would be replacing the whole standard if we

17 went this over time.

18 DR. MILSTEIN: I don't think so. I think the

19 Secretary might recommend that a higher -- that the ACGME

20 standard is too low and still defer to the ACGME for the

21 standard.

22 MS. BEHROOZI: Yes, I just want to say, I don't

1 think a third of the dollars necessarily drive a third of
2 the behavior. Because if you are going to lose a third of
3 the money that you would otherwise get, you're going to
4 change all of your behavior to try to get that third.
5 I just don't think it necessarily slices exactly
6 what the one-third of dollars at risk for performance-based
7 improvement, that two-thirds of the dollars then means that
8 two-thirds of the behavior stays in place. Because we heard
9 a lot from the industry when we were talking about taking
10 one point out of the IME points, which was 20 percent of the
11 IME, that that's a big deal, that's a big hit. They were
12 paying a lot of attention to that.
13 It's a huge change we're talking about already and
14 you're talking about trying to get broad-based support and
15 move forward.
16 So while I understand that it's consistent to go
17 that way, I just don't think that it's -- I think you'll
18 drive a lot of behavior with the third.
19 MR. HACKBARTH: It's clear from even this brief
20 conversation and show of hands that we don't have consensus
21 here so we won't do anything in the bold-faced
22 recommendation.

1 What I would envision is that we'll put in the
2 text that this is an issue and say here are pros and cons,
3 basically lay out what Arnie and Nancy described and what
4 Peter just said, and there are different ways you can look
5 at it.
6 It's too complicated an issue for us to try to
7 further debate and resolve right now.
8 Okay, so other comments on number one?
9 DR. CROSSON: Thanks, Glenn. And I support the
10 recommendation wholeheartedly. I think it's quite timely.
11 I suspect the future will show that the month just past will
12 represent an inflection point -- hopefully an inflection
13 point heading upwards -- with respect to health care in the
14 United States.
15 I think if you look through the legislation that's
16 passed -- and I haven't completely finished that yet. But
17 if you look at the parts that are aimed at changes in the
18 delivery system, delivery system reform or delivery system
19 improvement, you get the sense looking through it that
20 there's clearly something in there. There's a bias towards
21 a system-based practice. And that's likely, in the minds of
22 many, to represent an improvement over what we have now.

1 And this recommendation, as it relates to changing
2 the training of new physicians, is entirely -- I think --
3 consonant with that direction. I'm happy that we've worked
4 on this. I'd like to congratulate you for the work. I'd
5 like to congratulate Glenn, particularly, for the ability to
6 synthesize a lot of complicated and, in some cases,
7 contentious material into a set of recommendations.
8 Just a comment on Arnie's question, because I had
9 sort of the same sense when I looked at it. And perhaps
10 this is a rationalization but it's hard to get through a day
11 without a few of those.
12 I think this is a change. I think this
13 recommendation says that the Treasury no longer is going to
14 pay, as it has in the past. There's not going to be a
15 maintenance of effort or maintenance of expenditure for a
16 certain portion of GME payment. And that money will only be
17 expended, as Glenn has said, if in fact the product that is
18 produced through the graduate medical education process is a
19 better product. And not just a generally better product,
20 but a product which is more aimed at the long-term
21 sustainability of the Medicare program in specific and the
22 health care system in the United States in general.

1 So one could look at this, and I think I settled
2 on looking at it as a conscious investment. One hopes that
3 the investment will turn out to produce gain.
4 But I think it's possible to look at this as an
5 investment, essentially taking money that's already being
6 expended and invest it in a way that expects a long-term
7 gain for the program, both in terms of quality and
8 potentially also in the long-term cost trend.
9 MR. HACKBARTH: Other comments on recommendation
10 one?
11 MR. GEORGE MILLER: Yes, I also want to echo the
12 comments about the great work you did in putting these
13 recommendations together and probably note you had a little
14 sparring when you got together in talking with some of us.
15 I'm sure you will note that.
16 Let me just suggest, and it may be already
17 implied, but I'd like to bring this issue up on the second
18 bullet point on number one where you start out with the
19 standards established by the Secretary should, in
20 particular, specify ambitious goals for practice-based
21 learning, improvements, et cetera.
22 My thought, my direction I want to make sure it's

1 included, particularly to address disparities in health care
2 and that that whole issue is either included and if it's not
3 included I would like specific language to make sure to
4 address disparities and being able to provide services for
5 at-risk populations and the like.

6 So that the system deals with that whole issue. I
7 think we have enough documented proof that there are
8 disparities in health care in the current system and that
9 part of the change that needs to take place will address
10 that issue, as well.

11 If it's implicit, fine. But if it's not, then I'd
12 like specific language, although I don't want to wordsmith
13 here.

14 MR. HACKBARTH: Right.

15 MR. GEORGE MILLER: But I would like to add
16 specific language to deal with vulnerable populations,
17 populations at risk, disparities.

18 MR. HACKBARTH: You know, I think it is implicit.
19 We can make it more explicit in the text that follows the
20 recommendation.

21 In addition to that, I would say that one of the
22 conclusions we've come to as a group is that probably the

1 best way to influence the mix of people that come out of the
2 pipeline is to intervene earlier on --
3 MR. GEORGE MILLER: That part I understand, yes.
4 MR. HACKBARTH: -- as opposed to at the residency
5 training level. In terms of meeting the needs of now
6 underserved communities, getting the right people into the
7 system to begin with is an effective way to do that.
8 MR. GEORGE MILLER: I don't disagree with that.
9 MR. HACKBARTH: Having said that, whoever is in
10 the system, they ought to be well trained --
11 MR. GEORGE MILLER: Correct, cultural competencies
12 and all those issues.
13 MR. HACKBARTH: Right.
14 So Cristina, do you have a comment?
15 MS. BOCCUTI: I was just going to mention that
16 some of these things in that bullet, those topics that are
17 there, if you unpack them say in ACGMEs, competency-based,
18 you'll see competencies that are related directly to what
19 you're saying. And they often fall under the interpersonal
20 and communication skills and others.
21 And so what we can do is highlight that and bring
22 that out in the text, that these are some of the examples.

1 And it will show that.

2 MR. HACKBARTH: Just to pick up on Cristina's
3 point, I consciously used language drawn from the ACGME six
4 competencies. And there is, as Cristina says, now a quite
5 elaborate framework, elaboration of what those competencies
6 mean. A number of your issues would be encompassed under
7 the interpersonal communication.

8 MR. BUTLER: I don't dare suggest changes in
9 wording at this point. None of us are probably totally
10 comfortable with any of the wording. But we could have put
11 this money in a lot of buckets and we did discuss all that.
12 So my feeling and zeroing in on creating health
13 professionals who are at the top of their game for the
14 health delivery system of the future out of this training
15 process is the best way to leverage these dollars because it
16 will impact Medicare spending significantly if done right.

17 So we've toyed with the idea do we put it in
18 progressive health systems versus the curriculum, so to
19 speak. And we actually landed more on the curriculum side,
20 in effect. But you have nice wording that kind of gives
21 wiggle room. And I think the balance is just about right.

22 I only have one comment, and it is an important

1 one. We had a draft -- and Cristina, you suggested maybe
2 this is the place to bring it up.
3 We had a draft recommendation in March relative to
4 reducing barriers to ambulatory training, and some technical
5 adjustments that I think everybody was in agreement here
6 that says you've got to count all the resident's time,
7 regardless of the setting, they're practicing in for DGME
8 and IME payments. And most of it, I'm understanding, but
9 not all of it ended up in health reform legislation.
10 Therefore, we just didn't want to come back and approve what
11 already is in the legislation. But there are some technical
12 differences.
13 My understanding is you're thinking of a text box
14 to kind of clarify this issue as part of the draft report.
15 So I just want to make that statement and get some
16 confirmation that that's how you're going to handle it.
17 MS. BOCCUTI: That is what we've discussed. If
18 anyone wants us to talk about that more, we can. Or we can
19 talk more about it with you later.
20 But in short, this is about counting non-hospital
21 time and the recently passed legislation has specifics that
22 allow some more flexibility. But there are other ways it

1 could be more flexible. For the most part, it addresses
2 some needs.
3 So we thought that it would be good to mention
4 that in the text and talk about what it does and doesn't do
5 in a very straightforward way. Is that --
6 MR. HACKBARTH: Yes, I think that's good. This
7 was a judgment that I made, Peter. I didn't want to include
8 a recommendation that was sort of like 90 percent addressed
9 by the health reform law for fear that it looks like -- are
10 these folks even paying attention? Do they know what's
11 happened?
12 On the other hand, I have come to understand that
13 what's in the law may not be 100 percent of what's needed.
14 And I think this inclusion of a text box is a good way to
15 reconcile that.
16 Okay, moving along, still on recommendation one,
17 Mike?
18 DR. CHERNEW: I have, first, a round one type
19 question, which is the recommendation does two things. The
20 first thing it does is it removes the amount of IME payments
21 above the empirically justified amount. And then it puts
22 that into a new performance-based GME program.

1 And then there’s a sentence which says we’ll start
2 the performance-based GME program on October, 2013. Was
3 that intended to coincide with when the payments are
4 changed? Or was the payment change -- the removal of the
5 payments -- it’s just not clear from the phrasing the timing
6 you intend.
7 MR. HACKBARTH: The intent is that the payments
8 change when the new system for allocation is ready to go.
9 DR. CHERNEW: Right, so that should be probably
10 clarified because you could interpret that as you remove the
11 payments now and you wait --
12 MR. HACKBARTH: Yes, we will make that clear in
13 the text.
14 DR. CHERNEW: The second comment I had was in
15 response to some of this other discussion. There’s two
16 reasons why I think now is not the time to get into bigger
17 changes. Briefly, the first one is I would want to see say
18 the impact-type slide that comes up -- I would like to see
19 what that is if you were to make a recommendation that had
20 many bolder changes, like moving things around.
21 We don’t know, because of the complexity of the
22 system, how the whole system would change if, for example,

1 we put it back to the Treasury, which philosophically in
2 many ways I might like. But I'm a little hesitant to do
3 that without seeing a more detailed analysis of the impact
4 of that bold a recommendation, although I could anticipate
5 perhaps supporting that if we saw that.
6 And I'm hesitant to do that extra work now -- this
7 is my second comment -- because there's going to be this
8 graduate medical education commission. And so I think they
9 will make some recommendations that relate to that.
10 So that's my way of justifying why I'm fine with
11 this recommendation now that it's clarified.
12 MR. HACKBARTH: Shall we move onto recommendation
13 number two -- or actually, were you going to suggest vote
14 now or did you have something else to say?
15 MS. BOCCUTI: Yes, just the timing thing is that
16 we had discussed before -- and it's not in this draft -- but
17 on the first bullet it would have patients and consumers,
18 too --
19 MR. HACKBARTH: Oh, yes.
20 MS. BOCCUTI: -- for the point of voting. So I
21 apologize that we didn't get that on that version there.
22 But it would read "training programs, health care

1 organizations, patients and consumers, and health care
2 purchasers.”
3 MR. HACKBARTH: Thanks, Cristina.
4 Let's go ahead and vote so people don’t have to
5 try to remember what recommendation one was.
6 All in favor of recommendation number one, please
7 raise your hands? Opposed? Abstentions?
8 Okay, thank you.
9 Let's go onto two. Okay, let me just say an
10 additional word about number two. Some issues that Karen
11 raised very early on in the process were the genesis of this
12 recommendation. Karen said -- and Karen, please feel free
13 to take over here -- but as a program director it was often
14 difficult to know exactly what sort of money was flowing
15 into the institution to support graduate medical education.
16 After Karen had made that comment, I’ve been in a
17 couple of other forums where I’ve heard from program
18 directors in other specialities at other institutions, the
19 exact same thing, that this is a point of some frustration
20 and, on occasion, friction.
21 So the idea here was pretty straight forward.
22 These are federal funds. The people charged with training

1 residents don’t even know, in some instances at least, how
2 much is coming into their institutions. There ought to be
3 transparency about how federal dollars are deployed.
4 Peter didn’t object to that but suggested that we
5 ought to also include information about costs. You can see,
6 we’ve agreed to that request.
7 I would emphasize, though, that you can’t take the
8 data that would be published as a result of this
9 recommendation and do a profit and loss for teaching within
10 any institution. There are a number of other factors at
11 work in how profitable or unprofitable the teaching
12 enterprise would be.
13 Indeed, that is the purpose of recommendation
14 four, which calls for a systematic study of what the
15 economics of graduate medical education might be with a
16 fuller accounting of costs and potential financial benefits
17 to the institutions.
18 So with that preface, let me see hands for
19 comments on recommendation two. We’ll start on this side,
20 beginning with Karen and then Jennie and Bill.
21 DR. BORMAN: Just briefly, the comment that I
22 think -- lest we get a whole bunch tied up in details of

1 what is and isn’t in here and, as Glenn mentioned, potential
2 uses for it -- I personally would regard this as potentially
3 a work in progress evolving document. The point here is to
4 institute transparency with a beginning of a report and
5 facilitate the dialogue within the educator and teaching
6 hospital community. Being one of the people that was really
7 pushing for this, I just want to make clear I understand
8 where the reporting difficulties may be. We need a
9 beginning promptly.
10 MS. HANSEN: Yes, this, I support -- I just wanted
11 to clarify, Cristina, is the line that says the number of
12 residents and other health professionals that Medicare
13 supports. Would this be where, for example, some of the
14 nursing funding would be spelled out as part of the
15 transparency?
16 MR. LISK: I didn't have that in our list of
17 things but I guess we could envision that as something that
18 could be part of that.
19 DR. SCANLON: Let me add my thanks to you, Glenn.
20 I know it’s not just an effort this year but this has been a
21 multiple year effort to get to this point. And I think we
22 are at a good point.

1 You actually brought up some of the -- I guess I
2 would say concerns about this recommendation that I have,
3 which while I fully understand the motivations, I really
4 wonder about the feasibility of doing this correctly or
5 well.
6 One of the problems I think that we often have in
7 the Medicare program is we use a little bit of economics and
8 a little bit of bad data. And the combination creates
9 momentum to do things that are wrong.
10 Here the issue is it’s easy to measure the
11 revenues but how you measure the costs is a whole another
12 question. We’re talking here about an approximation to
13 begin with which is not even going to be -- in some respects
14 it’s not accurate in terms of the recommendation. Each
15 hospital’s associated costs are incurred costs. These are
16 estimates.
17 Craig’s characterization of what would be done
18 under recommendation four is incredibly accurate in terms of
19 how complex the economics or the business case for a
20 residency program are. My sense would be that we really
21 need to do that first. We really need to understand that so
22 we would have any -- we would have some idea about if we

1 produced these numbers, both of these numbers, how far off
2 we are. Because if we don't, we'll end up and we'll put out
3 more data that will then be used.
4 What I'm having here is a flashback to every
5 annual update meeting where we talk about hospital-based
6 SNFs and margins of minus 70 and minus 80. And there's
7 questions of why do they have a SNF if they're losing 70 or
8 80 percent? What should we do about it?
9 The conclusion always is wait a minute, we're not
10 getting the right picture by looking only at that number.
11 And I'm afraid we're creating another number of that sort if
12 we just go ahead here and do this too simplistically instead
13 of thinking about what would be the best way. And I think
14 looking at the economics of residency programs and
15 understanding them better might give us a much better
16 pathway to that best way than what we have right now.
17 MR. HACKBARTH: [off microphone] Other comments on
18 number two?
19 DR. MILSTEIN: We envision this same level of
20 transparency with respect to how the hospital was rated on
21 its training program.
22 MR. HACKBARTH: [off microphone] Number one?

1 DR. MILSTEIN: Yes. Would that be part of our
2 transparency recommendation or would that be a private
3 matter between the Secretary and the teaching hospital?
4 MR. HACKBARTH: No, I would not think that that
5 would be a private matter. That would be plugged into a
6 formula for distributing tax dollars and those evaluations
7 should be public.
8 DR. MILSTEIN: I guess my suggestion then is that
9 we either --
10 MR. HACKBARTH: Be explicit about that.
11 DR. MILSTEIN: -- that it would be something that
12 would also be available publicly so that the residents and
13 the faculty could be aware of how they relatively scored.
14 MR. HACKBARTH: Other number twos?
15 DR. STUART: I support this recommendation and
16 actually would take kind of the opposite side that Bill
17 took. I think that the last point on this slide is clearly
18 an underestimate of what is likely to happen if this
19 happens. I think this is definitely going to provide a
20 level of information that even though you may not end up
21 with exactly the right number -- and those of us who have
22 taken cost accounting know that right the exact right number

1 actually is in reality is largely a fiction.

2 But at least it's going to provide considerably

3 more information, valuable information in terms of trying to

4 understand this process. So I support this recommendation.

5 DR. KANE: One issue that I think will come up is

6 that the hospital level is not an adequate level for the

7 kind of information that I think Karen is really looking

8 for. So for instance, at my school we have a big teaching

9 budget based on tuition dollars. It goes to the

10 departments. And then the departments spend it not

11 necessarily on the teaching but on whatever they decide.

12 And I think I'm not sure, but that may well be

13 what you're really interested in, Karen. And I'm wondering

14 if that the hospital level just doesn't get you -- to go

15 back to Bill's comment, I'm not so sure you're going to get

16 what you want at a hospital level. I think what you want to

17 know is how much money is coming in and what residencies and

18 which specialties are accounting for that revenue. And then

19 to what extent is that revenue tracking with where those

20 residents are training or going elsewhere?

21 And I don't know that -- I agree with Bruce,

22 that's a huge tracking process that's traditionally kept

1 very close to the chest by the departments involved. And I
2 don’t think at the hospital level you’re going to get what
3 you need.

4 I’m happy to support it although I’m not sure it’s
5 taking you where you want to go. So in that sense, I’d have
6 to be better convinced.

7 MR. HACKBARTH: I don't disagree with anything
8 that you said. So the purpose of here is to help support
9 the beginning of a conversation, which is a really
10 complicated conversation. Even if you could map and track
11 all of the dollars in a detailed way as you described,
12 there’s still a huge conversation to be had about whether
13 that’s a fair distribution, appropriate distribution.

14 Our goal with this recommendation is modest, to
15 support the beginning of a conversation that, as Karen said,
16 will inevitably evolve over time. We shouldn’t have any
17 illusions that this provides answers to all of the questions
18 that need to be answered.

19 Any others?

20 DR. CROSSON: Well, I guess just a technical
21 question that came to me. Since before we talked about the
22 potential for new institutions, if that’s the right word, to

1 be the centerpiece for programs, do we really want to say
2 hospital?
3 MR. HACKBARTH: Oh, actually sponsoring
4 institution -- well, the dollars go to a sponsoring
5 institution like Rush and then it's allocated among programs
6 in different specialties. So I think the appropriate word
7 is sponsoring institutions.
8 MR. LISK: Yes, there are some technical issues
9 with sponsoring institution because sometimes from the ACGME
10 perspective the medical school is the sponsoring institution
11 and not the hospital. And there's financial transactions
12 that happen between them. Right now it's mostly all
13 hospitals.
14 We could put in the text about any institution
15 that's really receiving -- or we could put institution
16 instead of hospital.
17 MS. BOCCUTI: Yes.
18 MR. LISK: We can put institution. Not sponsoring
19 institution but each institution.
20 MS. BOCCUTI: Or facility.
21 MR. LISK: Or facility.
22 MR. HACKBARTH: Any objection to using the more

1 generic term institution, substituting that for hospital?
2 Okay, considering it done.
3 Any others on number two?
4 MR. BUTLER: I forgot, those aren't clarifying.
5 So I guess at this later hour to bring it up --
6 but I need to make my statement. I understand the language
7 is to get a dialogue going with your program director. And
8 frankly, if you can’t do that, I don’t know why we’re going
9 to have the Secretary of HHS or something facilitate that
10 dialogue. I mean, my idea of putting cost in here was to
11 say both to the program director here are the costs, but as
12 well as to get to what would be near and dear to Arnie’s
13 heart. Let’s look at the variation on the cost report and
14 the cost of producing a resident. Let’s look at how that
15 cost has evolved over time compared to the payment.
16 So I had a broader agenda than just creating a
17 dialogue with the program director within the institution.
18 Now maybe that second agenda belongs in
19 recommendation four rather than in this one.
20 MR. HACKBARTH: Well, that's how I conceived of
21 four, is that’s the more complex analysis. My goals for
22 this were very limited.

1 MR. BUTLER: Okay.

2 MR. HACKBARTH: Let me just quibble with your
3 words. I know you probably didn't mean them this way. I
4 don't see this as the Secretary facilitating a dialogue. I
5 see it as these are federal dollars and it seems to me that
6 it ought to be public information about where they go. That
7 can be the starting point for a dialogue but if there aren't
8 healthy relationships within the institutions, the dialogues
9 aren't going to go very far.

10 So I don't see this as the Secretary trying to
11 facilitate anything.

12 MR. BUTLER: Okay, would you accept -- I have one
13 very modest suggestion then and I'll let this go. Because I
14 don't understand what Medicare's share of direct and
15 indirect teaching cost is. That's not a simple thing to do.
16 Can we just make it Medicare's share of teaching costs
17 incurred and leave out -- I know exactly what the Medicare's
18 share of direct costs are. It gets very complicated to me
19 in defining what it's share of indirect.

20 If we took both of those out and just said
21 Medicare's share of costs incurred, it might make it a
22 little bit easier. It's a very --

1 DR. MARK MILLER: The other thing you could do is
2 take cost out all together and have it dealt with in study
3 number four. If the point here is --
4 MR. BUTLER: Which is fine with me. To me, if I'm
5 Karen, that really doesn't get at -- you know, I want to
6 know what my budget is, what the dollars are available kinds
7 of issues and how you reach that conclusion. And if you
8 just have some payment side it doesn't mean much. I think
9 it achieves her -- but if that's what we want to do, I don't
10 have any problem with disclosing or wanting to be
11 transparent about payments.
12 MR. HACKBARTH: Your call, Peter. As you know, I
13 added the cost language in response to issues that you had
14 raised. My very limited purpose for this is accomplished
15 without the cost information. I think the cost information
16 sort of adds complexity to the disclosure.
17 I do think that there are very important questions
18 that need to be addressed about how much of a benefit or
19 burden financially teaching programs are. I don't think
20 these data do it. I think the recommendation four study is
21 the approach you need to take.
22 MR. BUTLER: Okay.

1 MR. HACKBARTH: So I would be happy to see cost
2 dropped all together from this, if you're willing to do
3 that.
4 MR. BUTLER: Let's go with the flow. I'd rather
5 have it in and just drop the indirect and direct and say --
6 because I do think if the purpose is and the text says we're
7 trying to facilitate understanding within an institution, I
8 think we need to have costs in.
9 MR. HACKBARTH: Okay. Go ahead, Mitra.
10 MS. BEHROOZI: I'm sorry, because it says costs
11 earlier. It says "and each hospital's associated costs" in
12 the first sentence. But then the last one is the conclusory
13 Medicare's share of direct and indirect teaching costs. So
14 would we leave it in the front so that it's a report of
15 costs, without making a conclusion about what -- or would
16 you take it out all together.
17 MR. BUTLER: It first relates to the payments,
18 indirect and direct. The second I'm trying to get at is the
19 buckets that you would report out of. And you can't measure
20 the indirect costs in a specific teaching hospital. I
21 couldn't go to Karen and say here are my indirect costs.
22 You'd have to use a national standard which what does that

1 mean? It’s not helpful information.

2 MR. HACKBARTH: And so, here's the issue, Peter,
3 as I see it. If you start down the path of saying we’re not
4 doing just revenues, we’re also doing costs and you can sort
5 of envision in your mind’s eye a grid with the information
6 on these different elements. And then you get to indirect
7 and you have a revenue line and an empty box for a cost,
8 whereas all the other cost boxes are filled in. What does
9 that mean to the reader?

10 It can be interpreted as well, there are no costs
11 and this is all profit, this is all gravy, this revenue. Or
12 it can be interpreted as the costs exactly equal the
13 revenue. It just seems to me you’ve got to say something
14 about the costs associated with this revenue item.

15 The way the system works, the estimate of those
16 costs is the national empirical amount.

17 MR. BUTLER: I was afraid we would get into this.
18 I’d rather have a narrative part of the report that
19 expresses the national average than a cost in there and to
20 think that that is the indirect cost.

21 MR. HACKBARTH: Okay, we're not designing exactly
22 what this web page is going to look like, and we’re probably

1 at a level of detail that we ought not go. What we can do
2 is talk about this in the text and say this indirect cost
3 number is a different sort of number and it ought to be
4 handled appropriately in the display.
5 DR. SCANLON: I'm really concerned because I think
6 people don't read the footnotes. It's a disservice to put
7 out bad data and that's what, in a sense, we're proposing.
8 To characterize it kindly, we don't know whether it's going
9 to be bad data until the study in four is done.
10 And to me the wise course would be for us to
11 recommend, if we want to, publish revenues now. Do study
12 four. And at a future MedPAC meeting there is a discussion
13 that says we now understand the economic dynamics of
14 residency programs and here's our recommendations about how
15 transparency should be accomplished.
16 But right now, because again, I've said this many
17 times. Government, we do it once, regardless of how bad it
18 is we stick with it. Let's not set the momentum up to keep
19 something that we know has got real potential flaws in it.
20 Let's do revenues now. Let's, in the text, say we're going
21 to come back to this. We are very concerned that there be a
22 complete picture of revenues and costs but we understand how

1 complex the cost side of this is.

2 MR. HACKBARTH: I want to bring this to a

3 conclusion. What I hear you suggesting is strike costs --

4 DR. SCANLON: Costs from here. And in the text

5 say we understand we left it out of here. We want it to be

6 done eventually but we want to know how to do it and we

7 think that study four, the study in recommendation four, is

8 critical to understanding how we should go about doing this.

9 MR. HACKBARTH: Okay. So Bill has made a proposal

10 to strike the cost language and recast this recommendation

11 as providing only information on revenues and then have a

12 discussion about costs in the text.

13 DR. KANE: One question. Is the source of data

14 what's already on the Medicare cost report? Or is the

15 source of data a new -- because we know already the payments

16 and the number of residents.

17 MR. HACKBARTH: The source of data on the direct

18 medical education costs is from the cost reports.

19 DR. KANE: [off microphone] -- anything else.

20 MR. HACKBARTH: For the indirect, as Peter said,

21 it would be the national average empirical amount.

22 DR. KANE: So all you're really doing at this

1 point is putting on what’s already out there in the public
2 domain, but you’re putting it all together in one place?
3 MR. HACKBARTH: Yes.
4 DR. SCANLON: You can regard that as providing a
5 service or creating a danger. The question is which is it?
6 And I think that putting it out there, what is not easily
7 accessible now, is creating this danger because of
8 misinterpretation.
9 DR. MILSTEIN: What's the rationale for not making
10 it easy for the residents and the faculty to get access to
11 at least the direct cost component, since that does not
12 suffer from this weakness? I understand they can dig into
13 the Medicare cost report, but that’s not exactly what a
14 resident or a faculty member knows how to do or can do
15 easily.
16 DR. SCANLON: I guess I have much less concern
17 about that, but I don’t know what it tells them. Think
18 about the way the direct costs of reimbursement has been
19 structured. We’ve taken costs from what -- Peter tell me --
20 1983, 1984 with trending.
21 MR. BUTLER: But those are payments, Bill. The
22 cost reports would reflect --

1 DR. SCANLON: I’m sorry.

2 MR. BUTLER: My cost proposal really was to
3 reflect what’s on the cost report in the direct medical
4 education cost center and make that publicly available. And
5 that would help the program directors and others understand.
6 And that’s why I say I don’t care if there’s a blank box.
7 This gets semantics to how you present it I think that could
8 be overcome.

9 So I was getting at the direct costs as currently
10 measured today. And we allocate this fairly carefully.

11 DR. SCANLON: I'm sorry, I misspoke. I meant that
12 the payments have been trended forward. The costs, at this
13 point, are probably significantly in excess. And so I’m not
14 sure what tells anybody about -- particularly the program
15 directors -- in terms of leverage with their institution.

16 DR. MARK MILLER: I think, Arnie, the direct
17 answer to your question is the point that Glenn made a few
18 minutes ago. If you leave that box empty, what’s the
19 interpretation, that all of the IME, the cost is equal to
20 that? Or there’s no cost? And that was the concern that
21 set off the conversation.

22 DR. MILSTEIN: Yes, I thought the suggestion that

1 was previously made was reasonable, which is you leave it
2 blank with language that says we think this ought to be
3 filled in and we sort of -- you know, future location of X.
4 But since we do have institution specific
5 information on direct cost, why not make it as transparent
6 as possible.
7 MR. HACKBARTH: In this conversation we sort of
8 periodically hop into what the visual presentation of the
9 data are going to be. I don't think that's a productive
10 place for us to go.
11 So we've got a proposal on the table from Bill to
12 strip out the cost and make this focus only on revenue. I'd
13 like to see a show of hands on that. Who supports Bill's
14 proposal to strip out cost all together? In the text, we
15 would say the right way to assess the profitability is
16 through a recommendation number four type study.
17 All in favor of Bill's proposal?
18 So we'll keep the cost in. Peter, is there a
19 specific word or words that you would like to change?
20 MR. BUTLER: [off microphone].
21 MR. HACKBARTH: Hit your microphone.
22 MR. BUTLER: I almost think I could if I had five

1 minutes to kind of capture this. Let’s see, if we say the
2 Secretary should annually publish a report that shows --
3 MR. HACKBARTH: It's the last clause, Peter.
4 MR. BUTLER: I know, but I’m just reading what we
5 might modify -- Medicare medical education payments received
6 by each institution period. Let’s leave out, for a second,
7 that part.
8 This report should be public -- we should also
9 provide the direct medical education costs captured on the
10 cost report for each institution and make that public
11 available. These aren’t precise words.
12 And then you would say that it shall, at the
13 institutional level -- the rest of this.
14 MR. HACKBARTH: Could I make a simpler proposal?
15 Leave everything the same except in the last clause, just
16 say in Medicare’s share of costs incurred. And then in the
17 text discuss --
18 MR. BUTLER: Which is what I suggested earlier.
19 Leave out the reference to direct and indirect in that,
20 because then you start putting it in buckets.
21 MR. HACKBARTH: Right. And then in the text we
22 can talk about the --

1 MR. BUTLER: And I think you could probably find a
2 way to get at it that would be a simpler way to --
3 MR. HACKBARTH: So do people understand that?
4 Everything stays the same except in the last clause there it
5 says "in Medicare's share of costs incurred." And then in
6 the text we would, in a concise way, replay the conversation
7 that we've had here.
8 So with recommendation number two so amended, all
9 in favor of amended number two? Opposed? Abstentions?
10 So we've got one and one.
11 DR. MARK MILLER: You've got Bruce opposed.
12 MR. HACKBARTH: And Bill abstention.
13 Okay, so let's move on to three, four and five.
14 You'll recall that these three recommendations are for
15 studies, one of which we've just been referring to about the
16 economic benefit or burden on sponsoring institutions from
17 running training programs. That's number four.
18 Number three, I won't read it. Cristina will read
19 it instead. And then the last one is on the PHS pipeline
20 programs.
21 What I'd like to do is have Cristina read each of
22 those, go through them, and we'll just have one discussion

1 and not go through them separately if that's okay.

2 MS. BOCCUTI: I read them during the

3 presentation, so they're in the record. But I'd be more

4 than happy to read them again.

5 MR. HACKBARTH: It seems like a long time ago now.

6 [Laughter.]

7 MS. BOCCUTI: Would people benefit from that?

8 MR. HACKBARTH: Maybe we should just flash them up

9 in succession and let people read them themselves and we'll

10 spare Cristina's voice.

11 MS. BOCCUTI: Well, I will paraphrase, since

12 they're in the record.

13 MR. HACKBARTH: Yes.

14 MS. BOCCUTI: Draft recommendation number three is

15 about a workforce analysis and it specifically says that the

16 benchmark for such workforce analysis should be based on a

17 high quality, high value, and affordable care system and

18 that it should talk about physicians and other health

19 professionals.

20 Draft recommendation four is about the financial

21 performance, and I'll talk about this but Craig was the one

22 who did this in the presentation. It's about studying the

1 impact of residency programs on the financial performance of
2 the sponsoring institutions for them, the provider
3 institutions. That would be sort of a cost benefit look at
4 the financial performance of the residency programs.
5 And then draft recommendation number five is about
6 diversity and pipeline issues. And so it is to study the
7 best strategies that should be used towards the pipeline and
8 diversity goals that we discussed.
9 MR. HACKBARTH: Thank you, Cristina.
10 At the risk of wearing out my welcome, let me just
11 say a word about number three. One point that bears
12 emphasis is that we're talking about the needs of a
13 efficient, high value, high quality delivery system. What
14 are the workforce needs for that kind of a delivery system?
15 What I wanted to highlight is that, as everybody
16 knows, there's a lot of discussion these days about whether
17 the caps on GME should be lifted so that Medicare expands
18 its funding for training of new physicians. That may well
19 be necessary and appropriate. The message here though is
20 that before just adding more money into training the current
21 mix of physicians, we would do well to assess what our
22 future needs are both for numbers and mix. And then make

1 any decision about expanded funding based on that analysis.
2 If we just increase more funding for the current
3 mix, not only do we run the risk that that won't support the
4 delivery system of the future that we seek, it can actually
5 become an impediment to the development of that delivery
6 system because we'll have new cohorts of people coming into
7 the system with a stake in the status quo.
8 So three, four and five. Let me see hands for
9 comments on any one of those.
10 DR. DEAN: On number three, we've commented before
11 that attempts to predict what our needs are in the past have
12 not been very successful. And yet, if we're going to
13 proceed -- I mean, it's essential that we do it. We just
14 haven't been very good at it.
15 I think that we would like -- and I think when you
16 and I talked -- we would like to get to some kind of self-
17 correcting system that analyzes itself every so often to
18 decide if we're on the right track. So I wonder, probably
19 at least in the text -- and I don't know if it should be in
20 the recommendation -- but this is not a one-time shot. It
21 should be something that's redone every three years or
22 something like that.

1 Because predictions in the past have been
2 notoriously off track sometimes. We’ve got to keep looking
3 at it and try to -- if it were not on course, that we push
4 the thing back toward where we want to get to.
5 DR. KANE: Yes, actually, I don't know if we want
6 to make any mention of the fact that the new law has a
7 national health care workforce commission, and whether we
8 should make a statement that we should be doing this
9 independently or in conjunction with just --
10 MR. HACKBARTH: In the text we’ll mention the fact
11 that there’s a new law that provides for this and its
12 jurisdiction covers many of these same issues. So it will
13 be integrated in that way.
14 DR. KANE: Well, and whether we should work with
15 them or independently of them, I think is the other -- but
16 my real comment actually, apart from that -- that was just
17 noticing that there already is a commission being set up.
18 On our spending implications, whenever we tell the
19 Secretary to do a new study, we always say no spending
20 implications. And I guess in light of the well-recognized
21 lack of capacity of both CMS and HHS to keep up with the
22 volume of studies and new programs, should we keep saying

1 none when we say spending implications? I know Cristina
2 kept saying oh, it’s just a study so there are no spending
3 implications. Is that something we should start to
4 highlight, that all these new activities might well require
5 increased capacity of HHS?
6 MR. HACKBARTH: Yes. Clearly, they do require
7 resources to do. The numbers, compared to the buckets that
8 we use for our spending, these would all be in the zero to -
9 - what is it -- the $100 million. We don’t estimate
10 specific costs for anything. These are small numbers
11 compared to our buckets.
12 DR. KANE: But when you add them all up, you’ve
13 got a department that’s not keeping up.
14 MR. HACKBARTH: Yes, and that's an important theme
15 that we ought to continually repeat. I don’t think the best
16 way to contribute to that is by trying to estimate numbers
17 to put in these.
18 DR. KANE: I wasn't -- I was just going to suggest
19 we don’t say “none” but say small, incremental. Otherwise
20 people say we can just load it on and nothing has to change
21 at the level of HHS.
22 MR. HACKBARTH: My first point is that our

1 convention on doing the spending estimate is we just put
2 numbers in buckets and the bottom bucket is zero to some big
3 number relative to these costs. So we can always say it's
4 in the bottom bucket and do that.
5 DR. KANE: It's simply to change this attitude
6 that you can just add an enormous amount of work to an
7 agency and not ever have any spending implications.
8 DR. MARK MILLER: I think what we've done in the
9 past is we've said things like small administrative costs.
10 The reason I don't think I want to put it in the smallest
11 bucket, I think the smallest bucket is like $50 million or
12 something like that. And I don't think we're thinking that
13 this costs $50 million.
14 But we can certainly make a statement in the
15 report about small administrative costs to execute the
16 study.
17 DR. CROSSON: Just on this point, and just to
18 clarify, after six years? When we say this, are we talking
19 about the Medicare program? Are we talking about the
20 Treasury?
21 DR. MARK MILLER: All right. What we've done
22 generally, where we've done this, is we formulated buckets

1 to deal with program costs. So if you were having a benefit
2 impact you were reporting that. And that's really where
3 we've been.
4 There have been a couple of decisions where we've
5 made things like this where we've said yes, we should
6 mention the administrative cost. And I think here today we
7 just were kind of in the none mode, as opposed to the small
8 administrative cost mode.
9 But by and large, when we created those buckets
10 and scored things, as requested by the Congress, it was
11 benefit cost is what we were up to.
12 So your point is taken. We can make this point in
13 the text. By and large, that's been true.
14 DR. CROSSON: Right, I'm sorry to be repetitive.
15 When we make this recommendation to the Secretary, we're not
16 saying that that money should come from the Medicare
17 program?
18 MR. HACKBARTH: No, no.
19 DR. CROSSON: Right? Or are we?
20 DR. MARK MILLER: It comes from the appropriated -
21 - in this instance, it would come from the appropriated
22 amounts for HHS, which is different than the --

1 DR. CROSSON: Correct. So if our criteria in the
2 spending implications is the Medicare program, then the
3 right answer would be none.
4 MR. HACKBARTH: Having said that, we'll make the
5 point in the text. We're really in the weeds now, folks.
6 [Laughter.]
7 DR. BERENSON: I want to go back to the discussion
8 the two of you had about the fact that there's now a
9 workforce commission. It seems to me that recommendations
10 one, two and four, where we're asking the Secretary to do
11 certain things, it's not redundant to what this commission
12 would be doing. But here, it just seems a little strange
13 that we're asking the Secretary to do something rather than
14 asking the commission.
15 I mean, if we want to continue having these
16 recommendations and put in the text the reality of a
17 commission, that's fine. But it just seems a little strange
18 that we'd be asking the Secretary rather than the commission
19 to do three and five.
20 MR. HACKBARTH: What I would suggest is that we
21 put in the text a statement saying we recognize that Public
22 Law whatever-whatever established this new commission, it

1 might be the appropriate place to do this work. And our
2 recommending the Secretary should not be construed with
3 inconsistent with that.
4 Continuing on three, four, and five.
5 MR. BUTLER: [off microphone] Are you sure that
6 you want me?
7 MR. HACKBARTH: I'm sure that I don't.
8 [Laughter.]
9 MR. BUTLER: Put on four, and I'll see if I can --
10 I understand the gist of this but I would suggest a little
11 bit of a rewording.
12 This begins by saying the Secretary should report
13 to the Congress on how -- agree with the first part. And
14 then it says whether they should be all supported equally.
15 And then it jumps to maybe some don't need support at all.
16 I'll give you specific wording but it's guessing
17 what the conclusion is. I think there are some that might
18 require and merit additional support, and others that would
19 require less support or no support.
20 So I would like to have balanced language that
21 says you might end up saying some require more and some
22 little or none. This kind of leaves you -- you have an

1 opening sentence that maybe they shouldn’t be all equal and
2 we can cut some. That may be true but you may want to add
3 some, too.
4 So let me give you the specific wording, if this
5 helps.
6 The Secretary should report to Congress on how
7 residency programs affect the financial performance of
8 sponsoring institutions. Residency programs in all
9 specialties may not need equal support. Some residency
10 programs might merit additional support and others might
11 require less or no federal support.
12 MR. HACKBARTH: Okay, any questions for Peter
13 about what he said?
14 DR. MARK MILLER: Did you get it or would it help
15 to hear it again?
16 MR. LISK: It would help to hear it again.
17 MS. BOCCUTI: Just one thing that -- I hear what
18 you’re saying and I think you’re just paraphrasing and
19 making it more clear. But there seems to be a slight
20 distinction about that middle clause in there, the “whether”
21 part.
22 Did you want to exclude the possibility that -- or

1 maybe Mitra, if you’re nodding your head, maybe you want --
2 MS. BEHROOZI: Yes, I asked Peter do you want the
3 Secretary to make a recommendation on those separate three
4 things that you outlined because taking out the “whether” as
5 you say, Cristina, changes it. It’s just that there’s a
6 report. But whether they should is a recommendation kind of
7 thing. So what are you suggesting?
8 MR. HACKBARTH: I understand your point, that you
9 want a balanced statement that some may merit more, some may
10 merit less.
11 MR. BUTLER: Or none.
12 MR. HACKBARTH: Or none. I don’t want to try to
13 wordsmith it right now. Maybe we could ask Craig and
14 Cristina to write up the language and then, even if we have
15 to come back and vote separately on that recommendation once
16 that language is prepared. We are about 15 minutes behind.
17 I want to keep moving right now and real-time editing in a
18 group of this size is not a good use of time.
19 Is that okay with you, Peter? Thanks.
20 MS. BEHROOZI: I agree with Bob's point about
21 trying to figure out a way in the text to mesh with the new
22 commission on recommendations three and five, there’s

1 specific things about five.

2 On recommendation four, I want to open a can of

3 worms and it’s certainly not about the language of the

4 recommendation. But in the text, do we need to say anything

5 about additional information or reporting that needs to be

6 available to the Secretary to divine this kind of stuff? I

7 don’t know that it’s all readily available.

8 MR. LISK: They would need to have, in terms of

9 how they do the study and depending on how extensive it is,

10 they would need to have the cooperation of the hospitals and

11 programs and helping to figure out some of the stuff. So

12 it’s not something that can be done from just cost reports,

13 for instance.

14 So yes, we’d have some language in there saying

15 this is going to require the cooperation of some hospitals

16 and programs to help with this. They’re part of the study.

17 MR. HACKBARTH: [off microphone] Others on three,

18 four or five?

19 DR. CHERNEW: This is just a minor wording point.

20 In three you call it “delivery systems that provide high

21 quality, high value, affordable care.” You’ve said that

22 several times in three. I like that phrase fine.

1 But in one, you use a different phrase, which is
2 "reduce cost growth while maintaining or improving quality."
3 I would think about synergizing. They're mildly different.
4 MR. HACKBARTH: [off microphone] We've already
5 talked about one. See that train [inaudible].
6 Do you understand your assignment on number four?
7 MS. BOCCUTI: I think Craig got it down. Or
8 maybe, Jim, did you? I mean, Peter has it there. Did you
9 want us to come back?
10 MR. LISK: Did you have it written down, Peter?
11 MR. HACKBARTH: If you want to read it one more
12 time?
13 MR. LISK: Read it one more time and we'll put
14 recommendation four up and we can see where it changes and
15 maybe we can...
16 MR. BUTLER: Mitra is going to amend mine, I
17 think.
18 So you start the same and put a period after
19 institutions. Then you say "residency programs in all
20 specialties may not need equal support."
21 Then you say "some residency programs might merit
22 additional support and some might require less or no federal

1 support."

2 Now your comment, though, is you want the

3 Secretary to make sure that that's the scope of the report

4 with recommendations around that; right? So just do that.

5 MS. BEHROOZI: Yes, you know it's just a language

6 issue. You're stating the conclusion that the Secretary, I

7 guess, might draw. I think it's not clear that we're saying

8 the Secretary should be empowered to report those

9 conclusions. So it's just a matter of inserting a couple of

10 other words.

11 We're thinking of the same thing; right, Cristina?

12 Is that the question that you were looking for?

13 MS. BOCCUTI: I was just stating that there was a

14 difference. I don't want to be the one...

15 MS. BEHROOZI: No, no, I understand. But that's

16 the question that you had also, in terms of language.

17 DR. KANE: [off microphone] [inaudible].

18 MS. BEHROOZI: Yes, the secretary should, you

19 know, make a judgment on whether there -- you know, at the

20 end. Right. At the end you can say the Secretary should

21 report on whether there are certain residency programs that

22 fit into any of the foregoing categories needing less or --

1 MR. HACKBARTH: Karen is going to have the last
2 word.
3 DR. BORMAN: Perhaps there is an easier fix. I
4 think the Secretary and her advisors are bright people so
5 that they evaluate something as to whether all specialities
6 should be supported equally. The choices are equally, not
7 equally, and there are some permutations to not equally.
8 So could we not say "The Secretary shall report to
9 the Congress on how residency programs affect the financial
10 performance of sponsoring institutions and whether residency
11 programs in all specialties should be supported equally."
12 And then the Secretary can break it out according
13 to whatever criteria and buckets she wishes to address.
14 MR. HACKBARTH: I like surgeons. They cut right
15 to it.
16 [Laughter.]
17 MR. LISK: That's clear enough that you guys --
18 MR. HACKBARTH: Does everybody understand what
19 Karen had to say? That's what we're voting on.
20 I think we're done. So we have to vote
21 independently on three, four, and five now. On
22 recommendation number three, all in favor? Opposed?

1 Abstentions?

2 Recommendation four, all in favor? Opposed?

3 Abstentions?

4 And number five, all in favor? Opposed?

5 Abstentions?

6 Thank you. Good work.

7 Our next session is on shared decision making and

8 its implications for Medicare. Joan and Hannah, who is

9 leading the way? Joan, take it away.

10 DR. SOKOLOVSKY: Good afternoon. I'm used to

11 going fast now, so I should be finished in about a minute

12 and a half.

13 [Laughter.]

14 MR. HACKBARTH: Good thing we have a New Yorker in

15 this slot.

16 DR. SOKOLOVSKY: Today we want to update you on

17 changes in the law that affect shared decision making. Then

18 we will try to respond to some of your comments from last

19 month. We've tried to sketch out some of the ideas you

20 suggested for encouraging shared decision making. As you

21 could see from the mailing materials, they are far from

22 fully developed. Each strategy would require many design

1 decisions. We are hoping you will tell us which, if any, of
2 these ideas you would like to see us develop further in the
3 future.
4 The recent health reform legislation includes a
5 number of provisions designed to facilitate further
6 development of shared decision making. Under the terms of
7 the law, the Secretary must contract with a consensus-based
8 organization to develop and identify standards for patient
9 decision aids, review decision aids, and develop a
10 certification process for determining whether decision aids
11 meet the standards.
12 Secondly, acting through AHRQ, the Secretary is
13 also directed to award grants or contracts to entities to
14 develop, update, and produce decision aids, and to test aids
15 to see whether they are balanced and evidence-based, and
16 also to educate providers on their use.
17 Additionally, the Secretary is directed to award
18 grants to establish shared decision-making resource centers
19 to develop and disseminate best practices to speed adoption
20 and use of shared decision making, and providers would also
21 be eligible for grants to aid with developing and
22 implementing shared decision-making techniques using

1 decision aids.

2 And, finally, as you talked about this morning,
3 the law establishes a Center for Medicare and Medicaid
4 Innovation within CMS. According to the statute, one of the
5 possible directions is to test models that assist
6 individuals in making health care decisions.

7 Tom -- well, he will be back. He asked last month
8 about liability protection for physicians who engage in
9 shared decision making. Last month, we talked a little bit
10 about the demonstration project for shared decision making
11 at Group Health of Puget Sound established by law in
12 Washington State. This law also includes provisions to
13 provide legal protection for physicians who use shared
14 decision making. And as Karen said this morning, many legal
15 experts believe that poor communication between patients and
16 physicians is the root cause of many lawsuits. In other
17 words, patients must sign an informed consent form to get a
18 treatment, but they may not really understand the potential
19 risks of the treatment. And if they haven't understood that
20 there are potential adverse effects, they are more likely to
21 sue if one of these events takes place.

22 Although one may argue that the informed consent

1 form already signed by the patient should provide legal
2 protection, legal standards for informed consent are
3 ambiguous and vary from state to state -- and sometimes from
4 case to case. Under the Washington State law, documented
5 evidence that shared decision making took place serves as
6 prima facie evidence that the patient has, in fact, given
7 informed consent, and a plaintiff would have a very high bar
8 to argue against this in a lawsuit. The law has not been in
9 place long enough to determine whether it will have the
10 intended effects if challenged in the courts. However,
11 aside from its value in protecting against lawsuits based on
12 informed consent, some believe that a patient's clear
13 understanding of potential harms and benefits would prevent
14 lawsuits further downstream.
15 Last month several of you suggested strategies
16 that could encourage the spread of shared decision making,
17 and we have tried to briefly sketch what some of your ideas
18 might look like. For example, CMS could require providers
19 to engage in shared decision making for a select group of
20 preference-sensitive conditions. All of these ideas have
21 advantages and disadvantages, and they are not mutually
22 exclusive. We hope to learn from your discussion if there

1 are any options you would like us to pursue in the coming
2 year.
3 First, the Commission has in the past discussed
4 medical homes and accountable care organizations. Medicare
5 could initiate demonstration projects in either of these
6 delivery systems to test the feasibility of shared decision
7 making for the Medicare population. The demonstration site
8 would need support from physicians in the organization.
9 Because ACOs include physicians with multiple specialties,
10 they might be best positioned to incorporate shared decision
11 making for preference-sensitive conditions as determined by
12 the physicians within the practice.
13 These organizations would have the infrastructure
14 to implement shared decision making, and they would need
15 physicians within their organization who were willing
16 adopters of the program. As in other primary care settings,
17 shared decision making in medical homes could be difficult.
18 On the other hand, it might actually be a good setting to
19 test innovative ways to incorporate shared decision making
20 within primary care.
21 Medicare could provide incentives to physicians
22 and other practitioners to use shared decision making with

1 their patients, and incentives could be structured in a lot
2 of different ways, including rewards or bonuses to
3 physicians who distribute patient decision aids. These
4 strategies are discussed in your mailing material, and we'd
5 be glad to answer any questions you may have about them.
6 But I'd like to focus on one idea here, allowing
7 physicians to bill for shared decision making through the
8 Medicare fee schedule. Bob, you asked about existing codes
9 last month, and, in fact, the Medicare fee schedule includes
10 add-on codes to E/M visits that physicians can bill for
11 prolonged visits when medically necessary. These time-based
12 codes can only be used when more than half the duration of
13 the visit is spent on counseling. Documentation must
14 include a time estimate and a brief demonstration of what
15 condition and treatments was discussed. Time is measured
16 here by direct face-to-face contact between the physician
17 and the patient. The codes are most often currently used by
18 surgeons, oncologists, nephrologists, and other specialists.
19 However, these codes have a high denial rate, and some
20 believe they could trigger an audit with what's called
21 "excessive use."
22 So to use this code for shared decision making,

1 CMS would have to specify that these codes can, in fact, be
2 used by physicians who engage in shared decision making, and
3 they'd have to clarify what criteria would be needed to
4 document that shared decision making has taken place.
5 Medicare could also provide incentives to patients
6 for use of decision aids as a way to encourage shared
7 decision making. As detailed in your mailing material,
8 there are some small-scale programs that have done this and
9 demonstrated that incentives may increase the use of
10 decision aids and get patients to be more actively engaged
11 in their care and lead to less invasive treatment decisions,
12 thereby reducing costs. However, a challenge for any
13 incentive system targeting Medicare beneficiaries would be
14 having to tailor it to the benefit structure and the high
15 rates of Medigap and other supplemental coverage.
16 Everybody whose name I mentioned immediately
17 leaves the room, but there you go.
18 Arnie, you suggested, when you were here, that
19 Medicare could require shared decision making for select
20 preference-sensitive conditions. And, Mitra, you suggested
21 that Medicare could link coverage of specific treatments to
22 the use of shared decision making. Again, these strategies

1 would raise some design issues. CMS would have to define
2 quality standards for shared decision making and determine
3 which procedures the policy would apply to. Small providers
4 could be penalized if they do not have the needed
5 infrastructure to comply. And any requirement would still
6 need physician buy-in as our research has shown in many
7 different contexts. If physicians don't support shared
8 decision making, these strategies might be very difficult to
9 implement.

10 Well, that concludes our presentation. There will
11 be a chapter in our forthcoming June report on shared
12 decision making. It's informational only and won't contain
13 any recommendations. The mailing materials you received
14 represent a draft of that chapter, and we welcome any
15 comments you may have on that draft.

16 We would also like to know if you would like us to
17 further develop any of these ideas in the future with an eye
18 toward possible recommendations in the coming years. In
19 addition, Hannah and I would be glad to answer any questions
20 you may have about the mailing materials.

21 MR. HACKBARTH: Thank you, Joan.

22 Okay, let me start over on this side with round

1 one clarifying questions.

2 DR. CASTELLANOS: Joan, you mentioned in your
3 report that you were going to talk about informational and
4 cost and quality of health care services. I don't see any
5 information that you've distributed concerning costs, and I
6 think cost is a really important part of the decision
7 making. Are you going to plan to flesh that out in further
8 reports? Because I don't see anything discussed on cost.

9 DR. SOKOLOVSKY: The information that we've found
10 so far on costs has not been -- the evidence is not very
11 developed to say very much about it. It's one of the
12 biggest gaps in the shared decision-making area.

13 DR. CASTELLANOS: Let me just go one step further.
14 As a practicing physician, when I talk to a person, I really
15 want to let he or she and the family have some idea of their
16 cost requirements. Now, it would be an educational
17 experience for the physician because he or she probably has
18 no idea a lot of times what costs are, but that's an
19 important decision making for the family, and I don't see it
20 addressed at all.

21 DR. SOKOLOVSKY: I'm sorry. I completely
22 misunderstood your question. I think that that is a really

1 important issue, and I thought that that could be something
2 that we could take this further on, not in this chapter but
3 that could be something that we could look at in the future
4 if there is interest among the Commissioners.
5 MR. HACKBARTH: [off microphone] Other clarifying
6 questions?
7 DR. DEAN: If we were to try to develop incentives
8 to implement this, do you envision that we would have to
9 have some agreed-upon tool that would be used uniformly? Or
10 are we saying that it would be up to the individual
11 practitioner to pick the tool? Or how important is it that
12 there be agreement on the actual tool that's used?
13 DR. SOKOLOVSKY: I think this is why the law went
14 to the idea of setting quality standards for decision aids
15 and certifying that aids meet them so that you wouldn't have
16 to use any specific aid but chances are the incentive
17 program would require that you use an aid that is approved.
18 MR. GEORGE MILLER: I believe mine is going to be
19 more of a round one question. I don't think it's a
20 clarifying question.
21 MR. HACKBARTH: [off microphone] Other clarifying
22 questions?

1 DR. BORMAN: In the portion of the materials where
2 you talk about the evaluation and management service add-on
3 codes for counseling and coordination of care, I just wanted
4 to clarify. When you say that CMS could specify those codes
5 be used by physicians who engage in shared decision making,
6 those codes currently are open to all physicians. Are you
7 suggesting that they would be used -- that they could be
8 turned into non-face-to-face-time codes and that time added?
9 I'm just losing -- I'm not sure I understand what change
10 you're suggesting in the codes as they currently exist and
11 as they are available for use by all physicians.
12 DR. SOKOLOVSKY: That's a good question and part
13 of how this is not fully developed.
14 DR. BORMAN: Okay.
15 DR. SOKOLOVSKY: I think one of the main things I
16 was thinking about here is that the denial rates are really
17 high, I mean, 20 percent for one of them and 33 percent for
18 another; and that if this was going to become something we
19 wanted to encourage, that more clarification that says, yes,
20 you can use these might be helpful.
21 DR. BORMAN: Okay. I can make a suggestion off-
22 line to Joan.

1 MR. HACKBARTH: Let's move on to round two then.
2 DR. CASTELLANOS: Basically, you mentioned about
3 how the physician could bill for his or her time. It seems
4 to me a lot of this is going to be practice expense. You're
5 going to have to buy the equipment. You're going to have to
6 buy the supplies. You're going to have to buy the
7 brochures. And that would -- some of this I would assume
8 would come under practice expense. Is that correct?
9 DR. SOKOLOVSKY: I think it would depend on how
10 the program is set up. There are some of these that are
11 distributed where you wouldn't have to pay for the decision
12 aids. I don't think you would buy an information technology
13 system simply for this, so if you didn't have that
14 infrastructure, I think it would be hard to do this.
15 MR. HACKBARTH: It is dependent on the model.
16 Some private insurers have programs where basically the
17 insurer provides the access to the materials, and maybe even
18 a nurse who talks to the patient about the materials. And
19 so it's not a burden on the physician directly. There are
20 other types of programs where it is a physician practice
21 expense.
22 DR. CASTELLANOS: A second point. Somewhere in

1 the chapter, maybe we could talk about the goals of what
2 we're trying to accomplish here. I think some of the goals
3 that -- is definitely quality and basically outcome, too. I
4 think those are really important goals that we should stress
5 why we're doing it.
6 MR. BERTKO: First, I support the work you're
7 doing. You did a nice report to support shared decision
8 making. The comment about ACOs, though, I'd only caution
9 that they're going to be up and coming themselves, 2012
10 hopefully, maybe a pilot sooner. There's a lot of heavy
11 lifting to do there that I think will absorb the physician
12 and hospital managers first before they can get to the
13 infrastructure we were just talking about. But it's a good
14 place for them to be eventually.
15 MR. HACKBARTH: Yeah, yeah. I had a similar
16 thought. You know, if what we're trying to do is figure out
17 how this tool might be deployed in different types of
18 practices, you know, there are existing organizations, not
19 newly developing ACOs but group staff model HMOs that can be
20 used to test in that organized delivery system format. Then
21 if you're trying to look at how individual small practice
22 physicians might use the tool, again, you don't need to put

1 this on top of either medical homes or ACOs. You can do
2 that test separately.
3 I worry -- and I think this is John's point --
4 about adding all these burdens and new activities onto
5 nascent, newly developing enterprises.
6 Other round two comments?
7 DR. BERENSON: Yeah, I was going to say something
8 very similar to what the two of you just did. In an article
9 we wrote last year on medical homes, I put together a whole
10 bunch of wish lists that everybody wants to hang onto the
11 medical home, and so let's find some organizations that want
12 to do this rather than the ones we are going to sort of
13 expect to do it and learn something about it.
14 But your comment about and then Karen's discussion
15 about the denials for the add-on codes, I mean, ultimately
16 it may be time -- and I'm not saying that this should be the
17 highest priority right now, but something to think about, of
18 reviewing sort of the definitions of E/M services. They've
19 been in place for 20 years. The documentation guidelines
20 have been in place for 15 years. They're still, even though
21 they're in place, there's a lot of unhappiness about them.
22 And certainly in the area of managing patients with multiple

1 chronic conditions, the overemphasis on histories and
2 physicals and under-emphasis on decision making and shared
3 decision making really makes them less than ideal for
4 capturing the nature of physician work.

5 It would be a big deal to change them, and so I'm
6 not saying we go into this lightly. But, really, there is a
7 disconnect between the work that we expect physicians to be
8 doing, at least some physicians, and those increasingly
9 antiquated definitions we have where you have to then sort
10 of use sort of special techniques to get paid rather than
11 having it be encompassed with your basic payment structure.
12 It is a reason why, I guess, the medical home model is using
13 a separate per month payment because of some of the
14 limitations in the existing definition.

15 So, again, I'm not saying we go there now, but I
16 think it's something to think about. I mean, there's
17 actually people who are trying to work with electronic
18 health records to do decision support and registries,
19 actually tell me that some of the vendors are so oriented to
20 producing documentation guideline templates for doctors to
21 be able to code correctly that they lose a lot of potential
22 functionality because -- and so then what you have is a

1 whole bunch of stuff in the electronic health record that's
2 not improving communication at all.
3 So perhaps at the retreat we might want to talk
4 about this issue, about whether and how we would sort of go
5 on, take this on. It would be a big deal to take it on.
6 MR. HACKBARTH: Okay. Jay and then George.
7 DR. CROSSON: Joan, thanks for laying these out so
8 clearly. If I were to pick among the pieces of work that
9 you all would be doing, I think I'd go here. I think I
10 mentioned the last time we discussed this that I think the
11 uptake of this idea has lagged way beyond its potential.
12 And I think a lot of that is due to resistance on the part
13 of physicians. I wish it were not, but it is. And it's
14 really almost not related to whether the physicians are paid
15 prospectively, on salary, or on fee-for-service. I've seen
16 this comment made by medical directors in all different
17 sorts of situations. So I think there's some inherent
18 resistance to that.
19 I wonder whether particularly in fee-for-service
20 whether trying to change incentives for the physicians is
21 going to be effective. In other words, whatever incentive
22 one could create, would that counter the natural resistance

1 plus the inherent incentive to do the procedure, talking
2 about more invasive procedures often.
3 So where I would gravitate to, I think, would be
4 more looking at a combination of beneficiary incentives plus
5 being able then to pay the physician, whatever that would
6 require, for doing this. And that's just, you know, what
7 would appeal to me the most.
8 MR. GEORGE MILLER: Yeah, I'd like to ask my
9 question around the diverse populations and how this would
10 play in with diverse populations and cultural competencies
11 of the physicians in dealing with diverse populations. It
12 seems to me that this is a perfect place for it to fit in,
13 so I want to know a little more about if you found any
14 information on this, is that going to be part of the
15 recommendations when we get to that part of the
16 recommendations that would be included? While I certainly
17 understand the impetus with how busy a physician is, to pay
18 them to do this, there are some things that at least from my
19 perspective ought to be just part of the duty, and that is
20 to make sure every population of folks you treat get equal
21 treatment and the same information. It appears from things
22 that we discussed that that is not always the case. But I

1 don't have evidence of that statement for shared decision
2 making, so that's my question. A long question, but...
3 MS. NEPRASH: There have been some fairly small-
4 scale efforts to test shared decision making within
5 racially, ethnically, socioeconomically diverse populations,
6 and some of these are presented, although I'm happy to go
7 into more detail for you. They're also working on
8 translating decision aids into primary languages.
9 Joan, would you add anything?
10 DR. SOKOLOVSKY: I would just say that some of the
11 demonstration projects that are going on right now, the most
12 interesting are exactly on this issue, but they haven't
13 really been implemented, so we can't evaluate them. But I
14 think we -- for example, the demonstration project that
15 Johns Hopkins is working on right now to work with African
16 American families who have chronic kidney disease, to talk
17 to them pre-dialysis and educate them about the
18 possibilities of transplants and live donors and other
19 issues like that, with the goal eventually of being able to
20 develop shared decision aids that would address some of
21 these issues. But it's still in its pilot form. It hasn't
22 even fully been implemented yet. I think these are the

1 things that we find really exciting and want very much to
2 follow in the coming years?
3 MS. HANSEN: Does the Washington State one have a
4 particular subset for that that they're working on, do you
5 know?
6 DR. SOKOLOVSKY: I don't believe so, no.
7 MR. BUTLER: Just a little clearer about the MA
8 plans and their role in this. We don't really talk about a
9 lot in the chapter, and I realize they have a natural
10 incentive. They're capitated. We don't want to necessarily
11 hand them more money. But what are our comments on how this
12 interfaces with the structure that should be a natural
13 demonstration site?
14 DR. SOKOLOVSKY: There are some that are
15 experimenting with them. Some of the information that we
16 have about them, they're MA plans but they're not integrated
17 delivery systems. So it's at a distance. They're coaching
18 centers, people call up. Shared decision making is a part
19 of that for preference-sensitive conditions, but a much
20 larger part is trying to reach patients with chronic
21 diseases and educate them about them. And they collect all
22 the information together so they can't separate out the

1 effective shared decision making on the effective coaching
2 in general.
3 MR. BUTLER: So one of my points would be if an
4 ACO is an immature organization onto which you would do a
5 pilot, many MA plans are mature organizations and should be
6 able to assimilate a pilot like this, I would think, more
7 naturally, unless I'm missing something.
8 MR. HACKBARTH: I think you're right, and you can
9 use group and staff model plans for the highly structured
10 delivery systems and IPA models dealing with a broader array
11 of small and independent practices. You know, my impression
12 is that, you know, a fair amount of this testing has been
13 done in different types of plans. I don't know how
14 difficult you've found it, Joan and Hannah, to get
15 information from those organizations that have been working
16 on this.
17 DR. SOKOLOVSKY: The ones we checked with, we
18 found it was difficult. We can work farther on that, but
19 it's clear that when Washington State did its law, before
20 the law was passed, they already knew that Group Health
21 would volunteer to be the demonstration site.
22 MR. HACKBARTH: Okay

1 DR. SOKOLOVSKY: I'm sure there are plans that
2 would definitely want to work with us.
3 MS. BEHROOZI: You know I love this stuff so I
4 don't have to talk about that, but I think sort of picking
5 up on what Jay said about how it still feels like even
6 though there are all these examples that you have worked so
7 hard to pull together into this paper, it still feels like
8 insider baseball to be talking about shared decision making.
9 And even though -- and, you know, I was a little surprised
10 actually at the emphasis that it got in -- I'm calling it
11 PPACA. Do I have any more votes for that? Thank you.
12 That's what the lawyers will call it.
13 So I was excited to see that, but I think one
14 thing that we can do to help it penetrate a little more
15 broadly into, you know, health care policy making is to not
16 just have it be an agenda item in a paper, you know, every
17 so often, but have it come up in all those other places
18 where we occasionally make the connections. Off the top of
19 my head, you know, Nancy's comment earlier about incenting
20 states to take on medical malpractice reform, maybe you say
21 specifically you'll award states grants if they take on
22 shared decision making in connection with medical

1 malpractice.

2 And in benefit design, you know, talking about

3 incentives for patients, you know, Rachel is spending a lot

4 of time looking at a lot of dimensions of benefit design,

5 and maybe just slipping this one in there and how that would

6 work with sort of changing incentives for beneficiaries.

7 And what was the other one? There was another

8 one? I don't remember. But, anyway -- pardon?

9 DR. SOKOLOVSKY: Comparative effectiveness.

10 MS. BEHROOZI: Comparative effectiveness, GME,

11 there's a lot of different -- oh, CMS innovation. There's

12 just a lot of different places where it seems like we could

13 be more express in those other papers about identifying

14 shared decision making as one of the tools or, you know, an

15 area that should be incented.

16 DR. CHERNEW: So, again, I'm also a big supporter

17 of shared decision making. The challenge I have is sort of

18 more broad and more philosophical about the types of things

19 that come under the "what do we do," and let me explain what

20 I mean by that. The first thing is what's clear when you

21 read through this, at least to me, is there's really a

22 diversity of approaches that different people are doing --

1 different diseases, different ways of delivering, different
2 materials. There's a whole lot of things. And I'm not sure
3 we could project which one is best and which one is best in
4 which settings. So in that sense it all strikes me as
5 somewhat more complicated.
6 So I'm supportive of all efforts to evaluate and
7 study and do demonstrations and the extent to which this
8 would bubble up and something that the Secretary would want
9 to do, I would be very supportive of that. And I believe
10 there are probably some models that could really do good on
11 a number of dimensions.
12 However, I think philosophically at least where
13 I'm going is sort of away from trying to tinker in different
14 ways with a basically fee-for-service system and basically
15 tinkering with process-type measures where we decide that
16 there's a process that's good, and then we try and figure
17 out how to encourage this process that we think is good, and
18 then we figure out how to put that into a fee-for-service
19 system which I think raises a whole bunch of problems. And
20 I might add that the lack of payment for shared decision
21 making is only one of many deficiencies I see in a fee-for-
22 service system that doesn't encourage a whole series of ways

1 to communicate with beneficiaries by phone, e-mail, all
2 those sorts of stuff.
3 So why one would single our shared decision making
4 as opposed to others in a somewhat difficult-to-manage fee-
5 for-service system is difficult, but I would still support
6 trying to encourage more shared decision making
7 philosophically, but not probably through a fee-for-service
8 system. So I would rather move to a system that tries to
9 take measures of performance that shared decision making
10 would facilitate, and then allow organizations to use shared
11 decision making or any other tools to try and get outcomes
12 that we want. I think in general that's a better way to go
13 than trying to structure ways through a fee-for-service
14 system that's very complicated, that takes not an outcome
15 really but a process measure and just deems this one process
16 measure so important that we're going to do it in a very
17 specific -- and devote a lot of resources to it.
18 So I guess I wouldn't be opposed if someone said
19 we have a great demonstration, we'd like to use it. I would
20 be supportive of that. But when you get to some of the
21 bigger things that are listed on one of your slides, that's
22 where I get more nervous because I do see it as rewarding

1 process as opposed to outcomes and messing with a fee-for-
2 service system that I'd like to move away from.
3 So that's basically where I am in thinking about
4 shared decision making.
5 DR. BORMAN: Yeah, I think first off, I again, on
6 this topic as well, think that we're -- if each of us
7 defines shared decision making in this room, we might each
8 have an individual definition. We'd probably end up with at
9 least n plus one at the end of the day, because what I hear
10 are portions of patient education, coaching, informed
11 consent, a process of shared decision making, the decision-
12 making aids, which are an actual product. And I think
13 that's part of the problem we're having in getting to maybe
14 a crisp "how do we move forward."
15 In terms of a process that gets us to useful
16 places either in the program now or going forward, I might
17 offer considering -- and I sort of hear Nick Wolter a little
18 bit in my mind. What are the places where we consume a lot
19 of resources in the program, either by diagnosis, procedure,
20 test, whatever -- something, some criterion of cost or
21 danger perhaps; and that we then use several of those things
22 to focus this process on.

1 I also would advocate that perhaps we'd be very
2 careful about setting standards. To somewhat borrow from
3 Bill Scanlon's comments earlier, once you define something
4 as a standard, undoing it or modifying it is a little bit
5 more complex. And I think we may be at the process of
6 guidelines rather than standards, which is a little bit of a
7 connotative difference. But I'm not quite sure we're in
8 stone with where we need to go for various of these things,
9 particularly because some of the high-cost items here for
10 the program are things where the tools are not good,
11 therefore things about some of the chronic disease
12 management. And so, for example, if Tom has a conversation
13 with a patient about hypertensive drug A -- antihypertensive
14 -- versus B, is that shared decision making or is that just
15 part of an E/M -- you know, there's a lot of places we could
16 go here.
17 So my personal bias would be let's be sort of not
18 ready to quite prescribe standards; number two, to perhaps
19 use the economic impact as the basis for determining areas
20 that we might recommend be funded or encouraged or whatever.
21 I do believe that a number of professional associations have
22 started to move into this and are going to increasingly move

1 into with regards to some of these items. And just a
2 reminder that a lot of things that more easily lend
3 themselves to this, like procedures, are relatively small-
4 ticket items relative to the impact they will have on
5 program spending so that we should try and husband our
6 efforts toward bigger bang for the buck.
7 MR. HACKBARTH: Mike and Karen articulated some of
8 the things that were sort of rattling around in my head that
9 I wasn't quite able to put my finger on. The concept here
10 is very, very appealing. In fact, the concept is
11 fundamental to medical ethics, that, you know, the patient
12 needs to give informed consent to what you do. Patients
13 have autonomy. And this is just a particular aspect of
14 trying to deal with that very basic longstanding principle.
15 So nobody would contest how important shared decision making
16 is, but I do think we mean slightly different things. And
17 then we're trying to apply those slightly varying notions of
18 what it means to a group of patients that's very
19 heterogeneous in terms of how they wish to be engaged, and
20 then that variation is compounded by the enormous variation
21 in delivery sites and dynamics. So we're trying to take a
22 broad concept and figure out how to adapt it to this sort of

1 X-squared complexity in patient preferences and delivery
2 system sites. It's real hard to do, and one way to approach
3 it might be to focus really -- you know, the Nick Wolter
4 approach, let's try to look at some particular problems,
5 clinical problems, decision-making issues where there really
6 is evidence that this could be very important, and then try
7 to test it in a few different types of locations with some
8 different types of patient populations and proceed that way.
9 I'm not sure that's a solution, but I feel like
10 we're trying to go across a very broad front with something
11 that's quite general and difficult. We'll talk more about
12 this.
13 Any concluding comments before we move on?
14 [No response.]
15 MR. HACKBARTH: Thank you for your fast talking,
16 Joan. We appreciate it. Good work on this, and we'll be
17 back to it.
18 Let's see. Our last topic for today is improving
19 traditional Medicare's benefit design.
20 DR. SCHMIDT: Last month we had a lively
21 conversation about fee-for-service Medicare's benefit design
22 and how it might be improved. This month we're back to go

1 over a few more pieces of information, and I'll summarize
2 what is in our draft chapter for the June report. I think.
3 It's not cooperating here.
4 There we go. Just to give you a sense of what's
5 changed since last month, the draft chapter in your mailing
6 materials has a discussion of the changing context in which
7 Medicare beneficiaries will be making decisions about
8 supplemental coverage. Based on your comments last time,
9 there's less in the draft about combined deductibles and
10 more discussion of using nominal co-pays within private
11 supplemental insurance. And there is also a text box that
12 describes the Medigap provisions in the new health reform
13 law. We'll cover all of these as we go through the slides.
14 We've talked extensively about problems with the
15 status quo. Because of the structure of the fee-for-service
16 benefit, a small percentage of beneficiaries with the
17 highest health care spending accounts for the majority of
18 Medicare's cost sharing. Most beneficiaries have
19 supplemental coverage that fills in much of that cost
20 sharing, but premiums for that coverage can be pretty
21 expensive. A few beneficiaries do not have supplemental
22 coverage and for them, Medicare's lack of an out-of-pocket

1 cap can be financially devastating. At the same time, the
2 pervasive use of supplemental coverage contributes to higher
3 Medicare spending.
4 By considering changes to the fee-for-service
5 benefit and to supplemental coverage, we have an opportunity
6 to better align beneficiary incentives and goals for the
7 Medicare program. The draft chapter describes some near-
8 term steps aimed at building into the fee-for-service
9 benefit better financial protection for beneficiaries, as
10 well as improving their price signals by introducing some
11 co-pays into supplemental coverage. A further benefit of
12 those measures is that premiums for Medigap policies and
13 perhaps other types of supplemental coverage could be lower.
14 Over the longer term, we would also like to
15 improve beneficiary incentives so that their choices about
16 care help to transform how health care is delivered.
17 Introducing changes to the benefit design, perhaps along
18 with a greater degree of management in what is now fee-for-
19 service indemnity insurance, could transform the
20 organizational structure of providers and help move toward
21 more evidence-based care.
22 Last month Mike spoke about putting our discussion

1 about benefit design within the context of changes that we
2 see on the horizon. I've noted some of the expected changes
3 on this slide. On the left is the distribution of
4 supplemental coverage for Medicare beneficiaries from 2006.
5 But we know this distribution has already changed and will
6 change a lot more over the next 10 to 30 years. Employers
7 have cut back substantially on their offers of retiree
8 health benefits to current workers, so even though today
9 there are lots of Medicare beneficiaries with this
10 relatively generous form of supplemental coverage, we're
11 likely to see much less of it in the future. Unless we're
12 able to figure out how to slow growth in health care
13 spending, premiums for individually purchased Medigap
14 policies are likely to grow more rapidly than beneficiaries'
15 incomes.

16 The new health reform law calls for changes in the
17 Medicare Advantage program that will bring payments closer
18 in line to the costs of providing care in fee-for-service
19 Medicare. Depending on how well Medicare Advantage plans
20 are able to manage benefits, this could lead to fewer extra
21 benefits and/or higher premiums.

22 States are currently under a lot of fiscal

1 pressure, and this will continue into the future, which
2 could affect the relative generosity of Medicaid coverage
3 for dual eligibles. And all of these changes suggest that
4 there will be an increasing financial burden for Medicare
5 beneficiaries over time. In anticipation of that, we may
6 want make some improvements that will support beneficiaries
7 and the Medicare program through these changes.

8 As background, this chart shows the distribution
9 of fee-for-service beneficiaries incomes relative to the
10 federal poverty threshold. In 2006, the poverty threshold
11 was about $10,000 for single people and about $12,000 for
12 couples. If you look first at the far left-hand bar, you
13 can see that among all fee-for-service beneficiaries, a
14 little less than half of them are in the green, yellow, and
15 red sections, meaning that they have incomes of 200 percent
16 of poverty or less, so about $20,000 for singles, $24,000
17 for couples.

18 The bars to the right of this show the same
19 distribution by type of supplemental coverage. As you
20 glance across those bars, you can see pretty quickly that
21 lower-income beneficiaries tend to make up higher
22 proportions of people in Medicaid and in the group that has

1 no supplemental coverage. Generally speaking, beneficiaries
2 with employer-sponsored retiree coverage or Medigap policies
3 have somewhat higher incomes.
4 I showed this chart last time. It's the
5 distribution of Medicare cost sharing in 2008. This
6 reflects what beneficiaries owed providers, but in most
7 cases their secondary coverage paid for much of this
8 Medicare cost sharing. Most people did not pay these full
9 amounts out of pocket. Forty-two percent of beneficiaries
10 had less than $500 in Medicare cost sharing and 2 percent of
11 beneficiaries had $10,000 or more. Having a hospitalization
12 tends to be associated with high cost sharing, but it's not
13 the Part A cost sharing itself that accounts for the bulk of
14 what people owe. If you look at very high spenders, nearly
15 all of them have had a hospitalization, but most of their
16 Medicare cost sharing is for Part B services. So a lot of
17 it is for physician care in the hospital as well as for
18 office visits and other outpatient services they receive.
19 This chart shows, for a typical beneficiary, how
20 the amounts that they paid for premiums and out-of-pocket
21 costs compared to their income. For this slide, we ranked
22 all fee-for-service beneficiaries by their total Medicare

1 spending in 2005 and grouped them into quartiles. The left-
2 hand group of bars is for the lowest spending 25 percent of
3 fee-for-service beneficiaries, with the highest spending 25
4 percent to the right. The height of the bars reflects the
5 median amount that each group paid for out-of-pocket costs
6 and premiums, and here in premiums I'm including Part B
7 premiums as well as those for supplemental coverage. I
8 should note here that out-of-pocket costs are not strictly
9 those for Part A and Part B. There's prescription drug out-
10 of-pocket costs here, too. But with or without that drug
11 spending, the point is the same. The amounts that
12 beneficiaries pay relative to income varies all over the
13 map, depending on what kinds of supplemental coverage they
14 have and whether they use a lot or few health care services.
15 In the left-most bar, beneficiaries with low use of services
16 and without supplemental coverage -- what we call Medicare
17 only -- paid about 8 percent in out-of-pocket costs and
18 premiums. Among the highest spending 25 percent on the
19 right, Medicare-only beneficiaries spent about 35 percent of
20 their income. Across all of these categories, the median
21 financial burden ranged from about 1 percent of income to
22 about 35 percent.

1 Right now premiums for supplemental coverage can
2 be very expensive. I also showed this chart last time.
3 It's the distribution of Medigap policies in 2008. Notice
4 along the bottom of the table the average premium amounts by
5 type of plan. The most popular types -- plan C and plan F -
6 - fill in both the Part A and Part B deductibles and most
7 other forms of Medicare cost sharing. In 2008,
8 beneficiaries paid, on average, about $1,900 or $2,000 in
9 annual premiums for those policies. This is on top of
10 Medicare premiums for Part B and, for some people, Part D
11 premiums as well.
12 There are some new Medigap products on the market
13 that have lower premiums in return for beneficiaries paying
14 more of Medicare's cost sharing, but they are not popular.
15 This summer, Medigap insurers may start marketing other new
16 types of plans called Plan M and Plan N that also
17 essentially trade off more beneficiary cost sharing for
18 lower premiums. Plan N will institute co-pays for office
19 visits.
20 You can see the high cost of supplemental premiums
21 in this slide. Once again, the left-hand group of bars is
22 for the lowest spending 25 percent of fee-for-service

1 beneficiaries, with the highest spending 25 percent to the
2 right. The typical amounts that beneficiaries are paying in
3 premiums for Medicare Part B and supplemental coverage are
4 shown in yellow, and the typical amount of out-of-pocket
5 costs are in pink. If you look in the left-hand group at
6 the bar labeled Medigap, you can see that even among
7 beneficiaries who used relatively few Medicare services,
8 they paid between $2,000 and $3,000 in 2005 for the
9 combination of Part B premiums and Medigap premiums -- the
10 height of the yellow section of the Medigap bar. Similarly,
11 if you find the Medigap bar in the right-hand tranche, those
12 individuals were paying about the same amount in premiums.
13 So in absolute dollars, you can see that beneficiaries with
14 Medigap policies are paying quite a lot, whether they happen
15 to use a little or a lot of health care services.
16 We've talked about adding an out-of-pocket cap to
17 the fee-for-service benefit in order to provide better
18 financial protection. But, in addition, an out-of-pocket
19 cap would tend to help lower medigap premiums. Medicare
20 would start paying for some of the costs now covered by
21 secondary insurers. Since beneficiaries who have Medigap
22 policies pay the full premium for the supplemental benefits

1 of everyone in their insurance pool, including some
2 beneficiaries with high Medicare cost sharing, on average
3 all beneficiaries who have Medigap policies would see lower
4 premiums.

5 Last time I described options for changing the
6 fee-for-service benefit that added an out-of-pocket cap but
7 then also added a combined deductible in order to help keep
8 Medicare program spending budget neutral. Mitra and others
9 disagreed with that approach because it required a pretty
10 high combined deductible to pay for the additional costs of
11 the cap. You had concerns that the combined deductible
12 would keep beneficiaries from seeking appropriate care.

13 John suggested coming at things a different way --
14 adding a fee-for-service cap, but not allowing Medigap and
15 retiree policies to fill in co-pays for office visits and
16 for emergency room use. This slide is one take on John's
17 idea. We looked at the beneficiaries who today have a
18 Medigap or retiree policy that pays for all or almost all of
19 their Part B cost sharing and estimated what would happen if
20 their supplemental coverage could no longer fill in some
21 nominal co-pays. We used $10 for primary care office
22 visits, $25 for visits to specialists and certain other

1 nonphysician providers like chiropractors, and $50 for
2 emergency room use. We used behavioral assumptions that are
3 generally consistent with those used by CBO. And our
4 preliminary estimate suggests that the reduction in service
5 use from introducing co-pays would be enough to add about an
6 $8,500 or $9,000 out-of-pocket cap to the fee-for-service
7 benefit while keeping Medicare program spending budget
8 neutral. We assumed that there would be small co-pays above
9 the cap similar to the approach used in Part D. We think
10 most beneficiaries with Medigap policies would come out
11 ahead under this illustration because even though they would
12 now be paying co-pays, the reduction in their Medigap
13 premiums would be bigger. The effects on beneficiaries with
14 retiree policies are harder to predict.
15 I suspect John would say that, based on the
16 results of the contractor study we presented to you last
17 year, co-pays could help finance a lower cap than this. Let
18 me say that some of the difference comes from projecting
19 costs forward from the 2008 data I showed you last time to
20 the 2011 numbers shown here. But, in addition, we may want
21 to think about whether we want more beneficiaries to get all
22 the way down to the utilization levels of beneficiaries who

1 only have Medicare. Chris Hogan's work showed that some
2 people without supplemental coverage were using very little
3 care, which may not be a good thing. More generally,
4 though, I think this approach shows promise and could be
5 combined with other changes to the fee-for-service benefit
6 to help introduce out-of-pocket protection. We'll keep
7 looking at how to model this idea -- it's rather complicated
8 to model, actually -- as well as other potential changes to
9 the fee-for-service benefit.
10 I just want to remind you that in the new health
11 reform law, there is a provision that will affect Medigap
12 policies in the future. It asks the National Association of
13 Insurance Commissioners to revise its standards for the most
14 popular types of Medigap policies -- Plans C and F -- to
15 include nominal co-pays. It doesn't say exactly what those
16 co-pays will be. It leaves that decision to NAIC, but
17 directs them to use peer-reviewed evidence or examples from
18 integrated delivery systems. The new standards are to be
19 ready by 2015 and will affect policies issued after that
20 date. This grandfathers current Medigap policy holders.
21 The provisions in the health reform law are not as
22 sweeping as the illustrative option we just talked about.

1 It doesn't apply to current Medigap policyholders and
2 doesn't touch employer-sponsored retiree health coverage.
3 It also doesn't get to the kind of ideas that Mitra talked
4 about last time -- introducing more management of the
5 Medicare benefit. Still, this shows that the approach we've
6 been talking about for redesigning supplemental coverage is
7 being taken seriously.
8 Mitra reminded me that there are other provisions
9 related to benefit design in the new law, which I will add
10 to the draft chapter. Specifically, the law allows for an
11 annual wellness exam in which providers create a
12 personalized prevention plan, a personal schedule for the
13 beneficiary to receive preventive services. Beginning in
14 2011, beneficiaries will not owe cost sharing for those
15 preventive services. The law also gives the Secretary
16 authority to modify Medicare coverage of certain preventive
17 services based on recommendations of the U.S. Preventive
18 Services Task Force. So it sounds like there would be
19 certain types of visits for which nominal co-pays would not
20 apply -- for visits to receive certain preventive services.
21 Last time, Arnie spoke about how best to use
22 beneficiary incentives to help transform health care

1 delivery for the longer term. He argued that there may be
2 an earlier payoff to using Medicare's benefit design to help
3 reinforce changes in provider payment systems -- for
4 example, by charging lower cost sharing to beneficiaries who
5 receive care through accountable care organizations or
6 primary care medical homes, or higher cost sharing if a
7 beneficiary seeks care from providers identified
8 consistently as "resource use outliers." Arnie suggested
9 that this approach could have greater nearer-term payoffs to
10 the health care system.

11 I also heard a lot of support around the table for
12 moving toward value-based insurance design. But I think I
13 heard you say that we need to keeping working on the
14 evidence base to know which treatment options are more
15 effective and for which groups of beneficiaries so that we
16 can have more confidence about which services are of higher
17 value. And I also heard you say that cost sharing should
18 work both ways -- both lower cost sharing for higher-value
19 services, and higher cost sharing for lower-value ones.

20 As we continue talking about benefit design, you
21 may also want to discuss Mitra's idea about using more
22 management tools within the Medicare benefit. Fee-for-

1 service Medicare is one of the last vestiges of indemnity
2 insurance. Our goals for the Medicare program are to
3 continue providing access to care but also to improve the
4 quality of care for beneficiaries and to make the program
5 more financially sustainable for beneficiaries and
6 taxpayers. In order to do these things, we may need to
7 introduce a greater degree of management in the program than
8 there is today.
9 MR. HACKBARTH: Thank you, Rachel.
10 Let's start over here with clarifying questions.
11 DR. STUART: Actually, it's right on this slide.
12 It's the last two bullet points. My reading of the value-
13 based benefit design literature -- and it's hot and heavy
14 now with many more empirical examples of lowering cost
15 sharing on high-valued services. But my reading on this
16 suggests that in most of the cases it comes in conjunction
17 with disease management or some other explicit incentive to
18 change behavior, and so it really is the point, I think,
19 that Mitra was raising. And so my question is: In your
20 reading of this literature, do you find that to be true?
21 And is that going to be reflected in the chapter?
22 DR. SCHMIDT: Well, I think a lot of times it's

1 being used within the context of managed care or managed
2 benefits already, yes. And I think at this point the draft
3 is trying to reflect that, you know, a lot of the literature
4 dealing with changes in cost sharing as well as value-based
5 insurance design takes place within a managed care context.
6 DR. STUART: I have a technical point to raise.
7 What part of the change in consumer behavior is due to the
8 reduction in price? And what part of it is due to the
9 management of the benefit? And I think that's really
10 important to distinguish in order to get the tools right.
11 DR. SCHMIDT: So are you suggesting that we try to
12 look to see whether the literature can disentangle the two?
13 DR. STUART: Well, this is round one, and so it's
14 a question about whether this is something that you found in
15 the literature.
16 DR. MARK MILLER: I just want to put a marker down
17 because I think it's good that this comment came up here and
18 this is really a round two point. So you guys should talk
19 about it then. I think this is really important because I
20 think you can go into the literature, find something that
21 works, and drop it out into kind of an open-ended fee-for-
22 service system, and it won't have that effect at all. And

1 so I think that's something that needs to be thought through
2 very clearly, so I'm glad you made that point.
3 MR. BERTKO: So, Rachel, I want to congratulate
4 you. I think I'm going to award you a deputy actuary's
5 badge for being conservative. Can you flip up to --
6 DR. MARK MILLER: Rachel, don't take that badge.
7 [Laughter.]
8 MR. BERTKO: So what I meant by that is the $8,500
9 to $9,000 benefit I think is a very safe bet on a cap that
10 would keep the Medicare trust fund whole while putting that
11 cap on it.
12 Now would you go to the part where you have the
13 cost sharing for the various categories of beneficiaries?
14 Not that one. The one where you have the different
15 categories with different types of benefits. No, the one
16 where you have -- with the --
17 DR. SCHMIDT: [off microphone] Income or --
18 MR. BERTKO: Income, premiums, and cost sharing.
19 Yes. So the comment I would make here is we have in our
20 grasp the silver bullet, and I want to see whether Rachel
21 agrees with this or not. We're one to put in the cap and
22 the nominal cost sharing. We have first protected Treasury.

1 No more outcomes. That was part of the design there. But
2 basically the pink bars, the out-of-pocket costs, which are
3 the beneficiary side, would shrink; and the yellow bars,
4 which are the premium, would shrink. This is essentially a
5 win for all, and I think that we would want to keep that at
6 least in our thinking. Do you agree that I've characterized
7 that --
8 DR. SCHMIDT: I would agree. We were doing
9 preliminary estimates, and our rough crude estimates, which,
10 you know, aren't looking at individual insurance pools,
11 we're finding decreases in the average Medigap premium on
12 the order of 20 percent. It's hard to predict what the
13 outcome would be for people who have retiree benefits, the
14 other categories.
15 MR. BERTKO: Right. And then the only thing I
16 would add to this is there is a secondary or tertiary
17 benefit coming from the likely use of these minimal, nominal
18 cost sharing for bundling, medical homes, and ACOs, which,
19 again, much more difficult, but, again, there would be a
20 behavioral aspect of this that would lead to perhaps greater
21 savings in this case, mostly for Treasury but with, again, a
22 little bit of offset to the out-of-pocket costs of

1 beneficiaries, because if, for example, they replaced lower
2 back pain with a primary care episode versus an orthopedic
3 one, they'd be paying $10 instead of perhaps $200 in terms
4 of the cost-share portions of it. So, you know, I've kind
5 of leaked over into round two, but it was meant to be mostly
6 clarifying.

7 MR. GEORGE MILLER: Yeah, if you could, Slide 8
8 please. Just a clarifying question. In comparing these
9 two, the lowest 25 percent and the highest, is this overall
10 all Medicare beneficiaries, a specific disease, or it's just
11 overall?

12 DR. SCHMIDT: It's the overall fee-for-service
13 population.

14 MR. GEORGE MILLER: Very good. Then that answers
15 my question.

16 MR. HACKBARTH: Let's do round two.

17 MR. BERTKO: Okay. So this is one is where I'm
18 going to suggest that we consider adding a fairly strong
19 recommendation, suggestion, comment into the chapter. We
20 have under the new law those two new plans which Rachel
21 described that are going to come up with nominal cost
22 sharing. But we have a very urgent need to try to save the

1 Medicare trust fund and to reduce Part B. And so rather
2 than wait for the age-in, die-off -- and I'm an actuary. I
3 can say those things -- let's flip the switch as soon as
4 possible with the silver bullet, where everybody saves
5 money. And I think the stronger we can say that, the more
6 likely the folks at the other end of the Hill will listen to
7 us.

8 DR. MARK MILLER: [Off microphone] John, can you
9 be clear what the silver bullet is?

10 MR. BERTKO: The silver bullet is the trust fund
11 is protected or actually gets a decrease in spending.
12 Individuals have a cap on out-of-pocket costs, so high-cost
13 people are well protected for a change. And the average
14 person who's got supplemental coverage actually has a
15 reduction in their out-of-pocket premiums.

16 MR. HACKBARTH: Within the beneficiary population,
17 on average they may all come out ahead, but at the
18 individual level, some may gain and some may lose.

19 MR. BERTKO: In this particular case, the gainers,
20 in my quick estimation, will overwhelm any losers, and then
21 the losers are losing only $10, you know, for their co-pay
22 that they wouldn't have been paying today, while recovering

1 perhaps most of that in their out-of-pocket premium,
2 because, you know, you've made the point earlier in Medicare
3 Advantage about the 13-percent cost to -- you know, extra
4 cost per dollar. This one is more like a 40-percent cost
5 per dollar of cost sharing that's absorbed in that, because
6 Medigap, I think -- I'll look to Rachel to say -- is
7 probably much more costly in terms of the administrative
8 burden on it. So, you know, why pay $1.40 for $1 in even
9 the low-use people who you think might be losers, may be
10 really right on the edge if they're going to lost anything.
11 And the high-cost, high-spend folks are really well
12 protected.
13 MR. GEORGE MILLER: But your silver bullet is the
14 cap. You just explained the silver bullet. I think that
15 was --
16 MR. BERTKO: No, there's a combination. The
17 silver bullet is the cap and --
18 MR. GEORGE MILLER: Cap and --
19 MR. BERTKO: -- the nominal cost sharing, which
20 reduces Part B expenditures in particular. Now, there is
21 one loser in here, and that is the medical community.
22 Revenue goes down. But in the case where we've got, you

1 know, 30 million Americans coming in, they're going to get
2 some other revenue. There's plenty of work for those folks.
3 DR. MARK MILLER: And just to be clear -- I'm
4 sorry. I just want to be absolutely sure everybody follows
5 what the silver bullet was. The key point was flip the
6 switch, and I think what you're saying is the nominal cost
7 sharing with this catastrophic cap would start now --
8 MR. BERTKO: Yes.
9 DR. MARK MILLER: -- for Medigap and DSI. So
10 starting today, you would be required to pay some nominal
11 co-payment.
12 MR. BERTKO: Exactly.
13 DR. MARK MILLER: Not let the C and F sort of work
14 on an actuarial basis as the population changes over time.
15 MR. BERTKO: Yes.
16 MR. HACKBARTH: So as we continue with round two,
17 I would invite people to react to what John has said. I for
18 one still need some more time to understand the numbers, the
19 distributive impact, but let's just stipulate for the sake
20 of argument that John's right, that at the average level
21 it's a win and if you go down to the individual level, the
22 loser -- there may be losers, but it's modest amounts.

1 Let's just stipulate that for the sake of argument.

2 What I'd like people to react to or be invited to

3 react to is the basic design of what he's talking about,

4 which is to prohibit anybody from offering insurance, either

5 in the individual supplemental market or at the employer

6 level, that doesn't have at least a designated structure of

7 cost sharing.

8 DR. SCHMIDT: Could I say something, too?

9 MR. HACKBARTH: Sure.

10 DR. SCHMIDT: Let me qualify the numbers that I

11 gave you to say that these are preliminary estimates, and it

12 is a complicated thing trying to figure out, you know,

13 whether an entire cascade of services that, you know, might

14 be ordered after an office visit gets wiped our or in a fee-

15 for-service environment whether some of that happens anyway.

16 And so it's kind of -- these are preliminary numbers, and

17 there are some implementation issues to think about as well.

18 Remember last time we discussed what is the hook for having

19 a recommendation take effect over employers.

20 MR. HACKBARTH: Yeah. So what I'm trying to do is

21 flag at least a few really big sort of policy decisions that

22 are implicit in John's silver bullet, get people to react to

1 those. And one of them is a prohibition on selling any
2 other kind of insurance. That's a novel --
3 MR. BERTKO: And may I amend that? Bruce has just
4 reminded me on the ERISA self-funded retiree coverage, we
5 may need to make use of eligibility for the RDS, retiree
6 drug subsidy, money in order to do this. So it's a highway
7 trust fund kind of incentive/disincentive.
8 MR. HACKBARTH: Right, right. So that, you know,
9 is sort of one policy choice. Sort of another path to go
10 down is -- and we've talked about this before. You don't
11 have outright prohibitions but basically, you know, you tax
12 -- have a surcharge on policy designs that you think create
13 external costs that have to be picked up by the federal
14 government. Either of those approaches is a huge change
15 from where we've been. So let's continue round two.
16 DR. MILSTEIN: I think I'm supportive, you know,
17 per your request for comment on this. But I do think that
18 it would be useful to consider whether or not, you know, the
19 other mode by which this cap might be achieved, which is
20 allowing Medicare beneficiaries within the fee-for-service
21 program to agree that they would like to confine their non-
22 emergency use of services to, say, a hospital and its

1 affiliated medical staff that just even though they may not
2 have formed an ACO or medical home yet -- because those are
3 programs for the future. I'm trying to come up with
4 solutions for us to consider that could work sooner rather
5 than long term. The beneficiaries in exchange for that
6 commitment to get their non-emergency care from a smaller,
7 you know, network of Medicare providers that could be
8 identified through the same kinds of tools that Mark and
9 staff used to identify more efficient, high-quality delivery
10 systems in December.

11 That would be another -- should we consider that
12 as an additional avenue by which the beneficiaries would be
13 able to have their out-of-pocket costs capped? And the
14 reason I think that this might be something that's available
15 now rather than in the future is, A, it is not contingent on
16 us getting the ACO program up and going; B, it's not
17 contingent on us getting, you know, a big national medical
18 home program up and going; C, I don't know -- maybe, Rachel,
19 you can comment on this -- whether or not Medicare has
20 actually polled beneficiaries with respect to their
21 preferences in terms of their trade-offs. But I know in
22 California this research has been done, and the winner, you

1 know, by quite a bit of margin in terms of -- you know, in
2 exchange for less cost to you for health insurance, what
3 would you most be willing to trade off? The clear winner is
4 a narrower provider network. That's the clear winner.
5 And last but not least, you know, is it powerful
6 enough medicine to justify the cap? You know, I commend to
7 you the Institute of Medicine series that wrapped up -- done
8 this summer and for which the report is now out, which
9 suggests that of the mechanisms to reduce per capita
10 spending, that focusing on more efficient providers is
11 perhaps the most robust of available politically salable
12 options.
13 MR. HACKBARTH: I want to get Rachel to react to
14 what you say. It seems to me that there are already
15 existing mechanisms by which that is done. Of course, there
16 is Medicare Advantage under which, you know, private
17 insurers offer expanded coverage for people willing to
18 commit to a particular network. There's also a Select
19 option in the Medigap world --
20 DR. MARK MILLER: It sounds a lot like --
21 DR. SCHMIDT: Right, so the Medicare Select
22 products or Medigap policies where, if a beneficiary uses

1 what's essentially a network hospital, they can get a rebate
2 on their Part A deductible or avoid paying it. And there
3 are about, I think, a million enrollees in those plans at
4 the moment.
5 DR. MARK MILLER: Which I could imagine building
6 that option up and trying to build something like you're
7 saying.
8 MR. BERTKO: Yeah. And can I only say -- and
9 Scott can probably come back on this -- the Medicare
10 Advantage PPOs, when evaluated -- what, about five years
11 ago, Scott? -- were a mixed bag at best in terms of
12 effectiveness as measured against their bids with somewhat
13 narrower networks.
14 DR. MILSTEIN: Could I respond to that? I think
15 it's a very good point John makes. I don't think that, you
16 know, narrowing the network as a means of providing a cap
17 would work if implemented in the way that John just
18 explained, which is, you know, giving a discount and
19 utilization review light, which is what's going on in the
20 PPO.
21 I think what emerged in the Institute of Medicine
22 series this summer was this notion that's more closely

1 related to what I suggested in which we -- which MedPAC, you
2 know, provided a nice platform for, which is identifying
3 delivery systems that are actually naturally delivering, you
4 know, compared to their peers in the same geography, lower
5 per capita fee-for-service spending on Medicare after, you
6 know, adjusting for risk scores, et cetera.
7 MR. HACKBARTH: Again, I don't want to get stuck
8 on any one point when we can and should explore this
9 further. But sort of one of the basic policy design issues,
10 it seems to me, is do you allow private insurers to try to
11 identify high-value efficient providers and provide
12 incentives for patients to go there, and that's what
13 Medicare Advantage can do, and you could imagine Select
14 being structured better to do that, versus the government
15 trying to identify the high-value providers and steer, which
16 I think is a very different and more difficult proposition,
17 if not impossible proposition. So that's sort of, you know,
18 one of your policy crossroads. Is this a private activity
19 through MA, in Medigap, or is this a government activity?
20 DR. MILSTEIN: [off microphone] I'm not suggesting
21 that -- you know, since Mark and staff have demonstrated its
22 feasibility in Medicare fee-for-service -- technical

1 feasibility, you know, not political feasibility, obviously.

2 MR. HACKBARTH: Yeah.

3 DR. MILSTEIN: That that at least be an open --

4 openly considered as a short-term -- as one of the short-

5 term paths for enabling a cap.

6 DR. BERENSON: I think there's a difference

7 between having a theoretical feasibility and implementing it

8 in a program in which providers will have due process rights

9 and a whole bunch of ability to challenge these things that

10 you don't have with the private plan. And I'm not as

11 convinced yet that we've got the tools. But I was going to

12 make a different point.

13 On John's point, I'm sort of theoretically there,

14 but I'm not sure if that's where we want to go. I need to

15 think about it more and learn more about it. And here's the

16 question that I have. I guess at the last meeting I was too

17 oblique about a point I was trying to make, which is wanting

18 to know more about the degree to which cost sharing is a

19 fraud and abuse tool. And so all of the discussion today

20 has been about sort of doctor, hospital, real behavior

21 change by changing incentives. But do we know anything

22 about durable medical equipment, ambulances, the kinds of

1 things where there's fraud in the program to the degree to
2 which actually having cost sharing, whether directly in the
3 benefit design -- and so far we don't have it in some of
4 those benefits, any cost sharing -- or by prohibiting it in
5 Medigap we would actually see any return because of more
6 detection, more reporting, et cetera. That's a piece of
7 this that I'd like to understand a little more.
8 DR. SCHMIDT: And I'm sorry, I don't have a review
9 of literature to come back to you to answer your question
10 yet, but I will look into that further. You know,
11 anecdotally, I think we've all heard stories where we think
12 people at some point realize the cost of a DME item and are
13 shocked by it, and had they known earlier, they might have
14 behaved somewhat differently.
15 DR. BERENSON: There's either the cost of the DME
16 product or just the failure of the DME product being
17 provided -- in other words, overt fraud where, if you
18 suddenly get a bill, you say, "I never got such a" -- I
19 mean, so one is a discipline on the price, which is
20 conceivable. The other is just "It's a service I didn't
21 receive." And so I think that would help me figure out what
22 a policy would be here.

1 MR. HACKBARTH: Let me see hands of people who
2 want in.
3 DR. SCANLON: Yeah, I think that conceptually what
4 John is suggesting is something that we should be sort of
5 behind. One, it sort of creates Medicare as an insurance
6 program as opposed to this payer program which leaves you at
7 grave risk. It also kind of aims at eliminating an
8 incredibly inefficient purchase, which is to have somebody
9 write a check for $1 that you paid $1.40 for, you know, and
10 the med-sup people don't even do the utilization review.
11 It's like if you've got a Medicare Explanation of Benefits,
12 then they pay; if you don't, they don't. So it's kind of
13 they're not really providing sort of a great service there.
14 And I think we also do have precedent here, which
15 is in Part D we've got true out-of-pocket as a concept, and
16 so we can think about sort of building upon that.
17 Having said that, I would say over time I would
18 observe that the market for silver bullets is not that
19 great. People don't jump on them, okay? This idea of sort
20 of trading off sort of catastrophic protection for earlier
21 cost sharing has been a CBO budget option for God knows how
22 long. Senator Roth, when he was the Chairman of the Finance

1 Committee, was floating proposals like this, and he was even
2 not willing to go as far as mandatory. He was trying to go
3 voluntary. It had no traction.
4 You know, we got true out-of-pocket, we got
5 income-related premiums in the context of a big change,
6 which was a gift in some respects, Part D. We've had all
7 the changes that reflect our recommendations here in health
8 reform, but, again, it's in the context of a much bigger
9 thing. So to make a big change like this, to get a silver
10 bullet adopted, it's not easy to do it on a solitary basis.
11 It often is going to take a bigger context.
12 But one of the values of MedPAC is to be on
13 record, you know, and to keep reminding people this is where
14 you should be thinking about going, and when the time is
15 opportune, they can go there.
16 MS. BEHROOZI: Thank you very much, Rachel. I
17 really appreciate all the time and thought that you've put
18 into responding to a lot of the issues that I've been
19 raising.
20 So just to try to focus more narrowly on the John
21 Silver Bullet Plan, actually I understand that it's a big
22 deal to impose that all at once, but I think it's pretty

1 surprising and good directionally that, you know, Medigap
2 now no longer, prospectively at least, can fill everything
3 in. So it seems like it is a moment of opportunity to give
4 some more opinions about it. So two things I would say
5 about it.
6 One is that we often talk about patient incentives
7 for seeking more appropriate care or lower-cost care or, you
8 know, doing shared decision making or whatever -- see, I
9 knew I'd get it in there -- but then we say you can't give a
10 patient an incentive except by handing them a $20 bill, or
11 whatever, if Medigap is filling in all the cost sharing.
12 So I would want it to be clear that if we say
13 there can't be full fill-in of cost sharing, that we don't
14 want to undermine our own ability to incent people by
15 waiving cost sharing when we want to drive behavior in a
16 certain direction. I'm not necessarily right now judging
17 what those circumstances may be, but I think that, you know,
18 an absolute prohibition because it's always the right thing
19 to do to charge money flies in the face of sometimes saying,
20 well, you know, value-based benefit design, whatever the
21 items are, I think we should be careful to leave ourselves
22 that out. And the other thing is -- and we talked a little

1 bit about this, and you and I haven't spoken, after I read
2 the article by Amitabh Chandra on the CalPERS change from 0
3 to 10 co-pay.

4 So my approach has generally been sort of
5 beneficiary protective and also program spending protective.
6 Just looking at the program spending side now, I'm just
7 concerned that in both that article and the Travetti article
8 -- and I gather there are some other pieces out there that
9 might not be as prominent as those two, at least not on my
10 radar screen, whatever -- they indicate that there is
11 increased spending for hospitalization. It's not just
12 whether people got sicker because they avoided up-front
13 care, outpatient care, or drugs or whatever it is, so that's
14 a bad thing if they got sicker; but that there was increased
15 cost to the program.

16 So I know that you have reservations about the
17 methodology. I guess I just feel like if we're really going
18 to be counting those savings, we shouldn't leave ourselves
19 open to criticism that, you know, they're not really hard
20 savings, because in the end there will be additional
21 hospitalization costs. So to the extent -- and I don't know
22 if -- there's too much to do between now and publication of

1 this paper, but I would suggest going forward that if there
2 really are bases to sort of undermine those findings, that
3 we be very explicit about them or count those -- you know,
4 discount the savings possibly by increased hospitalizations.
5 DR. CHERNEW: So I am, first of all, thrilled that
6 you have this chapter -- she wants to say something. Look
7 at her.
8 DR. SCHMIDT: Yeah. I'm sorry. Just to say that
9 -- and I would like help from people who follow all the
10 health economics literature, to get your input on these
11 articles because they are two among other articles that have
12 had more mixed estimates of the overall effects of cost
13 sharing. So I gave them prominence because they're new, but
14 I think that there are some methodological issues. I take
15 your point that there are risks that there might be
16 increased hospital spending.
17 In the case of the Chandra article, I think they
18 noticed higher hospital spending but lower overall spending.
19 In other words, there was --
20 DR. CHERNEW: Yeah, because it -- I'm sorry. In
21 general, there's a confusion about whether or not hospital
22 spending is going up or down and whether that savings

1 offsets the other spending. So in all cases -- except in
2 the Chandra one there are some targeted cases -- you find
3 that if you raise co-pays, every actuary -- and I'm going to
4 count John in that bin -- with any badge will tell you that
5 if you raise the amount people have to pay, you save money
6 overall. You don't save as much money as you would expect
7 potentially because there are some offsets. But spending
8 still changes, and that's the crucial point in -- unless you
9 target really, really well. So if you look at the Chandra
10 one, they target particularly well. Allison Rosen has a
11 paper which you cite which targets some. We talk about some
12 in our work. So you can target to get around that -- I'm in
13 round two now.
14 MR. HACKBARTH: [off microphone] Three.
15 DR. CHERNEW: But it was my turn, though, so I
16 wanted to say something about this at the time, but I will
17 now pause. But that's what -- there's just this confusion
18 about the adding up of things that makes these answers
19 harder to get to.
20 MS. BEHROOZI: But also on the Chandra article,
21 what I understood -- I am not a health economist so I
22 shouldn't even be talking, but just reading the article, he

1 talks about the overall spending going down -- I'm sorry,
2 hospital spending going up, other offsets, but which
3 programs benefit that --
4 DR. SCHMIDT: They do note --
5 MS. BEHROOZI: He said the Medigap insurers get
6 the benefit of the lower spending on the outpatient, but
7 Medicare spends more on hospitalization. So that's what I
8 mean about being careful about addressing it all so that
9 nobody can say, oh, it's not going to be X amount of savings
10 and whatever. For Medicare, it's going to be a lower amount
11 of savings.
12 DR. CHERNEW: I know it's late so I'm going to try
13 and talk really quickly. I'm not going to limit what I say.
14 I'm just going to say it faster.
15 [Laughter.]
16 DR. CHERNEW: I think there's a philosophical
17 issue which is really important that this raises about what
18 role beneficiaries will play fundamentally in addressing the
19 Medicare program, and relative to a world which is all done
20 by payment and we cap, this chapter raises the issue, which
21 is one that I feel relatively strongly about, that
22 beneficiaries have some role to play. And there's a lot of

1 ways that can be implemented. I think there are certain
2 things that we generally know, and so let me go on record as
3 saying first I'm very supportive of a Bertko-like silver
4 bullet which relies on some type of cost sharing. I tend to
5 prefer the taxing. Part of what's going on is there's a big
6 essentially externality placed on the Medicare program
7 because the supplemental programs' policies are much cheaper
8 than their full actuarial value. And John's proposal
9 essentially tries to undo that, and the taxing, you could
10 get rid of that substitute in a number of ways. So I'm very
11 supportive of that.
12 I think the evidence is pretty clear that if you
13 do higher cost sharing for beneficiaries, you will -- you
14 can debate the magnitude. You will cause a reduction in use
15 of some things you would want people to use. It's very
16 likely that will affect lower-income people more than
17 higher-income people, and you'll have to worry about
18 disparity issues.
19 The type of solution in that framework is
20 essentially a value-based insurance type solution where you
21 try and carve out certain things. I believe U.S. Services
22 Preventive Task Force thing are good, but not a sufficiently

1 broad set of things that you have to address in that way.
2 But I think it is a start to couple a higher cost-sharing
3 strategy, whether it be tax more generous plans or prohibit
4 certain things with some type of value exemptions for things
5 that we really want. And I would expand that to go where
6 Arnie would say if you choose a capitated ACO that's a lot
7 cheaper, we would allow that ACO to waive whatever the cost
8 sharing is because you're making a choice to get extra
9 protection at the point of service in exchange for agreeing
10 to something else. And I think that is what the original
11 managed cares story was. You get low co-pays, but you join
12 this network. And I think that's a reasonable trade-off.
13 And so I think that you can design with some
14 cleverness and maybe an intermediate actuary badge a policy
15 which will, I think most people would agree, be better for
16 most people than the current benefit design now, and much
17 better than where Rachel very ably and eloquently pointed
18 out we're going, because we're going to a place that's going
19 to be a lot worse as costs rise. And so being able to think
20 forward how we work through that I think is really
21 important.
22 So I just want to say two other quick points. The

1 first one is in these value-based insurance design-type
2 riders to the Bertko insurance policy, the bar shouldn't be
3 that every individual one needs to save money. In general,
4 they won't save money, right? You need to be able to
5 finance and build a collective program that meets your cost
6 targets. Some of those things like lowering co-pays for a
7 lot of people won't save money, but you shouldn't because
8 our goal is not to save money for any particular thing. Our
9 goal is to provide a good benefit. You know, cancer care
10 doesn't save money, but we don't sit around saying, well, we
11 shouldn't give cancer care to anybody, right? So I don't
12 think dollar savings on any particular thing should be the
13 bar. It's the collective policy that matters.
14 I would also say that you're not -- I agree with
15 the point that Rachel made that we need to do a lot more
16 research, but there's a lot of areas we could do it already.
17 So just because we can't be perfect doesn't mean we
18 shouldn't start with some of the things that have been done.
19 And I think we could do a reasonably good job in many areas
20 now.
21 And the last thing I'll say is I don't think it's
22 our job to look ahead and see what's political and then only

1 make recommendations that ultimately we think would pass. I
2 do think we -- certainly IPAB, although IPAB can't deal with
3 benefits, incidentally, so this is the unique purview of
4 MedPAC. But in any case, someone is going to have to figure
5 out how to save money, and almost any money-saving solution
6 tends not to be that politically palatable. And I think
7 coming up with ways that I believe we could design a better
8 benefit package, provide more protection and better care
9 with a little crafting is worthy of a chapter, regardless of
10 whether we think ultimately it would or wouldn't pass
11 whatever political bars we think would be thrown in its
12 face. And I do think that would include some provider
13 tiering, ACO waiver things, as well as other incentives.
14 DR. CASTELLANOS: You said we could make some
15 comments concerning other people's comments. The most
16 important thing I see here is that up until now we've all
17 talked about the eight Medicare providers, and we've tried
18 to get everybody to be more efficient, to be quality
19 oriented and low cost. And this is the first time we really
20 are talking about the beneficiary, and I think that's great,
21 because if the beneficiary doesn't change his or her
22 behavior, we're really not going to have a big impact. So I

1 think that's really important, and I really think benefit
2 design is important.
3 John, you talk about the silver bullet. Well, if
4 you talk to Karen about the silver bullet, or Mike or
5 myself, in medicine the silver bullet is the colonoscope or
6 the sigmoidoscope, and you know where that is put.
7 [Laughter.]
8 DR. CASTELLANOS: The reason I bring that up is
9 you said that the medical profession -- everybody's going to
10 be a winner except the medical community, and they're going
11 to take a loss.
12 MR. BERTKO: No, no, I didn't say that. I said
13 revenue would go down.
14 DR. CASTELLANOS: Well, if revenue goes down, it
15 usually means a loss. But this wishy-washy economy, I don't
16 know. But let's put it that way. Let's say that the
17 economy -- that we are going to take a loss, and this 30
18 million people coming into the system is going to be our
19 rescue. Well, I don't know if you really look at the 30
20 million. Now, they're being taken care of now, but -- they
21 really are. They go to the emergency for the real serious
22 care, or they don't get care. Now, just follow me through

1 this, okay?

2 So for the hospital, when these people come

3 through there with Medicaid, you're going to get some

4 improvement. The device companies are going to do fairly

5 well. The drug companies are going to do fairly well.

6 Now, John, I guess I'm not a good businessman

7 because I lose money on my uninsured patients with no

8 insurance and I lose money on my Medicaid patients. I guess

9 I'm not a good businessmen -- let me just finish.

10 MR. BERTKO: No, I've got to respond to that one.

11 We're going to take -- Medicaid will pick up a big chunk,

12 but we're going to be likely converting many of those

13 uninsured patients into regular privately insured patients

14 at rates that I think you're probably pretty happy with.

15 DR. CASTELLANOS: Let me just finish, okay? So

16 these people are not getting access to care now. The

17 Medicaid population, whether you want to believe it or not,

18 has very poor, if any, access to care today. So now we're

19 talking about the physician community, we're talking about a

20 whole bunch of more people, and we've talked about graduate

21 medical education today, and we've talked about a

22 significant workforce problem.

1 Now, I kind of wonder who's going to be taking
2 care of these people. I mean, we have a significant
3 workforce problem. I think we all agree to that, with
4 primary care specifically, and Karen and myself feel there's
5 a lot of specialties that have that problem. So within the
6 medical community, we have a real concern about these 30
7 million people. Who's going to take care of them? And is
8 it worth it for me as a primary urologist to open up my
9 practice to the Medicaid population?
10 MR. HACKBARTH: Okay. This is an important topic,
11 but it's beyond the scope of what we can do right now --
12 since we're at the end of our time, anyhow. Let me just
13 offer a couple quick concluding thoughts.
14 We've talked about this topic several times now.
15 I think there's a broad consensus, perhaps not unanimous
16 agreement but broad consensus that it is important to look
17 at policy options that bring the patient, bring the
18 beneficiary into the task of trying to economize on the use
19 of resources. And I think there's also broad agreement that
20 in order to do that, you've got to address supplemental
21 coverage, whether arrived at through individual Medigap or
22 employer-sponsored coverage.

1 Beyond that, what I see is sort of a series of
2 policy choices that we've touched on, but we haven't quite
3 mapped out, and it seems to me the next step in this
4 conversation is to do -- pardon the nerdy comment, but like
5 a decision tree that says, you know, if you start from that
6 premise, then there are a series of choices that you face
7 and policy options, and I think that sort of a real
8 structured discussion next time that walks us through those
9 various decision nodes would be important to help us advance
10 our conversation on this.
11 We've talked about what some of those decisions
12 are already. I just want to add a couple others to the
13 list.
14 One is let's assume that you can figure out a way
15 to introduce cost sharing, a modest amount, has an effect on
16 utilization. We've talked about all sorts of different uses
17 of those savings. You know, one is you could plow every
18 penny back into expanded coverage for catastrophic,
19 whatever. Another is you could put every penny back in the
20 U.S. Treasury. And, you know, there's some obviously
21 between those. I think we need to wrestle with that very
22 explicitly, you know, what our goals are here.

1 Let me stop there. I'm just going to start to
2 ramble from here. But do you see what I'm saying, Rachel,
3 in terms of a real structure, you know, here's the series of
4 decisions? I think that would be --
5 DR. MARK MILLER: I mean, the other thing you
6 raised along this line was in response to if you're going to
7 couple this with kind of management on the provider side, is
8 that private or government.
9 MR. HACKBARTH: Right.
10 DR. MARK MILLER: You had made that point.
11 MR. HACKBARTH: Right. And another one is do you
12 prohibit or do you tax to discourage the undesirable
13 coverage.
14 DR. MARK MILLER: I already wrote that one down.
15 MR. HACKBARTH: So there is a series of these that
16 we can sort of lay out. Good work, Rachel. You have
17 succeeded in getting us engaged in this topic.
18 [Laughter.]
19 MR. HACKBARTH: Okay. So that's it for today.
20 Let's have our public comment period.
21 [No response.]
22 MR. HACKBARTH: [off microphone] Seeing none, we

1 are finished.

2 Let's see, we reconvene at 9:00 a.m. tomorrow.

3 [Whereupon, at 5:07 p.m., the meeting was

4 recessed, to reconvene at 9:00 a.m. on Friday, April 2,

5 2010.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, April 2, 2010
9:02 a.m.

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

AGENDA PAGE

Coordinating the care of dual eligible beneficiaries
-- Carol Carter, Christine Aguiar 3

Inpatient psychiatric care in Medicare: trends and issues
-- Dana Kelley 76

Public Comment 114

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

2 MR. HACKBARTH: Okay, we are going to proceed in
3 the dark. Now, I don't want any wisecracks about how this
4 is our usual way of -- so the best thing for them to do is
5 just turn off these lights while they figure out what the
6 problem is. So we're going to go with low lighting today.

7 Carol?

8 DR. CARTER: Okay. This morning we're talking
9 about dual eligibles who make up a disproportionate share of
10 Medicare and Medicaid spending relative to their enrollment.
11 Yet neither program really assumes full responsibility for
12 their care. As a result, their care is more likely to be
13 fragmented, which can raise spending and lower quality. The
14 conflicting incentives of the two programs further undermine
15 good care coordination.

16 Today we're presenting information on approaches
17 currently used to coordinate the care for dual eligibles.
18 We'll start by reviewing the four incentives to coordinate
19 care. We then review the characteristics and spending
20 associated with duals and then outline two approaches
21 currently in use to coordinate their care. And we discuss
22 the challenges in expanding the number of them and their

1 enrollment. We end with some concluding observations.
2 And before we get started, I wanted to thank Jae
3 Yang, who was really terrific in assisting us in this
4 project.
5 Last fall, we discussed the lack of incentives in
6 Medicare and Medicaid to coordinate care and the conflicting
7 incentives between the programs that undermine care
8 coordination. What would lower Medicaid's spending often
9 raises spending for Medicare -- and vice versa. Further,
10 under fee-for-service, providers have an incentive to
11 control their own costs by shifting costs onto other
12 providers, which in turn can transfer expenses onto another
13 program. The patterns of care that result from these
14 incentives are likely to raise spending and lower quality of
15 care. A good example of this is potentially avoidable
16 hospitalization of a nursing home resident that shifts
17 spending from Medicaid to Medicare.
18 Last fall, we reviewed the characteristics of
19 duals and noted that duals are more likely to be young and
20 disabled, have physical and/or cognitive impairments, to be
21 living alone or in an institution, and have less education.
22 But duals are not uniform. For example, duals are

1 more likely to be impaired, but almost half of them have no
2 or one limitation in their ability to perform activities of
3 daily living.
4 These characteristics will shape the amount of
5 services dual-eligible beneficiaries require, the mix of
6 providers serving them, and beneficiaries' inclination and
7 ability to seek timely care.
8 Turning to spending, we examined merged Medicare
9 and Medicaid claims data. Because the data pre-date Part D,
10 prescription drug spending is included in the Medicaid
11 spending. We concentrated on duals enrolled for an entire
12 year, or up until their death, and receiving full Medicaid
13 benefits. We excluded duals enrolled in managed care and
14 those with ESRD.
15 Average per capita Medicaid and Medicare spending
16 totaled just over $26,000 with slightly higher spending for
17 the aged -- that's the group in the middle -- and slightly
18 lower for the under-65 and disabled -- the bar on the right.
19 The Medicare share of combined spending -- in yellow --
20 averaged 37 percent but was higher for the aged and lower
21 for the disabled. Differences in Medicare shares in large
22 part reflect the amount of Medicaid-financed nursing home

1 care. But behind these averages are pretty different
2 spending patterns by the number of chronic conditions and
3 the physical and cognitive impairments.
4 Here we see spending varied considerably by the
5 number of chronic conditions and whether the beneficiary had
6 dementia. On this slide, you can see that the spending for
7 duals without dementia is in yellow and spending on
8 conditions that exclude dementia is in red. On the far left
9 is the combined spending for duals with one chronic
10 condition, and it was just over $16,000 without dementia and
11 over $31,000 with dementia. On the far right, spending for
12 duals with five or more chronic conditions was $43,000, but
13 with dementia, that was increased to $55,000.
14 In considering strategies to coordinate care, it
15 is also useful to look at the distribution of duals in these
16 groups.
17 The groups with the highest spending -- those were
18 the five or more chronic conditions -- with and without
19 dementia made up 8 and 11 percent of dual. That's the area
20 in grey and the light green. Those with the lowest spending
21 -- zero to two chronic conditions without dementia -- that's
22 the yellow and the red -- made up over half of duals. And

1 22 percent -- those are the areas in green -- are the
2 beneficiaries who had dementia.
3 Here we see some patterns of spending relative to
4 the average for all duals, and the average is the bar in the
5 middle, the vertical bar. At the far right, I've included
6 the percent that are institutionalized, and next to each
7 label on the left, I've included the share of duals that the
8 group comprises. For example, the top bar represents the
9 disabled with two or more physical impairments, and they
10 made up less than 1 percent of duals, all of them were
11 institutionalized, and spending on them was about twice the
12 average.
13 You can see that within each eligibility group,
14 spending ranged four-fold. Spending on duals with no or one
15 impairment was about half the average in both the disabled
16 and the aged groups, while the highest spending group was
17 about double the average. Clear trends other than these
18 were harder to discern. Groups with the highest rates of
19 institutionalization tended to have high spending, but not
20 always. For any given impairment subgroup, spending for the
21 aged groups tended to be higher for the disabled,
22 particularly for the cognitively impaired groups. We plan

1 to do more work to understand these spending differences.

2 The impairments and chronic conditions shape the
3 mix of services. On this slide, you can see the share of
4 combined per capita spending on hospital services -- that's
5 in yellow -- the physician and other part B services -- in
6 red -- nursing home care -- which is in grey -- and
7 prescription drugs spending -- which is in light blue -- for
8 three groups shown here, all duals, those with Alzheimer's,
9 and those with heart failure. Groups with high rates of
10 institutionalization, such as Alzheimer's patients -- the
11 middle bar -- had a high share of their spending in nursing
12 home care. Conditions with a high rate of hospitalization,
13 such as heart failure, have a larger share of their per
14 capita spending on hospital services.

15 As we consider ways to coordinate care for duals,
16 we will want to match designs to the care needs of different
17 subgroups. For example, care coordination for the
18 institutionalized might be best centered in the facility.
19 For duals living in the community, especially those with
20 multiple conditions, coordination strategies would emphasize
21 overcoming their fairly fractured system of care by ensuring
22 care management across their various providers. Strategies

1 need to factor in the beneficiaries' physical and cognitive
2 impairments since these will influence a beneficiary's
3 ability to access, understand, and manage his or her care.
4 Depending on a patient's risk, strategies would emphasize
5 avoiding unnecessary hospitalizations and nursing home
6 placements and ensure that medications are managed
7 correctly.
8 MS. AGUIAR: There are a number of considerations
9 when integrating care for the duals. One consideration is
10 the method of Medicare and Medicaid financial integration.
11 Any system of Medicare and Medicaid payment integration
12 would ideally be designed to ensure equity in beneficiary
13 access to care, to maintain program integrity so that
14 Medicare and Medicaid funds are properly spent, and to
15 eliminate cost shifting and conflicting incentives between
16 the two programs.
17 A second consideration is whether the method of
18 financial integration leads to care coordination. For
19 example, two methods of financial integration -- Medicare
20 assuming responsibility for dual eligibles and block grants
21 -- combine funding streams, but by themselves are not likely
22 to result in care coordination. Giving Medicare and

1 Medicaid payments to a provider group or insurer may be more
2 likely to result in care coordination if the entity is
3 properly incentivized to manage and coordinate care. A
4 third consideration is whether all Medicare and Medicaid
5 benefits, including prescription drugs and long-term care,
6 are integrated and whether an integrated program should
7 limit liability for high-cost services, such as long nursing
8 home stays. The development of outcome measures that assess
9 quality of care and level and success of care integration is
10 an additional consideration.

11 There are currently two types of fully integrated
12 care programs that have already been implemented. These
13 models are the state-SNP integrated managed care programs
14 and the Program of All-Inclusive Care for the Elderly, or
15 PACE. The vehicle for integration is a managed care plan
16 under the state-SNP model and a provider under PACE. Under
17 both models, the integration entity receives capitated
18 Medicare and Medicaid payments, and covers all services
19 including long-term care. These programs are at full
20 financial risk for the services they cover, giving them the
21 incentive to coordinate care in order to reduce unnecessary
22 utilization or high-cost services that they will have to pay

1 for.

2 To date, at least eight states have fully

3 integrated managed care programs for dual eligibles.

4 Development of these programs was often initiated by states,

5 and SNPs or MA plans are the integration vehicle. Less than

6 2 percent of duals are enrolled in fully integrated programs

7 through SNPs. Three of the states -- Massachusetts,

8 Minnesota, and Wisconsin -- began their programs under

9 demonstration authority and later converted to SNP

10 authority. Some of these programs reported having more

11 flexibility around service offerings while under

12 demonstration authority than under SNP authority. They also

13 report having had better integrated Medicare and Medicaid

14 administrative procedures, such as enrollment and marketing

15 materials. We are interested in looking more closely at

16 this change in flexibility of spending Medicare and Medicaid

17 payments and whether the move to SNP authority had an impact

18 on care management service offerings, beneficiary access to

19 the programs, and outcomes.

20 The majority of the state-SNP programs enroll both

21 the aged and the disabled. The subgroups of duals that are

22 most often excluded are the non-nursing home certifiable,

1 duals that live in institutional settings, and the mentally
2 retarded and developmentally disabled. Under most of the
3 programs, duals can voluntarily enroll in the SNPs for their
4 Medicaid benefits, and enrollment for their Medicare
5 benefits is always voluntary because of Medicare freedom of
6 choice. Most of the states with strong enrollment in their
7 state-SNP programs had statewide Medicaid managed care
8 programs in place before adding the integrated programs.
9 Other states' programs have struggled with enrolling large
10 numbers of duals due to voluntary enrollment, a lack of
11 state and managed care plan resources to dedicate to the
12 program, and competition from other non-integrated SNPs.
13 In addition, the state-SNP programs cover all
14 Medicare and Medicaid benefits; however, a few programs
15 limit the number of nursing home days that are covered.
16 Minnesota, for example, covers up to 180 days of nursing
17 home care. Care coordination is a central component of each
18 programs' model of care. Programs also include other
19 elements in addition to care coordination, such as Arizona's
20 program that reassesses institutionalized enrollees every
21 six months to see if they can be placed in the community.
22 Outcomes research on the integrated programs is

1 limited; however, results show that some programs have
2 reduced institutional and inpatient utilization. For
3 example, enrollees in Massachusetts' program had fewer
4 nursing home admissions and shorter nursing home lengths of
5 stay compared to duals in fee-for-service Medicare and
6 Medicaid. In addition, under the Minnesota program, nursing
7 facility utilization declined by 22 percent over five years,
8 and the number of seniors receiving home- and community-
9 based services increased by 48 percent.
10 A second model for full integration is PACE. PACE
11 is a provider-based program for elderly beneficiaries that
12 require a nursing home level of care. Enrollees are
13 transported by PACE to an adult daycare center where they
14 receive services from an interdisciplinary team of health
15 care and other professionals. PACE sites are at full risk
16 for providing a comprehensive set of acute and long-term
17 care benefits. The interdisciplinary PACE team consists of
18 many professionals, including physicians, registered nurses,
19 social workers, and therapists. PACE sites directly employ
20 the majority of PACE providers and establish contracts with
21 other providers such as hospitals and nursing facilities.
22 Evaluations of PACE are positive. PACE enrollees

1 had higher rates of ambulatory service utilization, as a
2 measure of primary care use, and significantly lower rates
3 of nursing home utilization and hospitalization compared to
4 a group of individuals that applied to PACE, but did not
5 enroll in the program. In addition, PACE enrollees reported
6 better health status and quality of life. However, the
7 program has grown slowly. As of February 2010, close to
8 18,000 beneficiaries were enrolled in 72 PACE organizations
9 in 30 states.
10 There are a number of challenges to the expansion
11 of fully integrated care programs to other states. The
12 majority of states and Medicare managed care plans do not
13 have experience with managed care for long-term care
14 services. As of January 2009, only 10 states had Medicaid
15 managed long-term care programs. The remaining states
16 either do not have Medicaid managed care programs for the
17 duals or carve long-term care services out of their managed
18 care programs. In addition, although institutional SNPs
19 have relationships with long-term care providers, they offer
20 Medicare benefits and are not required to contract with
21 states for Medicaid services. All dual-eligible SNPs are
22 required by 2013 to have contracts with states; however,

1 these contracts are not likely to initially cover long-term
2 care.
3 Many states also faced resistance from
4 stakeholders, such as provider groups, beneficiaries, and
5 advocates, during the development of their programs.
6 Provider groups opposed the development of Washington's
7 program due to loss of clients and reimbursement, and
8 advocates opposed enrolling the duals into managed care.
9 States are also concerned that Medicaid spending on care
10 management services lowers acute-care Medicare spending and
11 any savings to Medicaid from lower nursing home placements
12 do not accrue until years after program implementation.
13 Another challenge is the separate Medicare and Medicaid
14 procedures and administrative tasks. For example, duals
15 have to navigate two different systems for enrollment and
16 appeals, it can take years for states to obtain federal
17 approval for a Medicare and Medicaid managed care program,
18 and states and managed care plans cannot easily access each
19 other's claims, making it difficult to coordinate and manage
20 care. CMS may work on better aligning the administrative
21 barriers between the two programs through the Federal
22 Coordinated Health Care Office that was created by the

1 health reform legislation.

2 States vary in their history with and level of
3 acceptance to managed care; therefore, all states are not
4 likely to adopt the state-SNP model. In addition, although
5 dual-eligible SNPs are required by 2013 to have state
6 Medicaid contracts, these contracts are likely to initially
7 cover Medicaid cost-sharing, wraparound, or supplemental
8 services, but not long-term care. Therefore, the dual-
9 eligible SNPs by themselves will not result in more fully
10 integrated programs. The PACE model may not be a match for
11 all dual eligibles because PACE was designed to serve a
12 specific population of duals -- the frail elderly. Other
13 dual-eligible groups, such as the mentally retarded and
14 developmentally disabled or the non-frail duals, may not
15 need the level and type of services that PACE provides.

16 DR. CARTER: To improve the care coordination for
17 duals, we need to consider approaches that offer financial
18 integration and manage the care duals receive. Approaches
19 may differ in the range of services included -- for example,
20 whether long-term care services included -- but more
21 inclusive approaches are likely to be more effective at
22 coordinating care and controlling spending. Coordination

1 activities should be tailored to each individual's care
2 needs and risk. To assess whether coordination activities
3 improve care, performance measures would gauge the entity's
4 overall efficiency and how well it coordinates care.
5 Over the summer, we plan to interview many of the
6 fully integrated programs and conduct a limited number of
7 site visits to understand the features of best practices.
8 We will ask about their barriers to their implementation and
9 what challenges remain. We will consider how to facilitate
10 enrollment in integrated care models.
11 We have two questions for you. The first is:
12 Would you like us to prioritize our investigation of fully
13 integrated models, either by focusing on certain subgroups
14 of duals, a range of services, or an insurer- or provider-
15 based model?
16 And, second, are there other integration models
17 that staff should research further?
18 And with that, we look forward to your discussion.
19 MR. HACKBARTH: Thank you, Carol and Christine.
20 Well done. So let me see hands for round one clarifying
21 questions.
22 MR. BUTLER: So on slide 9, could you put that up?

1 I'm trying to understand. You have a lot of data on
2 dementia and Alzheimer's, and I'm trying to picture and
3 understand a little bit about where most of these patients
4 reside for treatment because you highlighted that 45 percent
5 of the spending for Alzheimer's patients is in nursing
6 homes, but I don't know how many patients, dual eligibles,
7 are actually in nursing homes being treated. And I don't
8 have a sense of what the alternatives are or in early stages
9 of dementia or Alzheimer's where these people are likely to
10 be if not in a nursing home.
11 DR. CARTER: I can't answer your question
12 completely, but I can help you out there. We know that
13 about 19 percent of duals overall are in institutions, and I
14 think there was another chart in the mailing that showed --
15 actually, I think here we can see on dementia about 28
16 percent of the disabled were in institutions, and among the
17 aged it was 79 percent. So, you know, that's where -- so
18 those are the shares that are in institutions for folks who
19 have dementia.
20 When they're not in institutions, they're
21 obviously living out in the community and hopefully
22 receiving support services, and those would include things

1 like home- and community-based services, and --

2 MR. BUTLER: So the definition of "institution"

3 for us is either a hospital or a skilled nursing facility?

4 DR. CARTER: It wouldn't be a hospital.

5 MR. BUTLER: Okay.

6 DR. CARTER: So these are folks who are living --

7 who are residing in an institution.

8 MR. BUTLER: And what would qualify as an

9 institution?

10 DR. CARTER: A nursing home or ICF/MR. And

11 assisted living might -- I'm not quite sure if that's right,

12 but those might be.

13 But I think for the majority it is living in a

14 nursing home because there's a very small population that

15 live in things like ICF/MRs.

16 MR. GEORGE MILLER: Two quick questions. Number

17 one, do you have demographic information of all these

18 categories for not only where they're residing, but each one

19 of the categories of the dual eligibles?

20 DR. CARTER: I do not. We could get that, but I

21 have not run that information.

22 MR. GEORGE MILLER: Okay. And, number two, do you

1 have a map or can you tell us where the PACE organizations
2 are? You said they are in about 30 states, about 18,000.
3 Are they in mostly urban areas? Or where are there? What's
4 the distribution of them? Are there any in rural areas?
5 MS. AGUIAR: We can get you the distribution of
6 where they are by states. They have typically been in urban
7 or suburban areas because they do have -- they do focus
8 around this adult daycare center. However, there has been
9 initiative to move more into rural areas, and so far, you
10 know, they're still in the stages where they're beginning to
11 develop those programs. But they are using health
12 information technology to be able to sort of get around --
13 you know, to be able to implement this daycare center-based
14 model in the rural area. So they're working through that
15 now.
16 MR. GEORGE MILLER: Thank you.
17 DR. SCANLON: Two questions, and they're primarily
18 about Minnesota. In terms of the 180-day limit on nursing
19 home use, does this mean that people that are long-term
20 residents of nursing homes wouldn't be eligible to come into
21 the SNP at the beginning, and then if they end up sort of
22 becoming long-term residents, are they sent out of the SNP?

1 Because I guess I'm thinking that they're probably some of
2 the people that need the coordination the most. And is that
3 typical of other states, too, that we're talking about you
4 have to be community dwelling to first enroll the program?
5 The second part was about their reduction in
6 nursing home use and whether or not they actually have a
7 complementary assisted living program, which I think in
8 terms of institutional use, we shouldn't be thinking sort of
9 only nursing homes. We should be thinking about sort of
10 residential settings and identifying sort of how we change
11 that, you know, whether you're at home or in some type of
12 formal residential setting.
13 MS. AGUIAR: To your first question, I believe
14 that the Minnesota program enrolls all of the aged, and so
15 that would be both the non-frail as well as the frail. I
16 have not seen anything that says that they will not enroll
17 you if you are already in a nursing home. Ideally, then, if
18 you are in the nursing home, the incentive is for them to
19 rebalance that and to move you back into the community.
20 I think the 180-day limit really is more of a
21 risk-sharing structure that after 180 days then they go back
22 into fee-for-service. So they're still in the nursing home,

1 but it's just paid through fee-for-service. That state does
2 -- Minnesota has another program that limits nursing home
3 use. It's for the disabled population. I believe it's to a
4 hundred days, and I believe it's also New York. There's one
5 other state that limits it to a hundred days as well.
6 DR. BERENSON: Yeah, this is very interesting. Is
7 there a received wisdom on how much -- what the differential
8 cost is of duals in an institution versus in the community?
9 Forgetting who's paying for it, but is it in most or all
10 circumstances less expensive to actually have the person not
11 institutionalized? Or what are the factors that would vary
12 that?
13 DR. CARTER: We haven't looked at that, and I
14 haven't seen data for that. I know that in the MA risk
15 model you get extra payments for being institutionalized and
16 for being dual. And I'd have to go back and see kind of
17 what those factors are currently. So I'd have to get back
18 to you with a more specific answer.
19 DR. BERENSON: Okay, because I guess one of the
20 positive achievements of some of the state-SNPs was reducing
21 institutionalization.
22 MS. AGUIAR: Right.

1 DR. BERENSON: And that sounds right from a
2 quality point of view. I'm just sort of curious.
3 MS. AGUIAR: Right, right.
4 DR. BERENSON: They are at-risk organizations, so
5 there must be a return on that. So I'd be interested in
6 knowing more about that.
7 MS. AGUIAR: Right, again, I think -- and Carol is
8 right. We do need to -- we will get back to you with more
9 of the specifics around there. But, you know, because these
10 organizations do receive capitated payments and are at risk,
11 it's better for them to have enrollees receiving home- and
12 community-based services rather than actually being in the
13 nursing home. They do have to pay for those services
14 themselves.
15 DR. BERENSON: I guess that's right. I guess I'd
16 like to know under what circumstances is it not better. I
17 mean, are they using some kind of -- you're raising your
18 hand.
19 DR. CHERNEW: The answer has been when people
20 wouldn't have been in the nursing home and would have been
21 in the community without home- or community-based services.
22 So if you could keep them at home without home- and

1 community-based services, that's cheaper than giving them
2 home- and community-based services.
3 DR. BERENSON: Well, unless it results then in
4 higher hospitalizations or other things like that.
5 DR. CHERNEW: Agreed.
6 DR. MARK MILLER: Another little thing, this is
7 not -- it may be best for the patient under any
8 circumstances to keep them out of the institution. But I
9 also think in some of this research, which we'll go back and
10 check and answer your questions, is if you keep somebody out
11 of the nursing home, you may have a less expensive
12 experience for that patient, but also the bed may be filled
13 by someone else. So, on net, there is also that angle that
14 occurs.
15 DR. SCANLON: The other aspect of this is that the
16 care is not equivalent. When the person is in the
17 community, there has to be somebody that does all the things
18 that are not being done sort of by the nursing home or the
19 other institution. So it becomes a problem, a
20 responsibility of the family. And there is -- we did look
21 at this when these were all fee-for-service programs, when
22 Washington, Minnesota, and Oregon in the mid-1990s started

1 to reduce institutionalization and started to substitute
2 sort of home care, they were paying about, I would say,
3 maybe one-fifth as much per capita for home services versus
4 a nursing home institutionalization. But, again, the people
5 in the community, you had to supplement that with family
6 care, and if that wasn't available, then there's a question
7 of the quality of care, people may have to go without.
8 DR. KANE: Do we have a sense of how much of this
9 is just watching one population get older and lose their
10 family care options? You know, for instance, the mentally
11 ill is roughly the same proportion -- you know, a little bit
12 more, but they kind of age into going into an institution.
13 They were at home and then they -- so to what extent is this
14 a stable population versus a lot of different people in the
15 aged versus the disabled. So rather than looking at them as
16 separate groups, is there some kind of longitudinal thinking
17 that might be useful to go into about, you know, how do you
18 deal with the loss of family members who were taking care of
19 you? I know it's nice to put them into the categories, but
20 I'm wondering if there's some natural longitudinal
21 transitions that might be worth thinking about or looking at
22 and thinking about where would interventions perhaps be more

1 useful.

2 DR. CARTER: So this slide actually looks at how
3 you originally qualified for the program, so if you were
4 disabled but now old, you're in the disabled group. But
5 you're right, all disabled, if they live long enough, turn
6 into aged. But that's not what this slide is about.

7 DR. KANE: The mentally ill particularly I'm
8 noticing is 17 percent of the disabled. It's about 16
9 percent of the aged. And I'm just wondering, are those
10 people who were disabled and then just their caregivers died
11 and they aged into an institution? And is it useful to be
12 thinking about it that way because there may be ways to
13 avoid the institutionalization if somebody thinks about what
14 do we set up for when families are no longer caregivers. Do
15 they all have to go into a nursing home or are there
16 alternatives for people who no longer have family embers?

17 DR. CARTER: Yeah, and given the share -- I mean,
18 since duals are much more likely to be living alone, I think
19 that that's a very real concern. But we have not looked at
20 that sort of over time, right? This is a one-year snapshot,
21 and what you're suggesting is a much more longitudinal
22 analysis that we haven't done.

1 DR. MILSTEIN: Two questions. The first is: Do
2 we have for this population any kind of a standardized
3 measurement instrument for quality of life? Somewhat
4 similar to what we have in MA, which is the health outcomes
5 survey, which is a kind of health-related quality of life.
6 But since this program is also aimed at the living
7 circumstances of an individual, you'd like a broader
8 instrument such as a quality-of-life, overall quality-of-
9 life instrument that would include but not be limited to
10 health-related quality of life. Is there such a
11 standardized instrument that the federal government and/or
12 the state governments as a matter of standard practice, you
13 know, ask these organizations to apply and measure so that -
14 - you know, in policymaking that element of the dashboard
15 would have a reading that one could use for purposes of both
16 program management and policy guidance.
17 MS. AGUIAR: I don't believe that there is a
18 standard for the entire dual populations. I know that the
19 SNPs do have to report on HEDIS and some other measures as
20 well. And so to the extent that you have the state SNP
21 programs, you are getting sort of a uniform set of
22 measurements there. To the extent that they capture quality

1 of life -- I know that those instruments are limited. That
2 said, some of the data that we do have, some of the results
3 in terms of quality of life and beneficiary satisfaction,
4 was from independent evaluations that were conducted of
5 either the demonstration programs or of PACE.
6 DR. MILSTEIN: A follow-up question, then I'll ask
7 my last question -- Jennie, go --
8 MR. HACKBARTH: [Off microphone].
9 MS. HANSEN: I think Christine just covered it.
10 There are some limited ones that were certainly applied, and
11 there were some previous HCFA, now CMS studies on looking at
12 that whole longitudinal aspect. But it hasn't gotten into a
13 standardized version. And I see some people who are in our
14 audience who probably know this well who may be able to help
15 us a little later in the public comment.
16 DR. MILSTEIN: Just a follow-on question before I
17 ask my final question. Has any researcher ever bothered to
18 evaluate whether or not, irrespective of whether it's
19 health-related quality of life or overall quality of life,
20 whether or not patients who are taken into these integrated
21 programs have an increase in quality of life or no change or
22 is it word, you know, per Bob's question? Have any

1 researchers examined that question as to whether or not that
2 dimension of quality increases for patients when they move
3 into these programs from whatever non-integrated care system
4 they were in before they enrolled?

5 MS. AGUIAR: I do believe a number have. I know
6 one evaluation of the PACE has and at least one other of the
7 state SNP programs, but we could get you those studies and
8 the results of that.

9 DR. MILSTEIN: Okay. My second question is the
10 other dimension of our value proposition, which is, you
11 know, is this something that might reduce, you know, federal
12 and state combined spending per capita? Do we have any
13 information -- understanding that right now so far, as I
14 understand it, the government programs just said, well, take
15 what it would have cost us had you not been here, and we'll
16 hand it over to the PACE or the state SNP. But has anyone
17 ever examined the actual so-called medical loss ratios of
18 these organizations to see whether or not, you know,
19 substantial margins or surpluses are being created because
20 those surpluses, you know, potentially could be shared
21 either with the beneficiary or with the federal treasury or
22 whatever? I mean, has anyone ever examined the surplus or

1 the margins being generated by these organizations?

2 MS. AGUIAR: I don't believe so. We haven't

3 specifically looked for that, and so we can. I think a lot

4 of the -- there has been a lot of focus just on SNPs in

5 general just in terms of what their margins are and what

6 their rebates are and what they're applying them to. But

7 that's been for all SNPs and not specifically to the ones

8 that are involved in these state SNP programs. But we'll

9 definitely check to see if there's any specific studies on

10 that.

11 MR. HACKBARTH: Okay, let me see hands for other

12 round one questions.

13 DR. STUART: Actually, one observation and then a

14 couple of questions. The observation is that the cost of

15 treating somebody who is nursing home certifiable, if they

16 could be adequately covered in a community- or home-based

17 structure, is cheaper. Now, whether it's higher quality or

18 not, I don't know. The problem with the home- and

19 community-based systems is that they're covering costs of

20 people who might be kept out of nursing homes, but might

21 have been not institutionalized in any case. And so the

22 insurance risk, if you will, is that if you pay a higher

1 payment in a home-based or community setting, and the person
2 would not have been institutionalized, then you're paying
3 more. And so it's really a fraction of the total number,
4 and it's a -- depending on what that fraction is, will the
5 total cost be greater or less?
6 The question, however, is: Are these home- and
7 community-based waiver programs considered integrated care?
8 MS. AGUIAR: As sort of by themselves, just the
9 waiver programs?
10 DR. STUART: Yes. In terms of the chapter, there
11 was a lot about integrated care, but I didn't see much about
12 the home- and community-based part of that.
13 DR. CARTER: We did not include those, mostly
14 because a lot of the services you're talking about are
15 trying to do a better job of managing mostly Medicaid
16 services and not stepping back and managing all of the care
17 under the Medicaid benefits as well. So when we were
18 looking at fully integrated programs, we were looking only
19 at those programs that were trying to manage all Medicare
20 and Medicaid services. Does that answer your question?
21 DR. STUART: Well, maybe it's a philosophical
22 question. If you do a really good job of managing Medicaid

1 services, wouldn't that also involve Medicare services
2 because of the combination of payment for certain services?
3 MS. AGUIAR: I just want to make sure I
4 understand. So you mean in terms of Medicaid managed care
5 programs that do include long-term care and that don't
6 receive Medicare funding? Would they do --
7 DR. CARTER: I took your question to mean on home-
8 and community-based services where they're managing the
9 Medicare side of the shop, if you will.
10 DR. STUART: Well, help me with this. If you're
11 doing a good job managing the Medicaid side of the house,
12 wouldn't there be spin-offs, potential spin-offs in terms of
13 savings to the Medicare side of the house?
14 DR. CARTER: I would think so.
15 MS. AGUIAR: Yes.
16 DR. STUART: Have you looked at that?
17 DR. CARTER: We have not.
18 DR. STUART: Okay.
19 DR. MARK MILLER: I also think, just the opening
20 part of your question which is do the home- and community
21 waivers, you know, explicitly, let's say, try to manage the
22 Medicare benefit, I think your answer is no.

1 DR. CARTER: Right.

2 DR. MARK MILLER: Not as a general proposition.
3 Then I think the second way to interpret your question was:
4 But aren't there indirect effects on Medicare? And I think
5 the answer to that is, yeah, possibly you avoid a
6 hospitalization because you're doing something right at the
7 home- and community-based waiver. Is that what you were --
8 those two things?

9 DR. STUART: [off microphone] Yeah, it is.

10 DR. MARK MILLER: Right.

11 MR. HACKBARTH: Could you put up the discussion
12 questions for a second, Christine?

13 So the chapter talks about two broad policy paths,
14 not mutually inconsistent paths, but one is to integrate
15 financing and the other is to integrate care. Your
16 questions here all focus on the integration of care. Why
17 just on that piece of the puzzle?

18 DR. CARTER: Well, we didn't mean to. I guess we
19 -- I'm hoping that the chapter was clear in that just
20 integrating the financing is not going to improve care
21 coordination. And so we sort of put those aside and then
22 tried to focus our efforts on programs that are doing both,

1 financially integrating funding and care coordination. And
2 so these are -- we don't mean to exclude. I mean, certainly
3 it's behind the question of do you want us to focus on sort
4 of insurer-based or provider-based, you know, who's assuming
5 the risk and how do the financing streams get integrated.
6 Those are things we want to look at. We don't mean to
7 exclude the financing side of things, but we want -
8 MR. HACKBARTH: Yeah, let me be a little bit more
9 specific by what I mean about the financing. So the paper
10 talks about, well, you could federalize responsibility for
11 these patients or you could use a block grant approach so
12 all of the dollars are in one governmental pot. And then if
13 you have that, certain options present themselves for then
14 how to take money from that pot and reward effective
15 integration, coordination of care.
16 The purchase that we're talking about here, SNPs
17 and PACE programs, they work within the constraints that
18 exist when you have money coming from two different pots and
19 then try to work around that and combine them in various
20 ways. You haven't looked at, you know, the big merged
21 financing models. The questions don't address the big
22 merged financing models, block grants, federalization. Is

1 that something that you envision coming back to later or why
2 approach it this way?
3 This isn't a trick question. I'm just --
4 DR. CARTER: No, I know. I'm trying to --
5 [Laughter.]
6 DR. CARTER: I am trying to understand it.
7 DR. MARK MILLER: We didn't mean to have a trick
8 answer to it. I mean, I think my line of reasoning in how
9 we're approaching this, we're thinking under any -- and this
10 is to reflect what we feel that we've heard very
11 consistently from the Commission time and time again, that
12 one thing we want to have a handle on is how are you going
13 to manage and coordinate the care for this population. And
14 so in trying to study these models up front, I think we're
15 trying to do two things. One, do we have a vision either
16 for specific populations or specific coordination models
17 before we get into those bigger questions? And, two, at
18 least study what the policy world so far has gotten actually
19 up and running, which is more of the coordinating at the
20 provider or managed care level of the two streams. But we
21 do plan work to come back and talk about the major financing
22 approaches behind this. We kind of assumed you would -- if

1 we had gone the other way, you would have said, But
2 shouldn't we be talking about populations and coordination
3 strategies? Because ultimately we'll want to come back to
4 that, you know, under any financing scheme as kind of our --
5 MR. HACKBARTH: You are probably right. I would
6 have said that.
7 [Laughter.]
8 DR. MARK MILLER: And I didn't mean that in any
9 bad --
10 DR. CARTER: Yeah.
11 DR. MARK MILLER: But, you know, it just felt
12 like, you know, the first thing that we hear, and I think
13 rightfully so, from you guys is, well, wait a second, what
14 about the diagnosis, what about the patient, what model,
15 that type of thing, and then were going to bring the big
16 financing stuff in behind --
17 MR. HACKBARTH: Yeah, that's literally. I was
18 just trying to understand, you know, how you envisioned this
19 unfolding. Okay. Round two.
20 DR. CHERNEW: First I want to make a quick comment
21 on Bruce's comment, which is -- he was exactly right in what
22 he said, and I think most studies in a fee-for-service

1 setting find that the offsets of reduced nursing homes don't
2 outweigh financially the costs of the added services, just
3 when you look at the numbers. So, by and large, when you do
4 the insurance calculation Bruce is talking about, the
5 programs themselves tend not to -- although I think you
6 could design them in ways that they could, I don't think
7 saving money in many ways is the ultimate goal of these
8 things if we could provide better-quality care. But, in any
9 case, there are people that know more than me about the
10 evidence about exactly that trade-off.
11 The second thing I wanted to say is I wanted to
12 compliment you actually on your perspective. I think
13 looking at people as opposed to siloed types of care, which
14 we normally talk about just in nursing homes, just the
15 hospice, just these facilities, I think it's much, much,
16 much better and it's --
17 [Laughter.]
18 DR. CHERNEW: No, really, and I think if --
19 DR. MARK MILLER: [off microphone] You do
20 actually.
21 DR. CHERNEW: Right, and I think it's really
22 refreshing because I think it does allow us to look at

1 quality measures on a personal level, think about
2 integrating. So I think that was really a very refreshing
3 approach.
4 I have one question. One of the things that's not
5 emphasized in this which I think is really important is just
6 the difference in prices. So just what happens when we
7 lower the MA payment rates? How is this affected by the
8 fact that the Medicare -- I know there's a problem with
9 program incentives even if the prices were exactly the same.
10 But a lot of what's going on apart from that is just
11 Medicare for certain services is much more generous or you
12 can get higher payment for basically the same thing in one
13 program or another. And so how do the price differences --
14 I'm not sure how to think about how much of this is a
15 fundamental institutional problem because we have different
16 programs and how much of that is exacerbated by the fact
17 that the price as across payers is really big, and if we try
18 and integrate things, sometimes we get the greater
19 integration, but now we've just lost all of the price gain
20 that you got us on the lower-price sectors, which may be a
21 problem for a bunch of other reasons. But that's my
22 question -- that's my concern, that we don't know a lot

1 about the prices.

2 MS. AGUIAR: I could just address that quickly.

3 We have heard talks with programs, the SNPs themselves that

4 are involved in these state SNP models, and there is concern

5 about the reductions in MA plan pricing, because they have

6 less ability to spread that on to the beneficiaries since

7 their beneficiaries are duals and there's restrictions about

8 the extent that they can increase their cost sharing. But

9 that said, I think the two pricing -- and this is something

10 we definitely want to address during the site visits. We

11 really want to get a handle on what's their pricing from the

12 Medicare side, what's their pricing from the Medicaid side,

13 and do the Medicaid rates really vary by setting of care and

14 how so. We tend to get a handle on both of those elements.

15 DR. CHERNEW: And when people get integrated, do

16 they typically pay for services at the Medicaid price, or do

17 they typically pay for services at the Medicare price?

18 MS. AGUIAR: Right.

19 DR. CHERNEW: Or do they typically pay for

20 services somewhere in between?

21 MS. AGUIAR: Right. That is a very good point.

22 MS. BEHROOZI: Just a whatever, not a very

1 important comment, but coming off of what you raised, Glenn,
2 about the questions about the financing as opposed to the
3 models of care. Maybe it's a little bit of an issue of the
4 structure of the paper because I think that I ended up
5 focusing more on the financing and thinking more about that
6 than I should have, and part of it is, I think, some of the
7 descriptions of the state programs which are really
8 important to understanding, you know, the range of things
9 out there are in an appendix, and there is much more of an
10 emphasis in the paper on the financing models than in your
11 presentation.

12 So I know it's a little late to the game in terms
13 of the June report, but if there's a way to somewhat just
14 restructure a little bit, maybe the financing can be the
15 appendix and the descriptions can come into the paper.

16 But that also leads me to want to ask whether
17 those entities that are running these state programs or PACE
18 programs or whatever -- actually, not so much PACE because
19 that's a special case. But the ones that are actually
20 operating within the constraints of the two streams of
21 funding, if it's possible to ask them what they think are
22 the problems, among them maybe being pricing issues or, you

1 know, other -- the internal tension between the offsets
2 between Medicare and Medicaid, you know, if we can get some
3 window on to the financing that way.
4 MR. BUTLER: Okay. You've asked questions around
5 the coordination of services and the coordination of the
6 financing, and then you've also said what subgroups of
7 duals. I think you've done a great job of profiling the
8 types of -- or the medical conditions that the dual
9 eligibles actually have. I'm back to my dementia and
10 Alzheimer's, and I'd say that this is such a big, huge
11 issue, you know, I would love to start with that population.
12 And just as we look at episodes of care last fall, how --
13 and these may be 10-year journeys, but what would the ideal
14 kind of evidence-based journey look like for dementia and
15 Alzheimer's? It's almost like it could be a chapter in
16 itself. But it happens that a lot of them fall into the
17 dual eligibles, and they could be -- you know, and how we
18 handle that for this population would be an interesting
19 thing to really flesh out, I think, from kind of the
20 patients' perspective, if you will, or the family's
21 perspective how this might work.
22 So my shorter answer is I would focus on that

1 subgroup as something to really test the model against
2 because it's such a big issue that's facing -- and the
3 trajectories are this is one of those diseases that is not
4 going to go away. And I think the public itself could very
5 much relate to us really kind of better understanding the
6 typical progression and services available for treating the
7 disease.

8 MS. HANSEN: Yeah, well, first of all, thank you
9 very much for doing this chapter. I think, you know, the
10 matter of covering the dual eligibles that we've talked
11 about for some time just seems to fit nicely just by
12 circumstance to the new office that's being formed, and some
13 of this information of the data will be very helpful in the
14 backdrop.

15 I have just a question about some of these state
16 projects that exist, and I think when Bill asked about the
17 180 days of nursing home eligibility that you have in the
18 project and then you go back into fee-for-service, have
19 there been any studies that have been done as to what the
20 outcomes of what happens to people when they leave the
21 special project and then what happens when they go out in
22 the community? With a related question to the Arizona

1 project that you mentioned, that every six months they do a
2 review on whether the person is eligible.
3 There's an implicit issue here that isn't really
4 identified -- and Bill alluded to it -- that it's all about
5 housing. In other words, once you go into a nursing home, I
6 think there has been some research that if you've been there
7 for about six months, you pretty much become
8 institutionalized, number one; and, number two, you've lost
9 your housing, and the ability to find housing for people
10 once they've gone in is very difficult, especially for
11 somebody with high needs. So, again, these are,
12 unfortunately, messy SES factors; these are not things that
13 are so quantifiable. But this is part of the life course
14 that people have.
15 And then I think there are -- I would love to see
16 more coming up on the Massachusetts programs and the ones
17 that you've cited that we can begin to take a look at
18 because they kind of broaden this whole effort of really
19 they have both PACE programs and then they have the senior
20 care options program, and then I think some other managed
21 care aspects. That would be an interesting state to watch,
22 and I think that Wisconsin has, again, done some phenomenal

1 work with looking at the younger disabled population in
2 terms of this coupled with some senior-focused programs. So
3 it would be nice to really feature other programs like that.
4 The question I had that I'd like to build --
5 actually, the request I have that I'd like to build on
6 Nancy's request is looking at this population over time.
7 And, Peter, you brought up the dementia, the Alzheimer's
8 population. I think the other area are people who are
9 mentally ill and also developmentally disabled. These are
10 some things that we can begin to get a trend of where costs
11 will be going so that as we look at just implications to
12 both the Medicare and the Medicaid program, this will start
13 to begin to show itself.
14 And then my other question is: With the other CMS
15 demos that we've had with the Medicare -- is it the medical
16 home support program? Are there any relationships there to
17 this work that we're looking at relative to dual eligibles?
18 MS. AGUIAR: I think there are a number of demons
19 like the "money follows the person" demo and the "real
20 systems change" demo. Those were really focused on the
21 Medicaid population, not looking at integrated between the
22 two.

1 MS. HANSEN: I see.
2 MS. AGUIAR: One of the more interesting demos
3 that I thought was in the health reform legislation that a
4 state, I think, could use -- and this gets to your point of
5 housing. There's one in -- and the exact name of it escapes
6 me, but I think it's called Community Transitions demo, and
7 it's to provide -- and, again, this is meant to be for the
8 state and not necessarily for integrated care programs, but
9 it is possible that the programs could, you know,
10 participate in this demo. It's funding to help the States
11 look at when they want to transition someone out of the
12 institution and back into the community, to help them with
13 things such as their rent, their first month's rent, their
14 utilities, to your point that they've probably lost housing
15 at that point.
16 And so I think these are all excellent points that
17 we would tend to follow up with on the states and definitely
18 looking at that issue as well as when they are trying to
19 sort of de-institutionalize and rebalance to home- and
20 community-based services, you know, do they have those
21 resources in place to address housing? Or can they take
22 advantage of any of the new programs in the health reform

1 legislation?

2 MS. HANSEN: Yes. And just to answer your

3 question about rurals, I think as Christine said, there are

4 15 PACE rural demonstrations right now that are going on

5 that have been up for maybe about a year and a half or so.

6 So one of the things that I think is promising about at

7 least using this model, the technology piece actually can

8 pierce maybe the option of what people saw as a barrier with

9 the adult day health attendance that people have had in

10 urban areas because of the concentrated population, and the

11 ability to do things differently, which is something that I

12 think we could learn from rural sites back into urban

13 sites in the future. And just the technical piece that

14 these adult day centers are not always the typical adult day

15 centers that people tend to know about. They are jointly

16 licensed as outpatient clinics, so, therefore, you actually

17 get clinical services -- you kind of get a two-fer, you

18 know, socialization and therapy. Depression is one of the

19 main certainly diagnoses of this population, but it's also

20 just a different way to think about that model.

21 MR. GEORGE MILLER: Thank you, and thank you,

22 Jennie, for that information. Michael pretty much covered

1 my question, but as I sat here listening and thinking about
2 this project, is our goal to look at what would be best
3 optimally from a policy standpoint and what elements there
4 should be in all of this? Are we going to, as Nancy
5 described, look at the whole thing longitudinally, is kind
6 of my question to focus on.
7 I've heard some good things about the PACE program
8 and other things that could be integrated. Peter mentioned
9 about studying dementia. So are we going to look at what's
10 out there or maybe come up with some recommendations that
11 should be there as a policy standpoint in all these programs
12 or if it's a financial issue? I think Michael covered it,
13 again, when he said that if you look at it from a financial
14 standpoint, in exchange for a better venue of service, you
15 may lost some of that financial. So I guess I'm wrestling
16 with the question. Do we make recommendations from a policy
17 standpoint, what should be included in a whole package of
18 services? Or are we going to look at what's out there
19 first?
20 MR. HACKBARTH: I'm not 100 percent sure that I'm
21 getting your question, but, you know, I think that broadly
22 we can perform two functions here. One is descriptive, and

1 I liked Peter's idea of, you know, looking at a large and
2 growing population and sort of describing how the system
3 works from that vantage point and sort of a granular look at
4 what's happening in the real world, and then secondarily
5 come back to policy options that facilitate good care
6 delivery models for not just that population, but the
7 broader group. So I think we want to do some of each.
8 Did I understand your question?
9 MR. GEORGE MILLER: My question is a little murky,
10 and I certainly understand you describe it, but I'm going on
11 from Michael's comment that -- do we want to -- if the
12 service is better in one venue but it costs more money, are
13 we going to look at that issue versus are we going to
14 describe finding the best possible services for coordination
15 of care regardless of the cost?
16 DR. MARK MILLER: For the moment, without
17 addressing the cost question -- and I'll come back to that -
18 - I think the way I would go at your question, which I think
19 is the same thing Glenn said, for the near term what they're
20 telling you is we're going to start looking at what's out
21 there, what models are out there, how do they work, which
22 populations, how do they net out in terms of outcomes and

1 impacts across the programs, that type of thing.

2 And let me say one other thing. I think our

3 direction is to make a set of recommendations.

4 MR. GEORGE MILLER: Yes

5 DR. MARK MILLER: Exactly about what is a little

6 bit less clear. We're hoping things like this happen in

7 this meeting, much like Peter said.

8 You know, one way I could imagine focusing this

9 conversation is dementia.

10 MR. GEORGE MILLER: Dementia, right.

11 DR. MARK MILLER: And he has an argument for that.

12 Or make sure if you're looking, look at this model; or I

13 heard about this program in this state, that type of thing,

14 so we could take it back, and then come back to the

15 Commission, and you can imagine outcomes like this.

16 There's a couple of populations where it appears

17 that there are models that seem to have a good effect,

18 either quality or cost, and the question of whether we

19 should do it even if it costs money will be, unfortunately,

20 a question that comes back to you.

21 MR. GEORGE MILLER: Right.

22 DR. MARK MILLER: Where we will come and say,

1 okay, as a result of this research we found this approach in
2 this model for this population, and it appears that you
3 could go at it a couple of different ways -- blend the
4 funding, federalize it, whatever the case may be. Then
5 we'll have to think of the cost implications and then,
6 unfortunately, that comes back to you and you'll have to say
7 worth doing, not worth doing, whatever the case. But that's
8 what I think is happening.
9 I think we have a fair amount of work in front of
10 us, but the idea is to get to the point where we can make
11 recommendations about some populations, some models here, I
12 think.
13 MR. HACKBARTH: I'm going to repeat this just
14 because things are crystallizing in my mind. I think we're
15 talking about sort of three different planes of looking at
16 this. One is a patient level, using, for example,
17 particular common clinical problems. And then a second is
18 an organizational model and different types of ways of
19 integrating, providing services well, both from a cost and
20 quality standpoint. And then the third is policy options
21 that facilitate the development of sound models.
22 Like Mark, I would hedge on the quality versus

1 cost issue at this point.

2 Does that make sense?

3 MR. GEORGE MILLER: Yes.

4 MR. HACKBARTH: Bill?

5 DR. SCANLON: First, a comment on Bruce's and
6 Mike's remarks about the cost of home care, and I think I
7 want to say this in part because I think it's important to
8 have a different mindset about long-term care than what we
9 typically have about health care. The way the services are
10 organized, the way the markets have worked is very
11 different.

12 When Bob and I were talking earlier, I mean for an
13 individual it costs less. Mike, sort of, and Bruce both
14 confirmed that.

15 For the population, the research has generally
16 been exactly what Mike said, that when you introduce the
17 home care services, it's going to cost more in aggregate
18 because there's not enough substitution.

19 The GAO report that I mentioned earlier, which was
20 done around 1995, talked about how there were savings for
21 the states that were expanding their home care services
22 because they did it as a part of a strategy. What they said

1 was: We are going to expand home care; we are not going to
2 allow any new nursing homes to be built.
3 And this is something that has become sort of
4 rather significant in terms of the nursing home supply. The
5 projections in the eighties were that we would, at this
6 point in time, have about 2.5 to 2.7 million nursing home
7 beds. We have 1.7 million nursing home beds because all
8 kinds of states have said we're not going to sort of build
9 more nursing homes.
10 Now the issue is how much the home care that is
11 being provided substitutes for the nursing home care that
12 would have occurred. So there's both a question of sort of
13 do families make up the difference, and are the states doing
14 kind of, in some respects, their share.
15 We know among the long-term care population that
16 about 20 percent of the people say that they're not getting
17 the help they need with activities like bathing, dressing,
18 toileting and eating. We know that that share increases
19 when there's less home care, formal home care, being
20 provided. So that's important to think about.
21 And also, I mean it's in the context of there's
22 huge variation across this country in terms of those

1 services. It’s like a three or four-fold variation in terms
2 of both nursing home care and home care. I mean it’s again
3 this mindset perspective when we think about these options.
4 The original comment I wanted to make was about
5 the sub-groups of duals, and I think the group that I would
6 focus on are these nursing home residents. It’s the area
7 where the incentives are the clearest for problems. A
8 nursing home, when someone has an acute episode, -- they get
9 flu or something like that -- the incentive is send them to
10 the hospital because the intensity of treatment in the
11 nursing home would increase. If they’re in the hospital for
12 three days, they may qualify for another Medicare nursing
13 home stay at a much higher rate than is being paid. And, on
14 top of that, state Medicaid programs often have bed hold day
15 payment policies where they’ll pay for the empty bed, so
16 that the person can return. So everything is wrong there in
17 terms of these incentives.
18 Now saying focusing on the nursing home residents
19 in terms of duals is one thing to think about, but in
20 thinking about a Medicare problem, this is a Medicare
21 problem that goes beyond duals. It goes for the Medicare
22 long-stay resident who is paying out of pocket in the

1 nursing home because there the perverse incentives increase
2 because it suddenly becomes in the interest of that
3 beneficiary to go to the hospital too because they're now
4 going to get some covered days from Medicare when they
5 return.
6 I mean Medicare right now, what happens is when
7 you go into a nursing home, we stop providing you nursing
8 services. If you were at home or in an assisted living
9 facility, where you're homebound and you need a skilled
10 service, you can get it under Medicare. Go into a nursing
11 home; you can't get it.
12 And so I know this is changing the direction
13 somewhat, but it's something to think about because we do
14 know that there is a real problem in terms of nursing home
15 residents being hospitalized, and we also know it's a
16 problem that can be addressed. The teaching nursing home
17 evaluations have shown that when you increase the skilled
18 nursing care in nursing homes, the utilization of hospitals
19 does go down, and so we have kind of an effective strategy.
20 The question would be how can we structure this and finance
21 it, so that we end up with savings.
22 DR. CROSSON: This may be a little tangential, but

1 just to build a little bit on what Peter said, I wonder if
2 there's a place here over the next year or so to take a look
3 specifically at the impact of Alzheimer's disease and
4 dementia on the Medicare program in general because it seems
5 to me when we went through, a number of meetings ago, the
6 hospice benefit and the changes that were going on as a
7 consequence of the apparent increase in incidents, or at
8 least the growing social burden, of Alzheimer's disease
9 particularly, I think we made the comment that that process
10 was changing the hospice benefit.

11 I think it's clearly one of the issues that is in
12 play here, and I wonder. And perhaps in other areas like
13 home health, Bill would know this better. But I just wonder
14 whether at some point there might be a piece of work here,
15 which is to take a look at this disease process, what seems
16 to have changed over the last 15 years or so and the broad
17 impact that it's having on various aspects of the Medicare
18 program.

19 DR. BERENSON: Yes, I guess two points. I will
20 first pick up on Bill's point. I just think that the three-
21 day hospital stay and the perverse incentives that that
22 creates just is a compelling problem and a solvable problem.

1 And the examples that we all have from family members and
2 friends of people who have urinary tract infections and wind
3 up in the hospital are just something that we should figure
4 out how to address. So I would certain do that.
5 But I also wanted to pick up Bruce's point
6 earlier, not the discussion around data, but the focus on
7 home and community-based waivers and what we know about the
8 impact of that on Medicare spending, and then on
9 organizational behavior. From your presentation, I sort of
10 got the senses that PACE might be a good program, but after
11 more than decade it's gotten to 18,000, and there's just
12 inherent, I think, limitations. It should maybe go to
13 50,000 or 80,000, but it's not going to be the solution
14 here.
15 And between a combination of cuts in Medicare
16 Advantage payments, the lack of states that have a managed
17 long-term care infrastructure suggests that the states' SNP
18 option is inherently limited also. So I think we need to
19 look really at what's going on in fee-for-service.
20 I learned something a few years ago. I did a case
21 study at the Washington Hospital Center's Geriatric Home
22 Visiting Program, which actually became the prototype for

1 the Independence at Home demonstration that is in the
2 recently passed legislation. Essentially, they were taking
3 payments from home and community-based waiver, Medicare fee-
4 for-service home visiting payments and subsidies from the
5 hospital to do what was in fact a very excellent, at least
6 in my judgment, program really targeted to the duals at
7 home.

8 What they were saying was that they were reducing
9 unnecessary hospitalizations, unnecessary ER visits by
10 having health professionals go to the home. They did have a
11 social service infrastructure providing a whole range
12 services.

13 The point here, not that that model necessarily is
14 the only one or the right one -- well, actually, that's
15 instructive because in the legislation they're getting a
16 shared savings incentive now. So the intent is rather than
17 merging the Medicaid and Medicare money up top somewhere to
18 give somebody a capitation, it is to try to align incentives
19 at the provider level to provide the right incentives to
20 keep people in the home and avoid hospitalizations.

21 But my hunch is there's a lot of other
22 organizations who are the ones receiving the home and

1 community-based waiver payments from the state, who are
2 probably doing some innovative things that have positive
3 spillover effects in this case on Medicare, and that we need
4 to understand that more and understand what the barriers are
5 to proceeding down that road. So, again, it seems to me
6 that's where most of this activity is going on and that we
7 need to understand that a little more, even if they're not
8 sort of technically models.

9 DR. KANE: Thanks. First of all, I want to say
10 how much I appreciate the opportunity to start going into
11 this subject, which I've been interested in for the entire
12 time I've been on MedPAC. So thanks for getting started on
13 this.

14 I think I agree with Jennie and Peter and Jay. I
15 think that it might be quite useful to look at dementia as
16 well as I think mental health and developmentally disabled.
17 I mean these are populations that are generally neglected in
18 many ways, or growing, and we don't have very good ways of
19 taking care of them. And I think the longitudinal approach
20 will give us some insight into how people end up where they
21 end up.

22 Then managing them at the end of that cycle is one

1 way to look at it, but I really think there's opportunities
2 along the way, and appreciating not just the individual with
3 the disease, but the family unit because there's respite.
4 There's all kinds of things that if you know the progression
5 of the disease and the impact on the family, that we might
6 find better models of taking care of those diseases that
7 don't leave us sort of with this end result of people in
8 nursing homes.
9 So I'm very supportive of exploring particularly
10 those three: mental health/mentally ill, developmentally
11 disabled and dementia.
12 I also think it would be great to look at the
13 whole idea of how do you manage long-term care, which
14 doesn't mean you have to be dual for that. And I agree with
15 Jay and others that it's not just the duals, that a lot of
16 people are just one degree north of becoming a dual in the
17 long-term care setting, and they're often being managed.
18 For instance, Evercare manages the nursing home patient
19 who's not dual but who could become a dual at any moment, as
20 they run out of money, and they're really trying to manage
21 them to keep from being hospitalized and all that.
22 So it would be worth looking at Evercare as a

1 model for managing the long-term care patient, and any other
2 models that try to manage patients so that they're getting
3 better care, regardless of whether -- and I think it does
4 save Medicare money. I know Evercare did.
5 Actually, it's interesting. From what I've
6 understood the states' willingness to pay for bed days has
7 actually really hurt Evercare. Nursing homes no longer want
8 Evercare in there, avoiding hospitalizations, because they
9 want those nice cheap bed days. Even looking at that whole
10 bed day policy and talking to some people might be a
11 worthwhile activity because I think it's not good for
12 Medicare to have nursing homes get these bed days and have
13 the incentive to get people admitted.
14 Then my final thought about this topic is it might
15 be useful to do a little bit of international investigation,
16 and I would be happy to go along to some of the places I
17 think. I know Germany pays family caregivers and has some
18 really thoughtful ways to help families deal with elders at
19 home. And Great Britain is, I think, pretty well known for
20 managing, putting supportive services in place to keep
21 people at home during their more custodial years, but
22 they're not necessarily institutionalized. So I think we

1 might be able to learn something by looking overseas.

2 DR. MILSTEIN: Obviously, to the degree these
3 programs could turn out to be a way of both improving
4 quality of life and reducing combined state and federal
5 spending, that would be what we're all after, what would be
6 our first choice. And so I would encourage you to take a
7 look at SCAN, which is a longstanding PACE program.

8 I think what's intriguing about SCAN is that for
9 quite a while they were either not generating any margin on
10 Medicare and Medicaid payments or they were actually, for a
11 while, losing money and in danger of going out of business.
12 Had we looked at SCAN then and said, well, does this program
13 have any potential to generate savings, the conclusion would
14 have been no. They're losing money on combined Medicare and
15 Medicaid spending.

16 But in SCAN what they did is they substantially --
17 they made very substantial changes in their care delivery
18 model, and it put them, swung them sharply into the surplus
19 column, and they began to generate some very substantial
20 surpluses.

21 The reason I think looking at it could be valuable
22 is understanding for any category of program, what

1 distinguishes the outstanding performers, the ones that are
2 delivering a lot of value, is potentially very good policy
3 information for us in understanding what subset of life
4 form, as it were, in these programs is the one that might
5 deliver the higher value to both the beneficiary and to
6 those who are funding, the governments that are funding
7 these programs. I think SCAN would be a very nice
8 illustration of that.

9 The second thing that occurs to me is you look at
10 these patients, about 15 percent of their spending not
11 surprisingly is for pharmaceuticals. And most of these
12 populations, for reasons alluded to earlier, are in non-
13 affluent urban neighborhoods. That's where you have
14 concentrations you need for these programs.

15 Also, in those neighborhoods typically are where
16 the safety net hospitals and the FQHCs are located, that
17 have access to 340B pricing on drugs, which represent in
18 general, as I understand it, I think the best source of -- I
19 don't know whether that's better than Medicare or not.

20 Maybe someone can -- the drug pricing. Can
21 someone help me on that? I believe it's --

22 DR. SOKOLOVSKY: [off microphone]

1 DR. MILSTEIN: So it’s not much of a savings over
2 the Medicaid pricing.
3 DR. SOKOLOVSKY: [off microphone]
4 DR. MILSTEIN: What she basically said, what Joan
5 clarified, is that 340B pricing does not represent a
6 substantial source of savings on drugs compared to Medicaid
7 pricing. So, assuming that that’s the case, then my second
8 comment is irrelevant and no need for me to go further.
9 MR. KUHN: In terms of additional models that we
10 might want to look at, we’ve talked about a lot of them
11 here, and you’ve got a huge workload already. But at least
12 in the Medicare program one that always intrigued me was the
13 High-Cost Medicare Beneficiary Demonstration, and it was
14 interesting because it did look at sub-populations. One I
15 remember specifically is they looked at people with chronic
16 kidney disease. So it was aimed pretty hard at the
17 prevention, so people didn’t go into full renal failure. So
18 it was not only better management but also a high dose of
19 prevention. I thought that particular model, or that
20 particular demonstration I thought held some real promise,
21 and there might be some learnings from that that we could go
22 look at further.

1 Also, one that's a Medicaid one, and we've talked
2 a little about it already, is the Money Follows the Person
3 Demo. I think it's a really good one and I think there
4 might be some opportunities for us to look at that.
5 The other thing that I think we ought to be
6 cognizant as we look at these new models, and it's a little
7 bit of what Bruce talked about earlier, is that is what are
8 the interdependencies or the relationship between what's
9 going on in the Medicaid side as well as the Medicare space
10 with this population. And in particular in the health care
11 reform legislation, there are advanced a number of new
12 payment delivery models, I think with enhanced matching
13 opportunities, for states to move pretty aggressively into
14 some of these new delivery systems. So my guess is the
15 states understanding or seeing that for opportunities of
16 savings will probably jump in with both feet.
17 And so with what we're looking at here on the
18 Medicare population, are the states going to be moving much
19 aggressively on another front? So, if not studying, at
20 least awareness of how those two will get together and are
21 there opportunities for the interdependencies, or are we
22 just going to be running parallel universes out there as we

1 go forward, and that's something at least we ought to have
2 some awareness of.
3 And the final comment I would make is that it's
4 been talked a little bit in terms of certain populations
5 with certain diseases here. But as we look at some of these
6 models, again going back to the High-Cost Medicare
7 Beneficiary Demo, things like that, is that when we look at
8 some of these demonstrations or some of these models out
9 there, they may nor may not show real promise. But as we
10 know, as researchers can drill down into them, there might
11 be certain sub-populations, some real frequent fliers in the
12 Medicare program, that with these interactions could really
13 be impactful. So the extent that if we look at a model and
14 we don't think it holds real promise for a greater
15 population, are there certain sub-populations we can learn
16 from that as well?
17 DR. DEAN: I was interested in the comparison of
18 the programs that you highlight with the medical home and
19 your text box about medical because it seems to me that this
20 group, if ever there's a group where medical home is
21 appropriate, it would be this group.
22 I guess I'm curious. I don't know that much

1 about, for instance, the PACE program. I'm assuming that
2 that program provides many of the same services and in some
3 ways acts as a medical home.

4 I'm just curious. What do you see as the
5 differences or the distinctions? Because the medical home
6 as a concept may be more broadly applicable, we hope, if we
7 can figure out a way to encourage it in a wider application.

8 MS. CARTER: Well, medical homes are really an
9 overlay for fee-for-service, and so actually the financing
10 is fundamentally different from PACE, where they're getting
11 two streams of money. And then there's a real bricks and
12 mortar to the PACE program, where there is an outpatient
13 clinic and a daycare center that duals and beneficiaries are
14 expected to go to.

15 Whereas, the medical home is really a provider or
16 a practice is paid a per member, per month amount to manage
17 the care. So it's really an overlay on fee-for-service.

18 That isn't to say that those are services that do
19 a good job of coordinating the care. They could. But just
20 in terms of what kind of model it represents, it's pretty
21 different from the PACE model.

22 MR. HACKBARTH: Although the physician working

1 within the PACE model would sort of be the medical home for
2 the patient. So it's like medical home would be a subset of
3 these broader models that bring in other services as well.
4 MS. CARTER: Right. And actually it kind of
5 reminded me of something Herb was talking, which is we may
6 want to spend some time thinking about things that work
7 within the fee-for-service context, given that is the world
8 we live in now and it's unlikely to change quickly.
9 DR. DEAN: I think in a fully developed medical
10 home model you really do include a variety of ancillary
11 services and supportive services and a team approach, even
12 though you may not have, like you said, the bricks and
13 mortar part of it. But it seems to me that the general
14 approach -- I understand the financing may be a little
15 different. The general approach would be pretty similar.
16 MS. AGUIAR: I would just add, I think the PACE
17 program in particular tends to have a really intensive --
18 again, with the interdisciplinary team, a lot of services
19 are providing onsite, and so I think that's also a
20 distinction from the medical home.
21 I know one of the reasons we also didn't touch too
22 much on the medical home is because it's being implemented

1 now in North Carolina. It's right in the beginning stages,
2 and so we have to really talk with the state to get more of
3 a sense of how it's going. We don't have any documented
4 results just as of yet.
5 DR. DEAN: I think the North Carolina structure is
6 one structure of a medical home. It certainly isn't the
7 only one. And actually it's been in operation quite a while
8 is my understanding, eight or ten years, something like
9 that.
10 MS. AGUIAR: Right. It has for the Medicaid-only
11 population, and they do have results, and they have been
12 successful. It has now recently been expanded to the duals.
13 So that's just expansion to the duals is what's recent.
14 DR. DEAN: Okay, I see.
15 MR. BERTKO: So I'm going to join, I think, Herb
16 and maybe Peter in suggesting looking at sub-groups of duals
17 is probably a good avenue to go down. My limited, and now
18 somewhat obsolete, knowledge of SNPs from the company I was
19 with would say that you have different opportunities there.
20 And here is where you may actually need to
21 assemble a panel of MA plans that offer the dual SNPs
22 because they may have a mix of kinds of people in the duals

1 and then the disease-specific SNPs may offer different
2 things, and you may need to ask them to take a look at some
3 of the sub-groups within the dual SNPs.
4 Arnie had a question earlier of do these save
5 money, and depending on MedPAC's relationship with the
6 office of the actuary they have those numbers there for the
7 dual SNPs, and I think probably Carlos and Scott know how to
8 ask the right people the right questions, depending on the
9 levels there that you can disclose.
10 And then let's see. The other part of this is
11 maybe to slightly disagree with Bob on will these go forward
12 because in my experience many of the dual SNPs are
13 regionally limited to high payment states, and even under
14 the new payment levels you start with 95 percent in those
15 high payment states and boost upwards. So these could in
16 fact be survivors and be some place that we can learn from.
17 I don't think they give you all the answers, but
18 they give you maybe a portion of the answers by seeing if
19 you can get some more info out of there. You may need it
20 more in terms of, rather than getting hard data, expert
21 opinion out of that.
22 DR. STUART: I think what you found is that you've

1 dug this small well, and it's turned out to be an artesian.,
2 and trying to figure out what you're going to do with all of
3 these really good suggestions.
4 I was a little surprised at Carol's response to
5 Glenn's question about whether this was primarily about
6 integrated financing of Medicare and Medicaid or
7 coordination of care, and you said, oh, it's coordination of
8 care.
9 And the way I read this chapter is that it is
10 restricted almost entirely to questions about coordination
11 of care within the context of integrated financing, and that
12 leads you to look at the state SNPs and the PACE programs,
13 and I think that's perfectly fine.
14 What I would like to see, or suggest, is that that
15 be put in this larger framework of other ways that one can
16 address some of the questions that have been raised around
17 the table. I'd like to reiterate one that I raised, and Bob
18 came back on this, which is, well, what is the return to
19 Medicare? We could think of this either in a narrow sense,
20 about how care coordination of duals, or on the Medicaid
21 side or even on the Medicare side, actually has a positive
22 impact on Medicare financing, and then presumably as a

1 result of quality improvements or stenting, and we could
2 take a look at that question.
3 But that would lead you in a different direction.
4 It would say, okay, well, let's look at the Evercare
5 program. Let's look at state level managed care programs in
6 Medicaid. Let's look at the home and community-based
7 waivers. But instead of focusing, perhaps, on the entire
8 person, and I'm not suggesting that that's not a good thing
9 to do, but focusing on whether these things have some return
10 to Medicare. But that would be a very different chapter.
11 I guess what I'm thinking here is that I think
12 it's unrealistic to do these things for a June report, and
13 it would be more realistic to say, okay, well, let's build
14 on what you've already done, which I think is very good by
15 the way. And then say, well, we're examining this, and this
16 is part of a larger context. And then at the end, to say,
17 well, here are ways that we might go.
18 And I would say the two ways, bringing together
19 the commentary, that would help direct future studies would
20 be to look at the question of management of care regardless
21 of whether it involves integrating financing or not. I
22 think that's one big area.

1 And then I fully agree with Peter and the
2 responses that have followed that about having a population
3 base because clearly this is really important, and it
4 transcends just the duals. It's something that is clearly,
5 is really a fundamental central question that happens to hit
6 us in the duals question because a lot of people have these
7 combinations of problems. But it can also elucidate care
8 quality issues as well as financing in Medicare.
9 I just see that as something that maybe in the
10 June, in the July retreat, we could say, okay, well, here
11 are these long-term care dual eligible issues that we need
12 to spend a little more time on to develop an agenda for
13 2011.
14 MR. HACKBARTH: Just for the benefit of the
15 audience, there will be a chapter in the June report on this
16 subject, but the cake has been baked there, pretty much.
17 Most of this discussion is to help guide our future agenda.
18 So don't expect to see all of these things woven neatly into
19 our June report.
20 Okay, very well done.
21 MS. HANSEN: I just would like to end by, you know
22 when Bruce just mentioned that we focus on, of course, our

1 statutory requirement of looking at the impact to Medicare,
2 and there are these other programs to look at. I think
3 we're at an inflection point with the start of this other
4 Medicaid commission, and so this may be something, that we
5 should really take a look at how both our coordination as
6 well as our joint work in some ways with them because it
7 covers very significant cost issues to both programs.
8 MR. HACKBARTH: Excellent point, Jennie.
9 As I think we talked the other day, now the
10 MacPAC, the Medicaid Commission, does have its funding. So
11 they will be starting to get up and running, and we have
12 every expectation of working closely with them on these
13 issues.
14 DR. MARK MILLER: Just a couple of things. You
15 know one of the things -- we had an explicit conversation,
16 but just there's what's happening in front of you and sort
17 of the sub-structure underneath that.
18 We are very much trying to approach, and in the
19 next presentation it will also be true, very much trying to
20 approach the questions as not being a silo base, whether
21 we're talking about Medicare and Medicaid or whether in the
22 next presentation talking about inpatient psych facilities

1 versus a broader episode. And we are trying to approach
2 these issues on much more of a coordinated episode type of
3 basis, which we felt like we've heard very strongly from you
4 guys. So that's one thing that you should see -- whether
5 you see it, but that's what's happening underneath it.
6 A second thing is, and Glenn and I have had just a
7 couple of glancing conversations about this, and we haven't
8 had this conversation. So I may be in deep trouble in about
9 one minute.
10 The other thing I think, particularly on a topic
11 like this, which -- you've said it, Bruce -- can be
12 extremely complex: two different programs, two different
13 funding sources, multiple populations, multiple disease
14 conditions, different strategies. I think that we are going
15 to try and push, to try and focus something here, so that we
16 have some thread to follow all of these issues, but some way
17 of trying to manage it.
18 So I just want to say that there may be some push
19 as we go forward to what do you, of all of these great
20 ideas, which ones do you want to deal with first because
21 otherwise these things can get very complex for us, to keep
22 coming back and try and have something that captures the

1 Commission's direction.

2 The other thing I would say is there was this
3 discussion of models and fee-for-service, all of which we
4 can look at and get a sense of different strategies.

5 But I also think the other thing I put in the back
6 of my mind is that's where financing can come into play
7 because if we decide that there's a better way to go, one of
8 the ways to incent is just to say, okay, there's a
9 coordinated approach to financing which you can get if you
10 take a certain path.

11 So even though there may be models and fee-for-
12 service, but if we prefer. Let's just pretend for a minute
13 we prefer a more coordinated model, maybe you use the
14 financing structure to draw people into that more
15 coordinated structure.

16 So the financing may also play that role in the
17 end, as a tool to draw people to a particular model that you
18 guys feel is worth pursuing. Sorry.

19 MR. HACKBARTH: I think Mark is exactly right.
20 There are so many dimensions to this topic, that we will
21 struggle if we try to look at it in some holistic way. So I
22 think the next step for the staff, given this input, is to

1 try to figure out ways to break it into more manageable
2 pieces, set some priorities.
3 It’s not to say that we won’t take multiple bites,
4 but we need to get something that we can wrap our arms
5 around. Otherwise, we’ll just have lots of long
6 conversations.
7 And we'll now move onto our last session on
8 inpatient psychiatric care.
9 Whenever you’re ready, Dana.
10 MS. KELLEY: Okay. Good morning.
11 Today I’m going to review our findings and some
12 policy issues related to Medicare's PPS for inpatient
13 psychiatric facilities, or IPFs, which will be included in a
14 chapter in our upcoming June Report to Congress.
15 As you saw in your mailing materials, this will be
16 an overview chapter with no recommendations.
17 The overview chapter does focus narrowly on IPF
18 care. But as we’ve explored this topic over the last 18
19 months or so, you’ve made it clear that you’re also
20 concerned more broadly with the general care furnished to
21 Medicare beneficiaries with serious mental illnesses, and
22 you reiterated that just a few minutes ago.

1 So, as Mark said, be assured that the staff are
2 exploring this in our work in several different areas,
3 including physician payment, the dual eligible work that
4 Christine and Carol are doing, and episodes of illness.
5 What we need for you today are your thoughts on
6 the draft chapter as well as your input on future areas for
7 analysis, both of the IPF PPS and of other issues related to
8 Medicare beneficiaries with mental illnesses.
9 Before I go any further, I just want to
10 acknowledge the analytic work that Jae Yang and Shinobu
11 Suzuki have done for this presentation and for the draft
12 chapter.
13 So let's start with just a review of the basics of
14 the IPF PPS. Phase-in began in January 2005 with full
15 implementation beginning in July 2008. In 2008, there were
16 almost 443,000 discharges from IPFs and spending was $3.9
17 billion.
18 A quick reminder of the basic mechanics of the
19 PPS. Payments are made on a per diem basis with adjustments
20 made for diagnosis and other patient characteristics such as
21 age, certain medical comorbidities, and length of stay.
22 Payments are also adjusted for facility characteristics such

1 as area wages, teaching status, rural location, and presence
2 of an emergency department. There is an add-on for each
3 electroconvulsive therapy treatment and outlier pool equal
4 to 2 percent of total payments.
5 Controlling for the number of fee-for-service
6 beneficiaries, IPF cases have fallen almost 4 percent since
7 the PPS was implemented. At the same time, spending per
8 fee-for-service beneficiary has climbed almost 15 percent.
9 The majority of Medicare beneficiaries treated in
10 IPFs quality for Medicare because of a disability. So IPF
11 patients tend to be younger and poorer than the typical
12 beneficiary. In 2008, 65 percent of IPF discharges were for
13 beneficiaries under the age of 65, and almost 29 percent
14 were for beneficiaries under the age of 45.
15 More than half of IPF users are dual eligibles.
16 IPF users, as a group, consumer more health care
17 services and are more costly than other beneficiaries. You
18 can see this here. This is for 2007, IPF users has much
19 higher spending for hospital inpatient services than did all
20 fee-for-service beneficiaries, almost $17,000 compared with
21 $3,000.
22 Now that's to be expected, of course, since IPF

1 users had at least one inpatient stay in a psychiatric
2 facility. But Medicare spending for IPF users on other
3 services was much higher than for the typical fee-for-
4 service beneficiary as well. Spending for these
5 beneficiaries was more than twice as high for hospital
6 outpatient services and about five times as high for SNF
7 services, and spending for Part D drugs was markedly higher,
8 as well.
9 Beneficiaries admitted to IPFs generally are
10 assigned to one of 17 psychiatric MS-DRGs but the vast
11 majority -- almost three-quarters -- are diagnosed with
12 psychosis. Psychoses include schizophrenia, major
13 depression, and bipolar disorder disorder.
14 The second most common discharge, accounting for
15 about 8 percent of IPF cases, is degenerative nervous system
16 disorders.
17 The coded diagnoses of Medicare patients treated
18 in IPFs have changed somewhat since the PPS was implemented.
19 Among the top diagnosis, there was disproportionate growth
20 in the number of degenerative nervous system disorder cases.
21 It’s climbed about 28 percent since 2004.
22 This growth may reflect increased incidence of

1 Alzheimer's Disease and other dementias among the Medicare
2 population, but it may also reflect a growing use of
3 inpatient psychiatric facilities by patients with these
4 conditions. Many IPFs now have specialty geropsychiatric
5 units which provide care specifically for elderly patients
6 with mental illnesses. These patients frequently have
7 activities of daily living deficits and often require a more
8 intensive level of care than other psychiatric inpatients.
9 In addition, we have spoken to patient advocates
10 who report that nursing facilities increasingly are
11 transferring difficult dementia patients to IPFs. These
12 patients may be due to a lack of nursing facility staff to
13 provide the close observation and other care that is needed
14 by patients with dementia. But it should also be noted --
15 and this came up in the last presentation, that nursing
16 facilities may have a financial incentive to discharge
17 patients to IPFs because upon return to the nursing facility
18 patients may quality for Medicare payment under the SNF PPS,
19 if the IPF stay is at least three days long.
20 You can also see here that there’s been a
21 significant decline in the number of cases with organic
22 disturbances and mental retardation. I’ve spoken with some

1 providers and industry representatives about this trend.
2 The consensus seems to be that this is largely due to coding
3 improvements under the PPS.
4 Prior to the PPS, facilities were not paid on the
5 basis of diagnosis so there's been quite a learning curve as
6 facilities have gotten used to the PPS. I can take more on
7 the question if you have interest in that.
8 You'll recall that IPF services can be furnished
9 in freestanding psychiatric hospitals or in distinct-part
10 units in acute care hospitals. As you can see here, the
11 distribution of patient diagnoses does differ somewhat
12 between the two facilities. IPF units are less likely to
13 care for patients with substance abuse diagnoses and more
14 likely to care for patients with degenerative nervous system
15 disorders. However, in both types of facilities, the vast
16 majority of patients are diagnosed with psychosis.
17 You can also see, in the last row of the slide,
18 that overall the majority of IPF cases are in IPF units,
19 about 29 percent cases are in freestanding IPFs.
20 There is a lot of information on this slide, so
21 let me draw your attention to a few things. First of all,
22 these numbers represents IPF beds that are paid for under

1 the IPF PPS. Available scatter beds are not included in
2 these numbers.
3 Note also in the last column that the overall
4 number of IPF beds has remained fairly constant since the
5 PPS was implemented. But the location of these beds has
6 changed. In the second and third rows you can see that the
7 number of freestanding IPF beds has grown 11 percent since
8 2004 while IPF unit beds have fallen 12.5 percent.
9 I told you a minute ago that freestanding
10 hospitals represented 29 percent of IPF discharges. In the
11 second row here you can also see that they represent 56
12 percent of beds.
13 Another thing to note on this slide is the marked
14 decline in the number of rural IPF beds and in the number of
15 non-profit IPF beds.
16 Here you can see some of the differences we're
17 seeing between freestanding IPFs and distinct-part units.
18 First, you can see that freestanding IPFs tend to be much
19 bigger than IPF units. Freestanding IPFs also have longer
20 lengths of stay, 17 days compared to 11 days. Aggregate
21 Medicare share is higher in IPF units, 29 percent compared
22 with 19 percent in freestanding facilities.

1 We also looked at data on admission and discharge
2 to see where IPF patients are coming from and where they go
3 after an IPF stay. You can see that IPF units admit many
4 more patients to the emergency department, not surprising
5 since relatively few freestanding IPFs have emergency
6 departments.
7 IPF units also discharge a smaller share of their
8 patients to the home and a larger share of their patients to
9 nursing facilities. The home category does not include
10 patients who are discharged to home health care.
11 These patterns suggest that patients in distinct
12 part units may be more severely ill than those in
13 freestanding facilities. They may be more unstable when
14 they're admitted, thus the emergency room visit, or perhaps
15 may have underlying medical conditions or complications that
16 might make it difficult for them to be cared for in
17 freestanding facilities. And they may be less likely to be
18 able to go home. Relatively more of the IPF stays in
19 distinct part units might be part of an ongoing episode of
20 care involving multiple providers.
21 One last thing to note on this slide is the
22 discrepancy in the share of for-profits and in the share of

1 rural providers.

2 Now I'm going to shift gears a little bit and talk
3 about some policy issues in this area. As I said before, we
4 know that you don't want to focus exclusively on the IPF PPS
5 but there are a few things that we might want to keep an eye
6 on. So I will review these and then I will speak a little
7 more broadly about work we're looking into at episodes of
8 care for beneficiaries with serious mental illnesses.

9 As we move forward with our analyses of the IPF
10 PPS, we'll focus on payment accuracy, as we always do, which
11 means that we'll need to understand IPF costs. Since a
12 large share of IPF cases is furnished in distinct part units
13 of acute care hospitals, it will be important for us to
14 understand how the allocation of acute care hospital
15 overhead to the unit affects unit costs. And we'll want to
16 look at how an IPF unit affects the acute care hospital's
17 overall cost structure and profitability, as well.

18 Given some of our findings, it will also be
19 important to consider whether there are systematic
20 differences in the mix of patients across the different
21 types of providers. Other research suggests that there may
22 be real differences.

1 Between 2001 and 2003 RTI, under contract to CMS,
2 conducted an analysis of patient and staffing mix and
3 intensity in IPFs. RTI found that overall, patients in
4 freestanding IPFs tended to be higher functioning and to use
5 considerably less nursing and staff time than patients in
6 IPF units.
7 To avoid favoring certain types of providers and
8 creating incentives for providers to admit certain types of
9 patients, Medicare's payments for IPF services must be well
10 calibrated to patient costs. But there's reason to suspect
11 that the payments may not track that closely.
12 When it developed the case-mix groups and weights,
13 CMS based its estimates of the routine costs on facility
14 average daily cost. CMS did this because claims data that
15 were used to develop the case-mix weights don't describe any
16 differences in the nursing and staff time across patients.
17 Using facility average routine costs will
18 necessary understate or compress patient-specific cost
19 differences. The PPS assumes then that the routine nursing
20 and staff time is the same both for an older patient with
21 dementia who requires significant one-on-one observation
22 time and assistance with several activities of daily living,

1 and for a younger depressed patient who has no ADL deficits
2 and spends a substantial portion of the day in group
3 meetings and activities.
4 So payments for patient requiring high levels of
5 nursing and staff time might be too low and payments for
6 patient requiring relatively little nursing and staff time
7 might be too high.
8 We know that almost three-quarters of IPF patients
9 are assigned to one MS-DRG and they receive the same base
10 payment. Payments are adjusted for payments with certain
11 comorbidities such as renal failure and cardiac conditions,
12 but there are no adjustments for other patient
13 characteristics that might significantly affect nursing and
14 staff time such as ADL deficits and the predisposition for
15 dangerous behavior.
16 Unlike with some of the other IPF diagnoses,
17 there's no major comorbidity or complication subgroup within
18 the psychosis MS-DRG, so providers may have some incentive
19 to avoid admitting patients who are perceived to have
20 greater need for nursing and staff time. But adjusting the
21 case-mix groups to better reflect patient costliness would
22 likely require IPFs to submit patient assessments or some

1 other form of data.

2 Turning now to quality in IPFs, the development of

3 mental health care quality measures for inpatient

4 psychiatric care has lagged behind that for medical care.

5 Quality of mental health care can be difficult to measure

6 because there are few meaningful frequent and easily

7 collected clinical outcomes measures that have been assessed

8 for validity and reliability. The value of many mental

9 health services is unknown, and many of the guidelines for

10 the treatment of mental illnesses are consensus-based rather

11 than evidence-based.

12 Until reliable outcomes measures can be developed,

13 process measures might be used to assess quality in IPFs.

14 The Joint Commission has been working to develop such

15 measures for use in IPFs through its Hospital-Based

16 Inpatient Psychiatric Services Core Measure initiative.

17 Beginning this past January, freestanding IPFs can satisfy

18 the Joint Commission's accreditation requirements for

19 performance measurement by adopting these measures. The

20 Joint Commission encourages acute care hospitals to use them

21 in their IPF units, as well.

22 There are two elements under the new health reform

1 legislation that will affect quality measurement in IPFs.
2 First, CMS is required to implement a quality reporting
3 program by 2014. In addition, a value-based purchasing
4 pilot program is required by 2016.
5 So other work we're looking into relates more
6 broadly to general care for mental illnesses. We intend to
7 look at beneficiaries' use of services over the course of an
8 episode or a episode of time. This will allow us to get a
9 better handle on the type and amounts of health services
10 beneficiaries with serious mental illnesses use.
11 We also want to explore the use of mental health
12 services in the private sector. Finally, we will want to
13 consider how the quality of outpatient mental health
14 services can be measured.
15 So that concludes my presentation and I've listed
16 a few possible topics for discussion here.
17 I'll turn it over to you.
18 MR. HACKBARTH: Okay, thank you Dana. Sounds like
19 there might be lots of opportunities to improve payment
20 accuracy here, hopefully.
21 Let's start over here this time with clarifying
22 questions. Ron.

1 DR. CASTELLANOS: Good job. I think I mentioned
2 the last time, there's no mention here about access to care.
3 Has that been looked at at all?
4 MS. KELLEY: In the chapter there is a small text
5 box on access to care. It is something that we've looked at
6 a little bit. It is difficult to get a handle on without
7 having a good sense for which patients need care and whether
8 or not patients are getting outpatient care as a substitute
9 for inpatient care or preventing inpatient care that might
10 be down the pike. But it is something that we've tried to
11 look into as best we can.
12 DR. CASTELLANOS: Have you looked at whether
13 there's access to care to an inpatient psychiatric facility,
14 not care in the community but whether there's inpatient care
15 available?
16 MS. KELLEY: That is something we're planning to
17 look at more. As you noted, there's been a decline in the
18 number of beds available in rural areas. And so that, and
19 some other things, we are planning to look into.
20 DR. CASTELLANOS: Thank you.
21 MR. HACKBARTH: Other clarifying questions on this
22 side? Arnie?

1 DR. MILSTEIN: Presumably if there was a
2 substantial opportunity to improve outcomes and lower cost
3 for this population, we might expect to see the emergency of
4 MA-SNPs, SNPs focused on this population, at least in urban
5 areas where you might expect adequate concentration. Have
6 any such SNPs emerged?
7 MS. KELLEY: There is at least one SNP that I'm
8 aware of that does focus on the seriously mentally ill
9 patients, and that is something we can look into a little
10 bit more in the future, that will help us as we look more
11 broadly at the total episode of care for a patient.
12 DR. BERENSON: Do we know why the number of beds
13 are declining? Is it about Medicaid funding? Or what do we
14 know?
15 MS. KELLEY: Well, it is interesting that the
16 number of beds in both freestanding facilities and in IPF
17 units had been declining before the implementation of the
18 PPS and that decline has turned around for freestanding
19 facilities but not for IPF units. So that is something --
20 so the PPS itself may have some influence here.
21 I think Peter has talked in the past about the
22 profitability of IPF units in acute care hospitals now that

1 the PPS has been put into place. That is also something we
2 can look into.
3 Certainly, Medicaid -- there's a whole host of
4 Medicaid issues that could be going on around here, too.
5 But I think it will be worthwhile to explore the impact of
6 the PPS.
7 DR. MARK MILLER: One other question on that. The
8 other thing, the bed counts that you have are for IPF beds
9 in a unit. But a hospital could also be using scatter beds
10 for this function; right?
11 MS. KELLEY: Yes, that's right. And the use of
12 scatter beds has increased since the PPS was put into place.
13 DR. MARK MILLER: So, I don't want to state this
14 as a fact but another thing to look into is whether unit
15 beds have been reclassified as general beds and then used as
16 scatter beds, is another underlying thing.
17 MS. KELLEY: Exactly.
18 DR. MARK MILLER: But just to be clear, there are
19 lots of people in the industry who say that the PPS has had
20 an influence on how profitable this service is. We can
21 continue to look at that.
22 MR. GEORGE MILLER: Do you have this information

1 for this segment demographically, as well?

2 MS. KELLEY: Yes, I do. And some of that is

3 included in the chapter. I think I have a slide here.

4 This slide, I didn’t show this before, but it

5 shows the breakout of discharges by beneficiary race. You

6 can see that there are some differences here.

7 A few things I’ll note is that the minority

8 population here reflects that of the under-65 Medicare

9 beneficiary population. So it does look as if a

10 disproportionate share of minority beneficiaries use

11 psychiatric services, but that there is a higher proportion

12 of minorities under the udner-65 Medicare population.

13 The other thing that’s important to note in

14 looking at these numbers is that there’s a strong age

15 component here. Psychosis primarily is diagnosed for

16 beneficiaries who are under 65 and more likely to be

17 minority and in Medicare, and degenerative nervous system

18 disorders are primarily diagnosed in older beneficiaries.

19 MR. GEORGE MILLER: Thank you.

20 MR. BUTLER: I'm just wondering why the

21 profitability data is not in there as one of the charts?

22 MS. KELLEY: The profitability of the acute care

1 hospitals or of the IPF units?

2 MR. BUTLER: You know when we do our updates, we

3 have the data for the profitability of the various

4 components, the freestanding, the distinct units.

5 MS. KELLEY: Yes.

6 MR. BUTLER: I guess you can't really have it for

7 the scatter beds, can you?

8 MS. KELLEY: It's hard. It would be very

9 difficult to do it for the scatter beds.

10 MR. BUTLER: But it would help explain, perhaps,

11 some of the trends.

12 MS. KELLEY: We can look at the profitability of

13 psychiatric MS-DRGs under the acute care hospital PPS to get

14 at some of the scatter bed issues. That's something we have

15 not done as yet, but would like to do in the future.

16 We started to sort of dig into the profitability

17 of IPF units. As I said, one of the major things we want to

18 work out is some of the issues related to the costs and what

19 they actually mean and the differences across the different

20 types of facilities. So that's something we're going to be

21 pushing forward on.

22 MR. HACKBARTH: Other clarifying questions? Okay,

1 let’s do round two comments, beginning with Ron and then
2 Herb.
3 DR. CASTELLANOS: Dana, just a couple of
4 questions. Maybe I’m opening up a bag of worms here but on
5 page 23 you mention in the text that you said that these
6 patients are non-compliant and have a lot of comorbidities.
7 You infer the readmission rate may be related more to the
8 disease process than anything else.
9 As we saw in the first or the preceding
10 presentation, these patients have multiple comorbidities.
11 And in a general hospital setting, or perhaps in a community
12 hospital setting where there’s no psychiatric bed, that’s
13 going to be a big part of the readmission rates for some of
14 the patients.
15 I’m not quite sure how you can separate the
16 readmissions on an inpatient psychiatric from a general
17 hospital. Do you get my question?
18 MS. KELLEY: Yes, and I don't think you can. That
19 was the point I was trying to make in this part of the
20 chapter, so I’ll go back and make that a little more clear.
21 That is precisely my point, that it is very difficult -- an
22 admission to a psychiatric facility is an acute episode in

1 what is generally a much longer mental health issue. The
2 psychiatric facility's job is to stabilize the patient and
3 discharge them.
4 Most of the patients are going to go on to have
5 other kinds of psychiatric services and it's difficult to
6 tell in sort of evaluating outcomes from the inpatient
7 psychiatric facility sort of when should the outcome be
8 measured and how much can the inpatient facility control in
9 a patient's course of illness? If a patient is ill for nine
10 months but has a 10-day inpatient stay, how much is the
11 inpatient facility in control other than just stabilizing
12 the patient for discharge?
13 Regarding the sort of comorbidities and
14 compliance, the nature of mental illness, as we all know, is
15 such that there are a lot of comorbidities that go along
16 with the disease, often substance abuse, in older patients
17 sometimes difficulties with activities of daily living. And
18 the compliance issues are difficult in this population
19 because so many have difficulty keeping track of their
20 medications or have side effects from medications that are
21 very undesirable and difficult to deal with.
22 So it's a patient population that is very

1 difficult to deal with. That’s the point I was trying to
2 make in this part of the report and I’ll go through and make
3 that –
4 DR. CASTELLANOS: Okay. You did a good job. Two
5 other questions.
6 Really, something that Peter just said, in my
7 observation on profitability, I look at what hospitals are
8 building. They’re building cardiac units, they’re building
9 orthopedic units, they’re building x-ray units. But I don’t
10 see them building psychiatric units. There must be a
11 reason.
12 I think profitability, we ought to look at that as
13 -- and maybe compare it to some of the other cardiac, et
14 cetera care. Because there’s got to be a reason why there’s
15 a shortage, in my opinion, of psychiatric services. There’s
16 certainly a need, but I don’t think there’s a real -- and so
17 I think it’s really important to look at profitability.
18 And the last issue, again, is the same issue as I
19 raised a couple of meetings ago, the workforce issue. You
20 know, I’ve looked around and I’ve asked some of my
21 colleagues. And what’s common in -- we have no
22 psychiatrists in our community that go to the hospital.

1 I’ve talked to some of the psychiatrists and what I
2 understand -- and it’s just one or two people I’ve talked to
3 -- is they go if the hospital subsidizes them and pays
4 extra. But because of the reimbursement rates, they don’t
5 go.
6 I can’t really blame them. Here, again, you can
7 say it’s a doctor complaining about costs. But it’s a real
8 issue for access.
9 MS. KELLEY: Yeah, I think -- I've also come
10 across mention of that issue, as well. And there is some
11 indication that it may play a role in some acute care
12 hospitals’ decisions to close IPF units because they can’t
13 get psychiatric coverage in the emergency room and things
14 like that. So it’s definitely something that we are tending
15 to look more into.
16 And as I mentioned at the beginning of the
17 presentation, the whole physician payment issue is something
18 we’re considering, as well.
19 DR. MARK MILLER: Can I just ask one thing to
20 follow up? Ron, in any of your conversation -- there does
21 seem to be some difference between the growth rates between
22 freestanding and hospital-based. Do you have any experience

1 or discussions with people how they view the freestanding
2 facilities? Do they view them any differently?
3 And if the answer is no, that's fine.
4 DR. CASTELLANOS: No, but I do have -- no. That
5 would be the best way.
6 MR. GEORGE MILLER: No ER call.
7 DR. MARK MILLER: [off microphone] [inaudible].
8 MS. KELLEY: Yes.
9 MR. GEORGE MILLER: Because there’s no ER call.
10 MR. KUHN: Dana, this is a good descriptive work
11 on an overview of the payment system, which I think a lot of
12 people will find useful. Also, there’s some really good
13 information here in terms of patient population serviced by
14 these facilities which I have not seen anywhere else. So I
15 think when people see this chapter, they’re going to find
16 some real value in your work here. So thank you for that.
17 And also, because as I recall, this is the last of
18 the PPS systems that CMS put in place, always with a
19 maturing PPS system it’s always ripe for refinement. So
20 this is timely work, as I suspect the agency is beginning to
21 look at a maturing PPS system. And I think if we can do that
22 along the way it’s going to be very helpful.

1 So in that regard, I think the one issue that you
2 put up earlier, the allocation of costs for hospital base is
3 one that really does deserve some serious look here. And so
4 I’m glad that that’s in place.
5 But also, I think one of the areas that we’re
6 probably going to need to look at in the future is the
7 limitations on data that’s out there and what we see in the
8 limitations.
9 So correct me if I’m wrong here but at least what
10 I understand is that in terms of most of the data that we
11 have kind of reflects a uniform charge data for the largest
12 component of costs that’s out there.
13 MS. KELLEY: That's right.
14 MR. KUHN: So it makes it very difficult to maybe
15 differentiate between geriatric and young disabled and
16 others like that.
17 MS. KELLEY: Absolutely. Well, there is an
18 adjustment for age. And generally speaking, patients older
19 than 45, as you get older there is an adjustment that goes
20 up for older patients. But as you started to point out,
21 about 80 percent of the costs are nursing and staff time,
22 and that’s the uniform charge from the facility.

1 MR. KUHN: So I think one of the things that we’re
2 going to need to think about as we go forward with possible
3 refinements in this area is how to collect data beyond the
4 basic administrative data.
5 MS. KELLEY: Yes.
6 MR. KUHN: And are there some other things that we
7 want to look at here as we go forward? Because I think that
8 sets the stage for us to maybe come up with useful
9 predictors such as ADLs, dangerous behavior, things like
10 that that might be useful for further refinements on a go
11 forward basis. So if that’s some of the work we could begin
12 to look at, as well, it would be helpful.
13 MS. KELLEY: okay.
14 MR. HACKBARTH: Herb, this happened while you were
15 at CMS. Was this something that the agency initiated? Or
16 did this just come from Congress?
17 MR. KUHN: You know, that's a good question. I'm
18 trying to remember -- I remember when it went in live in
19 '05. I think it was something that Congress, you know,
20 moved forward, but again, it was the last of the PPS systems
21 that went forward. So I think it was a congressional
22 mandate to go forward with this.

1 DR. BERENSON: I'm pretty sure it was a BBA --
2 MS. KELLEY: Yes, it was. There had been -- I'm
3 not precisely sure of the timing here, but around the time
4 of the BBA, CMS had been starting to look, I think of its
5 own accord, or having sort of, you know, seen what was
6 coming down the pike, started doing work looking at
7 developing a PPS. And I think that the agency began to
8 understand then and knows now that there are additional
9 elements that are strong predicters of cost in facilities
10 well beyond what diagnosis can tell us. And there was a
11 plan at the very early stages of planning the new PPS for
12 having an assessment tool to go along with the PPS, and my
13 understanding is that the industry was not in favor. And
14 there was work done to sort of try and work around that just
15 with the claims data, and they went forward with that.
16 MR. KUHN: I think Dana's characterization is an
17 accurate reflection of, I think, what occurred at the time.
18 MR. HACKBARTH: This is a theme that I've
19 mentioned before, but to me, you know, what I learned way
20 back at the beginning when hospital inpatient PPS was
21 developed, through the prerequisite for an effective
22 prospective system, is that you need to be able to define

1 relatively homogeneous, clear groups that you then price.
2 And I'm just beginning to learn about the inpatient psych
3 PPS, but I really wonder whether that basic requirement is
4 met for this population.
5 MS. KELLEY: It does, I would suggest, strain
6 credulity that 75 percent of the patients could look so
7 similar.
8 MR. KUHN: That's one of the things that I was so
9 concerned about, is the data limitations that we have here,
10 and that the opportunity for us to look on a go-forward
11 basis about some useful predictors -- I mentioned a couple,
12 but, you know, legal support -- I mean, there's a whole
13 variety of things that could go in play here as we go
14 forward and help the agency begin to think about refinements
15 in this PPS system in the future.
16 MS. KELLEY: There are a number of items, too,
17 that probably do help predict cost but that might be not the
18 right incentives we'd want in a payment system. But I do
19 think there are probably improvements that could be made
20 with additional data.
21 DR. MILSTEIN: This is following on Herb's
22 comment, something more forward looking than perhaps for the

1 June chapter. But if you were to do a failure mode analysis
2 of, you know, patients that end up getting hospitalized for
3 these conditions and asked, you know, what percentage of
4 them would likely have been preventable by a little bit
5 better upstream care, and compare that with med-surg
6 admissions, I think it would turn out that your opportunity
7 here is probably, you know, the vast majority of these
8 admissions. And so more for future reference, I think this
9 is an area that should be examined, and perhaps one way of
10 examining it, not for the June report, would be to talk to
11 whatever is the -- Parkland or Denver Health or the
12 equivalent that's really taking this one and actually can
13 demonstrate my last comment, that is, that 75 percent of
14 them could be preventable by somewhat enhanced upstream
15 care, because that's the big opportunity, I think, for
16 Medicare, is just to reduce the volume of these by 75
17 percent.
18 MS. KELLEY: I think that gets back to Ron's
19 comment earlier, too, that it's hard to assess when we see
20 the number of cases for fee-for-service beneficiary going
21 down. Is that a good thing, or does it indicate a lack of
22 access to care? And I think, as you pointed out, Arnie,

1 that relationship between outpatient care and this crisis
2 that takes place is very -- it will be important to
3 understanding access.
4 DR. MARK MILLER: We'll do that, Arnie, but the
5 other thing that struck me in this is when you think of,
6 well, if we had better managed outpatient, maybe we could
7 avoid these things. But there were some statistics when we
8 were talking, like 50 percent of the physician visits aren't
9 kept for some of these patients.
10 MS. KELLEY: Yes, and that gets back to the
11 compliance issue.
12 DR. MARK MILLER: So I'm not saying no. I'm just
13 saying the challenge extends not only to keeping them out of
14 the hospital, but if you can get them to go to the
15 physician's office.
16 DR. MILSTEIN: I completely agree with that,
17 although I think what we'll learn if we study the better-run
18 delivery systems is the fact that a patient particularly
19 who's got this problem doesn't show up in the office is not
20 the end of the story; it's the beginning of the
21 intervention.
22 MR. GEORGE MILLER: Just to follow up on that

1 point, Arnie, your point is if they had intervention
2 earlier, we may have saved considerable dollars on the other
3 side? That's your point? How do we figure that out and
4 what that savings would be?
5 DR. MILSTEIN: [off microphone] I think the
6 simplest way to do it -- because obviously, you know, being
7 a theoretical concept is useless to the Commission -- would
8 be to go to places like Denver Health and Parkland and find
9 a subset that have taken this on and can tell us, you know,
10 compared to their baseline level, they've reduced the
11 frequency of admissions, I suspect by a vast majority
12 amount.
13 DR. BERENSON: To me one of the most interesting
14 things you wrote in your chapter was that patients who were
15 readmitted to the IPF within three days of discharge are
16 considered to have an uninterrupted stay and don't get a new
17 payment. It strikes -- I'd like to know more about that.
18 It has always struck me that we have made our approach to
19 incentivizing hospitals on the inpatient PPS side to reduce
20 readmissions too complicated by having measures and then
21 figuring out who are outliers and rewarding or penalizing at
22 that level rather than just embedding the incentive into the

1 basic payment system by changing the reimbursement for a
2 readmission.
3 So I'd like to know how this works. Are there a
4 cluster of admissions on day four as people are avoiding,
5 you know -- I'd like to know more because I think there may
6 be lessons here for some of our other work.
7 MR. GEORGE MILLER: Are there quality measures for
8 this population? And I didn't read it in the chapter.
9 Maybe I missed it. But what quality measure are we using?
10 MS. KELLEY: The quality measures for inpatient
11 psychiatric care have lagged far behind those that have been
12 developed for general acute-care hospitals. I mentioned
13 previously that there is some work that the Joint Commission
14 has done, and they've implemented these new core-based
15 measures for free-standing IPF hospitals to use to meet
16 their requirement for performance measures for
17 accreditation. And the Joint Commission is encouraging
18 acute-care hospitals to use these same measures to evaluate
19 their IPF units as well. And this is really -- although I
20 do -- certainly there are hospitals that probably have their
21 own measures that they use, but this I think is really the
22 first step towards having more of a general broad

1 requirement for these kinds of measures. And as I said,
2 under the new health reform legislation, there is a quality
3 reporting program that's going to be required beginning in
4 2014. So hopefully this is, you know, sort of the start of
5 a lot more information about these facilities.
6 My understanding is that the quality reporting
7 program, the information will be publicly available, and
8 there will be a penalty for failure to report, so there will
9 be, you know, an incentive for IPFs to get on board.
10 MR. BUTLER: Well, Glenn, you hit on the key
11 issue, the payment inaccuracies here, so this has kind of
12 lagged behind the skilled nursing look, but it had some
13 similarities to it. And I don't really know the answer to
14 it, but, you know, I'm sure there's still some of this labor
15 cost spillover that kind of comes along with the hospital
16 culture and staffing mentality that is separate from the
17 nature of the patients. The more we can tease that out, the
18 better off we'll be. And I just would advocate if there's -
19 - I don't know if this can inform next year's payment
20 updates or not, but it would be nice if it could because
21 then we could sequence it because we'll get on with this a
22 year sooner than if we wait for a recommendation on this

1 later in the year.

2 DR. MARK MILLER: I'm actually really glad you
3 said that, and the sequencing might be a little bit
4 different in my mind or your mind, and I'm glad you
5 referenced the SNF situation, because I think the pattern
6 that we're seeing here is in the post-acute-care setting
7 broadly -- and the SNF example is a very good case study.
8 So we found this vast difference between SNFs in terms of
9 free-standing and hospital-based, and after some significant
10 work figured out that at least part of that, and not an
11 insignificant part of it, had to do with how the payment
12 system was handling a certain type of cost, which then
13 translated into a certain kind of patients, which ended up
14 more in one place versus another. And I very much would
15 like to sequence that thought process with the notion of
16 saying something about, you know, payments overall, because
17 I think it would be much more intelligent for us to come
18 forward and say it's not just about the level here. You've
19 got a lot of action happening between the settings so that
20 we could come forward with something that might actually
21 speak to some of the payment inaccuracies between the two
22 sides, you know, free-standing versus a hospital-based.

1 So I think that's what you were saying, but now
2 you're looking at me like you weren't saying anything like
3 that.
4 [Laughter.]
5 MR. BUTLER: No, no. I --
6 DR. MARK MILLER: It's dark so I can't really --
7 MR. BUTLER: You were perfect.
8 DR. MARK MILLER: And I'm very relaxed, and so --
9 MR. BUTLER: But I do have two more comments about
10 this. One is I don't have a -- you know, the for-profit
11 side of health care bothers me in many respects, not really
12 in this -- at least in my own experience, there's some very
13 good for-profit freestanding psych hospitals, at least in
14 our market. So I don't come from it really with that
15 perspective, although I always think about that a little
16 bit. Who are they really willing to accept in their
17 hospital, versus who we have in our own distinct units.
18 There is an issue there.
19 One other aspect that one of the two of you
20 brought up relative to scatter beds -- I think, Mark, you
21 said it -- are we increasing scatter -- distinct units are
22 going down but scatter beds, probably not too much. I view

1 this -- and again, seeing this firsthand in community
2 hospitals, the scatter beds are primarily -- you get a
3 choice. A lot of these are coming through the ED and you're
4 making a choice. Can I handle this in my own institution?
5 It's a detox. It doesn't require a lot of security. It's
6 the right thing for the patient? Or do I have to ship them
7 somewhere else because we're just not able to handle it as a
8 hospital. And that's really probably the distinct -- the
9 trade-off.

10 So if you had a distinct unit, it would likely be
11 a locked unit and have security and have certain kinds of
12 patients that once you got out of that business, you really
13 probably couldn't put most of those in your own scatter
14 beds.

15 DR. CHERNEW: Yeah, so I think Dana's answers to
16 George's questions highlighted what's sort of clear from the
17 chapter, which is we don't have good quality metrics. So
18 when we see a change from facility-based to freestanding,
19 from more beds to less beds, from anything to anything else,
20 we simply don't know whether that's really good and we need
21 to encourage more of it and it's not happening fast enough
22 and it's just a horrible shame that we're moving too slowly,

1 or if it’s an incredible travesty and people are just being
2 poorly treated for conditions that really matter.
3 So we kind of grope around with no norm and it’s
4 hard to tell, in some ways, what advice we need to give.
5 My personal opinion is in the lack of evidence of
6 poor -- in other words, I want affirmative evidence that
7 there’s poor evidence or bad quality problems before I go in
8 and try and solve a problem with money. So I’m not inclined
9 to think something’s happening and we need to solve the
10 problem. I’m inclined to say if you can’t show me there’s a
11 problem, let’s do it at least cheaper.
12 And so that’s -- I also would encourage people, of
13 course, to get better quality measures to justify more
14 payment.
15 The other thing I’ll say about this, which I think
16 does fit in with our earlier discussion, which is I really
17 find it frustrating that we talk about IPFs because so many
18 of the substitutes are not in IPFs. So I don’t care, per
19 se, about IPFs. I care about the payment we’re paying for
20 this population of individuals. And it might be keeping a
21 lot of them out of the facility is much better and we want
22 to discourage admissions per what Arnie said. It might be

1 that we need to encourage more.

2 But we really want someone to take care of the

3 person with the condition, as opposed to make sure what's

4 going on correctly is going on correctly just in the IPF.

5 And I think the more -- and I will say that in the year or

6 so that we've been here, that the orientation overall has

7 really been in that direction for everything. And the more

8 we can keep pushing it in that direction, the better. And I

9 view these types of things as sort of necessary holdovers

10 from a payment system that unnecessarily -- maybe not

11 unnecessarily -- that inherently silos people.

12 And as we move away from that, per the discussion

13 we had earlier on, long-term care is a perfect example of

14 where we have to worry about the site of care, getting that

15 right.

16 So I think the more you -- for the chapter you're

17 not going to change it. So I think the chapter is actually

18 very good and illustrates the lack of quality measures in

19 what we do. And we're forced to provide some updating for

20 it so we're forced to deal with it.

21 But I like the premise that if there's not

22 evidence that there's an access problem we shouldn't take

1 these changes of good or bad. We just don't know.

2 MS. KELLEY: And I tried to convey that in the

3 chapter. So if you have any suggestions about how I can

4 improve that, I'd appreciate it.

5 DR. CHERNEW: I think you did convey it in the

6 chapter. And I think your answer to George exactly conveyed

7 it in the chapter. But then the problem is, in part, it

8 leaves a -- it's hard to know what to say after you've

9 conveyed that.

10 MR. HACKBARTH: I agree with your initial point,

11 Mike, that absent clear measures of quality, it's not a good

12 idea just to throw money at it. And, in addition to that,

13 I'm always nervous when we make a payment change that

14 entails redistribution of the dollars for a service. I

15 assume there's been some significant redistribution of the

16 dollars are a result of instituting this system --

17 MS. KELLEY: Yes, and that was anticipated.

18 MR. HACKBARTH: -- without knowing what the --

19 yes.

20 And so we didn't know what the quality was to

21 begin with. We don't know what the quality is now. But we

22 said let's mix the dollar plot and -- yes.

1 Thank you, Dana. Well done.
2 We will now have a brief public comment period.
3 Now before you begin, let me just repeat the
4 ground rules. Begin by identifying yourself and your
5 organization and please limit your comments to a couple of
6 minutes. When the light goes back on, that signifies your
7 time is up.
8 MS. TRAMBLE: Okay, thank you.
9 My name is Emma Tramble and I'm a State Health
10 Insurance counselor in Philadelphia, so I'm very familiar
11 with the dual eligible population because they call the help
12 line a great deal.
13 But I'm also a caregiver of my mother, who's 93,
14 has Alzheimer's. She had to apply to for Medicaid to cover
15 the cost of her nursing home.
16 One of the issues I have is the design of some of
17 the programs, such as PACE, don't realistically account for
18 the impact on the family caregiver, which may prevent
19 widespread use of these programs.
20 AARP publishes a publication called "Care Giving
21 in America" and it indicates that the average caregiver is a
22 49-year-old woman who works full time. The implementation

1 of the PACE program in Philadelphia, and there are roughly
2 two programs, they pick up your loved one somewhere between
3 eight and nine o'clock and then they drop the loved one off
4 at four o'clock.
5 Since PACE addresses care for Alzheimer's
6 patients, anyone who has dealt with an Alzheimer's patient
7 knows some days are good and some days aren't. Just from
8 witnessing what happened with our next door neighborhood, I
9 could hear through the wall of our row home that some days
10 are very bad and it would take roughly hours to get her
11 mother even prepared to go to the program.
12 So moving forward, if you're going to look at
13 dementia care and programs that are designed to keep people
14 at home, if the expectation of the family is to provide for
15 care before and after the program, then truly coordinated
16 care must account for familial constraints.
17 MR. HACKBARTH: Thank you. We're adjourned.
18 [Whereupon, at 11;26 a.m., the meeting was
19 adjourned.]
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