

## MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

The Horizon Ballroom  
Ronald Reagan Building  
International Trade Center  
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MR. HACKBARTH: Welcome to those of you in the audience. Having completed the work on our March report to Congress at the last meeting, we are now taking up topics, many of which will be addressed in our June report. You will notice that we have somewhat fewer sessions but longer sessions in recognition of the complexity of some of the topics that we are wrestling with.

This morning, we have two sessions, one on accountable care organizations and the second on physician resource use measurement.

David, are you going to lead on accountable care?

MR. GLASS: Yes. Good morning. Today, Jeff and I will bring you up to speed our work on accountable care organizations. I will briefly review the rationale for ACOs, what characteristics our analysis shows they would need to have, and some of the implications of those characteristics. Jeff will then introduce an illustrative payment design, an outline two passed ACOs might follow, and raise some issues that will have to be addressed.

Medicare needs a way to control cost growth. Current spending growth is unsustainable. Constraining

1 fee-for-service rates in conjunction with other policies the  
2 Commission has recommended may improve policy and slow  
3 growth, but it's unlikely to be sufficient. ACOs could  
4 provide the Congress an additional lever by tying bonuses  
5 and penalties directly to the rate of growth in overall  
6 medical spending, which is ultimately what we want to  
7 control. Being able to control volume growth, not just  
8 price, is important and could create the trade-off between  
9 constraining fee-for-service rates and constraining ACO  
10 targets. For the same level of Medicare spending, stronger  
11 incentives for ACOs would mean fee-for-service rates could  
12 be higher and vice-versa, as we will explain a little later.

13           The objectives for an ACO policy are, first, at  
14 the highest level, to provide a path to delivery system  
15 reform that would improve care coordination and  
16 collaboration among providers.

17           Second, the ACO will tie physician and hospital  
18 payments to quality and resource use to help assure  
19 beneficiaries get high-quality care.

20           And third, it should achieve a sustainable  
21 Medicare spending growth rate. It can do so by creating an  
22 incentive to reduce unnecessary services. Data on regional

1 variation show it is possible to reduce unnecessary services  
2 and still maintain quality.

3 Finally, physicians and hospitals will have the  
4 common incentive to coordinate care and reduce unnecessary  
5 services because they will share in the efficiency gains.

6 The basic thrust of our ACO design is to give  
7 physicians and hospitals joint responsibility for the  
8 quality and cost of care delivered to a population of  
9 patients. Physicians and patients could be assigned based  
10 on Medicare claims, as Elliott Fisher has demonstrated in  
11 his work. We think there would be bonuses for high quality  
12 and low cost growth, penalties for low quality and high cost  
13 growth, and penalties would create more potential for  
14 Medicare savings. Some designs that been proposed are bonus  
15 only and depend on behavioral changes producing savings, but  
16 that weakens incentives and Medicare could end up spending  
17 more money for the status quo if providers continue to grow  
18 their volume at the current rate, which is why we include  
19 penalties in our design.

20 We are defining cost growth as the rate of  
21 increase in overall Medicare spending for beneficiaries  
22 assigned to the ACO. Overall spending would include

1 Medicare services patients receive outside of the ACO, as  
2 well. Under this design, ACOs would need to have the  
3 following characteristics.

4           We analyzed data from the Dartmouth group and  
5 found that ACOs would have to have at least 5,000 patients  
6 to tell the difference between real improvement and random  
7 variation. Even at the size, multi-year averaging would be  
8 required to reduce the random variation to low enough  
9 levels.

10           Several implications follow from making ACOs this  
11 size. First, the problem is ACO incentives for an  
12 individual to take actions that restrain volume may be too  
13 small to overcome fee-for-service incentives. That is, the  
14 individual provider will still have a greater incentive to  
15 do a procedure than to not do it. The tragedy of the common  
16 problem still exists. The bonus or penalty is shared by  
17 many; profit from the additional procedure all goes to one.

18           But there is also an opportunity here. Incentives  
19 for joint actions could be large enough to overcome  
20 fee-for-service incentives. An ACO jointly could change  
21 patterns of care and capacity. Actions that all members of  
22 the ACO take could make a difference. This, in turn, means

1 that successive ACOs will have to have the capability to  
2 make joint decisions, which means they will need  
3 organization and information. If savings come from  
4 constraining capacity, it will take time to see the effect  
5 and evaluations might have to take that into account.

6 An example of the difference between an individual  
7 action and a joint decision is as follows. This is from the  
8 perspective of the practice and what we are looking at is  
9 the decision to order the additional MRI. So the logic of  
10 the individual decision to order an additional MRI image,  
11 given the practice already owns an MRI, is as follows. The  
12 revenues would be \$500. The marginal cost for assuming is  
13 \$100, meaning a \$400 profit. So Medicare spending will go  
14 up by \$500. If you look at the effect that would have on  
15 the ACO bonus that they might get for restraining resource  
16 use, that is a negative-\$500 times 0.5, which we're saying  
17 have a 50-50 chance of reaching their bonus, and their share  
18 of the savings is 0.8. So there's a negative-\$200 there  
19 net. So the net incentive of \$400 profit and the minus-\$200  
20 effect on the ACO bonus is a net incentive of plus-\$200. So  
21 they would go ahead and order the additional MRI.

22 Now let's move from the first column we just

1 discussed to the second that is shown in yellow on the  
2 slide. So we're looking at the incentive under a ACO for  
3 the practice to lease an additional MRI machine. We assume  
4 revenue would be \$500,000, which would come from both  
5 Medicare and non-Medicare patients. The annual profit after  
6 a cost of \$450,000 is \$50,000 for the practice. But  
7 Medicare spending would increase by \$250,000. We're  
8 assuming here half the revenue is for Medicare patients.  
9 The bonus would go down by \$100,000. So the net incentive  
10 would be a negative-\$50,000 and the practice would not lease  
11 the additional machine. They would reach a joint decision  
12 not to increase capacity.

13           So the point of this slide is to show that once a  
14 practice has invested in a piece of machinery, they will use  
15 it. It will be difficult for ACO incentives to be large  
16 enough to give the practice an incentive to not use the  
17 machine. However, the ACO incentives could alter the  
18 initial decision to purchase a machine, and in general, to  
19 increase or not increase capacity.

20           Other examples of not increasing capacity would be  
21 not recruiting an additional cardiologist perhaps, or not  
22 building additional ICU beds. The other joint actions that

1 might arise are changing practice protocols. For example,  
2 when or when not to admit a patient.

3 One question is that the other payers don't follow  
4 the same approach, the power of the incentive will be  
5 diminished. I think this came up in yesterday's session,  
6 John.

7 Jeff will now explain how these incentives could  
8 be embodied in an illustrative ACO payment design.

9 DR. STENSLAND: Clearly, there's more than one  
10 reasonable way to determine bonuses and penalties, so here  
11 I'm just going to present one possibility. The idea is just  
12 to try to bring this down to a more concrete level for  
13 discussion.

14 In this system, physicians and hospitals would  
15 continue to receive fee-for-service payments less a  
16 withhold, and I'm going to walk into one method for deciding  
17 which ACOs lose their withhold and which ACOs get bonuses.

18 First, let's look at that far right-hand column.  
19 These are ACOs that lose the withhold. They lose it because  
20 they fail to meet the quality targets and they fail to meet  
21 them for three straight years.

22 In the middle column, we have ACOs that meet the

1 quality standards in one or two of the three years. They  
2 get their withhold back unless they fail to meet the cost  
3 benchmark for three straight years. For those that are  
4 mixed on quality and fail on costs for three straight years,  
5 they would get one-half of their withhold back.

6 Finally, let's look at the first column. These  
7 are ACOs that meet the quality target for three straight  
8 years, high-quality ACOs. These hospitals all get their  
9 withhold back. In addition, if the ACO meets the cost  
10 target for three straight years, they will get a bonus. So  
11 the bonus is for ACOs that consistently meet both their  
12 quality and their cost targets.

13 In the system of bonuses and withholds, Medicare  
14 would have some control over the growth rate of Medicare  
15 spending. If spending is growing too fast, Medicare could  
16 set more aggressive spending and quality targets. If  
17 Medicare spending growth is reduced to a sustainable level,  
18 Medicare could set easier spending growth and quality  
19 targets.

20 Now, the bonuses I just talked about depend on  
21 meeting targets. So how targets are set will be an  
22 important consideration.

1           Here we present one possibility of how we could  
2 set resource use targets. Our goal is to set fair targets  
3 that allow good providers to achieve bonuses in both  
4 historically high and historically low resource use markets.  
5 Medicare could do this by allowing a fixed dollar increase  
6 in spending per capita for each ACO in the country.

7           For example, let's start looking at the first  
8 column. It shows the national average spending of \$10,000  
9 per year per beneficiary, a target growth amount of \$500.  
10 This is equivalent to a national spending target of \$10,500  
11 per capita. Now, you may ask, why do we set a target of  
12 \$500 and not simply 5 percent. The reason is that if we  
13 used a 5 percent target, we would be rewarding providers  
14 that have historically had the highest level of utilization  
15 and this would not be fair to providers in areas of the  
16 country that have done a good job restraining resource use  
17 growth.

18           Now let's look at that second column. Here we  
19 have a low-spending ACO. For this ACO, a \$500 spending  
20 growth target is equivalent to a 6.3 percent increase in  
21 spending. We can contrast this to the last column. Here we  
22 have a high-spending ACO that has historically spent \$12,000

1 per capita. That high level of spending and the same target  
2 of \$500 results in a percentage growth target of 4.2  
3 percent.

4 The bottom line is that we want quality providers  
5 to be able to achieve a bonus whether they are in a  
6 historically high-spending area or historically low-spending  
7 area. The spending growth target of \$500 would be adjusted  
8 for regional wages, but it wouldn't be adjusted for any  
9 regional difference in utilization. So you won't get a  
10 higher target just because you happen to have a lot of  
11 imaging or a lot of visits in your market that other markets  
12 don't have.

13 Now let's look a little bit about how this would  
14 be used to compute payments. In this example, I contrast  
15 two ACOs. First, look at the left-hand column. The top  
16 line shows us one of these ACOs has high quality and the  
17 bottom line shows us the other ACO has low quality. The  
18 second column tells us that both of these ACOs have  
19 historically spent \$7,000 per capita per year. Due to equal  
20 historical levels of spending, they both have a spending  
21 target of \$7,500.

22 In this example, the high-quality ACO keeps its

1 spending level constant at \$7,000. The low-quality ACO  
2 increases its spending to \$8,000. The high-quality low-cost  
3 growth ACO is rewarded with a bonus. We see this in the  
4 last column. They are paid \$7,400 in total for the year.  
5 This consists of \$7,000 fee-for-service payments, having  
6 their withhold returned, and getting a \$400 bonus. The  
7 providers in the ACO benefit from the \$400 bonus per  
8 patient. The taxpayers benefit from a reduction in the  
9 growth rate of Medicare spending. Even after paying the  
10 \$400 bonus, the taxpayers still spend \$100 less than the  
11 target.

12 In contrast, let's look at the second row. Here,  
13 we have a low-quality, high-cost growth provider with \$8,000  
14 in billings, but it loses withhold and fails to get a bonus.  
15 The net result is despite providing more services per  
16 beneficiary, the low-quality provider receives a lower level  
17 of Medicare compensation. That's the \$7,200 in the lower  
18 right-hand column.

19 Now, here we have the high-value ACO in this  
20 example that was only paid \$200 more than the low-value ACO.  
21 But keep in mind that the high-value ACO would also have  
22 incurred lower costs due to providing a lower volume of

1 services. So the providers in the high-value ACO should be  
2 generating a significantly higher level of net income on  
3 Medicare patients due to having higher Medicare revenue and  
4 lower costs of care.

5 A key decision is whether ACOs should be voluntary  
6 or mandatory. Under a voluntary ACO model, the system of  
7 bonuses and penalties would have to be attractive enough to  
8 bring providers into the ACO, because under a voluntary  
9 system the providers could always opt out. If they opt out,  
10 they would not be held accountable for increases in  
11 utilization.

12 In contrast, mandatory ACOs hold all providers  
13 responsible for changes in utilization. Because the system  
14 is mandatory, Medicare could set the reward system up so  
15 that ACOs with very high utilization could lose under this  
16 method. This would not be possible under the voluntary  
17 model. The stronger incentives in the mandatory ACO could  
18 result in better constraint of service volume. The model  
19 would also create strong incentives for providers to join  
20 together into organizations that can cooperate to control  
21 volume.

22 It is important to remember that the current

1 Medicare spending growth rate is unsustainable. What  
2 unsustainable means is that it will change. Because  
3 spending is equal to prices times volume, either the volume  
4 will decline or the rate of increase in Medicare prices per  
5 unit of service will have to decline. Voluntary ACOs are  
6 limited to weak incentives so that they can attract  
7 volunteers. Mandatory ACOs could have stronger incentives  
8 to reduce volume, so they could be accompanied with softer  
9 restraints on fee-for-service rates. Remember, providers in  
10 the ACO are still all paid the same fee-for-service rates.  
11 With strong incentives to restrain volume, there would be  
12 less of a need to constrain fee-for-service rates.

13           The main point here is that there is a trade-off  
14 between reducing volume and reducing rates and the mandatory  
15 ACOs could have a stronger effect on volume.

16           The physician group practice demonstration is one  
17 example of how a voluntary ACO program could be designed.  
18 In this demonstration, physician group practices agree to be  
19 held accountable for meeting certain quality goals and  
20 constraining risk-adjusted annual Medicare spending for a  
21 group of beneficiaries assigned to their practice. The  
22 program provides bonuses for meeting targets but does not

1 have any penalties for failing to meet targets.

2           The good news in the PGP demonstration is that  
3 most sites improve their quality metrics. In fact, all did.  
4 The frustrating news is that Medicare costs at the PGP sites  
5 grew just as fast or faster than the comparison sites in  
6 most cases. Some PGP sites did get bonuses for their level  
7 of risk-adjusted costs, but this appears to be due to better  
8 coding at these PGP sites and not a reduction in the actual  
9 cost of care. In other words, it appears that the PGP  
10 demonstration has resulted in the coding of more conditions,  
11 but the PGP demonstration has failed to slow Medicare cost  
12 growth. While the PGP demonstration has not yet delivered  
13 savings, that does not mean it does not have long-term  
14 potential or that savings could not be generated if the  
15 incentives and processes were improved.

16           There are several design decisions that could be  
17 made to enhance the probability that the ACOs could generate  
18 savings. First, ACOs could be given spending targets in  
19 advance, and this is not the case in the PGP demonstration.

20           Second, CMS could speed the flow of information to  
21 ACOs. For example, ACOs could be alerted when patients are  
22 admitted to a hospital outside of the ACO to help the ACO

1 coordinate care and do discharge planning.

2 Third, if the ACO program was permanent, the group  
3 practices and the hospitals would have a stronger incentives  
4 to make long-term changes to restrain the growth in Medicare  
5 spending while improving quality.

6 For example, if we are asking an ACO to reduce its  
7 capacity by either not buying a new MRI machine or not  
8 hiring that additional interventional cardiologist, they're  
9 basically agreeing to reduce the growth of their long-term  
10 -- reduce the long-term growth in their revenue stream and  
11 they would say, well, if you're going to have me reduce the  
12 long-term growth in my revenue stream, you better have a  
13 permanent system of bonuses so I could have some long-term  
14 potential for bonuses from the ACO as opposed to a three- or  
15 four-year demonstration.

16 Fourth, private payers in Medicare could encourage  
17 ACOs to bring in other payers. If you had other payers  
18 involved, this would enhance the incentive to constrain  
19 capacity. Providers have told us that they basically treat  
20 all their patients the same, so if they change their heart  
21 failure protocols, it's going to affect all of their  
22 patients. If they don't buy an MRI, it's going to affect

1 their revenue stream from all their payers. So if you want  
2 them to be willing to reduce the revenue stream from all  
3 payers, they tell us they need to get bonuses from at least  
4 a majority of their payers to help make up for that lost  
5 revenues stream.

6 Fifth, we have discussed using both withholds and  
7 penalties to strengthen the magnitude of the incentives.

8 And finally, measuring performance over three  
9 years would reduce the volatility in performance and reduce  
10 the incentive to drop high-cost patients.

11 And finally, it would also help Medicare  
12 differentiate between truly good performance -- meaning  
13 consistently good performance -- and random variation in  
14 costs from one year to the next.

15 So now this brings us to our discussion questions.  
16 The first question for discussion is the big one, and that's  
17 whether Medicare should use ACOs as a mechanism to try to  
18 constrain volume growth.

19 If so, the next question is what would happen --  
20 what should happen to ACO providers if there was no change  
21 in volume? Basically, what should happen to providers if  
22 these incentives don't work? Should there be penalties?

1           The third question is how should bonuses and  
2 penalties be structured? We've offered just one potential  
3 design and that's in this paper, but we'd like to hear your  
4 comments and suggestions.

5           And finally, if you include the ACOs should be  
6 pursued, the next question is whether they should be  
7 voluntary or whether providers should be able to opt out,  
8 and providers should be able to opt out or whether they  
9 should be mandatory. If they are voluntary, we risk not  
10 affecting the behavior of providers in the highest-growth  
11 areas. That's because they may decline to join the system.

12           We now turn this over to your discussion. There's  
13 certainly plenty of issues to talk about.

14           MR. HACKBARTH: That's an understatement.

15           [Laughter.]

16           MR. HACKBARTH: Nice job. This is a very clear  
17 presentation and paper, as well.

18           So we will have our usual three rounds. The first  
19 is strictly clarifying comments. What did ACO mean, for  
20 example. Hopefully a little more honed in than that. But  
21 clarifying comments. Then the second round will give people  
22 an opportunity to make either an initial statement of

1 affirmation -- I think this looks good and we ought to go in  
2 this direction, or a statement of reservation. And then  
3 based on those two rounds, we will try to have a focused  
4 third round of discussion that really starts to hone in on  
5 the major issues that seem to be on people's minds.

6 So let me see heads for clarifying questions,  
7 round one. We will start over here with George, Nancy, Ron.

8 MR. GEORGE MILLER: Just one clarifying question.  
9 Again, I thought this was an excellent job, as the Chairman  
10 said. But I didn't see anything in here about  
11 beneficiaries' choice. In putting this together, what does  
12 a beneficiary -- what input does a beneficiary have with the  
13 choice of either a physician or health care organization?

14 DR. STENSLAND: In the example we've laid out so  
15 far is the beneficiary is still free to choose their doctor.

16 MR. GEORGE MILLER: Okay.

17 DR. STENSLAND: So if they think their doctor is  
18 not doing a good job, they could go ahead and try to visit  
19 another specialist, even if that specialist is outside the  
20 ACO. So it really puts pressure on that primary care doctor  
21 to have their patient think they are doing a good job and to  
22 keep those patients satisfied with the services that are

1 within the ACO, because a satisfied patient will stay in the  
2 ACO, a dissatisfied patient will leave the ACO. And if the  
3 patient leaves the ACO, the way this is modeled, you are  
4 still responsible for those costs.

5 MR. GEORGE MILLER: The same thing for the  
6 hospital?

7 DR. STENSLAND: The same thing for the hospital.

8 MR. GEORGE MILLER: Thank you.

9 DR. KANE: On page nine of your slides, you have  
10 an example of a bonus penalty calculation. So if actually  
11 billing was target for the good guy, the high-quality,  
12 \$7,500, the net payment would be 705 guys? And so they  
13 would get better revenue out of this if they ignored your  
14 volume incentive?

15 MR. GLASS: But their cost of delivering the  
16 services would go up.

17 DR. KANE: Yes -- well, yes, so the marginal --

18 MR. GLASS: The marginal -- yes.

19 DR. KANE: So I think that as soon as Medicare  
20 takes some of the lower volume reward, you create an  
21 incentive not to do it. I'm just trying to see if I  
22 understand this right. So if they actually spent the target

1 level, they would get more revenue?

2 DR. STENSLAND: [off microphone] Yes.

3 DR. KANE: So I guess what would be helpful is  
4 what your marginal cost assumptions are here, to understand  
5 better what the incentive really is.

6 DR. STENSLAND: I think this gets back to the  
7 other example that we showed with the MRI machine of saying,  
8 generally, the ACO incentive probably is not going to be big  
9 enough to overcome the marginal profit you're going to get  
10 from just running the machine more. But it might be big  
11 enough to overcome the average profit. So it might be big  
12 enough to convince you not to buy the machine because then  
13 you get the bonus, you don't have the cost of the machine,  
14 and maybe the combination of not having the cost of the  
15 machine plus the bonus overcomes that profit you would have  
16 -- the revenue you would have generated from the machine.  
17 It all depends on the magnitude of the marginal cost and the  
18 marginal revenues.

19 MR. HACKBARTH: So a corollary of that would be  
20 that to the extent that this works through creating systems  
21 thinking, thinking about investment in equipment or a mix of  
22 specialties and the like, you would expect the effects to be

1 greater over time, that you might have smaller effects in  
2 the short run than you could see in the long run. Is that a  
3 fair inference?

4 MR. GLASS: Right, and part of the logic behind  
5 that is the observation that in areas with a large supply of  
6 specialists and ICU beds and that sort of thing the use of  
7 supply-sensitive services is much greater, and that seems to  
8 be driving a lot of the variation in resource use.

9 MR. HACKBARTH: The existing PGP demo has lots of  
10 other issues, design issues that are different than what we  
11 have described here, but that also could be a reason why  
12 you're not seeing cost effects in the short run with the PGP  
13 demo. The system impulses is still developing.

14 DR. STENSLAND: I think that the PGP people who  
15 spoken to us or spoken publicly on this, they have said,  
16 well, this is a temporary program and it only affects a  
17 small part of our total payers so we're not fully invested  
18 in this thing because we can make long-term decisions  
19 because it might end in four years and then we're going to  
20 have this long-term revenue stream go away in exchange for a  
21 short stream of bonuses and that makes them reluctant to  
22 make big changes.

1 DR. CASTELLANOS: First of all, good job and I  
2 like this concept very well. Being a physician, my real  
3 interest is the patient and the patient's care. George has  
4 started the questions on, but what's the incentive for the  
5 patient? I don't see any incentive for the patient? We're  
6 not sure about quality. We're not sure about cost savings.  
7 And I'm supposed to, as a physician, cajole or talk these  
8 patients into staying because I'm going to be responsible no  
9 matter what for three years, whether they stay with me or  
10 not. So what's the advantage to the patient?

11 MR. GLASS: Well, I guess one advantage to the  
12 patient would be if high-quality ACOs were encouraged, the  
13 quality would go up. The quality of care would increase.  
14 And I suppose they could choose between -- if this was  
15 publicized, they could choose between a high-quality and a  
16 low-quality ACO. So they would know which one was  
17 delivering high-quality care.

18 DR. CASTELLANOS: But you won't know that for  
19 several years. I agree, there is a value of quality --

20 MR. GLASS: Well, you could do it retrospectively,  
21 I suppose. You could look retrospectively to see what this  
22 group has produced in the past.

1 DR. CASTELLANOS: Not an ACO that is just starting  
2 up.

3 DR. STENSLAND: So not at one that's just starting  
4 out. You'd have to kind of promise something. But there is  
5 an example of one of the ACOs brought up the other day at  
6 the conference that John was talking about and they improved  
7 their heart failure regimen. They would have people  
8 communicate every day with the system. And what they found  
9 out was they were able to dramatically reduce admissions for  
10 the heart failure, and if they are able to reduce the  
11 admissions for heart failure, they have got something you  
12 could sell to the patient. You say, you want to be in this  
13 ACO system because we have a system for monitoring you. And  
14 if you look at the chance of you having to go into the  
15 hospital, it's better than other systems. There is also a  
16 big incentive the ACO system to reduce readmissions, because  
17 readmissions are a big cost. And like I say, we want you to  
18 stay in this ACO system because one of the things we work  
19 hard on is to get right the first time so you don't have to  
20 come back into the hospital. If you could show that they  
21 actually have lower readmission rates, that might be a  
22 selling point to the patient.

1           I think part of the function of the ACO is to say,  
2 now when the system does those good things, when they reduce  
3 remission rates and they reduce their revenue because  
4 they're doing it, when they reduce admission rates and they  
5 reduce their revenue because they're doing it, they get some  
6 compensation for that through the ACO bonus.

7           MR. BERTKO: First, David and Jeff, nice report  
8 here and good presentation for clearing this up. As both  
9 David and Jeff have indicated, I've been part of the Elliott  
10 Fisher team looking at this, so we've done some thinking  
11 about it.

12           The one clarification comment I would have is  
13 we've looked at ACOs as being a big tent, and that while I  
14 would agree with you that a hospital physician group is  
15 probably the most likely one in there, I would see if you  
16 guys would agree that perhaps a large multi-specialty group  
17 by itself could be an ACO, and perhaps several other  
18 variations?

19           DR. STENSLAND: That's certainly an option and I  
20 think at some of our other ACO discussions over the last  
21 couple of years we brought up that option. The one thing  
22 for you all to decide is whether it's fair to leave the

1 hospital out. The reason that you might think it's not fair  
2 is that if you look at a lot of the savings that the ACO  
3 hopes to generate, a lot of is going to be due to things  
4 like reduced admissions, reduced readmissions. So the  
5 hospital's revenue might be the revenue that's shrinking the  
6 most, and if the hospital's revenue is the one that's  
7 shrinking, you might think they should have an opportunity  
8 to share in the bonuses.

9           The other factors, what we've gathered from you,  
10 is there's a lot of you that have suggested that it's very  
11 important for hospitals and physicians to work together, and  
12 so having them both in the ACO might make it easier for them  
13 to work together as opposed to if the hospital has a  
14 different set of incentives from the physician, which could  
15 create some discord.

16           MR. GLASS: Yes, and the other consideration was  
17 that we've kind of shown that they have to be able to make  
18 joint decisions and have some form of organization and the  
19 hospital may be the only one with enough assets to convene  
20 everyone and provide HID or whatever. So in our paper,  
21 we've been assuming hospitals are in. But that's clearly  
22 something the Commission could decide otherwise on.

1           MR. HACKBARTH: Could I just ask a follow-up  
2 question about the PGP demo. It's labeled physician group  
3 practice, but don't all of them include a hospital in the  
4 configuration?

5           MR. GLASS: I think there's one that does not.

6           MR. HACKBARTH: One that does not?

7           MR. GLASS: Middlesex, I think.

8           MR. HACKBARTH: You know, that's a big hunk of the  
9 dollars, 30 or 40 percent of the dollars are in the  
10 hospitals, so to the extent that you are trying to change  
11 that and having a hospital involved would seem logical to  
12 me.

13          DR. CROSSON: Glenn, excuse me. On that point, my  
14 understanding, and actually, I think Middlesex does have a  
15 hospital. That is the hospital. But my understanding is  
16 that although the savings available in the demonstration  
17 project come from both savings on the office side and the  
18 hospital side, that the hospital itself is not included in  
19 the potential for gain. I could be wrong, but I think that  
20 is the design element. It is the group practice that stands  
21 to gain.

22          DR. STENSLAND: I think that's correct, but I

1 think the point is that a lot of these group practices are  
2 part of a bigger system, so that if you give --

3 DR. CROSSON: Some are, but some are not.

4 DR. MARK MILLER: Let me just make one quick  
5 comment as to why this issue is -- you just made the set of  
6 arguments for inclusion, which I tend to agree with. I  
7 think the argument that the physician-only people make, and  
8 I don't whether you are in that camp or not, is that the  
9 more you include providers who potentially lose revenue, the  
10 more resistant they are to change. And this is probably a  
11 religious question in the end, but that's kind of the  
12 underlying discussion here.

13 MS. BEHROOZI: This is just the round one  
14 clarifying question, so I don't mean to sound skeptical  
15 because it all sounds -- you're putting out a lot of great  
16 information and it's great directionally, but it's really on  
17 the issue of involvement of other payers which you identify  
18 as sort of a principal point that would strengthen ACO  
19 design. In the paper, you make the comment, therefore, ACOs  
20 should be structured so that private insurers could also  
21 have an incentive to set up a bonus system similar to  
22 Medicare. The clarifying question is whether you have

1 thought about what that means, what that means in terms of  
2 the structure, which then also goes, I think, to the  
3 voluntary-mandatory question a little bit, or whether that's  
4 yet to be explored. That's the question.

5 DR. STENSLAND: We haven't done any serious  
6 thinking on that. The people in Vermont are trying to  
7 structure it that way, where they will have three main  
8 insurers, Medicaid and -- and they're hoping to get  
9 Medicare, they don't have Medicare in yet -- in the whole  
10 program, so we haven't done much work but there's others who  
11 are working in that direction.

12 DR. CROSSON: My question is sort of on the same  
13 topic, on slide nine again, which we still have up there.  
14 This assumes that -- I assume it assumes that the physicians  
15 and the hospitals are part of this ACO. So this gain here  
16 or the difference in the net Medicare payment example, as  
17 simple as it is, is actually more complicated because it  
18 assumes that that money, that gain, is going to be in some  
19 way shared between physicians and hospitals. So this is a  
20 combination of an increase in payments under Part B and Part  
21 A and then make some assumptions that there is some  
22 organizational entity and some process on the other end to

1 receive that in an equitable manner.

2 MR. GLASS: You could make it kind of mechanical  
3 and have Medicare do it if you wanted to, as a percent of --  
4 look at last year's spending, what percent of it was the  
5 hospitals, what percent was the physicians, and return it  
6 that way. So you could do a mechanically, virtually kind of  
7 if you wanted to. Or you could just give the \$400 to this  
8 organization and say, split it up however you guys like.

9 DR. CHERNEW: I have a question about slides five  
10 and six. Go to six, because it includes both. My question  
11 is, the big difference is that on the right in the yellow,  
12 you have the fixed costs included. On the left, you don't.  
13 Is that -- so what I think is misleading -- my question is,  
14 there has to be -- the right question seems to be what would  
15 happen under an ACO system versus not? But in either  
16 system, someone has to invest in the MRI. So the right  
17 comparison isn't what would happen if the MRI was free,  
18 which is sort of the marginal one on the left.

19 What seems to be missing on the left, or my  
20 question is, who bought the MRI on the left and what was  
21 their incentives to do it under the -- in the non-ACO world?  
22 Because the question you're trying to answer is if we put in

1 an ACO, how does that affect the incentives for investing in  
2 an MRI. But I don't think -- and correct me if I'm wrong --  
3 I don't think that is what's on the left here. I think the  
4 left here is just if the MRIs were free, the ACOs won't stop  
5 use.

6 DR. STENSLAND: I think you could think of this  
7 as, okay, we set up an ACO and it starts tomorrow and you  
8 have your own ACO. Do we really think you are going to  
9 start doing fewer MRIs on that machine you already have, and  
10 the probable answer is no.

11 DR. CHERNEW: Right.

12 DR. STENSLAND: But maybe you might not buy  
13 another machine to expand your capacity.

14 DR. CHERNEW: But the question for that, and this  
15 is what I'm sort of asking is, the issue is so maybe that's  
16 true. That's the column on the right. But what I don't  
17 understand is that has to be compared to what your incentive  
18 was to buy the MRI machine without the ACO, and that's not  
19 the column on the left.

20 DR. STENSLAND: No.

21 DR. CHERNEW: Right. So I'm trying to figure out  
22 how the ACO changes the incentive to buy the machine. I

1 agree with your point that the ACO won't affect the marginal  
2 incentive to use it. That I agree with. But I don't see on  
3 this how the ACO influences the incentive to buy the MRI  
4 machine because I don't see the non-ACO version of what that  
5 incentive was.

6 MR. GLASS: Well, there's no ACO - the effect on  
7 the ACO bonus goes away.

8 DR. CHERNEW: I know, but there was some other  
9 organization that was deciding to buy the MRI machine  
10 without the ACO and that had a set of marginal costs and  
11 fixed costs and whatever it was, and so that seems to me to  
12 be the comparison.

13 DR. STENSLAND: Yes. The comparison is just the  
14 first three rows in that upper right-hand column. So of  
15 there was no ACO, you would spend \$500 -- you would get  
16 \$500,000 in revenue, you have \$450,000 in costs, and your  
17 net profit would be \$50,000. And that's without an ACO, you  
18 have \$50,000 in profit and that's why you do it.

19 DR. CHERNEW: So the fixed costs are basically in  
20 the \$400,000.

21 DR. STENSLAND: Four-hundred-and-fifty, right.

22 DR. CHERNEW: In the \$450,000, yes. We set it up

1 as a --

2 MR. GLASS: It is \$400,000 is the fixed cost and  
3 the marginal is \$50,000 or something like that.

4 DR. CHERNEW: Four-hundred-and-fifty thousand  
5 would be your annual cost.

6 MR. GLASS: It is marginal and --

7 DR. STENSLAND: Annual costs of operation. So in  
8 the paper, we set this up as if you leased the machine  
9 annually so that your annual costs of leasing, maintenance,  
10 and operation is \$450,000.

11 DR. CHERNEW: So now given that, I'm sure it will  
12 take hours to get back to here. I will think about that  
13 again. But that helps.

14 [Laughter.]

15 MS. HANSEN: Just to follow up on the question of  
16 quality, I think, as well as post-acute care, not only  
17 hospital, in terms of quality, the worry sometimes of  
18 stinting, that still comes up. So is that taken care of by  
19 the fact that the accountability will still follow the  
20 primary care physician if the beneficiary goes someplace  
21 else? So there's a little bit of an incentive there that  
22 the accountability will still trail, and that's part of -

1           MR. GLASS: Because the quality would be assessed  
2 of the population, so that would be true.

3           MS. HANSEN: And then the second clarification is  
4 in the ACO, we're talking about the physician and the  
5 hospital, but so much about the outcome is also related to  
6 the post-acute care. So would that include places like home  
7 health agencies as part of that? Or is that just kind of a  
8 contract of provider consideration?

9           MR. GLASS: The spending on it would be included,  
10 but they wouldn't have to be officially part of the ACO.  
11 Presumably, the hospital and the physicians, when they make  
12 a discharge decision, would pay a lot of attention to where  
13 they were sending them and choose the SNF with high quality  
14 and low cost and less likelihood of readmission.

15          MS. HANSEN: Okay. So the payment would go to the  
16 ACO they would contract --

17          MR. GLASS: No, the fee-for-service payment would  
18 still go to, say, the SNF, but the hospital and physician  
19 would have a large incentive to make sure they were sending  
20 the patient to a good SNF.

21          MS. HANSEN: Thank you.

22          MR. HACKBARTH: Okay. Let's move on to round two.

1 Let me see, since Mike needs more time to think, I've got to  
2 start over here again. Peter, do you want to go ahead?

3 MR. BUTLER: Several comments. I'll answer the  
4 questions first as best I can, if you could put those back  
5 up. I favor mandatory over voluntary, but the devil is in  
6 the details obviously. But I think you will get more teeth  
7 out of this if you go on the mandatory versus the voluntary  
8 side.

9 The second question related to do you think it  
10 should be used to constrain growth. I have a problem with  
11 the way the question is framed. I think it should be, do  
12 you think it should be used to achieve appropriate care for  
13 the patients, which by the way is probably less utilization.  
14 But I think we should frame it in the context of the overall  
15 goals of the metrics we're trying to hit for the patient  
16 population. But having said that, I do think it should be  
17 used.

18 And then the way I would frame then the rest of my  
19 comments is if you look at the way we could intervene in the  
20 system from just on one end informing physicians of  
21 utilization patterns to the other end of the spectrum having  
22 competitive Medicare Advantage bids, I like this one almost

1 the best because it comes the farthest along the food chain,  
2 if you will, to kind of align the whole utilization  
3 question. It retains the Medicare rate, so you don't have  
4 to go through that nonsense, and helps -- I wouldn't call it  
5 nonsense, but administratively it is easier to kind of just  
6 pull it off. You've got great data. And I very much like  
7 the integration of the physician and the hospital activity,  
8 because frankly, not only is it positive, but all of the  
9 other payment reforms -- episode of illness, episode of  
10 care, and that kind of bundling -- is going to encourage the  
11 same kinds of things anyway.

12 I would say that there are some both large systems  
13 and small hospitals that have come an awful long way in  
14 terms of working with their physicians on all of the quality  
15 metrics, on readmission rates, and they're positioned far  
16 differently, I think, than they were maybe in the first  
17 round of managed care to accommodate all of this.

18 Not really stated in here, but you say, why is it  
19 different? I think also IT is not a small factor in this.  
20 A lot of big systems now are being able to measure this  
21 across the physicians and hospitals in ways they haven't  
22 been before, and often those investment decisions are also

1 bringing hospitals and doctors closer together, much better  
2 able to deal with this than maybe they were in the early 90s  
3 when capitation was first rolled out. So I like all of  
4 those aspects of this.

5 I do worry about the logistics. I do worry about  
6 revisiting the toxic impacts of handing out bonuses. It's  
7 not just between hospitals and doctors, it's within groups,  
8 between the primary care and the specialist.

9 On a positive note, I would say we have one of  
10 these PHOs. We do have quality and pay-for-performance now.  
11 We do hand out bonuses to both the hospitals and doctors and  
12 it works very well, so we would be anxious to participate in  
13 something like this.

14 My final point would be on the -- it's kind of  
15 referenced, but it's a very important point. If you have,  
16 say, 5,0000 of your so-called enrollees in a quasi-capitated  
17 system and maybe you have 95,000 that aren't, you don't  
18 exactly have the cultural tipping point in the organization  
19 to fundamentally do things differently. And that was a big  
20 roadblock, I think, in getting through the first round of  
21 all this. And so this by itself, I wouldn't say is going to  
22 flip over behavior, but I don't think we can ignore it and I

1 don't think it's an excuse not to try to do it, because if  
2 others were to jump on this, I think it's absolutely the  
3 right direction to go.

4 MR. HACKBARTH: I had promised Jack -- he assured  
5 me he was going to say something that is so profound as to  
6 alter the course of our --

7 MR. EBELER: Unfortunately, the profound here is I  
8 don't understand, and I have worked at this -- this is a  
9 part of health care that I come out of in a lot of ways.  
10 The statistical analysis has been, I think, the most  
11 powerful tool we have had in health care, this whole idea of  
12 looking at geographic contiguous units. It is a fabulous  
13 unit of analysis and we're trying to turn it into a unit of  
14 intervention. There's a part of this that -- and magic  
15 happens, step here. The statistics at the front end work  
16 and then your statistics at the back end work and it's sort  
17 of the thing. So I don't quite know what an ACO is.

18 The descriptions that we have sound like the  
19 discussions we used to have years ago about why it wouldn't  
20 be smart to start some type of an organized delivery system  
21 organized health plan, the kind of world I come out of. You  
22 say, gee, let's do that. The difficulty is -- and we talk

1 about it as though it's an exclusive organization. But as  
2 Peter says, the truth is this is a statistical construct  
3 nested within another statistical construct which is  
4 Medicare. So I don't quite understand how it works. I  
5 think there's possibly -- I think I hear two potential  
6 paths. One is we need to define what "it" is, and again,  
7 maybe this is my not getting it. And then figure out how to  
8 pay it. I mean, if Peter was to do this, let's figure it  
9 out. My personal guess is that we may be talking about a  
10 radical redesign of Medicare Advantage, because this is what  
11 Medicare Advantage was supposed to do.

12 And the other possibility I think I hear is people  
13 talking about implicitly geographic-specific budget caps in  
14 Medicare fee-for-service, sort of an SGR across all Medicare  
15 payment in the local area in fee-for-service, and then you  
16 opt out of that to be an ACO. I mean, those are two  
17 potential paths.

18 But you've got to help me --

19 MR. GLASS: Okay. Let's address why it isn't a MA  
20 plan first.

21 MR. EBELER: Tell me what it is. I can't tell  
22 what it is.

1           MR. GLASS: Let's take a really concrete example.  
2 In Vermont, they're talking about -- apparently, I'm not  
3 sure of the facts, but it's something like there's 13  
4 hospitals there and they exist quite in distinct markets.  
5 They tend not to have a lot of overlap among their patients.  
6 And they've started a medical home sort of thing where they  
7 have several -- and the idea is to bring several of the  
8 medical homes together with the hospital in the area and  
9 form a ACO out of that. So that would be, I think, the most  
10 concrete, simple to understand definition of an ACO. So it  
11 would be that hospital in that area, and it has a market  
12 area to itself, and it's got these medical homes that feed  
13 into it, and the combination of those things becomes an ACO.  
14 They cannot take insurance risk.

15           MR. HACKBARTH: Let me just leap in for a second.  
16 Arnie is going to have to step out briefly, so I wanted to  
17 give him a chance to get his comment in before he leaves,  
18 and then we can pick up with this. Arnie?

19           DR. MILSTEIN: Thanks, Glenn. I have been for the  
20 last several years with foundation support been trying to  
21 understand the, I'll call it the architecture of delivery  
22 systems that are achieving good quality of care with a much

1 lower level of resource use, both for Medicare and other  
2 chronic illness populations. And boiling it down, if one  
3 were to essentially draw conclusions based on, I'll call it  
4 these favorable outliers, one would have to come down very  
5 strongly in favor of allowing primary care groups to be  
6 ACOs, because they have, by far and away, the best leverage  
7 point on total spending in so-called supply-sensitive  
8 services. It's their success that affects whether people  
9 even need specialists and hospital services, and they are  
10 also in a wonderful position at the margin to direct  
11 patients toward higher-quality, lower-spending hospitals and  
12 specialists.

13           So if our goal is -- if we want to heavily weight  
14 the goal of sustainability of Medicare, my observations  
15 would suggest that we want to make sure that primary care  
16 groups are allowed to participate in this program, because I  
17 think they are by far best positioned to achieve the  
18 objectives of both Medicare's sustainability and quality.

19           The second comment I would make is in some ways  
20 derivative of that and it has to do with underlying all of  
21 this -- and I think it refers to, was it Mark or Glenn's  
22 comment about this is primarily a religious question.

1 Another way of framing the religious question, it's an  
2 equity question, because how you design this program, if one  
3 says that my primary goal is to improve affordability of  
4 health care, including Medicare health benefits, for low-  
5 middle-income Medicare beneficiaries and especially for  
6 service workers who are increasingly the nature of the  
7 American workforce, and shielding them from increases in  
8 what have to pay in Medicare taxes, then you come down very  
9 strongly in favor of tilting this program in some ways  
10 towards primary care groups and allowing in some communities  
11 some a pretty severe effects on hospitals and specialists,  
12 especially in those geographies where the suggestion is that  
13 there's a lot of supply-sensitive services going on, at  
14 least benchmarked against other geographies.

15           And so in some ways underneath all of this is a  
16 question of values and where you want to place your pain  
17 relief priorities. If the priority is toward Medicare  
18 sustainability and quality, then I think the evidence  
19 suggests you want to tilt ACO management and leadership  
20 towards primary care physician groups. And if you want to  
21 weight in the other direction toward limiting financial  
22 distress and acute pain for hospitals and specialists who

1 perhaps due to no fault of their own happen to find  
2 themselves in a practice environment in which there's a lot  
3 of supply-sensitive services going on, then you tilt in the  
4 direction of allowing specialists and hospitals to  
5 participate in the gains.

6 MR. HACKBARTH: Arnie, is an implication of that,  
7 the tilting towards primary care that you're advocating,  
8 well maybe you don't even need to do ACOs. You do medical  
9 homes on -- as you put it, I think, in one of our  
10 discussions on medical homes, medical homes on steroids with  
11 very strong performance incentives for total costs.

12 DR. MILSTEIN: Or at least allow them to -- yes.  
13 I think the point here that this paper makes is that if you  
14 want confidence in your savings numbers, you need at least  
15 5,000 enrollees and that obviously tilts in the direction of  
16 group aggregation of primary care practices.

17 MR. HACKBARTH: That was going to be my next  
18 point, is one of the issues with building the accountability  
19 for total cost performance on primary care is the small  
20 numbers problems. And so for total cost accountability, you  
21 are almost by definition talking about aggregations of  
22 primary care physicians, whether they're in a formal group

1 or some sort of virtual group.

2 Thank you.

3 MR. EBELER: I understood that "it."

4 [Laughter.]

5 MR. BERTKO: Let me go to one of the questions  
6 that was maybe answered, the difference particularly between  
7 MA and an ACO, and that is attribution of seniors at least  
8 into this. I think that was in the paper. MA has to have  
9 an active enrollment. This would attribute it, so, and I'll  
10 pick Peter, your hospital. You guys serve a ton of seniors,  
11 so you probably more likely have 50,000 seniors attributed  
12 to the physicians that work with your facility. That part  
13 of it can come into place instantly because that's a huge  
14 advantage over the whole roll-up of an MA enrollment.

15 Secondly, though, David made a very good point  
16 earlier about -- I think you used the word "convener" for  
17 the hospital. So convener and contracts are very important.  
18 I will come back to that with other comments, but that's an  
19 argument in my mind for voluntary in the short run as  
20 opposed to mandatory, because you need to have organizations  
21 and contracts in place to make it work.

22 MR. GLASS: But the other distinction, an MA plan

1 takes the full insurance risk. It gets full capitated  
2 payment, full insurance risk. This is still mainly  
3 fee-for-service.

4 MR. EBELER: This attribution issue, and to go  
5 back to Peter's, he said, I've got 5,000 in the ACO and I  
6 treat another 90,000. There's two "its" there and I can't  
7 tell exactly --

8 MR. GLASS: Well, if you went with the attribution  
9 model then -- go ahead.

10 MR. HACKBARTH: This is important. It didn't  
11 fully meet my expectations for profound.

12 [Laughter.]

13 MR. HACKBARTH: But we have a lot of people in the  
14 queue and we're running out of time, so I want to get back  
15 to people who have been waiting patiently. George?

16 MR. GEORGE MILLER: My follow-up second-round  
17 question has to do with the rural America and how they fit  
18 into this. I saw a little bit in the chapter, but I need a  
19 little more explanation because I'm concerned about  
20 distance. Although you're talking about 5,000 people, in  
21 rural West Texas, for example, 5,000 people could be  
22 hundreds of miles apart. I'm not sure how that works, and

1 let me lay the other issue on the table as you think about  
2 that.

3           Also, a high-quality low-resource -- I'm not sure  
4 I understand their incentive because the fact that they are  
5 lower resource users means they've already gotten all the  
6 low-hanging fruit. And to get more cost out of the system,  
7 they may have to affect staffing, as an example, since  
8 that's the largest piece of -- certainly a health care  
9 organization's piece. So I'm not sure I understand the  
10 incentive there. There are a high-quality provider, low-  
11 resource user. How do they figure into the bonus  
12 calculation? I'm not sure I follow that logic.

13           MR. BERTKO: Let me -- again, we've got all kinds  
14 of statistics, but I'll go back. Even in our measurements  
15 -- this is Elliott Fisher and John Skinner -- of low-cost  
16 places, and I'm thinking of the Dakotas here in particular,  
17 there is still enormous variation within places that, on  
18 average, are very low cost. That's the opportunity, I  
19 think.

20           MR. GLASS: Well, also, we set up the bonus as a  
21 set dollar target and that's why that low resource use ACO  
22 you were talking about gets a 6.3 percent target growth. So

1 we realize that they have taken some of the fat out of the  
2 system already, so they're given a higher -- their target  
3 growth is 6.3 percent whereas national it's 5 percent, and  
4 for the high resource use guy it's only 4.2 percent.

5 DR. STENSLAND: The advantage is that you're in  
6 North Dakota, even adjusting for wages, that \$500 is going  
7 to probably go farther because people just don't do as much  
8 high-tech stuff. All the distance acts like a giant co-pay,  
9 and so they might be able to do well because they're given  
10 that \$500 and they can do more with that than a big urban  
11 area.

12 MR. GEORGE MILLER: [off microphone] [inaudible]

13 DR. STENSLAND: Yes, I think that is an issue, and  
14 really to get up -- when we looked at some rural areas, like  
15 North Dakota, you would have to conglomerate a lot of small  
16 little towns into a big entity and that would be something  
17 you'd have to probably work out in more detail than we have  
18 already. But to get to 5,000 people, it would have to be  
19 something like all the CAHs in North Dakota would be an ACO  
20 or something like that. And how you would structure the  
21 bonuses and penalties to not make them too much at risk  
22 would be part of the factor. Also, maybe some of the

1    littlest towns wouldn't be that interested in the hospital  
2    is already getting cost as a CAH and the doctors are getting  
3    rural health clinic payments or costs as a community health  
4    center. They might be that interested in this kind of  
5    model.

6           MR. GEORGE MILLER: The voluntary versus mandatory  
7    issue question you asked at the end of the chapter.

8           DR. STENSLAND: Yes. So if it was mandatory,  
9    there would have to be some working through all those  
10   specific rural issues.

11          MR. GEORGE MILLER: Okay. Then it's hard to  
12   answer that question, because I'd like to know how many  
13   rural hospitals would fit in that category, so how do you  
14   make that mandatory if it wouldn't be a benefit?

15          MR. GLASS: Well, you could say that -- and you'll  
16   have to correct me -- I think it's North Dakota has a  
17   relatively small number of hospital systems that many of  
18   these small hospitals are affiliated with. So you could  
19   conceivably take the entire hospital system, which is, you  
20   know, a main hospital and several smaller hospitals,  
21   together as -

22          MR. GEORGE MILLER: In West Texas, as an example.

1           MR. HACKBARTH: Potentially, George, you could  
2 also cut it another way. You could say it is mandatory in  
3 certain parts of the country and voluntary in places like  
4 these where the nature of care delivery is different and  
5 more distant, less organized. It's not an absolute yes or  
6 no decision. It could be yes in some places.

7           DR. MARK MILLER: I know we're out of time, but I  
8 just want to say something quickly. I don't think we should  
9 just assume that these things can't work in rural areas.  
10 Geisinger is one of the biggest systems and it is in a rural  
11 area. These connections can be made. But that's not to say  
12 that your comments aren't valid.

13           MR. HACKBARTH: And Intermountain Health Care.  
14 They have an urban base, but then they've got 23 very small  
15 hospitals in very remote locations connected to the system.  
16 Nancy?

17           DR. KANE: I think we just need a set of  
18 principles to establish a context in which this could  
19 possibly operate. I think it is what we are -- and I think  
20 the goal is really to set up something that is really quite  
21 temporary to force organizations into bigger systems in  
22 rural areas and to -- I mean, I think that is what this is

1 really for, is to get organizations that have traditionally  
2 operated in silos to start talking to each other.

3           So in thinking about some of the principles that I  
4 would subscribe to or think we should at least consider  
5 talking about, one is that this will work best in an all-  
6 payer environment, and we've talked about it and kind of  
7 hinted at it. And I think in order to get to an all-payer  
8 environment, we need to talk about the role of States and  
9 whether or not we can create collaborations with States to  
10 create all-payer environments. And in bringing in States,  
11 we could also help tailor any of these ACO models to the  
12 local State situation rather than trying to create at the  
13 national level some cookie cutter approach that doesn't fit  
14 a lot of local environments.

15           So I think even though Medicare is a Federal  
16 program, now more than ever we need to consider how do we  
17 get to all-payer and how do we get States to help us design  
18 locally relevant payment methods. So that's my first  
19 principle, is how do we articulate a role for the States and  
20 encourage all-payer environments for any of these payment  
21 innovations.

22           The second principle, I think, is that we need a

1 geographically-based clinical information system. The  
2 biggest obstacle for an ACO is that the beneficiary can go  
3 anywhere, and at least have a way to notify the people who  
4 are on the hook for it that the patient has gone to the  
5 emergency room or has just gone to see a specialist outside  
6 the ACO.

7           There are increasingly better information systems  
8 and EMRs out there, but so far, they still don't talk to  
9 each other and they don't talk across systems, and yet the  
10 patient is still able to go over the place. I think we  
11 really at the Federal level, one of the real value added and  
12 one of the important contexts for this is you really need  
13 some type of interoperability that really works and that  
14 captures key pieces of information and that people who are  
15 care providers have access to.

16           I think related to what I think Ron was saying is  
17 you can't leave the beneficiary out of this. They do need  
18 some incentive to stay in the ACO or to notify the ACO of  
19 where they're going. You can't just drop this on the  
20 provider without any support for the beneficiaries'  
21 incentive. It's just not realistic if you think about the  
22 potential -- some of these systems have 60 -- I think even

1 Geisinger, 60 percent out-of-network use. You really have  
2 to think about how do you get the beneficiary to be a part  
3 of the solution here.

4           And then finally, I think -- well, actually I have  
5 two more. I'm sorry, but this is a long session, right? It  
6 does have to be long term. It can't go away because you are  
7 talking about massive system change, massive changes in the  
8 way organizations and providers relate to each other, and a  
9 three-year window is chump change. They can wait it out.  
10 They can lose money for a while, just wait it out, make it  
11 go away politically. You can't just put something up that's  
12 got a three-year window.

13           And I think the ACOs should really just be the  
14 temporary payment method that leads towards either  
15 unbearable withhold increases on the poor performers or a  
16 much more rewarding bundled payment, increasingly bundled  
17 payment for those who do well, and therefore they're better  
18 able to capture those benefits. So this fee-for-service ACO  
19 thing should really be seen as a vehicle to push  
20 organizations towards wanting to take at least episode-based  
21 payment or A and B bundled payments, at least on segments of  
22 their business as they began to learn how to collaborate

1 together. There has to be a constant forward motion to  
2 this. This should not be viewed as a static, can stay in  
3 place forever. It has to be viewed as pushing people out of  
4 it and into more bundled payments, because I think the  
5 inertia here is huge and if we can't get everybody rowing in  
6 the same direction, as soon as there's a break in the  
7 economy or a window of opportunity, this will collapse.

8 I guess my final comment is, in the meantime, if  
9 one of the purposes of this ACO is to not have organizations  
10 add MRIs and excess capacity, there are perhaps better and  
11 more direct ways to do that and we should consider them.  
12 That would include reviewing certificate of need and other  
13 types of planning mechanisms at a regional or geographic  
14 level. Again, here's where collaborating with the States  
15 might really help, and creating a context for which these  
16 might work effectively and encouraging or rewarding States  
17 that actually set up real controls on the proliferation of  
18 high-cost, high-fixed-cost technology.

19 So I just think we need a set of context  
20 principles that we say, if you're going to do this, this  
21 will work best under these principles, and the closer we can  
22 get to it, the more likely you'll see some real benefit from

1 it.

2 DR. MARK MILLER: A really quick informational  
3 point just in case anybody else misunderstands. We are not  
4 speaking of this as a three-year process. It's continuous.  
5 It's just you're evaluated on a three-year --

6 DR. KANE: I still think it needs to have other  
7 things that are better that is pushing toward, not just it.

8 MR. HACKBARTH: You could imagine that over time,  
9 this might evolve towards a global capitation and maybe not  
10 with full risk assumed by the ACO, but some sort of risk  
11 sharing, risk corridors with the government which would  
12 increase the power of the incentives significantly. As  
13 groups get more confident that, hey, we can manage this,  
14 they may welcome that as opposed to resist it.

15 DR. CASTELLANOS: First of all, I strongly support  
16 the direction we are going. We need to work together, all  
17 of this, primary care, specialists, physicians, hospitals.  
18 We need to work together and this is a great step. I agree  
19 with Nancy. I think we need to push on that because there's  
20 a great amount of inertia there.

21 I'd like to talk about MRI. It's not the MRI  
22 that's the problem. It's the person that's using the MRI or

1 the person that's ordering the test. There's no question  
2 ownership does have a role as being excess usage. But I  
3 think there's been some studies in Health Affairs and, in  
4 fact, Glenn and myself talked about one from Seattle where  
5 they really showed the big difference here is the practice  
6 pattern of the physician.

7 I think in our next topic, when we talk about  
8 physician resource use, this is intimately related to the  
9 issue of whether we can control growth on volume. We need  
10 to control growth in volume. It's way out of control. But  
11 I think one of the ways we need to do it is not just  
12 limiting the ownership, but limiting the use of it and the  
13 practicality and appropriateness of it.

14 Now, the question is should we do with voluntary  
15 or mandatory, well, mandatory, you will get it done but you  
16 are going to have so much resistance and so much static from  
17 every provider that I would certainly say start voluntarily.

18 DR. STUART: I have Jack's question in mind. I  
19 read this twice and I couldn't figure out what "it" is, and  
20 it seems to me that it really cries for some system  
21 examples. There's one sentence in here about Vermont doing  
22 something, and maybe you could tell us a little bit about

1 what Vermont is doing. One of my particular concerns in  
2 this is, is everybody covered in this? They are 13  
3 hospitals in Vermont. Are all the physicians and all the  
4 hospitals then going to be part of these things? Maybe that  
5 will help me figure out what "it" is.

6 MR. HACKBARTH: One thing -- I am very eager to  
7 get through the rest of the group and we're quickly running  
8 out of time. But one thing that we may consider, want to  
9 consider, is how to bring some more life to this. The  
10 example, as I said to Jack, that keeps coming to mind for me  
11 is my former employer, Intermountain Health Care. We had  
12 Brent James here a number of years ago, before many of you  
13 were on the Commission, and Brent, a highly regarded  
14 physician and one of their leaders in trying to improve  
15 quality and reduce costs, explained in some detail about how  
16 perverse the incentives are in the existing Medicare program  
17 for an organization like theirs. They are always fighting  
18 the incentives. Doing the right thing is costing them  
19 money.

20 So when I think of this, just because of my  
21 personal connection with them, I'm always thinking, how do  
22 we alter the program so that there starts to be some reward

1 for the Intermountain Health Cares of the world, the  
2 Geisingers, the Mayo Clinics, organizations for a variety of  
3 reasons have some Medicare Advantage business, and may  
4 actually want more Medicare Advantage business, but because  
5 of their patient choices, patients have chosen to remain in  
6 traditional Medicare. Not all of their activity is in  
7 Medicare Advantage. And so they still want to do the right  
8 thing, but we're penalizing them at every turn. How do we  
9 help them out, to me is sort of the basic question.

10 DR. REISCHAUER: Not to pile on here. The  
11 challenge that we have is bending the cost growth curve  
12 significantly sometime over the next ten years. I am very  
13 skeptical in the political environment we're in and the  
14 institutional environment we're in that ACOs are going to be  
15 a significant component of that answer. ACO-like things  
16 exist here and there, and of course the question is, is it  
17 just the incentives? Or is it something else that has kept  
18 them from spreading more robustly around the country? I  
19 suspect it's something else, as well as the lack of  
20 financial incentives.

21 I think one might make a success out of this if  
22 you really thought bonus payments could be quite large, ten

1 percent or 15 percent, and penalties could be ten percent or  
2 15 percent. But realistically, I don't think that's going  
3 to happen in my lifetime. Maybe my lifetime will be short  
4 and I will prove to be wrong.

5 [Laughter.]

6 DR. REISCHAUER: We have sort of imagined these  
7 things and talked about little examples of the cost, but  
8 nowhere in there is the costs of organization management  
9 keeping these things going, which is -- especially when  
10 they're loosey-goosey is a very complicated thing to do with  
11 components, hospitals, physicians who can go in and out  
12 depending on what their whim is or things like that. If I  
13 had to do this it would be mandatory because I don't think  
14 we would tolerate the kind of incentives necessary to make a  
15 voluntary system grow over time.

16 So I think we have to define something that has  
17 practical feet on the ground, and maybe there's a version of  
18 ACOs that might with a set of incentives that do, but I am  
19 unconvinced by where we are right now.

20 MR. EBELER: When he said it, he sounded profound.

21 [Laughter.]

22 MR. BERTKO: Sorry Bob, you've got two or three

1 years left to live.

2 [Laughter.]

3 MR. BERTKO: Now let me make a couple of comments.

4 DR. REISCHAUER: When an actuary says that, you  
5 know, you're really nervous.

6 [Laughter.]

7 MR. BERTKO: Good. I'm glad you picked up on  
8 that.

9 A couple of comments here. First of all, on the  
10 multi-payer aspect of it, absolutely true, the project where  
11 we're trying to recruit sites to become ACOs is we are  
12 pushing the multi-payer activity. The good news is, in  
13 virtually every market that I was in, you have a dominant  
14 two or maybe three payers. So if you have Medicare Plus,  
15 you're the local Blue, or in some markets, for example, the  
16 company I was with, you own 50 to 70 percent of the bodies  
17 that would be in there. You guys say it right, but I just  
18 want to reemphasize that, because it does require enough  
19 people under a change in management to get there.

20 I would follow up on a couple of people's comments  
21 on suggesting -- and this is kind of my opinions but I think  
22 reflecting the opinions of our whole team at Dartmouth and

1 Brookings -- that to start with, this ought to be a  
2 voluntary system, and I'll go back to the comments I made  
3 earlier.

4           You can get the attribution and the people in, but  
5 to make it be effective, you really need to have some form  
6 of organization and possibly some contracts, and -- I think  
7 it was your comment, Bob -- you need to have an  
8 infrastructure there.

9           We have been talking to enough people to say, yes,  
10 here's a hospital system that has 250 primary care  
11 physicians associated with it. We could probably turn that  
12 on 1/1/10 with everything, and so there are local groups  
13 there.

14           The next part is bonus versus penalties. I would  
15 be a bonus person for now because one of the things  
16 preventing this, at least with capitation for both PHOs and  
17 a variety of PSOs, if you remember that term, Glenn, the  
18 downside penalty is fairly big for groups that are worrying  
19 about this, and the hospitals in particular that we have  
20 talked to have recognized they're going to lose revenue.  
21 The lost revenue is offset by A, some bonus potential, but  
22 B, locking people into systems, and then C, they're going to

1 raid their competitors across the street because they are  
2 going to be higher quality, lower cost, and recognized as  
3 such. So it's a complicated one.

4 I could see going to a mandatory environment down  
5 the road after this was up and running and five years out,  
6 we learned a whole bunch of lessons to say, here's the book.  
7 Now it's mandatory. Get the book and follow it out. But I  
8 don't think it would begin to try to impose it in North  
9 Dakota or South Dakota today or tomorrow. I mean, that's  
10 just too soon. Thank you.

11 DR. CROSSON: I guess to start, I agree with  
12 Peter. It probably comes as no surprise from prior comments  
13 that I have made at the Commission that I think this is one  
14 of the more important ideas that we've talked about and will  
15 talk about.

16 I think I also agree with Bob that this is not  
17 easy. This kind of change that we are talking about is  
18 probably as difficult a change as we've envisioned in all of  
19 the times that we've talked here because it fundamentally  
20 involves changing eventually not only the structure of  
21 health care delivery, but the way it's paid.

22 I also agree that the kind of change that's

1 envisioned here and the kind of change in costs that are  
2 needed to take the country to are not going to be brought  
3 about by two or 3 percent bonuses. It has to be more  
4 substantial than that or it won't work.

5 I have some of the same concerns that Jack raised,  
6 and that has to do with the issue of taking a research model  
7 that Elliott has used which attempts to assign by a  
8 preponderance of claims a certain number of individuals to a  
9 certain delivery system or collection of hospitals and  
10 doctors and operationalizing that. I'm not quite sure how  
11 that works because if you're going to eventually morph this  
12 to the level of accountability that I think Bob was talking  
13 about, you just can't have open access. You just can't have  
14 people going out and taking a flight to the Mayo Clinic and  
15 recharging to the accountable care organization a \$250,000  
16 bill. It just won't work that way.

17 Now, there may be some stepwise process to get  
18 from that model to something which is more robust and  
19 perhaps has more of a defined population and more control  
20 over the use of resources. But I think that has yet to be  
21 described.

22 I think in addition to the question of voluntary

1 versus non-voluntary for the providers, there is the  
2 question of voluntary or non-voluntary for the  
3 beneficiaries. I think George touched a little bit on that.  
4 And I think as we think this through, we might want to think  
5 about something that Jack was referring to, which is  
6 essentially Medicare Advantage for provider organizations,  
7 where, in fact, perhaps incentives that the Medicare program  
8 could create, individuals could, in fact, voluntarily enroll  
9 for a period of time into one of these delivery systems,  
10 which would fix some of the attribution issues. I'd like to  
11 see us think about that.

12           With respect to the question of whether the  
13 accountable care organization should be just a physician  
14 delivery system or a collection of delivery systems versus  
15 physicians linked to a hospital, I have to come down very  
16 strongly on the latter. The reason is I think most of the  
17 savings that could eventually be used to create incentives  
18 really come from the physicians' impact on the  
19 hospitalization process. And you really, I don't think,  
20 could have a successful system if all of the incentive to  
21 manage the appropriateness of care was on the physician side  
22 and the hospitals only stood to lose. You'd have complete

1 malalignment of incentives in that process.

2           So I agree with Peter that I think it implies in  
3 some way that these work together, and in fact, I think  
4 there are many downstream advantages from having that kind  
5 of coordination.

6           I would raise again the question of whether we  
7 want to look at the issue of cumulative incentives as  
8 opposed to simply annual incentives, so that in order to  
9 strengthen the incentive here in this process, one could  
10 provide annual bonuses. One could also use the performance  
11 year over year to change the update process to both the  
12 hospital and physician component, and by creating a  
13 cumulative incentive, you create more power even though you  
14 don't move all that much money from one year to the next.

15           And then I will throw in one other really annoying  
16 thing, and that is the question of whether or not to  
17 actually, if we can take Part A and Part B on together, why  
18 not consider Part D in this? Because again, there is a  
19 significant amount of incentive power created by the  
20 physician pen with respect to the use of pharmaceuticals.  
21 Now, I realize that it's really complicated, but it might be  
22 worth taking a look at.

1           In the end, I do think that this is important. I  
2 think this is an evolutionary thing. It is going to take a  
3 long time because we are dealing with a system that doesn't  
4 work right now, both the payment system, and to my mind  
5 anyway, the disaggregation of the delivery system. Changing  
6 that is going to take a long time. But I do think I have,  
7 and many of us have, an intuitive sense that there is a  
8 place that we could go to which is better than where we are  
9 now, even though we are, as they say, looking through a  
10 glass darkly at the moment.

11           MR. HACKBARTH: Following up on Jay's comment,  
12 something that might be useful background for our next  
13 conversation on this is under Medicare Advantage, my  
14 recollection is that there was a provision introduced to  
15 allow provider sponsored plans, I forget the --

16           DR. CROSSON: MA-PSOs.

17           MR. HACKBARTH: PSO, which hasn't taken off. Just  
18 understanding why that -- and why is that? Are there  
19 modifications that could be made in that that might make it  
20 more attractive as sort of another door into this set of  
21 issues. That might be worth some studying.

22           MS. HANSEN: I just have a short comment related

1 to that. I think one of the things that people were talking  
2 about, the difficulty of the structure and the payment --  
3 and Jay, you just said that it takes a long time for this to  
4 occur. I think a large piece that just has to be elevated,  
5 just to acknowledge the ability to have it happen, is the  
6 delivery behavior that actually has to occur. That's a body  
7 of work by itself. We were informally talking about it as  
8 just the execution process of it. So one is knowing where  
9 the bones are and you know what the money is. But making  
10 that squishy middle really happen is one of the things that  
11 makes the biggest difference, to have something aligned all  
12 of the way through.

13           So it's really not our role technically on a  
14 policy commission, but I think the acknowledgment of why  
15 things take so long to really come about, because they're  
16 not fully aligned because the belly of it is so difficult.  
17 And it is about practice, behavior, relationship changes  
18 that are always messy but really are necessary for a real  
19 change to occur.

20           DR. CHERNEW: I think one of the reasons why there  
21 is some confusion about what the "it" is is because there  
22 are different "it"s. I don't think there is one "it" that

1 we are trying to identify, what is it, but there's different  
2 versions in different people's mind.

3           The one version that I have, and John, I will look  
4 to as sort of the authority, is sort of a virtual version of  
5 this. In other words, people get assigned in a sort of  
6 claims way to of these organizations. Of course, that means  
7 the beneficiaries just are where they are. It's totally  
8 virtual to them.

9           In that model, though, there's no organization  
10 change needed at all. Depending on how you set it up, it  
11 may encourage organizational change in the way we're talking  
12 about, but that's going to be really sensitive to the actual  
13 parameters that you use. And we can't in the level of  
14 detail that we're discussing now figure out whether the "it"  
15 that would like it to be is the "it" that it will become,  
16 because that's going to depend on all of the parameters that  
17 we set up for what these things are.

18           So if I understand sort of the easiest version of  
19 this, which is I think this virtual we assign people and  
20 claims to an ACO and make them responsible in one way or  
21 another, but we do it weakly because there's a lot of noise  
22 floating around in the system. There's evidence on

1 withholds from years back. I'm not an expert now on exactly  
2 what that evidence on having withholds and stuff are, but  
3 the evidence isn't overwhelming that withholds were that  
4 useful. I think the reason you get the math that you guys  
5 got in the slides five and six -- and again, I could be  
6 wrong -- is basically this is a way to lower prices to  
7 people and lower prices more for people that do high volumes  
8 of stuff, because you have your price, they take away the  
9 withhold. So then you just have a lower price. For  
10 everything you do, you get a lower price. If you keep  
11 volume down, you get some of that but not all of it back.

12           So the reason in your example it is not profitable  
13 to buy the MRI is you have lowered the revenue associated  
14 with that and you've lowered it particularly if you've done  
15 a lot of stuff. So it's harder to make that MRI profitable.  
16 It is just keeping prices down for things and it's bundled  
17 in a whole lot of fluff, but I think in the end -- I'm sorry  
18 John, it's wonderfully crafted --

19           [Laughter.]

20           DR. CHERNEW: -- but I think in the end, it just  
21 works out because prices have gone down.

22           So I'm not inherently opposed to that one way or

1 another. I think what we really need to think through is  
2 the details. I work a lot that it ends up being a  
3 distraction. So the chapter has a whole set of things on  
4 how this could work with existing initiatives, things we've  
5 done, and it goes through medical homes and other types of  
6 things, all of which is very good.

7           But again, I'm so glad I don't have your jobs  
8 because it must be really hard to write given you don't know  
9 the details of a lot of these different parameters and  
10 you're trying to write how this -- so I agree with the tone  
11 of the chapter that this could work with medical homes. But  
12 I fear in sort of my gut that we have so many things  
13 floating around that it's going to be a big distraction,  
14 that we're going to end up having a whole thing on medical  
15 homes.

16           And I agree, we could craft a health care system  
17 with medical homes, episode payment, and ACOs. We could  
18 work them in a way that might fit in a virtual way  
19 voluntarily that worked also in North Dakota. That's hard.

20           [Laughter.]

21           DR. CHERNEW: So I guess where I come down on all  
22 of this is I just personally feel it's just way too early.

1 My earlier comment that I made was elevating this to a  
2 chapter of where ACOs would fit into a broad system of  
3 health care reform in that sense, for me -- I personally am  
4 just not there yet because I have a lot of concerns about  
5 what it is. I have a lot of concerns that the literature  
6 that suggests the mechanisms by which I see this working  
7 might not be as optimistic as one would think, and the most  
8 optimistic -- if I keep talking, he'll be back for the other  
9 conversation -- but I might be amongst the more pessimistic,  
10 giving me a shorter lifespan, but I'm not so sure that we  
11 know enough. We can aspire to have this be a building block  
12 on an evolutionary path to having the health care system  
13 that will aspire to, which I would be 100 percent for. I am  
14 just not there yet based on the evidence and what I see that  
15 we know where this is.

16           So in the cases where there's a provider system  
17 that we think would be integrated now and great and we could  
18 find an incentive system to let them reap some of the gains  
19 from doing good stuff, I am again completely for that. I'm  
20 not sure you need a ACO proposal necessarily to get there,  
21 but that's a sort of separate question. And I think we need  
22 to step back and think about where this fits into the broad

1 set of things.

2 MR. HACKBARTH: So let me ask you this, Mike. So  
3 a possible implication of what you're saying, if I  
4 understand you correctly, is an approach that bears some  
5 consideration is increase uniprice pressure, use a mechanism  
6 that doesn't require as much complexity, like maybe the  
7 MA-PSO, modify that a little bit as the refuge, the  
8 opportunity for truly integrated organizations that want to  
9 get out of fee-for-service payment and don't necessarily  
10 want to just do it through a standard insurer. And so push  
11 real hard on uniprices and create an escape opportunity  
12 that's simpler than this.

13 DR. CHERNEW: I would be --

14 MR. HACKBARTH: And also has stronger incentives.

15 DR. CHERNEW: I wouldn't want to see them sort of  
16 side by side, but if you ask me right now, I would probably  
17 be leaning a shade toward something like that, because I  
18 understand it better.

19 MR. HACKBARTH: Okay. Bill is going to have the  
20 last comment. We are well behind schedule here.

21 DR. SCANLON: It relates to something that Mike  
22 said and to the voluntary/mandatory issue, and it's very

1 easy to understand, sort of the interest in mandatory,  
2 because if something is going to work and if you can make it  
3 work universally, it's a lot more powerful.

4           But I think, and consistent with Mike, is that the  
5 mandatory idea which would involve virtual ACOs needs more  
6 development. There's the issue of governance. The  
7 incentives need to be at the provider level. And if the  
8 providers are not linked to an organization, and in the  
9 voluntary world, they will be. I mean, they're going to be  
10 there because they want to be there. But in the mandatory  
11 world where we've created them virtually, if I am the  
12 outlier and my bad behavior benefits me but harms the  
13 organization, I may not change my behavior. This is kind of  
14 the classic thinking about this in economic terms is the  
15 externalities. If I'm the factory that pollutes, how does  
16 the community get me to stop polluting? Does it pay me or  
17 does it outlaw my pollution? What's going to be the  
18 leverage that an organization is going to have over this  
19 provider that is going to, in some respects, go against sort  
20 of the community's good?

21           This is critical, because I think that we are not  
22 going to learn if we demonstrate this with voluntary

1 organizations. What is going to happen if we try to make it  
2 mandatory and create these virtual organizations, because we  
3 haven't prepared for this critical difference, which is the  
4 people that are participating are not there because they  
5 want to be. They are there because we force them to operate  
6 as a group. But we've still allowed them, because it's  
7 going to still be a fee-for-service world, to operate  
8 independently while they're, quote, "part of a group.". So  
9 I think that needs a lot more development before we could  
10 think about a mandatory world.

11 MR. HACKBARTH: Okay. In the interest of time,  
12 I'm not going to try to summarize right now, but I did hear  
13 some fairly consistent themes that I think we can use to  
14 focus the discussion next time. So this was very helpful to  
15 me. Good work, guys, on the paper and the presentation.

16 Our next agenda item is physician resource use  
17 measurement. We have got to get a new term.

18 MS. PODULKA: I don't want it to trip off your  
19 tongue.

20 MR. HACKBARTH: Right. We are right now about 20  
21 to 25 minutes behind schedule for anybody keeping score. I  
22 guess it occurs to me we may want to give the lunch people a

1 heads up that we're going to be running late. I don't  
2 envision we are going to make up a whole lot of time in this  
3 conversation.

4 Jennifer, whenever you're ready, we can start.

5 \* MS. PODULKA: Thanks, Glenn. I'm here to talk  
6 this morning about physician resource use measurement and  
7 I'm going to warn you to begin with that I have five  
8 threads. They don't necessary weave together to tell a  
9 complete story so I'm giving you a heads up. The five items  
10 are the MIPPA physician feedback mandate, which implements  
11 our recommendation; CMS's pilot to test it out; guiding  
12 policy principles for our final program; options for  
13 releasing Medicare claims; and an update on our latest data  
14 analysis results.

15 In the interest of time and lunch, I will talk  
16 about all of these briefly. All five are described in  
17 greater details in your mailing materials and I'm happy to  
18 go into them more on Q&A if you'd like.

19 So the first item. In our March 2005 report to  
20 the Congress, the Commission recommended that Medicare  
21 measure physician resource use and share the analysis with  
22 results with physicians in a confidential manner. The

1 Congress enacted this recommendation in the Medicare  
2 Improvements for Patients and Providers Act of 2008, or  
3 MIPPA, and Congress has begun to pilot test how they will  
4 implement the final program.

5           The MIPPA mandate grants the Secretary flexibility  
6 on several characteristics of the physician feedback  
7 program. The Secretary may chose to use other data in  
8 addition to claims, provide feedback to individual  
9 physicians or to groups, include feedback on quality of  
10 care, and the resources can be measured on either a per  
11 episode or a per capita basis or both. And finally, the  
12 Secretary may choose to risk adjust the data.

13           MIPPA also grants the Secretary flexibility to  
14 focus the physician feedback program on specialties that  
15 account for a significant share of Medicare spending,  
16 physicians who treat high-cost or high-volume conditions,  
17 physicians who use a high amount of resources compared to  
18 other physicians, physicians in certain geographic areas,  
19 and physicians who treat at least a minimum number of  
20 beneficiaries.

21           So in response to the MIPPA mandate, Medicare has  
22 begun to test ways to measure physician resource use and

1 feed back the results confidentially to physicians. The  
2 work is referred to as the Resource Use Report Pilot and it  
3 will inform the design of the final permanent physician  
4 feedback program.

5 In phase one of the pilot, which is currently  
6 ongoing, Medicare is sending feedback reports to a large  
7 sample of physicians in multiple communities and conducting  
8 one-on-one interviews with them to get their input.  
9 Specifically, the physicians are being asked about the  
10 program's measurement methodology and the feedback report  
11 format. The pilot uses both per episode and per capita  
12 measurement and focuses on four acute and four chronic  
13 conditions.

14 We're going to switch topics. Given that MIPPA  
15 grants the Secretary so much flexibility in designing the  
16 program and CMS is in the midst of their pilot to test  
17 aspects of the final program, we think it is an opportune  
18 time to discuss some guiding policy principles. The list  
19 you see here is informed by efforts by other organizations  
20 and hopefully reflects your comments from our November  
21 meeting when we last discussed them. I'm not going to go  
22 through all nine now, but I do want to highlight a few of

1 them.

2           First, the program should be transparent.  
3 Medicare should make publicly available an explanation of  
4 its measurement methodology and a description of the data  
5 sources used. Currently, CMS's pilot relies upon  
6 commercially available episode grouper software packages,  
7 but this is only to allow Medicare to evaluate features of  
8 the software packages that could be included in a Medicare-  
9 specific open source software package. CMS and MedPAC have  
10 never expected Medicare to purchase black box off-the-shelf  
11 software. CMS doesn't regularly make a habit of pursuing  
12 this kind of strategy. It regularly contracts with vendors  
13 to develop tailored programs, such as DRGs, and then makes  
14 them publicly available. The final episode grouper software  
15 that's used for the physician resource use measurement  
16 program should also use a Medicare-specific transparent  
17 method.

18           Second, the program should provide actionable  
19 feedback. It can't just tell a physician that he's  
20 inefficient. It needs to explain why by including detailed  
21 breakouts by type of service and condition and other  
22 attributes.

1           Third, the program should have the flexibility to  
2 use multiple measures, especially per episode and per  
3 capita. As you've indicated, relying on just a single  
4 measure, such as per episode, may mask important differences  
5 in practice patterns and even allow opportunity for gaming.

6           Fourth, to be sustainable, the Medicare program  
7 needs to provide an opportunity for physician input into the  
8 design of the program. The pilot that's currently happening  
9 and publishing a proposed rule in the Federal Register are  
10 both good steps. Medicare should continue these efforts and  
11 perhaps seek additional opportunities for gathering  
12 physician input. For example, Medicare may want to consider  
13 establishing a formal physician feedback advisory board.

14           And finally, to be effective, the program must  
15 invest in outreach and education to ensure that physicians  
16 understand the feedback they receive. Simply mailing a  
17 feedback report to physicians is not going to be enough.

18           Switching topics again, as we move from Medicare's  
19 physician resource use measurement and feedback program to a  
20 related issue, which is releasing Medicare claims data. You  
21 may have heard that there's been a recent court decision  
22 that ruled against patient release of physician-specific

1 claims data. The case began when Consumers Checkbook sent a  
2 FOIA request to CMS for patient claims so that it could post  
3 information on its website about the number of procedures  
4 performed by each physician.

5 Some stuff happened in between -- I'm not going to  
6 go into detail -- but the latest decision from the U.S.  
7 Court of Appeals concluded that physicians have a right to  
8 privacy, in essence because their Medicare payments can  
9 closely approximate their total personal income.

10 The Court case aside, however, there is interest  
11 in releasing Medicare claims data so that entities such as  
12 private plans can aggregate Medicare data with their own to  
13 measure physician resource use. Data aggregation could  
14 address the small "n" problem, where private plans because  
15 of their low market share too few positions or too few  
16 claims to appropriately measure their resource use.

17 Note that releasing Medicare claims data could  
18 assist private plans in their physician resource use  
19 measurement, but without reciprocal data sharing from these  
20 plans, Medicare would not benefit from the data release.

21 Data aggregation is also suggested as a way to  
22 address the problem of physicians receiving contradictory

1 scores from different entities. However, releasing Medicare  
2 claims data for aggregation would not result in consistent  
3 physician scores without some mechanism for standardizing  
4 the measurement methodology. Remember, if these plans use  
5 an episode grouper package, there are at least three major  
6 packages they can choose from and that management using  
7 episode groupers requires numerous methodology decisions on  
8 the part of the user, such as grouping claims into episodes,  
9 attributing to physicians, selecting peer groups for  
10 comparison, setting a minimum number of episodes, and  
11 setting thresholds for outliers.

12           Entities can and will make different but perfectly  
13 legitimate methodology decisions that will lead to different  
14 results using the exact same claims data. The issue becomes  
15 even more complex once other measures besides episodes, such  
16 as per capita and quality, are included.

17           So to help frame what comes next, we have outlined  
18 two broad options for your consideration. First, Medicare  
19 could release Medicare claims data with appropriate  
20 beneficiary privacy protections to entities such as private  
21 plans. These entities would then be able to either  
22 confidentially or publicly report their physician

1 measurement results.

2           Or Medicare could create a claims data  
3 clearinghouse to which interested entities could send their  
4 claims, where they would be merged with Medicare claims,  
5 grouped into episodes, and attributed to physicians using  
6 Medicare's methodology. The clearinghouse would return to  
7 the entities either the measurement results or the results  
8 plus the original Medicare claims data. Like the first  
9 option, appropriate beneficiary privacy protections would  
10 apply and the entities could then report their results.

11           Switching topics for the last time. In our  
12 ongoing analysis using Medicare claims and episode grouper  
13 software to measure physician resource use, we have most  
14 recently explored the stability of physician efficiency  
15 scores over time and the trade-offs between different  
16 attribution methods. We go into much more detail in the  
17 mailing materials, but basically we found that physician  
18 scores were relatively stable over two points in time, 2002  
19 to 2003. Correlations between physician efficiency scores  
20 were quite high for the two years, ranging from 0.84 to  
21 0.91. We further analyzed physicians whose efficiency  
22 scores qualify them as outliers in the first year, and 94

1 percent remained outliers under a slightly broader rule in  
2 the second year.

3           Next, we explored the question of whether to use  
4 single or multiple attribution. Single attribution is  
5 designed to identify the decision-maker, perhaps a primary  
6 care physician, and hold this individual responsible for all  
7 care rendered in the episode. Multiple attribution occurs  
8 when a single episode is attributed to more than one  
9 physician. It acknowledges that the decision-maker, if  
10 there is one, has incomplete control over treatment from  
11 other providers, even when the decision-maker referred the  
12 patient. There are significant trade-offs between these  
13 methods, so we wanted to see if a quantitative analysis  
14 yielded a clearly better method. The punchline is that it  
15 doesn't.

16           Physicians' efficiency scores are pretty similar  
17 regardless of which attribution method we used. Of course,  
18 multiple attribution resulted in more physicians being held  
19 accountable. We found that multiple attribution based on  
20 total dollars resulted in about 70 percent of physicians  
21 attributed responsibility for a minimum 20 episodes, where  
22 single attribution methods resulted in about half of

1 physicians being attributed responsibility.

2           So finding no clear winner among attribution  
3 methods based on our statistical analysis means that the  
4 choice between attribution methods probably comes down to a  
5 qualitative decision based on the policy goals of the  
6 program. For example, if Medicare would like physicians to  
7 focus more on the effects of the referrals, they might  
8 select a single attribution method. Alternatively, if they  
9 would like to trigger conversations amongst physicians, they  
10 might select a multiple attribution method. In fact, there  
11 might be reason for and room for more than one attribution  
12 method in the final program.

13           So we've gotten through five items and I wanted to  
14 remind you for the Q and A session. First, MedPAC has  
15 recommended that Medicare develop a physician resource use  
16 measurement program, and this was enacted in MIPPA. CMS is  
17 currently piloting physician resource use measurement and  
18 feedback to explore issues, so now is an opportune time to  
19 discuss policy principles. Sharing Medicare claims data  
20 raises various issues. We find that physicians' efficiency  
21 scores are stable from year to year. And finally, there are  
22 policy trade-offs between single and multiple attribution,

1 but both yield similar results.

2           And if it's of assistance, we've outlined a few  
3 discussion questions. First, what policy principles should  
4 guide the physician feedback program? Second, is there a  
5 policy direction for Medicare claims data sharing? And  
6 third, are there any technical questions you'd like to  
7 revisit on the data analysis results?

8           Thanks, and I look forward to your discussion.

9           MR. HACKBARTH: Nice job, Jennifer. Thank you.

10           What I propose we do is have our round one  
11 clarifying questions, and then when we go to round two, I  
12 would like to use the discussion questions to help focus the  
13 feedback that we give Jennifer. In particular, I would like  
14 to see some focused discussion on the second bullet, well,  
15 on both the first two bullets. I think those are good  
16 topics for us to focus on.

17           So round one, just quick strictly clarifying  
18 questions. Let me see hands. We'll start over on this  
19 side.

20           DR. CROSSON: Maybe this is a clarifying question  
21 with respect to the presentation, but also with respect to  
22 the discussion. Are we considering the two first bullet

1 points as separate issues? Or are we considering the  
2 interrelationship between the two?

3 DR. MARK MILLER: I guess I'll take this one. I  
4 think we had started off the notion of treating them as  
5 separate question, that right now, the Congress has said go  
6 forward, put this information out, engage the physician  
7 community. It's starting to happen, and you could take the  
8 first set of issues as what do we as a Commission think how  
9 that process should go. And then we envisioned the second  
10 question as, if we're going to be sharing this data with the  
11 private sector to make their own efforts, how should that  
12 occur? Is it just letting the data go, or do you have more  
13 this clearinghouse function? So I think we conceived of  
14 them, and Jennifer, as two different questions, but maybe  
15 you see a relationship here that we didn't see.

16 DR. CROSSON: I do, but I'll do that in the second  
17 round.

18 DR. REISCHAUER: This is just an extension really  
19 of your discussion of the pilot. They are doing a pilot and  
20 a subsample of the pilot is being subjected to interviews,  
21 mostly about the method that they're using. I was wondering  
22 if anybody is thinking about a control group for this, for a

1 different topic, which is does this kind of information in  
2 talking to physicians affect behavior? We have a lot of  
3 evidence on profiling and its effect or lack thereof. But  
4 it strikes me the environment has changed very much in the  
5 last few years, and so unless that evidence is worthwhile, I  
6 mean, it's just something worth thinking about for the  
7 future.

8 MS. PODULKA: What's going on right now is phase  
9 one of the pilot, and that does not include questions about,  
10 and what have you done to change your practice.

11 DR. REISCHAUER: I wouldn't expect it to, but you  
12 can then go in later and look at the practice behavior for  
13 unaffected people, people who are part of the pilot, people  
14 who were part of the pilot and were interviewed, and see if  
15 there are changes.

16 MS. PODULKA: Right, so I was going to add is  
17 phase one is going on right now. The agency already  
18 anticipates a phase two that would begin later. So it's not  
19 necessarily included right now, but they're considering the  
20 design for phase two, and one option would be to include a  
21 look-back with the original group.

22 DR. KANE: I share Bob's question. First of all,

1 is there any design in here for evaluation of the impact on  
2 behavior? It sounds like not yet.

3 And then the other question is, is there anything  
4 in the design that helps -- that creates a vehicle for  
5 physicians to share best practices and how they improve  
6 their efficiency in reaction to this data?

7 MS. PODULKA: There is an official evaluation of  
8 the program, which could include a function about physician  
9 behavior. GAO is mandated to report by March 2011, I  
10 believe. Right now, there isn't necessarily a mechanism  
11 that I'm aware of for physicians to share best practices,  
12 but one thing I mentioned which I think is kind of a nifty  
13 idea about the Physician Feedback Advisory Board, it could  
14 definitely be a format for having that shared.

15 DR. CASTELLANOS: Good job. The question I have  
16 is the question that you brought up on the feedback  
17 concerning a large sample of physicians and the one-on-one  
18 interviews. I kind of looked into that. Do you really  
19 think it is a large sample of physicians?

20 MS. PODULKA: Well, they are sending it to -- now  
21 I don't have total "n" --

22 DR. CASTELLANOS: They are sending it to 125

1 physicians in each of the six communities. There are eight  
2 focal conditions and there are 13 specialties involved.

3 MS. PODULKA: They have six communities so far,  
4 but in the end, they are going to have 13 total communities.  
5 It is in the hundreds, or over 100 in each community.  
6 Again, CMS is somewhat constrained by resources. I know  
7 this is a perennial topic and --

8 DR. CASTELLANOS: I'm not arguing with that. What  
9 I'm suggesting is maybe we could suggest really getting a  
10 robust or a larger population feedback.

11 MS. PODULKA: That's definitely something they  
12 could consider for the phase two.

13 MR. GEORGE MILLER: Very quickly, in the report  
14 you mentioned about the geographic variation of Medicare  
15 spending suggests there's more variation in physician  
16 practice patterns. I want to tease that a little bit with  
17 other issues that I brought up before, and that is the  
18 disparity in treating minority populations, and if that was  
19 at all reflected here about resource use. I'm not sure I  
20 can tie that together, but we've had discussions where  
21 minority populations didn't get the same care as the  
22 majority populations, and again, I don't know if that has an

1 impact, but just raising the question if there could be --  
2 quite frankly, it may be the reverse, that not enough  
3 resources are being used for minority populations, if that  
4 was taken into consideration.

5 MS. PODULKA: Absolutely. I think in many ways  
6 this could be a very effective tool, because a lot of  
7 attention is paid to the high-cost outliers.

8 MR. GEORGE MILLER: Right.

9 MS. PODULKA: But you can also use physician  
10 resource use measurement to look at all sorts of efficiency,  
11 and when we use efficiency here, we refer both to the cost  
12 of the care and the quality. And so you can look at sort of  
13 best practices for efficiency, and when you include some  
14 robust risk adjustment that includes characteristics of  
15 those beneficiaries being treated, I think you can really  
16 zero in on who is doing good things and who is doing bad  
17 things.

18 MR. HACKBARTH: So this is really about developing  
19 a fairly robust analytic tool that can then be applied to a  
20 lot of different purposes, including looking at disparities.

21 MR. BUTLER: In order for me to answer number two,  
22 I would just like a little bit more information. You say

1 that in the examples, that the private health plans would be  
2 the most likely user of the aggregated data and you -- at  
3 least that's the theme. And it talks about pediatric  
4 cardiac surgeons, you have a greater "n". I'm not sure  
5 exactly what health plan decisions would be made differently  
6 with this data, so if you can think about what that would  
7 be.

8           And then, also, who are the other likely people  
9 that are chomping at the bit to get their hands on this  
10 data?

11           MS. PODULKA: I'm not -- I do think private plans  
12 would be very interested in using this to aggregate with  
13 their own data to address problems where they have small "n"  
14 for physicians. But the court case involved Consumers  
15 Checkbook, which is known for making the comparison of the  
16 Federal employee health plans. So there could be all sorts  
17 of numerous entities out there who might be interested, both  
18 for-profit and not-for-profit. They could use it for their  
19 own services, like a private plan might use it for their  
20 networks. But they could also use it for very public  
21 information. Consumers Checkbook wanted to post this on the  
22 website.

1 DR. MARK MILLER: Peter, was that what you were --

2 MR. BUTLER: The answer, I didn't -- so if there  
3 was a small "n," what would they do if they had a bigger "n"  
4 with respect to -- what problem are they trying to solve?

5 MR. BERTKO: Peter, let me try to address that.  
6 Small "n" that means that if there are 150 cardiologists in  
7 the greater Chicago area, one plan in particular might only  
8 be able to have enough "n" to look at the 20 of them. With  
9 Medicare in particular and cardiology in particular, you  
10 might be to combine the data and look at 100 of the 125.

11 MR. BUTLER: What do you want to look at, is the  
12 question. You contract based on rates and other --

13 MR. BERTKO: Well, I want to have the -- in my  
14 particular case, it was the relative efficiency and quality  
15 compared to the people -- their peer group in Chicago in the  
16 same practice.

17 MR. HACKBARTH: So to develop a network, for  
18 example.

19 MR. BERTKO: Network development, in particular.

20 DR. CHERNEW: It helps John tier doctors.

21 DR. MARK MILLER: It could be that. It could also  
22 be we notice among our physicians an uptick in the use of

1 this service and we think that there is a clinical argument  
2 for that or a clinical argument not for that, so now we are  
3 going to educate physicians on the use of this particular  
4 service. And I think there's not simply building the net,  
5 where there's also watching patterns of care and saying, why  
6 did this service begin to spike or why is the service  
7 falling, that type of thing.

8 MR. BERTKO: No, it's not, but there are practices  
9 out there, I mean, and Jennifer said this. It works. It's  
10 reasonably stable.

11 MR. HACKBARTH: Okay. Let's turn to round two,  
12 and as I said earlier, I'd like to get to these questions,  
13 so put your hands down for just a second because Arnie is  
14 first and so I'm going to put on my best Arnie imitation  
15 here. Obviously, these comments aren't specifically focused  
16 on the questions, but still important, and I hope I do this  
17 adequately.

18 Arnie's first point was that we're spending a lot  
19 of time, as in the ACO discussion, trying to figure out new  
20 payment system structures that will alter the behavior of  
21 physicians and other providers, and he's not against that by  
22 any stretch, but he said it also is important, even if you

1 do those other things, to shape physicians' understanding of  
2 their own practice. And so this is an important and  
3 necessary step no matter what else you do in terms of other  
4 payment policies. This is education, in Arnie's view, for  
5 physicians, helping them understand their practice as it  
6 compares to their peers in their community.

7           A second point is that although this is sometimes  
8 seen as a set of tools developed by, for example, insurers,  
9 to be imposed on physicians in sort of an adversarial way,  
10 Arnie thought it important to emphasize that, in fact, the  
11 origin of these tools is with physicians. You have  
12 physicians with a research bent, but physicians who care  
13 about good practice have been involved in developing these  
14 tools in that spirit, as a way of helping physicians do a  
15 better job.

16           A third point was the tools are imperfect, as are  
17 all the tools we ever talk about at MedPAC. They need  
18 continuing refinement, and arguably they are not yet  
19 sufficiently refined to link to payment. But in Arnie's  
20 view, they are certainly good enough to provide meaningful  
21 information to physicians in terms of how they compare.  
22 They're pretty good at distinguishing between, as Arnie put

1 it, the top, the middle, and the bottom. They may be less  
2 good at distinguishing degrees of performance in the middle  
3 range, but at a high level they are pretty good  
4 discriminators.

5           A fourth point is that he believes it's very  
6 important for Medicare to enter this field, which has to  
7 this point included mostly private payers and researchers,  
8 and it's particularly important because of the size of the  
9 Medicare population and what that data can do to enhance the  
10 power of the tools. It follows from that that he would like  
11 to see Medicare data made available for pooling so that all  
12 payers can better assess the performance of physicians. The  
13 physicians have a stake in that, that they are going to be  
14 evaluated one way or the other and it is in physicians'  
15 interest that they be evaluated on the most robust data  
16 available as opposed to small slivers of their practices, as  
17 often now the case.

18           So he would like to see sharing of data, and his  
19 notion about the best first step to do, that is option 2(a)  
20 in the paper.

21           Jennifer, why don't I have you describe that for  
22 the benefit of the audience. Did you go through that in

1 your slides? Well, I guess at the bottom there, yes.

2 MS. PODULKA: Right. So 2(a) refers to the option  
3 to create a claims data clearinghouse and send the results  
4 alone back to the entities.

5 MR. HACKBARTH: So the raw data would not be sent  
6 out to Humana or another, but Humana could say, here are our  
7 data, combine it with Medicare and analyze it using your  
8 tool and give the reports back to us. And so Arnie  
9 advocates that option as the first step.

10 Next, he said that, again, these are imperfect  
11 tools, but nothing improves tools so much as use. As we use  
12 these, they will get better. We will get input from a lot  
13 of people, including physicians, that will help us make the  
14 tools better over time.

15 So I think those were Arnie's major points. The  
16 bottom line is he thinks this is a very important thing to  
17 do.

18 Now let me see other hands for round two. Again,  
19 I'd like you to focus on those two questions in particular.  
20 Let me start with Karen and we'll go down this row and  
21 around.

22 DR. BORMAN: My bias and my comments will be that

1 I think that this and bundling, in my view, probably  
2 represent potentially the most useful tools we have going  
3 forward, because I think they are things that potentially  
4 build on some things that we have and therefore are an  
5 easier transition to make, in addition to the places that  
6 they potentially impact. They could then build into some of  
7 the other things we've talked about.

8           In terms of the policy principles, I think the  
9 first one you brought up, transparency, I cannot over  
10 emphasize the import of that. It just will have no  
11 credibility without that. That will be an absolute deal  
12 breaker, cut you off at the knees, whatever, so transparency  
13 is absolutely necessary.

14           I think maybe the second piece is that the  
15 transparency will in part enable is what I might term  
16 collegiality or collaboration. That is the tone in which  
17 this is brought forward and the mechanisms to actually make  
18 it be, as Arnie's comments were just related to, a growth  
19 experience. One of the things that sometimes happens in  
20 residency when we tell you to go do something that seems  
21 unpleasant is we tell you it's a character building  
22 experience. There's going to be some element of this on the

1 recipient no matter how you slice it. So I think that this  
2 collegiality piece is important.

3           And I would say that in addition to the  
4 transparency part, that the Physician Advisory Board or some  
5 entity, some process other than, yes, you can send us your  
6 to the Federal Register or whatever, is important beyond the  
7 value of any comments that might come out of it as a  
8 commitment to a mechanism for dialogue.

9           I would suggest, and I will relate to comments  
10 later, that that group, in addition to establishing this  
11 collegiality, should also be a vehicle that will enlighten  
12 potential strategic planning to later phases of this and, in  
13 fact, should include individuals who represent various  
14 specialty boards, and I'll flesh that out in a moment.

15           Another principle that I think is fairly important  
16 is the "keep it simple" principle here. And while I think  
17 we are all excited about the potential power here, all of  
18 the ways we can think of to permute the data and use this  
19 process, the first thing we've got to do is make this work  
20 in some way, make it viable in some way, accept it in some  
21 way. If we try and craft a grand scheme the first time  
22 around, I'm afraid that we will not enable success of what

1 could be something very important. This is one of those  
2 times where we need a base hit and build on that, and not  
3 necessarily to blow it out of the park.

4           So I would suggest that some of the things in  
5 keeping it simple relate to how we define the participants,  
6 we define the conditions, the validity of the measures that  
7 we use. And also very much so the nature of the  
8 explanations provided with the data and then all the ways  
9 that the outreach happens. The driving principle for that  
10 interaction, I think, needs to be some element of simplicity  
11 and focus. I think focus is as much of a piece as  
12 simplicity. So that would be another principle in my mind.

13           Another one would be looking at this as a multi-  
14 pronged or staged phenomenon. For example, I could  
15 hypothesize that in a first phase of gains that the gains  
16 will be merely from actually seeing what you do in a  
17 measured way that will have some validity put to it. As  
18 much as practicing physicians we may whine about various  
19 systems or things -- one of the things that I certainly  
20 teach in practice management courses and so forth is that  
21 you may not like Medicare rules, but they are in black and  
22 white and you can go read them and you know more so than any

1 other payer what you're getting and why you're getting it.  
2 And so I think that does transfer to some inherent  
3 credibility to data that comes from the government, if you  
4 will.

5           And so in that respect, I think there will be just  
6 some, wow, for the outlier particularly, I'm way out here.  
7 There will be that shock value piece, whatever, that will be  
8 the first round of gains with this. And just the notion  
9 that, you know, I'm a little off, particularly if you're in  
10 a group practice where your partners get materially  
11 different scores. That may have an impact.

12           I think the next phase and probably the one that  
13 will last longer is the potential use of this for practice-  
14 based learning and performance improvements and change by  
15 the individual, and that, in my view, should be linked to  
16 the maintenance of certification process for those who are  
17 board certified. For those who are not, perhaps to the  
18 maintenance of licensure process, which I'm not as  
19 conversant with. But being a board member, unless John  
20 tells me otherwise from an actuarial standpoint, in a few  
21 years, I will come up on my third recertification  
22 examination. The American Board of Surgery has

1 recertification since 1976. It was one of the very early  
2 boards to have the process. So we have lots of people who  
3 have done their third recertification.

4           Obviously, the process now is much more multi-  
5 pronged. There's things that have to be done every one to  
6 two years as opposed to just study up for a big exam, a  
7 single high-stakes exam at the end. I think that the boards  
8 are charged -- one of the ABMS principles relates to  
9 performance assessment and practice. This could be a huge  
10 step toward facilitating that and it incents the physician  
11 because they get a two-fer, at least. They get something  
12 that they've got to do relative to MOC. They get something  
13 that enables them to, just on a personal motivation to get  
14 better, and potentially allows them to figure out practices  
15 that will allow them to get into some of the bonus or at  
16 least no withhold program. So it becomes an enabling tool  
17 for multiple things.

18           So I think thinking of this in a phased strategic  
19 way, not losing sight of that, and making sure that this  
20 physician communication board doesn't just get hung up in  
21 the details of answering questions or whining that it thinks  
22 about that strategy would be important things.

1           MR. HACKBARTH: On that point about how this links  
2 to the activities at the various specialty boards, I'm  
3 involved with the Board of Internal Medicine and can't speak  
4 anywhere near as authoritatively as Karen has, but what she  
5 just said really resonates with conversations I've heard  
6 members of the Internal Medicine Board have. If you can  
7 link this to their own internal activities assuring quality,  
8 assuring that physicians are improving their performance, it  
9 becomes a two-fer and its power is enhanced and the burden  
10 on physicians is reduced. The ABMS is in the process of  
11 trying to beef up that process for all of the various  
12 specialties, the recertification process.

13           Arnie, I'm far enough behind schedule that you  
14 could have made your own comments, but I did want to begin  
15 this discussion with the points that you have made. I'll  
16 allow you to leap in at your well. We are now in the  
17 process of going around with our round two comments and  
18 Peter is next.

19           MR. BUTLER: A lot of people to speak, so I will  
20 be brief. This is at the heart of comparative  
21 effectiveness. We can't make advancements if everything is  
22 sitting in a black box that people can get at, so I'm

1 supportive of the principles pretty much as written with  
2 obviously some added good comments around the table.

3           With respect to the second question, I don't think  
4 we're at option one of releasing at all and just letting  
5 people go after whatever they'd like. I'd kind of defer to  
6 Arnie's suggestion of option 2(a), although my only  
7 hesitation is we've got to make this easy to get at. So if  
8 it becomes a bureaucratic thing, that you send in your data  
9 and eight months later you get it back maybe the way you  
10 wanted it or not. We just have to think through how that  
11 would work because it should be pretty darn easy to get in  
12 and out of the data if we're going to make it accessible.

13           MR. HACKBARTH: Arnie, did you want to make a  
14 comment? Let me see the other hands on this side. Nancy?

15           DR. KANE: I think the policy principles look  
16 good. I would add that there should be efforts to evaluate  
17 behavior after these reports are out in practice after a  
18 while.

19           On the claims data sharing, we haven't mentioned  
20 this yet, but the way it is phrased now, the only people who  
21 get data back are those who produce claims and I'm wondering  
22 if we need to think about a broader audience for the data,

1 particularly the providers themselves or the health systems  
2 that may want to use this to inform themselves about how to  
3 develop what clinical protocols or performance measurement  
4 systems that target a certain diseases and the way they  
5 through the system.

6           And then the other group who might want access to  
7 this claims data would be health service researchers, and  
8 I'm thinking about George's question about how can we use  
9 this data to identify disparities and other types of things  
10 that would inform policymakers.

11           So I just think the claims data sharing piece  
12 needs to be expanded, perhaps, not right away, but not just  
13 to those who provide claims but to others who may want to  
14 use that data for appropriate purposes.

15           MS. PODULKA: To start, and maybe you can jump in  
16 if I -- there is a mechanism for health services researchers  
17 and other entities to have access to Medicare data. The  
18 problem that surfaced in the Consumer Checkbook case -- and  
19 you're right that they don't have their own claims -- is the  
20 way they wanted to report them at the physician individual  
21 level. So right now to have access to Medicare claims, you  
22 have to comply with the way Medicare sees its responsibility

1 to steward those claims. What we are recommending would be  
2 beyond or outside of their current authority or  
3 interpretation of their authority.

4 DR. KANE: I didn't mean just the Medicare claims.  
5 I mean the combined -- if there is a clearinghouse where  
6 both private and public sector claims are placed, I think it  
7 would be helpful to think about how do you make that  
8 available for more than just people who put claims in.

9 MS. PODULKA: So you mean if Humana and United  
10 send their claims, they don't just get back the Humana and  
11 Medicare claims. They get the Human and United Medicare  
12 claims.

13 DR. KANE: Not just them, but others who are  
14 trying to do research.

15 DR. CASTELLANOS: First of all, I agree with Karen  
16 and all her very good points that she made. When this data  
17 becomes available, it needs to be actionable. In other  
18 words, a physician or the provider really needs to be able  
19 to act on that data, so it really needs to be pretty well  
20 identified, also.

21 MR. HACKBARTH: Say what you mean by identify it,  
22 Ron.

1 DR. CASTELLANOS: Well, a lot of times you'll get  
2 a report from especially the private companies telling you  
3 to do something and they said, out of this percentage of  
4 patients you did this. Unless I know who the patients are  
5 and I can look at the data and go back to my records, it  
6 doesn't make any sense to me. So the data needs to be  
7 actionable, where I can look back and say, you know, you're  
8 right. I should have done this.

9 MR. HACKBARTH: Jennifer, any reaction to that?

10 MS. PODULKA: We've actually gone through with  
11 some of the companies their capabilities for drill down.  
12 Now, these aren't necessarily utilized by the private plans  
13 when they're doing analysis, but we were amazed. Mark, I  
14 think you sat in one of these. They can start at your  
15 overall level. They can break it down by conditions or type  
16 of service. And then they can further break it down to the  
17 individual visits and show you the patient who came in and  
18 the services you provided that day.

19 Now, that level of detail doesn't fit very well in  
20 a printed report. And so one of the things I noted, just  
21 mailing a five-page feedback report is not going to be the  
22 final step. It can't be. The program should ideally have

1 the capability to allow physicians to see this level of  
2 detail.

3 MR. HACKBARTH: Is that something that CMS is  
4 planning to do, that drill down capability?

5 MS. PODULKA: I can't say. I don't know if they  
6 are.

7 DR. MARK MILLER: I think they're very much at  
8 stage one, and some of the things that I think Jennifer is  
9 talking about is you would have the ability to perhaps go  
10 online and say, okay, now I want to dissect this report and  
11 dive for your own experience.

12 MR. HACKBARTH: Okay. Anybody else on this side?  
13 Let me just see the hands here so I know how much we have  
14 got to do. John?

15 MR. BERTKO: A couple of quick comments. I'm also  
16 very supportive of this. It is, as Arnie said through  
17 Glenn's lips, good enough for now. On the question --

18 MR. HACKBARTH: I was more eloquent than that,  
19 Arnie.

20 [Laughter.]

21 MR. BERTKO: A question here about having a  
22 clearinghouse. I'm for 2(a), which is the clearinghouse

1 with results, with a note that it takes a while to combine  
2 other people's databases. You have to be repricing  
3 everything. So I'd want the caveat hopefully to read  
4 something like, start with Medicare data and then and the  
5 other payers' claims data in there. And you'd have to say,  
6 I think, that you get combined data, that is other payers  
7 plus Medicare, if you contribute, because otherwise there  
8 would be little incentive to do the work of contributing.  
9 So just if you can consider those nuances.

10 DR. DEAN: Thank you very much. This is very  
11 interesting stuff and, I think, important. I would  
12 certainly, first of all, second what Karen said. We need to  
13 keep it simple and understandable because if it's not, we're  
14 going to drive away a lot of participation or may get a lot  
15 of pushback.

16 Secondly, I would really argue that for the  
17 multiple attribution part of it, at least depending on the  
18 structure of the practice or the structure of the system  
19 you're in, I mean, I think people should only be held  
20 accountable for things they can control. For instance,  
21 there's an awful lot of things happen with my patients that  
22 I have no control over once they get into the system. So

1 they get referred from one specialist to the next and I  
2 don't find out about it until three or four levels down the  
3 line.

4           And so, now probably, for instance, in the Kaiser  
5 system that doesn't happen, my guess is. And so it depends  
6 on the structure of the system. But in my setting, I have  
7 no control over a lot of the things that happen.

8           I was struck by something Nancy said, and I don't  
9 know if she was referring to this, but a question of who has  
10 access to the data. For instance, it would be extremely  
11 helpful for me as a referring physician to have access to  
12 the performance data of some of the consultants I use,  
13 because quite honestly, I don't know them. Many of them are  
14 a long ways away. I don't see them on a day-to-day basis.  
15 I don't exactly know what's happening. And I don't really  
16 know whether that's possible or not, but --

17           MR. HACKBARTH: Let me link Tom and Ron here.  
18 We're not using this for payment. We're using this for  
19 information. Ideally, Tom would be able to look at his  
20 data, in fact, see that when I refer to Dr. so-and-so, it  
21 produces lots of imaging and lots of additional specialty  
22 consults, whatever. When he gets his data, is he going to

1 be able to see, oh, it's my referrals to Dr. so-and-so that  
2 are producing this stream of stuff, or is it going to be so  
3 aggregated that he can't figure out which of his consults is  
4 producing all this stuff?

5 MS. PODULKA: You raise a very good question,  
6 Glenn. Anytime you start to disaggregate and you drill down  
7 by condition, and as I described, even individual episodes  
8 and patients, you're going to start to be able to figure  
9 that out. And I could see that it would be of tremendous  
10 benefit even just to list which other specialists and  
11 providers are involved. You might not even be aware, I  
12 mean, other than the initial referral, if there's things  
13 down the line. If you just had a list of the names of who  
14 else are involved in that episode, it could be helpful. But  
15 then we're raising the policy question of the  
16 confidentiality. So then this sort of goes back into your  
17 lap.

18 MR. HACKBARTH: The confidentiality of the other  
19 physician, you're talking about, not patient  
20 confidentiality. Again, this is, to me, reminiscent of some  
21 of our discussions around medical home, also, where we say,  
22 well, we want these physicians who are designated as homes

1 to influence these patterns of care, but they don't know  
2 about them or they may only know little pieces that they  
3 hear from patients. They don't get systematic information.  
4 This is the sort of tool that we need to be developing,  
5 including the drill down capability that allows them to  
6 learn what happens when I refer to Dr. Jones.

7 DR. DEAN: And Arnie wrote a very interesting  
8 paper about practices that were successful in controlling  
9 costs and upholding quality, and somehow they had much  
10 better data about the consultants they used than I do. I  
11 don't they did it. I admire what they did. But this would  
12 be a very valuable tool if we could make it available.

13 DR. MARK MILLER: One step down that road, which  
14 is not every consultant that you used, but the point that  
15 Jennifer was making earlier about multiple attribution. If  
16 you go to a process of saying, okay, I'm going to make the  
17 attribution for this episode to the heavy hitters in the  
18 episode, then at least there may be two or three physicians  
19 that you're aware of and say, okay, this is the report of  
20 what happened to the episode, even if it's not each and  
21 every consultant.

22 DR. DEAN: [off microphone] There certainly are a

1 couple of specialties that consume most of the resources.

2 MS. BEHROOZI: This is really fun, and actually I  
3 see a lot more integration between your five separate parts,  
4 I think, than you gave it credit for. Partly the way you  
5 wrote it helped with that.

6 But also Jay's comment earlier about the  
7 relationship between the policy principles and the data  
8 release point. I think they really come together,  
9 particularly around the options for data release that  
10 include results, because that's where you get to reinforce  
11 or build on the policy principles of transparency and buy-in  
12 and things like that.

13 It does seem to me that we're not talking about a  
14 confidential feedback system anymore, right, if we're  
15 talking about releasing results to other entities that may  
16 be using it right, private payers or whatever might be using  
17 it differently. So that's a big step and so all of those  
18 policy principles then, it seems to me, we need to be really  
19 clear that we are doing this the right way so that because  
20 it will now be used in a different way than just  
21 confidential feedback, there can be a high degree of  
22 confidence and reliability and consistency. So I think

1 that's one way they relate.

2 I think also just the whole notion of -- you  
3 talked about Medicare not wanting to buy things off the  
4 shelf. But in general -- and Medicare is special. But in  
5 general, the idea of customization runs counter to  
6 efficiency, sort of generally when you're implementing  
7 change and implementing systems and things like that. That  
8 doesn't mean customization is a bad thing, but it's a  
9 trade-off.

10 So in our overall system where we spend whatever  
11 it is, \$700 billion too much because of administrative  
12 burdens and things like that, a lot of that is because  
13 individual entities are reinventing wheels that shouldn't  
14 have to be reinvented. And it does seem like accountability  
15 measures, as Arnie called it earlier, is not necessarily one  
16 of those places that benefits by the free market competitive  
17 branded version of, ooh, my physician resource measurement  
18 tool is better than yours, but rather building the best one  
19 together brings down costs overall somewhat in our system  
20 and produces these other positive results of having it be  
21 reliable and having buy-in and things like that.

22 I just wanted to make one more point unless you

1 wanted to talk on that point.

2 I think that just releasing raw data as opposed to  
3 releasing the results are like two opposite things. You put  
4 them as sort of alternatives on a continuum, but I think  
5 that they really run kind of in counter directions when it  
6 comes to that issue of not customizing and having things be  
7 that much more reliable. So I think that's it.

8 MR. HACKBARTH: I was just going to pick up on  
9 your point about customization, which is I think is a very  
10 good one, and in fact, as I have tried to learn about these  
11 things from a physician perspective, one of the things that  
12 I hear often now from physicians is I get all of these  
13 conflicting reports. One says I'm a good physician. The  
14 other says I'm a bad physician. What am I supposed to do  
15 with this stuff? Their reaction is to just ignore it. I  
16 can't reconcile it. It doesn't make sense. So having all  
17 of these different flavors is, in the real world, a real  
18 problem.

19 The customization issue here for Medicare is a  
20 little bit unique in the sense that it's closely linked to  
21 transparency. Medicare can't take an off-the-shelf product  
22 which is a black box, the details not knowable, and say,

1 we're going to use that. That just won't hold water for a  
2 public program.

3 So to some extent, Medicare is forced by that to  
4 have its own. But then that makes 2(a) sort of appealing.  
5 At least let's give people the option to say, private  
6 payers, we're going to use the Medicare product in the name  
7 of standardization, consistent signals to physicians, and  
8 pool the data.

9 MS. BEHROOZI: Right, exactly. Not that anybody  
10 should be prohibited from inventing their own wheel, but  
11 Medicare having customized it in the best way possible  
12 according to all those policy principles, with buy-in and  
13 input, that should be the new thing.

14 But the other point I wanted to make was in terms  
15 of the data that you're talking about, it's just  
16 fee-for-service data right? The claims data.

17 MS. PODULKA: Correct.

18 MS. BEHROOZI: So I just wondered about -- and you  
19 say that Medicare has a big enough "n," but we look at it on  
20 a national basis. I'm sure there are pockets, whether it's  
21 specialties that you identified or areas where there isn't  
22 enough "n." So how about requiring those MA plans that pay

1 claims, like private fee-for-service, requiring them to dump  
2 their data into here, and now I know I'm going far afield,  
3 but CMS does administer Medicaid and Medicare. HHS  
4 administers them both. Let's maybe suggest to Congress that  
5 States be required to report their data and then they get it  
6 back, and boy, wouldn't they love to be able to look at the  
7 quality of Medicaid providers, and probably a lot of them  
8 don't have the resources to do this themselves, so anyway.

9 DR. STUART: Recall that CMS has a regulation --  
10 I'm not sure that they've actually put this into place yet -  
11 - that will get MA event-level data and claims from those  
12 who actually have claims, and because that is supposed to be  
13 used for risk adjustment and because you're talking about  
14 risk adjustment here, it sounds to me that a way could be  
15 made to include that in here, as well.

16 DR. CROSSON: I am an enthusiastic supporter of  
17 reporting physician use information. I have been from the  
18 beginning for all of the reasons that Karen delineated. And  
19 I think the principles that were laid out in the paper and  
20 some of the other ones that Karen added, also I would  
21 support. So that's fine.

22 The concern I have with respect to the second

1 question and the options, or in fact how we think about the  
2 public release of the information, relates to what I thought  
3 was the thinking process we went through when we originally  
4 supported the idea of the reporting of the physician use  
5 information. And that was, and maybe I remember  
6 imperfectly, but it was essentially to be a step-wise  
7 process. In other words, we would first report  
8 confidentially. The idea there was several-fold. It was to  
9 try to make sure that the reported information got a chance  
10 to be improved around things like risk adjustment, the  
11 clinical relevance of some of the stuff, to give the  
12 physicians the chance to recover from the fact that this is  
13 a new thing in their life, to have some input into the  
14 process, and also to begin to change behavior. There was a  
15 sense that the physicians respond really quite well, and it  
16 has certainly been my experience, at least initially to  
17 confidential information and to have a chance to change  
18 behavior before something else transpires, including up to  
19 changing reimbursement based on performance. All of which I  
20 support by the way.

21           But it seems to me here now we have sort of two  
22 parallel things going on. One would be now based on the

1 law, CMS going ahead with the confidential reporting process  
2 based on an analysis of the Medicare claims data.

3 But then a separate process, even under option  
4 2(a), where basically the same information is now provided  
5 to private entities, clearinghouse or not. And then as it  
6 says in each one of these three options, the entities would  
7 then be able to either confidentially or publicly report the  
8 physician measurement results.

9 So my concern is whether or not -- whichever one  
10 we pick of these -- we have essentially sort of two things  
11 in conflict. One is we're trying to bring forward a  
12 confidential reporting process to gain the trust of  
13 physicians, to incent behavior change, and then  
14 simultaneously we're going ahead and supporting another  
15 process which has a very different reporting process and  
16 could completely supervene the one that we started out with.

17 So one potential solution to that would be if we  
18 end up choosing option 2(a), which is the one of those that  
19 I would pick, is to put some proviso in there that this  
20 issue of publicly or confidentially reporting be managed  
21 somehow in parallel to the CMS initiative. In other words,  
22 when the CMS initiative is confidentially reporting, then

1 these would have to be reported confidentially also. But  
2 then when CMS moves on to more public reporting or to other  
3 levels of accountability, then the other process would be  
4 released for that purpose.

5 MR. HACKBARTH: I think you're right, and Mitra  
6 touched on the same thing. There is a disconnect here if we  
7 go to 2(a) immediately with our prior emphasis on  
8 confidential and we need to figure out how to reconcile  
9 that.

10 I have Mike and Bill and Jack and then we're done.  
11 Mike?

12 DR. CHERNEW: I believe strongly that the  
13 principle of transparency is important, although I'm afraid  
14 that that's going to be a bit of a barrier to moving quickly  
15 for a number of reasons. So I have a question about that.  
16 The first one is how transparent are the HCCs and the risk  
17 adjustment methodology and other sort of technical things  
18 that are done with in the Medicare program? I'm afraid that  
19 if we wait for Medicare to develop its own, or maybe  
20 purchase one, that it will just take a long time until you  
21 get this to work and you'll end up with a product that  
22 conflicts with existing ones. So anyway, I think

1 transparency is really crucially important, but it gives me  
2 pause.

3 I also think that the idea of risk adjustment is  
4 really important, but I'm very worried that it's going to be  
5 imperfect in however you do it. One of the ways that no  
6 matter how you risk adjust it, people will look at it and  
7 say, well, but you didn't realize I had blah, blah, blah.  
8 And that's just the way it is.

9 As long as we're just releasing information to  
10 people, I'm fine with all of those flaws. So despite my  
11 concern, I would rather release the information, try and do  
12 the best job we can before having Medicare develop their own  
13 process with public comment and make sure everyone's done  
14 whatever they've done and gotten everything right. So  
15 anyway, that's my view on that, but I do think those are  
16 incredibly important principles.

17 With regards to 1(a), 1 and 2(a) and that question  
18 that was raised, so as a philosophical point, I'm generally  
19 supportive of as much data release as is politically  
20 feasible, subject to various confidentiality rules, but I  
21 think that should be released. I'm very skeptical of the  
22 2(a) method, and I would be supportive of it if you could

1 convince me that CMS could do it well in a timely manner.

2 I remember a discussion we had about an hour ago  
3 about an under-resourced, not always given the most ability  
4 -- and this is a relatively complicated thing, and I've been  
5 working with some people that have been working with  
6 groupers and it is a -- the idea that even claims data,  
7 coming from different organizations in different ways --  
8 this is a non-trivial information technology exercise. And  
9 the idea that we're going to put the resources into an  
10 organization that is going to do it well and have output  
11 that is then confidential is wonderful in a world that has  
12 the appropriate resources and I would be all for giving them  
13 the resources to do that. But I think that in the process  
14 we go through, that might be underestimated and we might not  
15 end up as well.

16 I actually prefer releasing the data in an option  
17 one kind of strategy. I'm not subject to the political  
18 reasons. I can see a lot of reasons why that's not a good  
19 thing to do. I'm afraid when you do that, no matter what we  
20 say about how the data is going to be used, you'll see it  
21 for tiering. You know, Medicare might not use it in certain  
22 ways, but believe me, public payers -- private payers,

1 they're going to see the power in this data and it's going  
2 to go well beyond having a physician understand how they  
3 stacked up.

4           So I think we really have to have a discussion  
5 about how far we want to go down this road between something  
6 that's sort of quick and easy and confidential and giving  
7 feedback, which is sort of where we started, to this system  
8 would be a whole heck of a lot better if Tom could figure  
9 out how the specialists that he's referring to actually  
10 behaved in a somewhat timely manner without six DUAs and a  
11 bunch of other things that in North Dakota everyone's going  
12 to hit the asterisks.

13           The other thing I'll say in response to Karen's  
14 comment about simple and understandable, again, I agree  
15 wholeheartedly about simple and understandable. I just want  
16 to add a third adjective, that it needs to be right. And  
17 the problem sometimes with simple and understandable is  
18 you've made compromises to make it understandable and simple  
19 as to what you're doing, which then later people will  
20 explain to you why it's not credible.

21           And so there is -- I know this in the work that I  
22 do -- there is always a tension between getting it in a way

1 that people think is credible -- risk adjustment is the  
2 perfect example. This simplest way to do it, ignore a lot  
3 of the risk adjustments. It's just this is your average  
4 claim per person. You understand exactly what it is. It's  
5 very simple, you know what it is, but it's not going to have  
6 any credibility. And as soon as you start worrying about  
7 other aspects of how you've done these things it becomes --  
8 if you do it without multiple attribution, for example,  
9 people say, well, that's just not credible because I refer  
10 to one person and now it's all going wherever it is. I  
11 don't find that credible. If you do it with multiple  
12 attribution, it's much more complicated and people are going  
13 to argue about the aspects of the attribution.

14 I think Jennifer did a great job of saying, you  
15 know what? It doesn't make that big of a difference, and I  
16 believe that completely. Someone is going to say, that's on  
17 average, but for me, it's different. It's not true in  
18 Cleveland or wherever it is and I have a different type of  
19 practice because all my patients are over six-foot tall, or  
20 whatever it is.

21 So I guess, again, my view is I'm glad that this  
22 is after all of our payment update meetings and this is the

1 beginning of a process to figure out how to do this, because  
2 I think it does require a lot of philosophical and technical  
3 discussions to make sure we come up with something that's  
4 sufficiently sophisticated to achieve the goals that I think  
5 we all would like it to achieve.

6 DR. SCANLON: Like Mike, I see the real power of  
7 these data, but I reach the exact opposite conclusion, which  
8 is why I wouldn't allow it to be released sort of in the  
9 claims form, because it would totally destroy the issue of  
10 transparency because we'd have all kinds of people using it  
11 in different ways and we wouldn't know sort of how they're  
12 using it.

13 MR. HACKBARTH: Just so I understand, Bill, you're  
14 saying you wouldn't allow the Medicare data to be used by  
15 private --

16 DR. SCANLON: In the aggregate, yes, but not as  
17 claims. Not releasing of claims. So I'm in favor of 2(a),  
18 as well.

19 I think a part of this is that it's important --  
20 I'm on the National Committee on Vital Health Statistics,  
21 the HIPAA advisory body, and basically there's a sense that  
22 de-identified data today is a becoming an oxymoron. De-

1 identified data of the type we're talking about here today,  
2 which is data that were going to be useful for something,  
3 where you know the physician, you know the diagnosis, you  
4 know the date, you know the service, that's not de-  
5 identified. That's going to be -- and you take away the  
6 patient ID, people are going to tell you about their ability  
7 to mine that data and identify sort of the person that was  
8 involved.

9           The assurance from a privacy perspective that can  
10 come here is the entity that receives the data and the  
11 requirements that are imposed upon that entity, the  
12 penalties that would be imposed upon that entity if they  
13 disclose the information, it's not going to come from the  
14 data itself. So we need to think about it in those terms,  
15 not this idea of just stripping off the name, because that's  
16 not going to work.

17           MR. HACKBARTH: Just so I'm sure I understand,  
18 Bill, what I hear you saying is that if we give these sorts  
19 of data to private insurers, it's not just physician  
20 identification that is known, it's ultimately patient  
21 identification.

22           DR. SCANLON: They will be able to infer who the

1 patient is through a variety of mechanisms. And it even  
2 applies to certain levels of aggregation. We can say that  
3 we've put together five people, but if we put them together  
4 in a particular way and there's enough information there and  
5 their characteristics are unique enough, the combination of  
6 those characteristics are going to identify some of those  
7 people.

8           It's again to this issue of data mining. You have  
9 other data sources that you can bring into play and that you  
10 then sort of can identify an individual in a data set that  
11 has supposedly been anonymized, but it isn't in reality.  
12 It's the --

13           MR. HACKBARTH: If you do 2(a), does that avoid --

14           DR. SCANLON: If you do 2(a) at a high enough  
15 level of aggregation, there is no issue. But this is -- I  
16 mean, it started with, I think, with Tom's comments. What  
17 level of detail do we want to give different parties sort of  
18 that are going to be part of this process? And in thinking  
19 that through, we have to think about sort of what are going  
20 to be the risks in terms of identification. And we're not  
21 going to always be able to say that we've totally eliminated  
22 the risk of identification, so therefore we have to turn to

1 sort of plan B in some respects, which is to say we have got  
2 to impose a responsibility on the person receiving this that  
3 they are not going to disclose this information. That's the  
4 critical piece here in terms of protection of privacy.

5 DR. CHERNEW: Glenn, could I just say I agree 100  
6 percent with that comment about that's how you have to deal  
7 with the confidentiality issue, and I think the only  
8 challenge is how good you think 2(a) could be. It has the  
9 advantage, if you could get data from all the different  
10 plans. If you just release it, you get just the Medicare  
11 and United or Medicare and Humana. So I agree completely  
12 with Bill's assessment.

13 DR. SCANLON: The second comment would be to the  
14 issue of, again, sort of Mike suggesting that our risk  
15 adjustment process today has its problems. We could do a  
16 better job in terms of episode definitions, etc. Think  
17 about this, not for the short term but for the longer term,  
18 in terms of the linkage between this and the \$20 million for  
19 health information technology and the idea of meaningful  
20 use.

21 What is it that we want in exchange for the \$20  
22 million in terms of the kind of data that are going to flow

1 to sort of both Medicare and private payers that would allow  
2 much more robust analysis to be done here? I think that's  
3 sort of a key. And it also could be combined with a notion  
4 of actually trying to achieve one of the original goals of  
5 HIPAA, which was administrative simplification. Instead of  
6 having sort of the information come in, or be requested by  
7 every payer in somewhat different form when it comes to  
8 adding on additional items to a claim, okay, that we end up  
9 standardizing the information in a way that it simplifies it  
10 for the provider perspective, but increases the power for  
11 the payers and the Medicare program in terms of being able  
12 to analyze the information and understand much better what  
13 they purchased.

14 MR. HACKBARTH: Okay. Mark, you gave me a big  
15 budget and lots of time and I managed to over-spend it by a  
16 fair amount.

17 We will now have a brief public comment period  
18 before lunch.

19 MS. McILRATH: Hi, I'm Sharon McIlrath with the  
20 AMA. There may be somebody in the room from CMS that could  
21 clarify this, but on the subject of the reports that are  
22 going out, in a meeting with the physician person it was, I

1 think, the understanding of everyone in the room that there  
2 were going to be 250 reports total to the 12 cities and in  
3 eight conditions, 13 specialty groups.

4           So when you do the math, it's not very many  
5 reports.

6           And there was a fear in the physician community  
7 that it's going to be going to one specialist in a community  
8 and if that person doesn't choose to fill it out, they're  
9 not going to get a lot of information.

10           And I think it does have to do, they've been very  
11 good about trying to reach out to the physician community.  
12 I think it has a lot to do with the resources, which is sort  
13 of the perpetual problem here.

14           So just in terms of thinking about what you can  
15 do, and perhaps we all had the misunderstanding, but I think  
16 that needs to be clarified.

17           Also, I just wanted to thank you for doing the  
18 principles and to sort of weigh in on the side of the  
19 transparency.

20           There's an issue that's going on now with the  
21 review, the medical review software that CMS has sent out  
22 and that the MACs and the RACs are using. And I won't go

1 into it here but it's causing some real problems and it's  
2 also going to mess up a lot of the data because it's turning  
3 out that some things that are really inpatient admissions  
4 are now being coded as observation care so that the hospital  
5 will at least get paid something, rather than having the  
6 claim denied.

7           And then I just wanted to also weigh in on the  
8 side of giving the physician the identification of the  
9 patient. Although it seems like that should be a simple  
10 thing and it would also help Dr. Dean figure out who the  
11 consultants were if you knew who the patient was, there is  
12 at least one demo where it's my understanding that CMS has  
13 not been willing to release that information to the  
14 physicians because of the fear that maybe they've got  
15 somebody else's patient in with your data and so the  
16 physician might not be looking at only their own patients'  
17 data. So it's sort of a Catch-22.

18           MR. HACKBARTH: Okay, we will adjourn for lunch  
19 and reconvene at 1:30.

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

22



1           Looking at this you will see that most  
2 beneficiaries, that first tall yellow bar, live in counties  
3 where the Medicare fee-for-service spending is less than  
4 \$741 per person per month. At the other end of it just 3  
5 percent live in areas where fee-for-service spending is  
6 above \$900 a month. Now, the unusual breakpoints on this  
7 chart are related to the MA benchmark floors of \$741 and  
8 \$819 as we show on the next slide.

9           In this graph we have the green bars, which are  
10 the ones to the right, which show the distribution of the  
11 enrollees in MA plans by the MA benchmark of the county  
12 where they live. There are no benchmarks below the lower  
13 floor of \$741 which is that first blue line. About 15  
14 percent of MA enrollees are in counties with benchmarks of  
15 \$741 to \$818, and that is above the lower floor but below  
16 the large urban floor which is the second blue line. Most  
17 enrollees, 60 percent, are in areas where the benchmark is  
18 between the large urban floor and up to \$899 a month.

19           Finally, almost 25 percent of enrollees are in  
20 areas with benchmarks over \$900 a month. The difference in  
21 the distributions gives you a clue as to why spending on  
22 your average enrollee in a MA is much higher than for the

1 average beneficiary in fee-for-service.

2 One other distribution of interest is that of  
3 high-quality plans. We show here the distribution of plans  
4 by their CMS quality railings. The green bars are the local  
5 Coordinated Care Plans, that's either local HMOs or local  
6 PPOs. The Yellow bar is regional PPOs or private  
7 fee-for-service plans. CMS ranked MA plans on a 5-point  
8 quality scale, with the average being 3, and note that there  
9 are many plans that rank 3.5 stars or above, the last three  
10 bars on the chart there; we refer to these as above-average  
11 or high-quality plans. Almost all of these high-quality  
12 plans are local Coordinated Care Plans. Only one private  
13 fee-for-service plan ranks at 3.5 stars or above.

14 Now, there are a lot of caveats behind this chart,  
15 not all plans are ranked and that sort of thing, but our  
16 point here is to note that there are some high-quality plans  
17 available, and almost all of them are CCPs. And by the way,  
18 these 96 high-quality plans include a 41 percent of the CCP  
19 enrollment.

20 Returning to the report, let's remember where the  
21 Commission is coming from as we think about the third task.  
22 MedPAC has a long history of supporting private plans in the

1 Medicare program. The Commission maintains that  
2 beneficiaries should be given the choice of delivery systems  
3 that private plans can provide. Private plans have the  
4 potential to improve the efficiency and quality of health  
5 care services delivered to Medicare beneficiaries. That is  
6 because they can use financial incentives, care  
7 coordination, and other management techniques that  
8 fee-for-service cannot.

9           If the plans are paid appropriately plans would  
10 also have the incentive to be more efficient than Medicare  
11 fee-for-service and offer better value for the taxpayers.  
12 To provide MA plans has the incentive to be more efficient  
13 than fee-for-service Medicare, the Commission has  
14 recommended that the program be financially neutral between  
15 fee-for-service and Medicare Advantage Plans. That is, pay  
16 the same for similar beneficiaries. The commission is  
17 concerned the current MA system is not financially neutral.

18           Specifically, the Commission is concerned that the  
19 payments under the current MA payment system are too high,  
20 14 percent above the costs of caring for similar  
21 beneficiaries in Medicare fee-for-service.

22           Second, Medicare is subsidizing the participation

1 of inefficient plans and these are plans not designed to  
2 coordinate care and improve quality.

3 Finally, even though some beneficiaries get extra  
4 benefits from MA plans, Medicare is heavily subsidizing  
5 those extra benefits, as much as \$3.26 for each dollar of  
6 extra benefits in private fee-for-service plans. This is  
7 not a wise use of Medicare funds, particularly given the  
8 concerns for Medicare's sustainability and the federal  
9 deficit.

10 This brings us to today's discussion on future MA  
11 payment systems. The Commission maintains that all the  
12 options considered should set benchmarks at 100 percent of  
13 fee-for-service costs, consistent with the prior Commission  
14 recommendations. Doing so will restore incentives for plans  
15 to be efficient. CBO estimates that returning MA to payment  
16 neutrality will reduce spending by \$150 billion over 10  
17 years.

18 The second consideration is that the availability  
19 of efficient, high-quality plans is an important goal for  
20 the MA program. If we are going to pay for private plans in  
21 Medicare, we expect them to be an efficient alternative and  
22 we should require them to provide high-quality care to

1 beneficiaries. This leads us to the following points:

2           During the transition to financially neutral  
3 payment levels, payments will likely remain above  
4 fee-for-service is Medicare phases in lower benchmarks to  
5 lessen disruption for enrollees. Those higher payments  
6 should be contingent on higher quality. That is, higher  
7 quality plan should be paid more than low-quality plans.  
8 This would encourage high-quality plans to stay in the  
9 program.

10           One possible outcome is that, after the  
11 transition, MA payments could be higher for plans with  
12 demonstrated quality higher than the traditional  
13 fee-for-service program. In other words, payment could be  
14 financially neutral on a quality adjusted basis. We have a  
15 forthcoming report and how quality in MA plans could be  
16 compared to quality in fee-for-service plans.

17           Scott will now address the third task, other  
18 approaches to MA payment.

19           DR. HARRISON: Congress has asked the Commission  
20 to examine alternate approaches to MA payment. We have  
21 previously recommended larger payment areas than the county  
22 level, but we're not going to talk about that today.

1           In this section we examined the alternatives for  
2 setting payment benchmarks for the MA program. We look at  
3 four options for setting benchmarks administratively and we  
4 look at some of the challenges involved in simulating  
5 competitive bidding options.

6           We modeled each of the alternative benchmark  
7 formulations with data from 2009 plan bids. We included all  
8 plan types, but we have excluded special needs plans and  
9 employer group plans because they are only available to  
10 subgroups of Medicare beneficiaries. We also eliminated  
11 counties in Puerto Rico because we are missing some  
12 important variables for those counties. The results I will  
13 present assume that plan bids and service areas do not  
14 change. We compare plans, 2009 actual bids, with the new  
15 benchmarks that would result under each alternative. We  
16 assumed that plans that bid below the simulated benchmarks  
17 would continue to do so and therefore be available, although  
18 the extra benefits they offer would probably be reduced.  
19 This is a conservative assumption in that plans might bid  
20 lower than they currently do in order to attract or retain  
21 market share.

22           All of the options we simulate are financially

1 neutral, meaning they would reduce the average benchmark  
2 from 118 percent of fee-for-service to an average of 100  
3 percent of fee-for-service spending in the first year. Our  
4 simulations are static and look at what would happen if the  
5 new benchmarks applied in 2009. However, some of the  
6 options could encourage shifts in enrollment patterns over  
7 time, which could affect the savings generated by the  
8 option.

9 I'm going to show you a series of simplified  
10 graphical representations of each of the four options.  
11 Imagine the counties arrayed along the bottom in order of  
12 fee-for-service Medicare spending in the county. The  
13 corresponding benchmarks run up the side. So, a point on  
14 the graph would represent the fee-for-service spending in a  
15 county in the benchmark for that county under whatever  
16 option we are discussing.

17 Let us first consider the current benchmarks. The  
18 yellow lines show the simplified relationship between  
19 fee-for-service spending and the current benchmarks.  
20 Basically, benchmarks cannot go below the floor, which David  
21 mentioned is \$741, and above the floor, benchmarks generally  
22 are slightly above fee-for-service spending, which here is

1 represented by the light blue line. For visual simplicity,  
2 we are ignoring the fact that there were actually two floors  
3 and that benchmarks can sometimes be significantly above  
4 fee-for-service.

5 Now, one option would be to set benchmarks to  
6 local fee-for-service, which would mean setting the  
7 benchmarks along the blue line. Note that all counties  
8 would see a reduction from their current benchmarks but some  
9 counties might seem rather small reductions.

10 One criticism of the local fee-for-service  
11 approach is that there are some very high fee-for-service  
12 spending counties with very high use of services. Some  
13 policymakers may find it inequitable that those counties  
14 should receive high MA benchmarks based on high  
15 fee-for-service utilization. These high benchmarks enable  
16 plans to offer significantly more generous benefits which  
17 are not available to the rest of the country. Also, there  
18 are some very low fee-for-service spending counties where  
19 the providers and beneficiaries have been very frugal and  
20 plans cannot survive at those low rates and provide any  
21 extra benefits. So, one option that would address this  
22 criticism would be to set a floor at the low end, use

1 fee-for-service spending rates in the middle, and set a  
2 ceiling at the high end. This so-called hybrid option was  
3 actually suggested by some of the Commissioners.

4 The floor and ceilings could be set in different  
5 ways. For these simulations we picked a \$600 and a \$960  
6 ceiling so that the average benchmark approximated 100  
7 percent of fee-for-service.

8 One option indicated in the mandate that we have  
9 discussed before is setting the benchmarks that take into  
10 account expected plan costs. That is, benchmarks would be  
11 higher in areas where plan costs would be expected to be  
12 higher and lower in areas where they were expected to be  
13 lower. More specifically, we interpret MIPPA as asking us  
14 to examine an option where the benchmarks would be set using  
15 a blend of local fee-for-service spending and national  
16 fee-for-service spending.

17 Low spending areas on the left of this graph are  
18 the places where plan costs might be expected to be higher  
19 than fee-for-service spending. Those areas would have a  
20 higher benchmark than fee-for-service. Those high spending  
21 areas on the right where MA costs are expected to be lower  
22 than fee-for-service would have a lower benchmark than

1 fee-for-service.

2           The blend line pivots off the 100 percent of  
3 fee-for-service line and those lines intersect at the  
4 national average for fee-for-service, which, for our  
5 simulations here, are \$734 per person per month. Because  
6 the national average is below the current floor, it is clear  
7 that all counties would see a reduction from current  
8 benchmarks under a local/national blend.

9           Here we see another option for setting benchmarks  
10 that take expected plan costs into account. Local  
11 fee-for-service rates account for both local service use and  
12 local input prices. In theory, managed-care plans can  
13 manage utilization so there would be less variation across  
14 the country.

15           So, we take the national average fee-for-service  
16 spending and adjust by local input prices to set the  
17 benchmarks. The formulation would set benchmarks higher in  
18 areas where plan might be expected to have to pay providers  
19 more, but would not set higher benchmarks based on higher  
20 service utilization. Another way to put it is that we've  
21 created a normative standard for utilization. We would be  
22 saying that plans should be able to provide the Medicare

1 benefit using no more than average utilization.

2           Now, this option cannot be illustrated with a  
3 line, so we have that cloud there. The cloud around the  
4 national average line illustrates that there is almost no  
5 relationship between local fee-for-service spending and  
6 local price levels. Areas with similar prices can have very  
7 different fee-for-service spending patterns. We've added  
8 points representing Minneapolis and Miami. Despite the fact  
9 that fee-for-service spending in Miami is about \$400 per  
10 month higher than in Minneapolis, average prices are about  
11 the same and actually Minneapolis would have a slightly  
12 higher benchmark than Miami under this option. Under this  
13 option, also, some benchmarks would rise from current  
14 levels.

15           Now, I want to point out to the Commissioners that  
16 there are two versions of this option in your meeting  
17 materials, but to simplify it, we're only presenting the one  
18 labeled input price adjusted blend.

19           This is a summary of some of the characteristics  
20 of the four options. You see that the 100 percent of local  
21 fee-for-service option would produce the largest benchmark  
22 differences between high- and low-spending counties, but

1 each county would have its benchmark equal to local  
2 fee-for-service. The input price adjusted blend would  
3 produce the narrowest range of benchmarks but would have  
4 benchmarks in some counties either well above or well below  
5 local fee-for-service spending.

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

16 So, now, with a look at the simulation results.  
17 Policymakers want to know whether plans will be available if  
18 the benchmarks are changed to produce the estimated savings.  
19 The simulations measure plan availability by whether the  
20 plan bids are above or below the simulated new benchmarks.  
21 As I said earlier, we assume that plans that bid below the  
22 simulated benchmarks would continue to do so and therefore

1 be available, although the extra benefits they offer would  
2 probably be reduced.

3           Currently, 100 percent of beneficiaries live in  
4 counties with plans bidding below the benchmark. Of all the  
5 alternatives, option four, the input price adjusted blend,  
6 maintains the highest levels of availability. 94 percent of  
7 all beneficiaries and 88 percent of rural beneficiaries  
8 would have a plan available.

9           The 100 percent local fee-for-service benchmarks,  
10 option one, results in the lowest availability: 80 percent  
11 overall and 67 percent in rural areas. The main reason that  
12 the input price adjusted blend results of the highest  
13 availability is that it turns out that these benchmarks were  
14 actually good predictors of plan costs and really even  
15 better than the blend.

16           Here we present a second set of availability  
17 results for local Coordinated Care Plans, which include HMOs  
18 and local PPOs only. We report separately on the local  
19 Coordinated Care Plans because the Commission has raised  
20 concerns about growing plans committed to coordinating care.

21           The plans with the most potential to coordinate  
22 care are the local CCPs, so we look to see how widely

1 available they might be under different payment  
2 alternatives.

3           Local CCPs are currently available to 87 percent  
4 of Medicare beneficiaries, but even with current benchmarks  
5 as high as they are, they did not result in high  
6 availability in rural areas. Only 60 percent of rural  
7 Medicare beneficiaries have a local Coordinated Care Plan  
8 available.

9           All alternatives that reduce the benchmarks reduce  
10 availability significantly in both urban and rural areas.  
11 As before, the input price adjusted blend preserves the most  
12 availability; 75 percent of beneficiaries overall, and 46  
13 percent of rural beneficiaries would have local CCPs  
14 available. Meanwhile, the local fee-for-service option  
15 would result in 66 percent overall availability and 31  
16 percent in rural areas.

17           Now, the Commission is especially interested in  
18 assuring beneficiary access to high-quality plans. We have  
19 simulated how these benchmark options might affect the  
20 availability of players that have demonstrated higher  
21 quality. Currently, 55 percent of beneficiaries and 34  
22 percent of rural beneficiaries live in counties where they

1 could enroll in high-quality plan. Measurement issues  
2 suggest that there may be additional high-quality plans  
3 available in Medicare Advantage, but we are limiting the  
4 category to those plans that have successfully submitted the  
5 data that allow CMS to award 3.5 or more stars.

6           The table shows that all of the options that  
7 reduce benchmarks reduce the availability of high-quality  
8 plans. The lowest availability occurs under the local  
9 fee-for-service option. However, the input price adjusted  
10 blend does not produce a steep drop in availability.  
11 Overall availability drops from 55 percent to 49 percent  
12 overall, and availability in rural areas drops only 3  
13 percentage points. Further, if Medicare provides quality  
14 bonus payments for high-quality plans, availability might  
15 not drop much from current law while the program could save  
16 some money.

17           Now, let's consider something other than  
18 availability. Policymakers have also been concerned about  
19 the level of extra benefits plans may offer. We simulate  
20 the level of extra benefits offered by simulating the  
21 rebates resulting from plan bids and the new benchmarks  
22 under each alternative. I need to note that this table is

1 different than the one in your meeting materials because I  
2 have removed the plans with zero rebates to characterize  
3 only the plans that bid below the benchmarks.

4 In the group of plans that we are using to  
5 simulate the alternative benchmarks, the average rebate paid  
6 by Medicare is \$96 per member per month. The average rebate  
7 for urban plan enrollees is \$101 and it is \$59 for rural  
8 enrollees. Under any of the options, the average rebate is  
9 also reduced.

10 The option two shows the highest level of rebates  
11 is setting the benchmark at 100 percent of local  
12 fee-for-service spending. The reason this option provides  
13 the largest rebates is because it changes the benchmarks in  
14 the highest spending areas the least. Miami in particular  
15 is known for its high fee-for-service spending and the very  
16 high level of extra benefits offered. The input price  
17 adjusted blend provides the lowest level rebates. And  
18 across all options, rural beneficiaries have rebates about  
19 half as large as urban beneficiaries.

20 These numbers show that the benchmarks could be  
21 reduced to fee-for-service levels and plans could still  
22 provide a high enough level of extra benefits to attract

1 enrollees. Further, if the benchmark were reduced to  
2 fee-for-service spending, it is conceivable that  
3 policymakers might allow the plans to keep the full  
4 difference between the bid and the benchmark for extra  
5 benefits rather than the current 75 percent share that they  
6 get. In that case, each of these rebate figures would be  
7 multiplied by 1.33.

8           Now we're going to move from administratively-set  
9 benchmarks to setting benchmarks based on the plans' bids,  
10 as there has been a lot of interest in that lately. This  
11 slide is just meant to give you a flavor of what the bids  
12 look like. Plan bids vary widely, and as we move to the  
13 right, the average fee-for-service spending in a plan's  
14 service area increases, the ratio of the bids to  
15 fee-for-service spending declines, and the variation in bids  
16 increases.

17           If we use bids to set the benchmarks, we would  
18 likely have benchmarks well above fee-for-service in low  
19 spending areas and benchmarks well below fee-for-service in  
20 high spending areas; however, there are many problems to  
21 overcome in order to simulate the effects of using bids to  
22 set benchmarks.

1           To simulate how such bidding might work requires  
2 making any assumptions on both the nature of the bidding  
3 itself and the response of the MA plans to the incentives  
4 caused by bidding rules. For simulations, specific controls  
5 would have to be finalized. At a minimum, decisions would  
6 have to be made on features such as: what point in the bid  
7 distribution would determine the new benchmark, lowest bid,  
8 immediate bid, the mean? How would the bids be weighted?  
9 Do all bids count? Are there limits? Answers to these and  
10 many other questions are needed to simulate a competitive  
11 bidding design.

12           Further assumptions on plan behavior would then  
13 have to be made. For example, we don't have plan bid data  
14 by county. A plan submits one bid for its entire service  
15 area, which normally covers more than one county. If the  
16 bids were to determine the benchmarks for each county,  
17 presumably plans would need and want to submit separate bids  
18 for each county. The assumptions we make with regard to how  
19 plans would bid at the county level would strongly influence  
20 the results.

21           Finally, our simulations assumed the new  
22 benchmarks are fully phased for 2009 to compare with the

1 plans' 2009 bids. When the bids are used to set benchmarks,  
2 we believe there would be a dynamic process that would play  
3 out over several years as plans try to outmaneuver one  
4 another to secure market share. Again, the gaming  
5 assumptions and assumptions about plan entry and exit would  
6 greatly influence the results.

7           Because the results of the simulations would be  
8 very sensitive to all these assumptions, we did not run  
9 simulations for this option. However, we would expect that  
10 the benchmarks would be lower than current benchmarks but we  
11 don't know how high they would eventually be relative to  
12 fee-for-service spending. We also would expect that bidding  
13 would result in benchmarks higher than fee-for-service in  
14 some areas and lower than fee-for-service in others, and we  
15 would expect that bidding would result in lower levels of  
16 extra benefits than today.

17           As in the past, whenever we have recommended  
18 setting benchmarks at 100 percent of fee-for-service, we  
19 have acknowledged that there should be a transition to the  
20 new benchmarks to limit disruption to beneficiaries. Under  
21 a transition, the new benchmarks can be phased in over  
22 several years.

1           Because the Commission is especially concerned  
2 with retaining high-quality plans, a key point of the  
3 transition should be to limit the loss of any high-quality  
4 plans. During the transition, extra payments could be made  
5 to plans that have demonstrated good performance on quality  
6 indicators. As benchmarks are lowered to attain financial  
7 neutrality, high-quality plan payments would not decrease as  
8 fast and low-quality plans would either improve or their  
9 payments would decrease more rapidly and they would likely  
10 exit the program.

11           Of course, a transition would lower savings for a  
12 few years. CBO's estimated 10-year savings are predicated  
13 on full implementation of the 100 percent benchmarks in  
14 2011. If full implementation were delayed, savings during  
15 the transition would be lower.

16           So what's next? We are on schedule to report to  
17 Congress in June. At our meeting next month, we will  
18 finalize our discussion of the measurement issues  
19 surrounding CMS's estimates of county-level fee-for-service  
20 spending.

21           But now, I want to invite your comment and I'm  
22 sure a lot of discussion. Are there other benchmarks you

1 would like us to simulate for the report? And we would  
2 especially like some feedback on the transition. Thank you.

3 MR. HACKBARTH: Good work. Very good work.

4 Let me start out with a couple comments to frame  
5 the discussion. This is a mandated report originally due in  
6 2010 but we have accelerated to try to complete for our June  
7 report this year. We did that because there was a lot of  
8 interest in getting our analysis and thoughts earlier.

9 What I envision for this report is that we would  
10 go through a series of options, much as the materials in the  
11 notebook do and Scott's presentation did, and say here are  
12 different ways that you could restructure the payment system  
13 and here is some information about the impact as presented  
14 just now and here's some commentary about that, without  
15 making any boldfaced recommendations that you choose number  
16 one or number four or whatever. This is an analytic report  
17 on options that they have asked us to consider and some  
18 we've generated on our own. So that's the product that  
19 we're looking to produce.

20 Now, another word about the context, clearly,  
21 based on the President's budget and other discussions, some  
22 people are looking at Medicare Advantage savings to finance

1 other things that they want to do, whether it's health care  
2 reform or offset SGR. They're looking at this as a way to  
3 reduce Medicare outlays and produce savings for other  
4 things. And so, that's the context in which we are doing  
5 this work, which is a source of some anxiety for me -- and  
6 David and Scott and Mark are aware of this -- because I  
7 think that estimating the long-term budget impact of these  
8 different options is very tricky. So, even though there --  
9 work out to be 100 percent of fee-for-service in year one,  
10 where they would end up over the 10-year budgetary time  
11 horizon, I think, is a very different question. I would  
12 think that you would get pretty different results depending  
13 on the option chosen.

14           So, would you go back to 15 for a second?

15           If you look at the two right-hand columns, the  
16 benchmark under the different alternatives compared to  
17 fee-for-service, and you see as you go down through the one,  
18 two, three, four options, you've got an increasing -- it  
19 doesn't necessarily increase in a straight-line fashion.  
20 You've got some options where there is wide variation;  
21 there's going to be big changes. The bigger the change, the  
22 greater the likelihood of a strong behavioral response. So

1 if you all of a sudden have some benchmarks that the  
2 relationship to local fee-for-service costs varies widely,  
3 either at the high end or the low end, you're going to get a  
4 behavioral reaction to that which may mean that even if it's  
5 100 percent of fee-for-service in year one, the year ten  
6 result could be very, very different. So, I'm anxious about  
7 that, people look through this and look through our analysis  
8 and say, well, here's the impact analysis on plan  
9 availability and say, with this option we've got lots of  
10 available plans, we've got lots of high-quality plans, it's  
11 neutral to 100 percent of fee-for-service. Oh, this is a  
12 great option -- neglecting the fact that, in year ten, it  
13 may be way more costly than 100 percent of fee-for-service.  
14 So, I just feel better now. I've shared my anxiety with you  
15 all about how all of this stuff is interpreted.

16 DR. MARK MILLER: Actually just a different way to  
17 put that. I think some of -- or a different way to help  
18 people understand: As we showed at the beginning of the  
19 presentation, you have a lot of people in some of the higher  
20 cost areas. If you drive the benchmarks down there, then  
21 plans may not people to attract people, which means the  
22 savings that people are getting might be smaller than you

1 would be guessing over time.

2 MR. HACKBARTH: And conversely, if you have large  
3 gaps at the other end where were paying private plans still  
4 substantially more than fee-for-service, and that process  
5 continues to run its course, you can get more and more  
6 people opting for that option which means that it's going to  
7 be expensive.

8 If all of your growth is in the areas under the  
9 newly structured system where you have very high MA payments  
10 relative to fee-for-service and you choke off the growth in  
11 Miamis and the Las, you're going to have all our private  
12 plan enrollment where it adds to costs and none of it where  
13 it reduces costs. That's the dynamic effect that I'm  
14 worried about.

15 So, with that as preface, let me see hands for the  
16 first round of clarifying comments.

17 DR. CHERNEW: All of these numbers are  
18 risk-adjusted and assume the risk adjustment; is that right?

19 DR. HARRISON: Yes.

20 DR. CHERNEW: And you're comfortable that the risk  
21 adjustment behind this is reasonable relative to the old era  
22 of that was just age/gender stuff, that this is -- that the

1 risk adjustment does a pretty good job?

2 DR. HARRISON: Yes, to a rough approximation.  
3 It's what's working now. We don't have any reason to  
4 suspect that it's not, particularly for these kind of  
5 purposes.

6 MR. BERTKO: Scott, current law includes the  
7 removal of the deeming tool for private fee-for-service and  
8 that is likely to perhaps -- I say this carefully --  
9 eliminate lots of those plans. Have you eliminated them in  
10 this?

11 DR. HARRISON: No, these options are for 2009.  
12 What would happen if the bids came in this year and the  
13 benchmarks had been set this year.

14 MR. BERTKO: Okay. I would suggest that because I  
15 think we would want to compare current law to some future  
16 law as opposed to the status quo.

17 MR. EBELER: We have a phenomenon of a lot of  
18 plans and products but relatively few competitors because of  
19 the concentration in this industry in ways you've shown in  
20 previous charts. Do we have data that we'll be able to put  
21 in here that shows how many different companies are bidding  
22 in these different market areas? I just think it will be

1 particularly relevant when we assess the competitive bidding  
2 model.

3 DR. HARRISON: We certainly could do that. We  
4 have not, now. A lot of times you have one contractor  
5 offering many plans, also. So, sometimes we're not always  
6 sure who owns who.

7 MR. EBELER: My sense is, if we look at  
8 concentration, and it's an empirical question, in some of  
9 these communities there's not as many competitors as it  
10 sounds like, and we should just know that what we think  
11 about competitive bidding.

12 DR. REISCHAUER: If you could put up slide 19.

13 These are the rebate dollars and I just wanted to  
14 make sure I understood what you said right, which was that  
15 if we were to say to plans under one of these alternative  
16 systems that we'll give you the total difference up to 100  
17 percent of fee-for-service rather than just 75 percent for  
18 your extra benefits, and it was 33 percent more, which means  
19 that the average amount that the average plan would have  
20 would be bigger than what it has now for extra benefits?

21 DR. HARRISON: Bigger, and actually -- right.

22 DR. REISCHAUER: There would be \$100 for the 100

1 percent of the fee-for-service, so you'd have a sense -- a  
2 bigger pot of money for extra benefits.

3 DR. HARRISON: But they're not available  
4 everywhere.

5 DR. REISCHAUER: Yes.

6 DR. HARRISON: Right.

7 DR. STUART: Yes, that's interesting.

8 You talked about the number of plans that would be  
9 high-quality plans that would come in under the benchmark  
10 and then also, overall, the bid level relative to the  
11 benchmark. What's the correlation between bid level and  
12 these quality stars? Do you know?

13 DR. HARRISON: We have not run that.

14 DR. KANE: On slide 18, this does that mean that  
15 only 33 percent of -- if you could switch to 100 percent  
16 local fee-for-service -- this just means that their bid  
17 would now be only 33 percent instead of 55 percent would  
18 have their bid -- but it doesn't adjust for the fact that  
19 they may change their extra benefits or -

20 DR. HARRISON: Correct.

21 DR. KANE: So, this doesn't -- so, okay, I think  
22 it's pretty hard to figure out what it means.

1 DR. HARRISON: That's why we also did the rebate  
2 one.

3 DR. KANE: But you didn't do it by quality. You  
4 only did by plans -- you didn't buy the high-quality plans.

5 DR. HARRISON: You'd like to see rebates for the  
6 high-quality plans?

7 DR. KANE: Yes. We're talking about the plans  
8 that we want to preserve and I guess it would be helpful to  
9 get a bigger sense of what that means in terms of rebate  
10 dollars and what their flexibility might be. So, if they  
11 got -- yes -- It's hard to put it all together when they're  
12 different populations for the slide.

13 DR. HARRISON: We're trying to keep the number of  
14 slides down.

15 DR. KANE: Yes, I know.

16 MR. GEORGE MILLER: One question I have is, by  
17 definition of the counties, I believe you said that if a  
18 plan offered an MA brand in the county, it is covered, but  
19 because they're offered doesn't mean that -- I mean, because  
20 the plan is available doesn't mean it's offered to all of  
21 the residents in that county but it seems you're giving  
22 credit for that.

1 DR. HARRISON: No, it does mean it's available to  
2 all people in the county. Now, they may not sign up for it,  
3 but it's available to them.

4 MR. GEORGE MILLER: Or they may not market or have  
5 local brokers selling that plan.

6 DR. HARRISON: They're supposed to.

7 MR. GEORGE MILLER: Okay. All right. That's my  
8 concern in rural areas, because that -- my anecdotal  
9 information says that is not correct, but I'm not sure what  
10 you do about that.

11 The second part of my question, though, is the  
12 assumption in this whole analogy is that fee-for-service is  
13 an efficient provider of services even at the low end or the  
14 high end and that may not necessarily be true. A low rural  
15 provider may be more efficient than high spending urban area  
16 but everything is calibrated specifically to  
17 fee-for-service, correct?

18 DR. HARRISON: Except for the option of -- could  
19 you put up the cloud option?

20 MR. GEORGE MILLER: This is interesting.

21 DR. HARRISON: What we found just by doing this is  
22 utilization varies widely and it has nothing to do with the

1 price levels.

2 MR. GEORGE MILLER: And therefore the efficiency  
3 issue is taken care of here with the cloud but on the  
4 high-end that 100 percent of fee-for-service can be totally  
5 inefficient.

6 DR. HARRISON: But there the option would be to  
7 actually pay based on the average utilization so you'd be  
8 giving more advantage to counties where it was efficient.

9 MR. GEORGE MILLER: Okay. I think I got that.

10 MR. HACKBARTH: Just to be clear, George, I don't  
11 think anybody is saying that 100 percent of local  
12 fee-for-service represents efficiency. That is not the  
13 argument for using that as a potential peg for Medicare  
14 Advantage rates. In fact, I would say that nobody that I  
15 know of who has thought more than 15 seconds about Medicare  
16 thinks that 100 percent of fee-for-service represents a  
17 level of efficiency uniformly across the country. That's  
18 what all of the variation analysis is about when we have  
19 these huge differences in Medicare spending per beneficiary.  
20 We all know that isn't efficient.

21 DR. MILSTEIN: Looking at these models -- looking  
22 at these options that we've modeled reminds me of how

1 fundamentally clunky this approach to incentivizing, at this  
2 point, in this example, plans to improve Medicare  
3 portability and quality is. Have we given any thought to a  
4 greater deviation from the existing model?

5 I'm sort of struck by the contrast between this  
6 and the transparency and relative appeal of what we saw in  
7 the accountable care options where you basically say, okay,  
8 everybody starts out in a given place in efficiency. We've  
9 got to figure out how we get everybody in the country to  
10 migrate down. In some ways, our accountable care  
11 organization proposal was a way of doing that in which the  
12 unit of intervention was an accountable care organization.  
13 Have you given any thought to essentially modeling a more  
14 profound shift in how Medicare pays for Medicare Advantage  
15 Plans with something more analogous to what we've  
16 hypothesized for accountable care organizations in which the  
17 plans, to extend the analogy, rather than the accountable  
18 -- just like the accountable care organizations, begin to  
19 have an opportunity to be incentivized to more strongly  
20 improve quality and reduce Medicare spending?

21 Right now I have other bases for rewarding plans  
22 than whether or not they are reducing Medicare spending

1 growth and quality. Did we consider a more radical --

2 DR. HARRISON: You mean like quality bonuses?

3 DR. MILSTEIN: No, just a more -- right now we  
4 have this benchmark process and these examples take as a  
5 given that the current bidding approach should continue and  
6 now where trying to think about how we change -- within the  
7 context of the current bidding approach, we might make  
8 alterations. Have we considered modeling something that is  
9 a further departure from the current bidding process in  
10 which we begin to simply, at the margin, incentivize the  
11 Medicare Advantage Plans to do the same thing that we were  
12 attempting to do with the accountable care organizations?

13 MR. HACKBARTH: Let me take a crack at this and  
14 then Mark and Scott and David can rescue me. In a one sense  
15 they're similar. The model we discussed at accountable care  
16 organizations started where they are and said, this is what  
17 you've been spending. That's how Medicare Advantage works,  
18 too: It says this is the spending level in Miami or  
19 Minneapolis, wherever. And your rewards are going to come  
20 from changing where you started; that, they have in common.

21 Now, where they're different, the model of  
22 accountable care organization that was presented towards the

1 end of the paper said, in terms of how we calculate future  
2 increases, let's use a flat dollar sum, and this was the  
3 \$500 example, which translates into a higher percentage  
4 increase for those ACOs that have low cost to start with,  
5 and a smaller increase for those that have a higher starting  
6 point. So that is different than Medicare Advantage, and  
7 that's why you're focused in on it.

8           Now, here's the rub. Whether you're talking ACOs  
9 or Medicare Advantage Plans, if it's voluntary and you allow  
10 people not to participate and you start to ratchet down  
11 tighter and on the high cost ones and you've been  
12 historically too high costs -- we can get you down and it's  
13 voluntary, they say, okay, I won't participate. I will go  
14 back to unconstrained fee-for-service.

15           If you really want to address geographic variation  
16 in a way that people can't escape it, you've got to do it in  
17 traditional Medicare and on a non-voluntary basis. If you  
18 make it voluntary either by, you can do it with Medicare  
19 Advantage Plan or not or ACO, you can do it or not, your  
20 tool just doesn't grab, would you try to ratchet down and  
21 deal with the geographic variation issue?

22           So, in some ways, you keep coming back to the same

1 policy choices. If you really want to deal with geographic  
2 variation, which I think is imperative for the Medicare  
3 program, you start to go to, it's got to be across the board  
4 for everybody; there's no escaping it.

5 DR. MARK MILLER: I'm not sure that I have a lot  
6 to add. When you mentioned it, I started, in my mind,  
7 immediately started going to the \$500 thing. Is that what  
8 you meant as a different way to set the benchmark? So I  
9 don't think I have anything to add.

10 DR. MILSTEIN: In some ways, thinking back on my  
11 clinical career, we've got somebody that's addicted, and  
12 we're trying to figure out how to bring them down in a way  
13 that doesn't create a lot of social waves. It's a very  
14 analogous problem.

15 DR. KANE: If you're successful on your  
16 fee-for-service, wouldn't that make the plans have to keep  
17 up? I don't know if you built that into your model at all,  
18 but if fee-for-service itself was being pushed into a more  
19 cost-constrained mode, then the benchmark should go down  
20 with that, shouldn't it?

21 MR. GLASS: If you correct the current problems in  
22 the benchmark setting, the ratchet problem, yes.

1           MR. HACKBARTH: Let me try sort of another angle  
2 on this. I am really sympathetic with the people, including  
3 members of Congress and Senators from the low-cost states,  
4 of which Oregon is one, who feel like this system is unfair.

5           Under traditional Medicare, in the high-cost  
6 areas, plow in all this extra money. We're talking about  
7 twofold more differences on a per beneficiary basis. The  
8 quality, as shown by Elliott Fisher and others, is often  
9 worse. So, that's in traditional Medicare.

10           And now, in Medicare Advantage, we say, well, if  
11 you're a beneficiary that lives in one of those high-cost  
12 areas that you're fortunate enough to have Kaiser Permanente  
13 and CLA, they can come in under the high traditional --  
14 umbrella of the high traditional Medicare fee-for-service  
15 costs and offer a very rich benefit package that people in  
16 Iowa and Minnesota and Oregon and other places don't have if  
17 you go to a 100 percent of fee-for-service on Medicare  
18 Advantage. This isn't right. This is perpetuating a  
19 regional inequity.

20           So, whatever the logic of my 100 percent of  
21 fee-for-service might be, it doesn't meet with their  
22 perception of inequity. So, I've been wrestling with other

1 ways that you might deal with that without creating what to  
2 me is an equally bad incentive of rewarding people for going  
3 into private health plans that do no more than mimic  
4 traditional Medicare except it costs more. Is that really  
5 the signal we want to be sending to either the plans or the  
6 beneficiaries? That's what I fear we're doing right now.

7           The alternative that I've been playing with is to  
8 say in, well, those low-cost parts of the country where  
9 traditional Medicare is an efficient plan, as George was  
10 mentioning, maybe what we ought to be doing is, within  
11 traditional Medicare, rewarding the beneficiaries in those  
12 areas. If all of Medicare looks like Minneapolis, we have a  
13 very different set of issues to deal with on health reform  
14 and long-term Medicare sustainability. The problems  
15 wouldn't go away completely but they would be greatly  
16 relieved.

17           So why don't we give some reward to the people in  
18 those places where Medicare is doing pretty well and maybe  
19 squeeze a little bit more? John estimates and proposals or  
20 you could squeeze some more in the very high-cost areas,  
21 probably not wipe out plan participation and beneficiary  
22 enrollment, and do some reallocation of dollars there. But

1 don't flow the benefits for Iowa and Oregon and Minneapolis  
2 through Medicare Advantage, do it through traditional  
3 Medicare, through premium discounts for Medicare enrollees  
4 in those areas.

5           Now, there's lots of complicated math to work  
6 through to figure what the budget impact of different ways  
7 of doing that might be, but that seems to me a better way to  
8 deal with some of the strongly felt feelings about regional  
9 inequity without corrupting Medicare Advantage as a tool for  
10 encouraging innovation and importing innovation into the  
11 Medicare program.

12           MR. BUTLER: I was feeling great about this  
13 chapter. I feel I actually understood it until you called  
14 it clunky. The methodologies, because I think that they  
15 really are laid out well.

16           DR. MILSTEIN: Not the chapter.

17           MR. BUTLER: I know, but the methodologies,  
18 because I think that they really are laid out well.

19           My question relates to availability in that you  
20 make a very black and white decision. Above benchmark,  
21 you're not going to participate, below, then you will.  
22 Obviously this will be one that Congress will be very

1 sensitive to. And just as I think the floor was largely put  
2 in to create, in a clunky way, accessibility, I think they'd  
3 want to know a little bit more about the predictability of  
4 departure.

5 Now, there have been departures in the past for a  
6 variety of reasons. Do you think if you had more time or  
7 more analysis you could be a little bit more predictive of  
8 who might actually leave the market if you put in some of  
9 these methodologies?

10 DR. HARRISON: Back in the late 90s when there  
11 were a lot of plans left, a couple of factors. One, plans  
12 that were new to the area and didn't have deep roots tended  
13 to pull out, and those that didn't have a lot of enrollees  
14 there tended to pull out. Other than that, and rural areas,  
15 also.

16 MR. GLASS: There are plans that pay that actually  
17 charge premiums and are in now. In other words, they are  
18 plans that bid above the benchmark and are there now and we  
19 could describe them somewhat.

20 DR. MARK MILLER: I had two thoughts when he  
21 mentioned that. One was the one that you went right to,  
22 which is to remind people of what has happened in some of

1 the past experience, and that's stuff that we could  
2 summarize pretty quickly and easily and have as part of the  
3 report.

4           But the other thing I thought of what he said that  
5 was we can express -- this would be maddeningly complex -- I  
6 see it as probably more as an appendix type of thing - but  
7 express the variation around the benchmark: What proportion  
8 of plans and availability fall within a couple of points of  
9 the benchmark versus quite far away from the benchmark that  
10 get some sense of that? But I don't know that we can be  
11 much more sophisticated than that, Scott.

12           DR. HARRISON: You may also get a little bit of  
13 flavor from where the bids are. Basically, and I can't  
14 remember what the cut point was -- I think it was in the  
15 paper. Something like, if your fee-for-service is under --  
16 I don't know if it was 550 or 600 -- nobody bids within 10  
17 percent of fee-for-service; they just can't do it.

18           Whereas, you see what the bids look like at the  
19 high end, they're all well below fee-for-service. So it  
20 really will depend on what kind of area you're in as to what  
21 the bids look like. You can also see that the variation is  
22 a lot tighter at the low end.

1           MR. BUTLER: I would just think that where the  
2 costs of entry or departure are small, then you would have  
3 it more likely to be responsive to the changes in rates.  
4 So, a private fee-for-service plan might come and go a lot  
5 more quickly, for example, than some of the others that have  
6 a whole managed-care infrastructure associated with them. I  
7 think that would be the kind of thing that we'd want to  
8 know, or at least comment on if we thought that was a  
9 likelihood.

10           DR. HARRISON: We can do that. Yes.

11           MS. HANSEN: Just a clarification, especially with  
12 the private fee-for-service plans in discreet counties, can  
13 it be filtered out -- especially, I think one of the  
14 concerns oftentimes legislatively is with rural areas. So,  
15 the ability to discern the difference of population of  
16 Medicare beneficiaries who are under now private  
17 fee-for-service and still under regular Medicare -- a  
18 regular fee-for-service, I mean?

19           MR. GLASS: You mean penetration rates by County?

20           MS. HANSEN: Yes, proportion.

21           MR. GLASS: Yes.

22           DR. HARRISON: We know that but how would you like

1 that summarized?

2 MS. HANSEN: I guess the concern was just looking  
3 at some of the arguments of -- I think they made that  
4 earlier in the morning, the argument sometimes that we would  
5 deprive people of plans. And if the plan, from my  
6 understanding, is not fundamentally different from regular  
7 fee-for-service, there is just a begged question of who is  
8 subsidizing that 118 percent extra on the private  
9 fee-for-service side.

10 DR. HARRISON: One of the ways we tried to look at  
11 that, and I don't know if this is quite getting at this, is  
12 really looking at the Coordinated Care Plans and getting rid  
13 of the private fee-for-service. So, these figures would  
14 show what it would be like without the private  
15 fee-for-service.

16 You'll see right now, for instance, only 60  
17 percent of rural beneficiaries have a local Coordinated Care  
18 Plan available.

19 DR. KANE: Isn't that the population we're worried  
20 about disrupting are the ones who are actually in at  
21 already, not the ones that have access to it?

22 DR. HARRISON: Well, that's one way of putting it.

1           MR. GEORGE MILLER: There is an equity issue,  
2 though, because all taxpayers are subsidizing the MA plans,  
3 and yet the rural population, which has a smaller percentage  
4 in the MA plans -- 100 percent of them are subsidizing it.  
5 And you even go down with the alternatives. So is that an  
6 equitable issue?

7           DR. KANE: Isn't the population --

8           DR. REISCHAUER: Those are just the managed-care  
9 plans, the CCPs.

10          DR. KANE: Yes, but are we worried about  
11 beneficiaries having access to them or that -- or what  
12 happens to beneficiaries who are actually in them, because  
13 they are the ones who are enjoying these benefits of excess  
14 of fee-for-service that everybody is subsidizing? How many  
15 people are we dealing with who are actually in the -- I'm  
16 not so sure that we have to worry as much about the ones who  
17 have access to them.

18          MR. GLASS: You want to look at enrollees.

19          DR. KANE: Yes, the people who are vulnerable to  
20 this change are the ones who are actually enrolled.

21          MS. HANSEN: There are two points: one is the  
22 vulnerability of the changes that may come down when if

1 they're going to be reductions. What's the transition  
2 question for that?

3 My first one was still just, when people don't  
4 want to change, understandably, the normal resistance of  
5 taking away, say, the subsidy and the growth of the private  
6 fee-for-service plans as a subset that has been so rapid,  
7 and if my information is right, that the difference between  
8 really the private fee-for-service plans operating under the  
9 MA mantle as compared to regular fee-for-service is  
10 fundamentally not different. So, is that assumption  
11 reasonably correct? I need to be corrected on that  
12 otherwise.

13 MR. GLASS: Think that's what Glenn means when he  
14 says that these plans essentially mimic fee-for-service  
15 Medicare, just at a higher price.

16 MS. HANSEN: So my point I guess is really  
17 relative to just having an argument of, even if we were to  
18 start to differentiate where some of the transitions would  
19 occur first, it seems like it would hurt beneficiaries least  
20 in those environments where the fee-for-service plan and the  
21 private fee-for-service plans really become the first  
22 discussion point.

1 DR. HARRISON: I think you're right. Yes.

2 DR. CHERNEW: The payment is indifferent. So, if  
3 you lower payments in an area right now, you're not  
4 targeting just the private fee-for-service. I mean, I guess  
5 we could have that discussion.

6 You're targeting all the MA plans in that area.

7 DR. HARRISON: But the fee-for-service plans tend  
8 to bid higher so they are going to be hit quicker by  
9 reductions in the benchmark.

10 MR. EBELER: I want to make sure we don't lose the  
11 purpose of this chart.

12 Your question is right. One of the criteria that  
13 politically has to be looked at is how many people are  
14 currently in plans, because we have dramatically overpaid,  
15 that we need to worry about. The theory of this chart is  
16 slightly different. There is another policy criteria that  
17 says, are we trying, are we encouraging, the plans that we  
18 think are the ones that will be the agents that will help us  
19 with delivering reform?

20 So, I'm not disagreeing that we need to chart you  
21 need, and this may not be the right way to state it, but  
22 it's a different objective than what we're talking about

1 here.

2 MR. HACKBARTH: Let me jump in on this. I feel  
3 deeply ambivalent about this transition issue. On the one  
4 hand, just by my nature, I don't like abrupt changes and I  
5 worry about abruptly changing rates and the effect on  
6 people. I generally believe you want to move in new  
7 directions in a gradual basis, particularly when we're  
8 talking about potentially hurting Medicare beneficiaries.

9 On the other hand, the longer that you keep  
10 overpayments in place the more people are going to roll, and  
11 your transition problems in some ways get bigger. Not only  
12 more beneficiaries are affected but also more political  
13 resistance. And so, how do you strike that balance is  
14 tricky.

15 I want to remind people of one thing that was  
16 suggested in a presentation in the paper. One way that you  
17 can potentially divide plans for the transition is based on  
18 quality scores. There are reasons to have reservations  
19 about the quality scores, in some ways that they are crude,  
20 but in a way, I find them more compelling than planned type  
21 categories. We, many of us -- I know we're not fans of  
22 private fee-for-service, but, boy, there's huge variation as

1 to what constitutes a Coordinated Care Plan. Some of them I  
2 think would be wonderful and I really am worried about  
3 protecting them against an unduly fast transition; others,  
4 frankly, I'm not so worried about, because although they  
5 fall under the legal category of Coordinated Care Plan,  
6 they're really not doing much good for Medicare  
7 beneficiaries.

8           If you focus your transition protection more on  
9 high-quality plans, one of the ideas offered in the  
10 presentation, that might be a reasonable surrogate for plans  
11 that actually can do something to improve care. So, just  
12 food for thought on the transition issue.

13           I want to get to round two. You have round two  
14 written all over your face.

15           [Laughter.]

16           MR. HACKBARTH: We've got a little less than a  
17 half-hour to go. If I could, let me establish a framework  
18 for round two that would be helpful to me at least.

19           This is going to be a two-part report. Part one  
20 will cover all of the analytic stuff, not just what we  
21 reviewed today but things that we talked about in the paper  
22 having to do with the questions that were asked about

1 administrative costs and are they properly accounted for,  
2 the rate geographic unit and the VA issue. So all of that  
3 is the analytic stuff that will be in part one.

4 Part two, as I said at the outset, won't have any  
5 boldfaced recommendations, but it our opportunity to help  
6 Congress think about the analytic work that we've presented.

7 I think the lead section in part two is, what are  
8 your goals for the program, because the goals for the  
9 program drive what the right payment mechanism is. If your  
10 goal for the program is maximizing plan availability, you do  
11 one thing. If your goal is to maximizing opportunity for  
12 quality improvement and cost reduction, you do something  
13 very different. And so, to me, that's sort of the first  
14 step in our commentary, if you will.

15 A second piece as I mentioned earlier might be a  
16 subsection of part two that says, we understand the  
17 geographic equity issues that are at stake here, and the  
18 frustration that they cause. Here are some other ways that  
19 you might think about addressing geographic equity. I  
20 mentioned one, and it's not the only one by any stretch.  
21 And so, if people have some thoughts on that geographic  
22 equity issue I would welcome those in round two.

1           A third category and we've just been touching on  
2 it is transition issues. So that's another thing I think we  
3 probably ought to address in our commentary in part two.  
4 So, those are the three boxes I see. I urge you to help me  
5 help the staff fill them, but if you think there are other  
6 boxes that ought to be in part two, please say so.

7           So, let me see hands for round two comments.

8           DR. CHERNEW: I find this fascinating although  
9 difficult to get my head around for a reason I'll mention in  
10 a second but I just wanted to sort of go on record, and I  
11 think this is consistent with what has been said by others  
12 here, that I for one believe that one of the benefits from  
13 the MA program, at least a subset of the plans in the MA  
14 program, is that they create systemwide spillovers to other  
15 aspects of the program.

16           And in thinking about the analysis, instead of  
17 thinking about it conceptually as separate -- this is what  
18 fee-for-service is -- here's what we're going to pay to MA  
19 plans. The MA plans, particularly, sort of, types of MA  
20 plans, need to be given some credit for helping the system  
21 evolve in a certain way. I think that's important, although  
22 I think it's hard to quantify and hard to figure out how to

1 deal with that in a policy way.

2 But it does suggest, for example, that in high-  
3 cost fee-for-service places, we might want to most encourage  
4 the MA plans because they might have the most did they can  
5 do their relatively speaking, although the geographic equity  
6 issues that would come up with a policy of that nature are a  
7 little complex, admittedly.

8 That brings me to my last point, which is I think  
9 in thinking through all of these types of options a paradigm  
10 of policy analysis -- if we did this, how would behavior  
11 change -- is really important. So, I understand why you've  
12 done which is done because it's very difficult to think of,  
13 but I guess I'm still struggling with as much as we know  
14 about how the plans would change behavior in response to X,  
15 Y, or Z, how the bidding would change or not. And there's a  
16 lot of complicating things in here that I think just need a  
17 little more fleshing out from all of us, anybody. Most  
18 important to me is the ramifications of things like putting  
19 the fee-for-service costs into the bid calculation for  
20 benchmark versus not and how you think about the pros and  
21 cons of issues like that.

22 I think this is a great start in thinking about

1 how to do this and I wish the issues were a little simpler,  
2 but I enjoyed it a lot.

3 DR. CROSSON: Thank you. I have one question and  
4 then one comment. The question is that I realize we're not  
5 heading towards a point recommendation, but what I wonder  
6 for the next discussion, will we be able to see or is there  
7 anything, really, that we can look at at the next meeting to  
8 sort of compare the competitive bidding approach to the  
9 administrative benchmark approach and kind of look at the  
10 pros and cons to those two things, without necessarily  
11 saying, and therefore we support this one or the other? I  
12 think that would be at least helpful to me.

13 MR. HACKBARTH: I think that's a question for you  
14 guys.

15 To me, the overall theme of part two, the  
16 commentary section, is, here's our analysis of these  
17 options, the pros and cons of doing it each way. So I think  
18 I would focus the question, do we plan on come to including  
19 competitive bidding as one of the options here given what  
20 was in the President's budget?

21 DR. MARK MILLER: Our discussion of the  
22 competitive bidding wasn't motivated by the President's

1 budget. We actually were getting questions well in advance  
2 of that from the Hill saying, as long as you're thinking  
3 about this, think about this too.

4 I think the best that we could do to deal with  
5 your question, and obviously you guys need to pay attention  
6 here -- I don't know that we could quantify and compare in  
7 that way, like, have a hard simulation and say, here are the  
8 results of one versus another. What we could do is  
9 qualitatively compare and contrast an administrative  
10 approach with a competitive bidding approach. I think that  
11 is within reach, but I think what Scott was trying to say in  
12 his part of the conversation is there are too many moving  
13 parts for us to, in any reasonable way, simulate the effect  
14 and have any confidence. You even hear some trepidation in  
15 our confidence in the static administrative proposals and  
16 how they play out over time. So, it would have to be almost  
17 a side-by-side, here's some issues with administrative,  
18 here's some issues with the competition, and kind of go at  
19 it that way.

20 DR. CROSSON: That's what I thought.

21 DR. MARK MILLER: Have I over-committed you? Yes,  
22 but can we do it anyway, I think is the question.

1 DR. CROSSON: Then, the comment has to do with the  
2 transition piece and I appreciate the focus on that. I do  
3 think that there is a value to phasing this in over time. I  
4 understand the other side of the equation also.

5 But there will be potentially, I think, disruption  
6 of beneficiaries as well as, quite frankly, disruption to  
7 some of the plans, particularly those that have the  
8 infrastructure, and probably as you stated, Glenn, a  
9 compelling interest in trying to support the continuation of  
10 the high-quality plans during that transition.

11 I like the proposal to do that, to link  
12 performance of various kinds to the rate of change of  
13 payment. I think that's consistent with our thinking on  
14 other issues of payment.

15 And I would just ask one other thing, and that is  
16 as we do that transition analysis and think about what to  
17 look at and what to bring forward that we also take into  
18 account the actual 2010, if you will, payment baseline that  
19 we will be working off of as a function of both the current  
20 payment mechanism but also as a function of some of the  
21 recommended changes in the 45-day notice it will likely  
22 impact on the actual payment, the baseline from which that

1 transition would likely take off.

2 DR. DEAN: I appreciate Mike's comment about  
3 struggling to get you your arms around it; it's a struggle.  
4 I would also say that one of the things that has confused me  
5 for some time is really what, just to follow up on your  
6 comment -- what are the goals of this program? Because I  
7 think we started out, as I understood it, it was to be  
8 innovation and cost-saving and new models. And then it  
9 seemed to me that a lot of the policymakers -- it sort of  
10 evolved into a way to expand benefits, and then there was  
11 the whole equity issue which got very -- it's really a  
12 serious issue.

13 I just wonder, and I haven't thought through the  
14 implications of all of this -- but I wonder if it wouldn't  
15 make sense just to take away the requirement that any plan  
16 that bids below the benchmark has to give away part of that  
17 potential profit in new benefits. In other words, maybe we  
18 haven't provided enough incentive for people really to  
19 innovate, and we've added in this requirement that they have  
20 to have these additional benefits which has created lots of  
21 tension and frustration and aggravation.

22 I don't know. It seems to me that it may have

1 confused the issue more than -- in an attempt to make it --  
2 I don't know whether it is an attempt to make it more fair  
3 or whatever, but it certainly has confused the issue.

4           The second quick point is that I think some point  
5 we have to realize that not every model is going to work  
6 across the country. We have sort of taken this model and  
7 said, it really doesn't work in rural areas, and yet we're  
8 trying to make it work in rural areas and it's costing us a  
9 lot of money; that's where, largely, the private  
10 fee-for-service model came from. I think everybody said it  
11 doesn't work very good. It cost us a lot of money and I  
12 think we really just have to face up the issue. We've got  
13 to use models based on what the realities of the environment  
14 are. I don't know, it's very confusing.

15           MR. BERTKO: A couple of questions and then I'm  
16 going to make Scott and David's life both harder and easier.  
17 So, the questions are, I'm much in favor, as Mark knows and  
18 Scott, of the competitive model. The first reason is that I  
19 think there is substantial savings opportunity in the high-  
20 cost areas.

21           And Scott, if I remember, your chart there is 30  
22 percent of beneficiaries who live in high-payment areas.

1 So, there are bucks to be had.

2 The flip side, I think the mirror image is also  
3 true, that there are also probably, I think, good CCPs in  
4 areas where they can't deliver at 100 percent of  
5 fee-for-service. I, at least, for one, would be quite open  
6 to saying, okay, you need 110 percent but you're delivering  
7 excellent care, go ahead.

8 And then, this is where the details of the  
9 competitive bidding mechanism comes into play. I want them  
10 to begin elbowing each other towards the bottom of the  
11 competitive bid. Whether the payment rate is chosen by the  
12 middle or at the lower end of that I think could make some  
13 difference in moving downward, at least on that pressure.

14 Secondly, I'm going to just emphasize what Jay  
15 said on transition. No matter what we do it's likely that  
16 beneficiaries are going to have changes in benefits. I  
17 think a three- to four-year transition process in my mind is  
18 appropriate for bringing them downward to the new level that  
19 they end up with. It's the same thing for plans, too.  
20 Believe me, it's really hard to have an abrupt transition.

21 So, thirdly, here's the pluses and minuses, Scott.  
22 I'm going to look back on the pictures that you have there.

1 I'll start with the easiest one to first. These are your  
2 graphs of alternatives.

3 Option four, where you have input price  
4 adjustments. I think we all know that input prices are --  
5 and you've shown it here -- are a very small part of the  
6 difference and it seems illogical to ignore the demand,  
7 fraud and abuse, other kinds of things. So if I were you --  
8 and I'll ask Mark and you, Glen, to think about it -- throw  
9 that one away because it's not likely to have -- well, I  
10 think any benchmarks you come out of that payment rate are  
11 going to be just arbitrary, but that's an opinion only.

12 There's a similar answer about, I think, option  
13 three -- no, option three is okay because it attempts to at  
14 least include some parts of the local cost delivery  
15 elements. I mean, it's a blend, and that didn't work  
16 particularly well following the BBA but at least this one  
17 doesn't have the very firm caps on it.

18 Slide 12, I think, has some similar arbitrary  
19 elements. You said it yourself that -- wrote down the 960  
20 and 600s are completely arbitrary. It might be more than  
21 600 or less than 600. It might be difficult to get down to  
22 960, although I think in some places it would be fine, in

1 other places that might be difficult. So I think two is  
2 also very arbitrary. So, I would leave you with one and  
3 three for modeling purposes, and that's the simplification.

4 Making it more complex, I think I'll follow the  
5 comments made earlier about actually trying to do some  
6 dynamic modeling with a very parsimonious set of  
7 assumptions. That is, you might say a couple of things  
8 change and we then use the simplified assumptions to say  
9 what happens to the margins and then use your same rule to  
10 pop in or out, whether you still have plans left in those  
11 particular counties.

12 That would include a maybe a substantial P4P. So,  
13 I'd go up to a 4 percent plus and a symmetrical minus 4  
14 percent for good and bad plans, particularly in this  
15 transition period.

16 MR. HACKBARTH: Let me pick up on that for a  
17 second. We talked about potentially linking payment to  
18 quality as a transitional device as a way of, in particular,  
19 limiting the impact on the really high-quality plans.  
20 People will remember that we have recommended for a long  
21 time P4P overall in the Medicare Advantage program, and I  
22 could imagine a system that might say, we're going to,

1 without endorsing a particular model -- we're going to  
2 tighten the relationship between plan payments and  
3 fee-for-service costs. We recognize that in, say,  
4 Minneapolis, that might mean Group Health is now in a  
5 situation where its Medicare Advantage Plans or payments are  
6 really going to be squeezed.

7           If Group Health of Minnesota is demonstrably  
8 producing higher-quality than is available in the rest of  
9 the Minneapolis community, that might be a reasonable basis  
10 for, pay more to them, not just as a transitional matter,  
11 but in the long run. My concern right now is that we're  
12 paying more to all plans without regard to their quality and  
13 their ability to improve relative to the ambient level of  
14 quality in the community.

15           So, that is another angle that we may want to  
16 address in part two of this report, is a better way to deal  
17 with the Group Health of Minnesota problem is quality of  
18 payment enduring in the long term as opposed to trying to  
19 jigger the basic MA payment structure. Another thought for  
20 people to consider.

21           DR. REISCHAUER: I didn't until you spoke, and  
22 John to.

1           I was wondering if you have a correlation between  
2 quality and the size of rebates or the value of added  
3 benefits? Because John says, well, there are some areas  
4 that this high-quality plan maybe just can't survive at 100  
5 percent, but the high-quality plan might be one also that's  
6 providing extra benefits and it's the extra benefits that,  
7 in effect, are making the quality high. And so, we have a  
8 problem of disentangling A/B from the CCP package. I think  
9 we've got to work on that before we get too far down this  
10 line.

11           In theory, I agree with this idea that  
12 high-quality plans, we should cut them some slack, but in  
13 any kind of transition and more permanently -- because I  
14 think where we would like to be is pay-for-performance that  
15 includes traditional fee-for-service Medicare as well as  
16 Medicare Advantage Plans and transferring resources from one  
17 pot to the other if there are qualitative differences.

18           MR. BERTKO: So let me give you an example. This  
19 is in the under 65 area. One of the big health plans is  
20 offering a diabetes into its under 65 members in which case  
21 they pay much more for diabetic supplies thus improving the  
22 health but costing more because they're paying more money

1 out the door.

2 DR. STUART: Much of what I had has already been  
3 said, so I will be very brief.

4 I like the idea, actually, of including some  
5 discussion of equity because I think equity is a really  
6 important issue here and it cleaves kind of on the political  
7 side, too. I'm not saying that you ought to get into that.  
8 But the last thing that we want to do is to come up with a  
9 recommendation that we know is going to be dead in the water  
10 as soon as it gets to Congress. I think paying attention to  
11 that is something that makes sense.

12 What I have heard around here is that, at least on  
13 efficiency grounds, there's not a very strong argument for  
14 trying to push these health plans in rural areas. We want  
15 the opportunity to get the extra benefits, and some of that  
16 extra benefit that you get in the high-cost areas is  
17 something that should be examined in the context of where  
18 you want to be. So I think it's one of the fundamental  
19 principles of you're not just trying to improve efficiency  
20 but you also want to pay real attention to equity.

21 And that, I think, is also at issue you can raise  
22 with respect to these models. You say the likelihood is

1 that the benefits will drop, the extra benefits will drop.  
2 Well, that's obvious: It is going to drop. Where is it  
3 going to drop? How much is it going to drop? Are some of  
4 these -- I'd pick up the point that Glenn did, that the  
5 easiest way to do equity in the rural area would simply be  
6 to have a premium rebate or a lower-cost premium. So, some  
7 of that flavor, I think, is important to have in this  
8 chapter.

9 MR. HACKBARTH: And sometimes traditional Medicare  
10 is the high-quality efficient plan.

11 DR. KANE: I am wondering how much agonizing over  
12 the transition we really need to make, given that, in the  
13 policy debates I've heard out there the Medicare Advantage  
14 Plan has already been cut about six times and has funded  
15 most of the health insurance coverage reforms as well as the  
16 SGR fix. So, I just don't know how much political will  
17 there really is hear about a rational transition, but that's  
18 just one observation. I've heard several people spending  
19 that away already in the last months.

20 DR. KANE: They haven't done it yet. Talk is  
21 cheap.

22 One of the things I was wondering is I remember

1 reading about the bigger geographic area helping to smooth  
2 some of the variability in the high fee-for-service -- some  
3 of the variability around the fee-for-service benchmarks.  
4 Would it be helpful to include -- assuming they went ahead  
5 with smoothing the geographic -- making larger geographic  
6 areas as the starting point? First of all, what would that  
7 do? And then, how would you make the transition smoother,  
8 less onerous, and particularly for the high-quality plans?

9 We're kind of treating some of these separately,  
10 but it seems to me that these bigger geographic area reforms  
11 might take care of some of the inequities right off the bat.  
12 I'm not sure that's true but it just struck me that that was  
13 -- separating them didn't always make sense to me.

14 MR. HACKBARTH: Do you have any sense of that,  
15 Scott?

16 DR. HARRISON: For the simulations that doesn't  
17 really help because we take the bids by service area as  
18 opposed to bid for each county, which is one reason we can't  
19 do the competitive bidding very easily.

20 And so, even rejiggering into the larger service  
21 areas, it all depends on what rules we pick for, would they  
22 go into the larger service areas or not?

1           So, I've done a version, and it comes out pretty  
2 much the same as what you've seen now.

3           MR. HACKBARTH: There is variability at every  
4 level that you look at. You carve it up in different sized  
5 units and you're always going to find variability.

6           And one of the reasons, as you point out, for  
7 going to the larger geographic units was that we wanted to  
8 avoid sharp cliffs as you move across these boundaries. And  
9 so, you're smoothing some of the local variation, and that's  
10 one of the strengths of this. But that variation is small  
11 compared to the national issues that we're talking about.

12          DR. KANE: It just struck me that we have other  
13 tools going on at the same time and it got a little  
14 confusing.

15          I guess the last thing is that the -- it seems to  
16 me the transition -- the goal -- I would put forth a  
17 possible goal is protecting the plans with a lot of enroll -  
18 - the high-quality plans with a lot of enrollees, not a lot  
19 of beneficiaries with access in the transition because  
20 that's where the political pain is, is really the people  
21 that are already in there and receiving these, not weighing  
22 them by how many people have access but really weighing them

1 by how many people are actually in them.

2 And then, in the long term, you want to balance  
3 the geographic equity and the access. But in the short term  
4 I think it is just the enrollees -- and focus on the  
5 enrollees more than the number of people in the market area.

6 MR. GEORGE MILLER: First, I want to thank the  
7 Chairman for focusing us on goals because I said earlier  
8 that we need to decide as we go through all of these  
9 chapters what the ultimate goal is. I like to think that  
10 you start with the patient in mind, what we're dealing with.

11 But the question comes to mind, are we trying to  
12 save money or are we trying to improve quality or doing  
13 both? As we design this, we should keep that in mind.

14 Nancy brought up a point on transition -- I'll get  
15 to that in a second -- but I think either John or Bruce  
16 mentioned about the equity issue, particularly in the rural  
17 areas. Again, I will recant that all of us as taxpayers,  
18 we're paying for the additional benefits for the MA programs  
19 and the rural areas just have a disproportionate lower share  
20 of that. That's inequity part.

21 Then, going to transition, if I don't have a  
22 benefit and someone else has it and you tell me I've got to

1 wait longer and pay more to help that other person keep it,  
2 then that's the other side of the transition issue. So, no,  
3 I guess I've said enough, other than the point about  
4 competition.

5 I somewhat support the competition, although I  
6 understand you can't model it. I'm just wondering if  
7 getting the wider areas, you couldn't use the Medicare Part  
8 D area for the simulation for a larger area.

9 DR. HARRISON: I don't think that's our problem  
10 necessarily. It's really that -- in other words, you would  
11 have -- all plans would have to serve these multistate  
12 areas?

13 MR. GEORGE MILLER: Correct. It would be larger,  
14 but a county is an artificial geographical boundary and  
15 that's not where the market goes.

16 DR. HARRISON: We had gone to someplace between  
17 those two, between the county and the region.

18 MR. HACKBARTH: This happened, George, before you  
19 came on the Commission.

20 MR. GEORGE MILLER: So, I'm a new guy again.

21 MR. HACKBARTH: I think it was three years ago we  
22 did a lot of analysis to try to identify new geographic

1 units. And basically, what we would be doing in this report  
2 is referring to that work.

3 MR. GEORGE MILLER: It's the new guy issue, again.

4 [Laughter.]

5 MR. BUTLER: One question and then I'll make my  
6 comment.

7 My understanding from what you said, it sounds as  
8 if the competitive bidding will be in the chapter, but  
9 looked at from a qualitative standpoint in terms of the pros  
10 and cons. Is that where we're headed? We're going to try  
11 to accommodate that?

12 MR. HACKBARTH: And just to reiterate my opening  
13 point, all of -- I think the 10-year conversation on all of  
14 this is qualitative, because of the dynamic effects.

15 So, for some of these options, we'll have first-  
16 year estimates of their impact. For competitive bidding, we  
17 wouldn't even have first-year; for all of them, the 10-year  
18 horizon is qualitative as opposed to quantitative.

19 MR. BUTLER: Then my comment would be, as drafted,  
20 this looks like competitive bidding doesn't jump out at you  
21 as something that we would be anxious to do necessarily.  
22 You site some experience from competitive bidding under Part

1 C to date which really hasn't gone very far.

2 Now, there are different circumstances. I'm  
3 actually not one in favor of competitive bidding. I have  
4 great reservations about it working, for some of the reasons  
5 it hasn't worked here. Or you can turn even to our  
6 experience with DME for god sakes, right? A different  
7 program, but putting together competitive bids and doing it  
8 is not something that government does all that well. You  
9 can go back to Medicaid selective contracting and a number  
10 of other things. Now, I know there are obviously  
11 differences of opinion at the table around that, so that's  
12 why I'm bringing it to our attention, that we ought to do as  
13 well as we can on that pros and cons, and I think the draft  
14 as it is, we'll have to put some more on the table to kind  
15 of clarify some of those, and I think it is important issue.

16 MR. BERTKO: Can I just point, Scott and Peter,  
17 maybe you, to Choice Care in Massachusetts which I just got  
18 a blip on one of my sets that said that they actually are  
19 going to come in flat or maybe even some cost decreases in  
20 their third year, which is a competitive bid for a single  
21 benefit program. Nancy, you probably know about that a  
22 little bit.

1 DR. KANE: They were sort of forced to.

2 MR. BERTKO: [off microphone] Commonwealth Care,  
3 not Commonwealth Choice.

4 MR. EBELER: I have an open mind.

5 MR. HACKBARTH: We're down to our last few minutes  
6 here.

7 MR. EBELER: Just quickly, I think we have to help  
8 frame what is being described as the equity issue and  
9 particularly the efficiency of running the equity money  
10 through a health plan -- I think it's something Glenn raised  
11 -- but you've done the previous analysis where we showed the  
12 three-for-one cost of the extra benefits.

13 We may want to do that analysis on the A/B bid  
14 itself, how much of that money actually flows to the  
15 community that George is worried about in the form of  
16 benefits versus how much is in fact absorbed in  
17 administrative and non-benefit payment costs. I just think  
18 we need to help them think through that issue.

19 Just another minor point, this crosscutting issue  
20 of paying for quality. My guess is, in the short term,  
21 we're not going to be able to compare plan to its community  
22 just because we don't have enough data in its community.

1 We're going to have to rank order the plans in the short  
2 term. In the long-term, we obviously want to aim there.

3 MR. HACKBARTH: Correct and, of course, everybody  
4 remembers another one of our mandated reports is to try to  
5 help Congress develop a system whereby plan quality can be  
6 compared to fee-for-service quality in the community. But  
7 that's a complicated thing that's down the road a ways.

8 MR. GLASS: Right. So, through the transition,  
9 plans would be compared to other plans, and then eventually  
10 to the fee-for-service.

11 DR. SCANLON: Just a quick point. If we are going  
12 to get into the equity area, I think that's it important  
13 that we do look at the geographic distribution of where the  
14 Medicare money comes from, because the Part B premium which  
15 is flat per capita across the country is probably less than  
16 20 percent of total revenues. The Medicare Part A payroll  
17 tax, there's an unlimited base there, and then the rest of  
18 it, about 45 percent, is coming from general revenues, which  
19 is based primarily on income. So, that distribution, from  
20 looking at inequity -- that distribution matters a lot and  
21 is going to potentially mirror some of the costs differences  
22 we see in terms of spending because it's tied to price

1 levels in these different areas.

2 DR. CHERNEW: One thing that I'm worried about a  
3 bit in the bidding stuff, which I don't think came out, is  
4 the stability of this over time. because you could have  
5 plans not knowing that much about what the benchmarks are  
6 going to be until they get it and then it can change from  
7 one year to the next and the benefits could rise or fall.  
8 So, on an ongoing basis, even if it was working well once,  
9 debating on the structure of it, we would have to at least  
10 worry about what the stability for what the beneficiaries  
11 are. Because they can't switch -- they don't want to switch  
12 from one plan to the next on an ongoing basis based on what  
13 happens to them has ramifications for how a bidding system  
14 would work.

15 DR. REISCHAUER: I might have heard him wrong, but  
16 I think John recommended that we drop options two and four  
17 and I would disagree with that. I like them all -- I mean,  
18 I like some better than others, but to go through the range  
19 of possible ways you can handle this, I think it's important  
20 to lay out all four plus the competitive one.

21 A lot of talk about equity. George mentioned the  
22 taxpayer and the taxpayer is represented in this as the \$150

1 billion that we're going to "save."

2 Bill mentioned that maybe we should look at where  
3 the money that supports Medicare comes from geographically.  
4 I would stay a million miles away from that if that were  
5 possible. We're getting into a very different kind of issue  
6 which strikes me -- I'll let you come back.

7 My two cents on the equity is, let's not forget  
8 the equity issue that these overpayments cause Part B  
9 premiums to be higher and so fee-for-service folks have a  
10 little -- and that's not counted in this \$150 billion; it's  
11 a saving to individuals.

12 And finally, a question for Scott and David,  
13 urban/rural, remind me, is this metropolitan, non-  
14 metropolitan, or is it a different designation? Is it  
15 Department of Agriculture rural/urban?

16 DR. HARRISON: It's just urban/rural, but it's  
17 based on the Metro areas, right Dan? Yes metro/non-metro.

18 DR. REISCHAUER: It's metro/non-metro, which is  
19 really very different from urban/rural. George is real  
20 rural, non-metropolitan isn't.

21 DR. SCANLON: My statement was, if we're going to  
22 consider equity, I would stay a million miles away, too, but

1 it's this issue that is raised which is that everybody pays  
2 the Part B premium and therefore we've got to somehow  
3 equalize Medicare payers across areas. I think that's  
4 totally wrong. We should be thinking about efficient  
5 purchasing across areas. I'm happy to be with you as long  
6 as we keep it off the revenue sources -- off the table  
7 completely.

8 MR. HACKBARTH: Arnie, last word, real quick.

9 DR. MILSTEIN: Go back to Jack's comment about  
10 reconceptualizing this program as what we'd like it to be,  
11 which is a vehicle for a delivery system reengineering and  
12 better value.

13 I was reflecting on this discussion, and  
14 respecting Michael and Peter's comment about one of the  
15 critical variables here is stability for the beneficiaries,  
16 I just want to raise for staff consideration whether or not  
17 we are standing far enough back from this program to  
18 consider all of the variables that could be manipulated to  
19 better achieve that vision for the program.

20 One of the variables that I guess I'd appreciate  
21 some staff feedback, not immediately but as you get a chance  
22 to process it, is this notion that the length of the

1 beneficiary commitment can only be one year. Can we convert  
2 that into a policy variable? Obviously, all of this assumes  
3 it's a policy constant, it's the same as it always has been.  
4 But there are many benefits, not the least of which is  
5 preserving of stability of plan option if we were to model  
6 the implications of letting the plans bid for more than one  
7 year, and obviously giving the beneficiaries an opportunity  
8 to lock in a plan of benefits for more than one year.

9 MR. HACKBARTH: Okay, have we given you enough to  
10 think about for next few weeks? Thank you. Good work.

11 Next is another mandated report that I don't think  
12 we've talked about at all to this point. So this one  
13 pertains to chronic care demonstration programs.

14 MR. RICHARDSON: Thank you. Before I start, I  
15 would like to acknowledge the work that Hannah Miller did on  
16 this paper and presentation.

17 Good afternoon. In this session, I am going to  
18 present the results of the work that we have done in  
19 response to a mandate from the Congress to the Commission in  
20 the Medicare Improvements for Patients and Providers Act to  
21 report on how Medicare could improve the way it tests,  
22 evaluates, and disseminates innovations in the care for

1 Medicare beneficiaries diagnosed with chronic conditions.

2           First, I am going to give some brief background,  
3 very brief, on the impact that chronic disease has on  
4 beneficiaries and in the Medicare program to illustrate why  
5 it is important to focus on payment and delivery system  
6 reforms for chronic disease care and beneficiaries. I will  
7 then touch on the mandate in MIPPA for the Commission to  
8 review the results of the most important experiments that  
9 Medicare has tried for the past 12 years to improve care for  
10 beneficiaries with chronic conditions in fee-for-service  
11 Medicare, most of which, but not all, have failed to produce  
12 the hoped-for results.

13           I will summarize the results of four of these  
14 initiatives and the preliminary lessons learned that  
15 researchers are starting to draw from these activities.

16           I will then go over a proposal for one specific  
17 approach to changing how Medicare could improve the research  
18 and development of chronic care improvements, namely, the  
19 Medicare Chronic Care Practice Research Network. In the  
20 interest of time, I will go over the results of the  
21 demonstrations and the network proposal fairly quickly.  
22 There is a lot more detail in your mailing materials that I

1 won't go into here, but we could talk about in question-and-  
2 answer during the discussion period.

3 Last, I would like to introduce some broader  
4 issues of Medicare research and development that are raised  
5 by the mandate in MIPPA and that are a natural extension of  
6 work the Commission has been doing for a number of years.

7 First, as background, it is important to  
8 acknowledge the combination of chronic disease and care  
9 coordination gaps and the problems that it causes for the  
10 Medicare program.

11 Medicare spending is concentrated among a small  
12 percentage of beneficiaries. That is shown on this slide,  
13 Slide 4. A MedPAC analysis in 2004 looked at Medicare  
14 claims for the Medicare fee-for-service population and found  
15 that the top 25 percent of beneficiaries accounted for  
16 almost 90 percent of Medicare spending. This distribution  
17 of spending was also looked at by the Congressional Budget  
18 Office in a similar report which found that 75 percent of  
19 the beneficiaries in those high-cost categories had one or  
20 more chronic conditions.

21 MedPAC, the Institute of Medicine, the National  
22 Priorities Partnership, and others have looked at the care

1 coordination gaps that contribute to these high-cost and  
2 low-quality outcomes. Lack of care coordination among  
3 multiple physicians results in duplicative testing,  
4 including laboratory and diagnostic imaging, poorly  
5 coordinated care transitions from one setting to another and  
6 poly-pharmacy issues.

7           To illustrate the number of physicians that are  
8 involved for beneficiaries with multiple chronic conditions,  
9 I would introduce this figure from my Pham and colleagues at  
10 the Center for Studying Health System Change, which clearly  
11 show that as the number of chronic conditions among Medicare  
12 beneficiaries in fee-for-service increases, the number of  
13 physicians involved in their care also increases rather  
14 dramatically. The purple bar is the median number of total  
15 physicians involved in their care, and the yellow bar on the  
16 right-hand side of each of those tranches is the number of  
17 practices. So not only is there a greater number of  
18 physicians involved in the care, but those physicians are  
19 spread across a greater number of physician practices.

20           Finally, previous work by the Commission has  
21 established that Medicare fee-for-service payment structures  
22 and payment policies create distinct disincentives for care

1 coordination. As was mentioned earlier, in Medicare fee-  
2 for-service doing the right thing often costs providers  
3 money. It can lead to lower utilization and, therefore,  
4 less revenue for hospitals, physicians, and others in the  
5 payment system. And as we discussed last year in our work  
6 on the medical home, there often is no payment under  
7 Medicare fee-for-service payment rules currently for  
8 conducting care coordination activities that improve the  
9 quality of care and potentially lower costs.

10           The Congress and CMS have initiated several  
11 demonstrations and pilot programs over the past decade that  
12 have taken a variety of approaches to try and find out what  
13 does and does not work in improving care coordination for  
14 beneficiaries with one or more chronic illnesses. As part  
15 of the MIPPA provision that directed the Commission to  
16 undertake this study, the Congress specifically required us  
17 to examine two of these initiatives: the Medicare  
18 Coordinated Care Demonstration and the Medicare Health  
19 Support Pilot Program.

20           We also believe it is informative to look at the  
21 results to date of two other ongoing demonstrations that are  
22 using different types of care coordination interventions to

1 improve the quality of care and reduce costs: the Care  
2 Management for High-Cost Beneficiaries Demonstration and the  
3 Physician Group Practice Demonstration.

4 The MIPPA provisions specifically instructed the  
5 Commission to use the results of our analysis to assess the  
6 feasibility and advisability of establishing a Medicare  
7 Chronic Care Practice Research Network, and we are to report  
8 to the Congress on this work by June 15th of this year.

9 Next, I am going to go over the three  
10 demonstrations and one pilot program, and then we will get  
11 to the Chronic Care Practice Research Network proposal.

12 First up is the Medicare Coordinated Care  
13 Demonstration, or MCCD. This was authorized by the Balanced  
14 Budget Act of 1997, and it actually launched in 2002. There  
15 were 15 sites in this demonstration, and most of the sites  
16 targeted beneficiaries with multiple chronic conditions,  
17 although a couple of them focused on beneficiaries with only  
18 one.

19 Each site was paid a monthly fee which ranged from  
20 \$80 to \$444 per member per month, with an average of \$235 at  
21 the start. The fees that were paid to the sites were not at  
22 risk, but the programs were expected to be budget neutral.

1           There was voluntary enrollment in all of the  
2 sites, and the beneficiaries who volunteered to participate  
3 in the demonstration were then randomized into a treatment  
4 or control group at each site. At its peak, the  
5 demonstration had slightly over 18,000 enrollees spread  
6 across the 15 sites. The sites varied in size from 90  
7 enrollees in the treatment group to over 1,500. But most of  
8 the sites, about 9 out of the 15, had between 400 and 750  
9 beneficiaries in the treatment group.

10           The results of the MCCD as far as cost and quality  
11 are displayed on this slide. None of the programs reduced  
12 net Medicare costs. The only statistically significant  
13 results that were established by the independent evaluation,  
14 done by Mathematica Policy Research, were that the costs to  
15 Medicare were actually increased in the sites that had  
16 statistically significant results by between 8 and about 40  
17 percent. There were no positive effects on patient  
18 adherence measures that were evaluated by Mathematic. There  
19 were a few positive outcomes on the process of care  
20 measures; there were, however, high levels of beneficiary  
21 and provider satisfaction with the programs.

22           Two of the sites, however, were approximately

1 budget neutral or close enough to be budget neutral for CMS  
2 to negotiate with them to extend for another two years, and  
3 they will be extending their activities through 2010. The  
4 final evaluation for the program will be available later  
5 that year or probably more likely in 2011.

6           The Medicare Health Support Pilot Program took a  
7 slightly different approach. It was authorized by the MMA  
8 of 2003, and it had eight sites which launched in 2005, also  
9 after a competitive Request for Proposals process. Each of  
10 the sites here were also paid a per member per month fee,  
11 and they were at risk for cost and quality, unlike in the  
12 MCCD.

13           The research design here was different. It was an  
14 intent-to-treat model where about 290,000 Medicare  
15 beneficiaries across all the sites were randomized into an  
16 intervention or comparison group in the eight geographic  
17 areas served by the sites. The Medicare Health Support  
18 organization were then given contact information for the  
19 beneficiaries assigned to the treatment group, and they were  
20 allowed to begin outreach to those beneficiaries and their  
21 providers. The cost performance, however, was based on the  
22 Medicare cost for the entire treatment group, whether they

1 enrolled with the Medicare Health Support organization or  
2 not. So obviously the organizations had an incentive to  
3 enroll as many of the beneficiaries as they could, intervene  
4 with them, and try and alter the trajectory of their medical  
5 costs.

6 Here the fees were between \$74 and \$159 per member  
7 per month, and there was initially a requirement under this  
8 pilot that the sites save 5 percent in medical costs plus  
9 the fees that they were being paid. Later this was changed  
10 to simply budget neutrality; the sites, though, still had to  
11 recover at least the fees that they were being paid.

12 The results of this pilot program were that the  
13 cumulative fees paid to the sites far exceeded the savings  
14 produced. Before taking into account the fees paid, four of  
15 the sites actually did reduce medical costs by about 1 to 2  
16 percent on a PMPM basis. But once those fees were factored  
17 in, all of the sites increased costs to Medicare by between  
18 about 3.5 and 9.4 percent, or roughly \$50 to \$130 per member  
19 per month.

20 The independent evaluation of this pilot, which  
21 was done by RTI International, found limited impacts on  
22 beneficiaries' satisfaction with their care; some positive

1 but, again, limited impacts on self-management measures --  
2 that is, the beneficiaries' ability to maintain their  
3 medication regimens, perform exercise, check blood glucose  
4 levels, and things like that; and also some limited impacts  
5 on the physical and mental health functioning measures that  
6 were evaluated by RTI.

7           They did find some positive effects in some sites  
8 on process-of-care measures, but as far as outcome measures  
9 go, there were no statistically significant effects on  
10 hospital admission/readmission rates or the use of the  
11 emergency department.

12           The third demonstration we looked at was the Care  
13 Management for High-Cost Beneficiaries demonstration.  
14 Unlike the other two, this was actually a CMS-initiated  
15 demonstration. CMS solicited proposals under a competitive  
16 process from six sites. They required each of the  
17 applicants to be a physician group, a hospital, or  
18 integrated delivery system. Unlike the other programs, CMS  
19 did not define targeted chronic diseases in this  
20 demonstration. Each site was allowed to propose its own  
21 enrollment eligibility criteria.

22           Most of the sites participating have

1 beneficiaries, since they are focusing on people of high  
2 cost with multiple chronic conditions, with congestive heart  
3 failure, diabetes, and one of the sites is actually focusing  
4 on beneficiaries with chronic kidney disease, which is  
5 unlike most of the other demonstrations.

6           Like the Medicare Health Support, this also uses  
7 an intent-to-treat model where CMS identifies the  
8 beneficiaries in the service area, tells the sites who these  
9 beneficiaries are, and then allows them to go enroll as many  
10 as possible to intervene with them.

11           These sites started in the fall of 2005 and the  
12 summer of 2006. It is smaller than the other  
13 demonstrations. It only has about 5,600 beneficiaries  
14 enrolled in four sites at the time that number was  
15 generated. These sites, each of the sites has between about  
16 540 and 2,200 enrollees. This is a bit of a ray of  
17 sunshine, I guess you could say, in the demonstrations so  
18 far in that CMS recently announced that -- in January of  
19 this year, they announced that three of the sites had  
20 achieved close to budget neutrality and met the financial  
21 terms and the quality performance terms of the  
22 demonstration, and were going to be extended for one

1 additional year with an option for up to two more years if  
2 they continue to succeed.

3           Unfortunately, CMS hasn't released a lot of  
4 information, not nearly as much as they have about the  
5 Coordinated Care demo and Medicare Health Support. So we  
6 will be looking for more information from them as that comes  
7 out.

8           Lastly, we looked at the Physician Group Practice  
9 demonstration. This wasn't specifically designed to be a  
10 program for care coordination interventions; however, we  
11 think it is relevant because what a lot of the physician  
12 group practices and other participants in this demonstration  
13 are doing is working on improving care coordination to  
14 reduce the medical costs and improve the quality of care for  
15 the beneficiaries that they treat.

16           We have talked a lot about the PGP demo before,  
17 including this morning in our ACO discussion, so I won't  
18 belabor the details here. I will just take a quick snapshot  
19 here of the results.

20           First, on costs, I describe them here as possible  
21 reductions in total costs. I just want to make sure that I  
22 am clear about what that bullet means in case there is any

1 confusion given what Dr. Stensland said this morning about  
2 the results from the perspective of looking at it through  
3 the ACO lens. The MedPAC staff have some significant  
4 questions about whether these savings being reported by CMS  
5 are actually being achieved once you have controlled for  
6 some of the coding and other issues that are going on  
7 potentially at the sites. However, it still remains a fact  
8 that CMS in August of last year announced that this  
9 demonstration had saved \$17.4 million over what would have  
10 been spent in the absence of the program and awarded about  
11 \$13 million to those four sites. So we are in a somewhat  
12 different place than CMS, but from the agency's perspective,  
13 they are seeing savings there.

14           It is unequivocal, however, that they have  
15 improved the quality measures that have been tracked in the  
16 course of this demonstration. These relate to diabetes and  
17 congestive heart failure, and all of the sites have had  
18 noticeable and statistically significant improvements in  
19 those quality measures.

20           CMS has extended what was originally a three-year  
21 demonstration for one more year, and that performance year  
22 will end in March, at the end of this month.

1           So, to summarize all of the foregoing analysis, in  
2 terms of costs, we have seen little evidence to date of cost  
3 neutrality let alone savings. Having said that, there does  
4 seem to be some apparent success in some of the  
5 demonstration sites with some elements of the population and  
6 certain elements of the interventions, and I can talk a  
7 little bit more about that in the Q&A.

8           In quality, there seems to be some evidence that,  
9 again, some of the programs and some of the interventions  
10 with some of the beneficiaries can improve quality.

11           A lot of the experience with these three  
12 demonstrations and one pilot program, though, have raised  
13 some significant questions about what CMS' capabilities are  
14 in operating and administering this type of activity, both  
15 in terms of the resources that they have to devote to it and  
16 the process of putting together a demonstration, running a  
17 demonstration, and evaluating its results.

18           There seems to be too many observers' eyes,  
19 limited flexibility in CMS to generate, test, and evaluate  
20 potential policy improvements. This includes flexibility to  
21 adapt the demonstrations once they have started, and there  
22 also seems to be no clear process for translating the

1 results of these demonstrations into policy improvements.

2           In light of that, there has been a proposal put  
3 forth by a coalition of provider and research organizations  
4 called the Medicare Chronic Care Practice Research Network.  
5 This is a proposal from these organizations that are listed  
6 in your mailing materials -- and also shown illegibly on the  
7 slide up there -- which are a group of academic medical  
8 centers, care management service providers, and long-term  
9 care providers to form what is essentially a practice-based  
10 research network. The graphic that you see there shows the  
11 individual entities that would form the sites on the bottom  
12 of that figure, and up above that is an administrative  
13 structure and a research structure that would be used to  
14 come up with ideas, evaluate the ideas, and rigorously test  
15 and evaluate the data that is being generated by the  
16 practice-based research network itself, which is the area  
17 surrounding the circle.

18           In the paper, I call attention to the fact that  
19 there are many similarities between the design of this  
20 proposal and practice-based research networks run by the  
21 Agency for Healthcare Research and Quality, or AHRQ, and we  
22 can talk some more about that in our discussion, if you'd

1 like.

2           The key points of the MCCPRN proposal is a network  
3 to test specific care coordination interventions, and this  
4 is very much in the spirit of practice-based research where  
5 there are specific policies, procedures, and protocols that  
6 would be tested through the network, that would be evaluated  
7 as part of the network's mandate, and to the extent that  
8 they were found to have positive effects, either on cost or  
9 quality -- ideally, both -- the network would produce  
10 guidelines about best practices which could include in their  
11 proposal -- as described in their proposal, I should say,  
12 toolkits, how-to guides, and operations manuals, which then  
13 could be disseminated across a number of different settings  
14 and used to improve the quality of care for beneficiaries  
15 with multiple chronic conditions.

16           The network itself, though, would also be an  
17 experiment to develop faster evaluation methods and measures  
18 for how these interventions can be tested, evaluated, and  
19 disseminated out into the clinical practice.

20           Now, financially, the network would be funded out  
21 of the Medicare trust funds. There was a legislative  
22 proposal introduced in the 110th Congress, in 2007, that

1 would have authorized \$60 million over five years for the  
2 operation of the network. It is important to remember that,  
3 similar to all of the other demonstrations and pilots I have  
4 talked about, the underlying Medicare fee-for-service  
5 payment policies and structures would remain in place. So  
6 essentially out of this funding amount, let's say for the  
7 sake of discussion that it is \$60 million, that would be  
8 used to fund the administration of the network and to pay  
9 care coordination fees to the sites participating. But the  
10 proposal, as put forth anyway, does not envision doing any  
11 significant reforms to the payment policies under Medicare  
12 fee-for-service. The proposal also points out that the fees  
13 paid to the network sites would not be at risk in terms of  
14 cost outcomes or quality.

15           The staff have some concerns about the proposal  
16 for you to consider, the first one of which is that the  
17 network sites in this proposal would not be competitively  
18 selected. There is an issue here of a precedent being set  
19 for having an established network come forth basically as is  
20 and having CMS adopt it as is. And I think one way to think  
21 about this is the question of whether this particular  
22 constellation of providers and the administrative structure

1 that would go on top of it is the right network to test the  
2 interventions in a way that generates generalizable and  
3 scalable results.

4           Alternatively, should CMS, as AHRQ has done with  
5 its practice-based research networks, define criteria ahead  
6 of time that would be used to solicit a proposal for a  
7 network and build it and then under that structure use task  
8 orders to more quickly disseminate ideas and test them, do  
9 the analysis, and investigate whether those results are  
10 applicable to a broader set of settings? That is, is the  
11 structure of this network representative enough of the bulk  
12 of Medicare providers in the community to be a good  
13 laboratory for testing these innovations and having them be  
14 embraceable by the bulk of Medicare providers?

15           Second, we have some concerns over whether the  
16 fees that are paid to the sites should be at risk. In our  
17 analysis of care coordination activity in 2006, the  
18 Commission looked at two different ways that sites in any  
19 care coordination program could be at risk, which is that  
20 the fees themselves could be at risk, as in the Medicare  
21 Health Support program, or we could have a shared savings  
22 approach like they use in the Physician Group Practice

1 demonstration. One question for you to think about is  
2 whether that is something -- whether either of those  
3 approaches is something you would like to use in a network  
4 like this.

5           Third, we have some questions about the role that  
6 CMS would play in the administration of the network. If  
7 you'll recall from the paper, the governance structure as  
8 proposed would include CMS among all of the network sites  
9 that would also participate in the network, and we have some  
10 questions about whether -- and part of this is the nature of  
11 how a practice research network would work. Some of the  
12 ideas for what should be tested should come up from the  
13 network, but CMS, working together with 13 organizations in  
14 the administration of the network, could raise some  
15 questions about how much control and influence CMS could  
16 have over the types of innovations that are being  
17 investigated.

18           And, finally, as I noted, AHRQ has several  
19 practice-based research networks already in place. One of  
20 them is organized around thousands of primary care  
21 practices. The other is organized around several integrated  
22 delivery systems. And we have a question of whether there

1 might be some duplication of a practice research network  
2 like this that would be operated by CMS and not AHRQ.

3           But, more broadly, this proposal and the results  
4 of these demonstrations and pilots raise some larger  
5 questions that we think the Commission -- we would be very  
6 interested in hearing the Commission's views about, really  
7 about the whole enterprise of Medicare research and  
8 development. And these are very fundamental questions that  
9 the Commission has grappled with over the last several  
10 years, and we think that this presents a good opportunity --  
11 not necessarily for the specific report that is due in June,  
12 but over the next report cycle perhaps -- to think about  
13 these broader issues. Where should these ideas for research  
14 and development originate? How much should they come up  
15 from the grassroots versus coming from the top down? How  
16 can these policy ideas be tested and evaluated more rapidly  
17 and create replicable and scalable interventions?

18           If the current system is not working and there are  
19 some other ideas out there, like the practice-based research  
20 network concept, that might improve them, is that something  
21 that the Commission could look at?

22           What changes do we need to have in the R&D process

1 to accelerate the dissemination of evidence-based practices  
2 out into the community? If one of the problems with the  
3 current research and development activity at CMS is that a  
4 lot of good ideas come up but they do not go anywhere, how  
5 can that dissemination process be sped up?

6 And, finally, looking at CMS itself, what  
7 capabilities does CMS need to have to be able to do research  
8 and development on a \$460 billion program? The current ORDI  
9 budget within CMS is about \$30 million. That may be  
10 somewhat out of scale to \$460 billion.

11 MR. HACKBARTH: Very efficient.

12 MR. RICHARDSON: Extraordinarily efficient at  
13 doing what it does, which there are those who question what  
14 that is.

15 So, with that, I will be quiet and look forward to  
16 your questions and discussion.

17 MR. HACKBARTH: Good job, John. I have been  
18 wrestling with this one a little bit myself and just  
19 thinking about this process and how long it takes to try to  
20 do, if you will, a new idea in Medicare. And sort of my  
21 rough timeline is, you know, for a large-scale project,  
22 given how small ORDI's budget is, if you want to do

1 something large scale, it has to be specially authorized by  
2 Congress along with the funds, and, you know, that takes a  
3 year, at best, to go through the legislative process.

4           Then once that happens, you know, you have got a  
5 year or a year-plus in planning, implementation, and signing  
6 people up. And then you've got two or three years for the  
7 demo itself, another year or two for evaluation, and then it  
8 goes back through the legislative process for another year  
9 or two. You know, you are talking about a process that runs  
10 anywhere from six years to 12 years to do something.

11           That scale doesn't quite fit well with the pace of  
12 innovation that we need, so I think this is a very important  
13 topic.

14           Let me see hands for the first round of clarifying  
15 questions. We'll start with Karen.

16           DR. BORMAN: You've nicely, here and in the  
17 chapter, you've all reprised the efforts thus far and sort  
18 of the striking lack of demonstrable effect, and I have to -  
19 - I guess this is more a comment than a question, but a  
20 little bit of a question is the things you've pulled out  
21 from the last one, you know, three did this in some things,  
22 whatever, is that not potentially when just chance that at

1 least some positive results would be found? It just seems  
2 to me that we are grasping at some serious straws in that  
3 particular piece, and we need to be honest about that.

4 I guess the other thing is what, if any, of these  
5 studies, as you've looked at them in great detail, have any  
6 kind of attempt to measure out a placebo effect here. I  
7 think we all know, certainly those of us that have seen  
8 patients and those of you that have been patients can  
9 appreciate sometimes the therapeutic effect of, you know, a  
10 good conversation with a physician and/or the fact that  
11 you've got somebody to call, or whatever.

12 I just kind of wonder here about can we separate  
13 out the background noise of sort of this analogy to the  
14 placebo and chance alone here based on any of these study  
15 designs.

16 MR. RICHARDSON: I think on the statistical issue  
17 -- I'll do that one first -- that goes to the question of  
18 how big do these need to be. I mean, the larger the cohort  
19 that you are studying, the more statistically you can be  
20 reasonably sure -- there is always going to be -- even if  
21 you have a 95-percent confidence interval, you are always  
22 going to have that possibility of the result you are seeing

1 due to chance. But the more people you have involved and  
2 the more sensitive your measures are to an effect -- and I  
3 will get to your second point in a second -- you know, the  
4 better statistical validity you will have in those results.

5           So one of the potential problems of having a  
6 demonstration or a study that is too small is that you need  
7 some very large effects in, say, reduced hospital admissions  
8 with a small group of people to be reasonably sure that the  
9 effect that the -- I am sorry, that the intervention that  
10 happened with those people are the reason for the effect  
11 that you are seeing.

12           DR. BORMAN: If I could touch on that, I guess  
13 maybe what we are getting to is a question of  
14 interpretation, and just to pick on the last one that you  
15 went through where you had a fairly extensive study and the  
16 only thing positive that could be said out of it was that in  
17 these three things on some measures, something was better,  
18 if I understood things correctly. Okay.

19           One could look at that, that that is just -- you  
20 know, if we said that the alpha here is going to be 0.95,  
21 that this is sort of -- out there in the 5 percent, that if  
22 we tested enough, did it often enough, that we are going to

1 find some positive effect that may or may not be related to  
2 the intervention. That is one potential.

3 Another one which I think you have just described  
4 is that you are imputing that this is potentially a type two  
5 error, that there were not enough subjects in the  
6 appropriate groups to detect the difference if a difference  
7 exists.

8 Based on what you know from an extensive review of  
9 this, can you make a judgment about which it is more likely  
10 to be? Is this more likely that these positives were just  
11 because we have tried to break this out into enough sub-  
12 group analysis, about enough sub-topics that we finally  
13 found something to be positive about? Or is this more  
14 likely to be that we've missed an effect based on what you  
15 can judge about the studies, recognizing that it is an  
16 imperfect world?

17 MR. RICHARDSON: Given the breadth of the effects  
18 that they were looking for in terms of quality improvement,  
19 process-of-care changes, you know, some of which are  
20 subjective -- not process of care necessarily, but  
21 beneficiary satisfaction and things like that -- I would  
22 tend to think that they are detecting real effects, and I am

1 more confident about that when the effects are larger, I  
2 guess is all I'll say. But it is interesting. One of the  
3 sites in the MCCD had a very large negative reduction in  
4 hospitalizations. I am going to hazard a guess that that  
5 was a result of the intervention, given its size and its  
6 direction, which was the intended effect. However, that was  
7 one of the sites that was not budget neutral because the  
8 care coordination fee that was paid was so large, it  
9 obliterated all of the savings achieved from that reduction  
10 in hospital admissions.

11           So if you pull them apart like that, you can see  
12 something. Put them back together and suddenly that  
13 disappears.

14           MR. HACKBARTH: Let me ask this, and maybe, Karen,  
15 you can help me. My understanding of the design of a lot of  
16 these things is that we break them up into sites where the  
17 intervention, broadly defined, is tried and the sites often  
18 have, you know, 500 or 750 people involved. The  
19 intervention actually varies across these sites, and so we  
20 are testing the intervention uniquely in groups of 500 and  
21 750. But when we were talking about ACO, we were bandying  
22 about the number of 5,000 as a minimum to be able to detect

1 reliably differences in total cost of care. Yet here we're  
2 looking at cells with 50. Aren't we biased towards finding  
3 no effect?

4 MR. RICHARDSON: With the exception of the  
5 Medicare Health Support pilot, which was much larger.

6 MR. HACKBARTH: Yes, right. But isn't that sort  
7 of -- aren't there scale issues with --

8 MR. RICHARDSON: Yes, and I think that goes to the  
9 question, some of these larger questions: How do we design  
10 a research and development process that can give us some  
11 results that we have some confidence the intervention --

12 DR. BORMAN: Motivated by our thought about  
13 comparative effectiveness, I am also motivated by how I as a  
14 physician have to use, albeit imperfect, medical literature  
15 to make a decision about how to treat a class of patients.  
16 And at the end of the day or in the middle of the night in  
17 the operating room, I've got to make a decision. Do X or do  
18 Y and make a judgment.

19 If I were studying a twist on an operation this  
20 many times and this many ways and this is all I could come  
21 up with positively, I'd probably stop doing that twist on  
22 the operation. So just, you know, trying to bring this into

1 a world that has some face validity relationship to clinical  
2 care. That was the purpose of the question.

3 DR. MILSTEIN: John, two questions. First, what  
4 is the scope of the question that we're trying to answer?  
5 Are we trying to make a recommendation with respect to an  
6 R&D process that would uncover methods of producing more  
7 health with less money? Or are we trying to make  
8 recommendations on an R&D process with respect to Medicare  
9 policies that might have a better chance of eliciting  
10 methods of delivering care, you know, that would produce  
11 more health for less money? That is my first question. Why  
12 don't you answer that first.

13 MR. RICHARDSON: For the purposes of the report to  
14 Congress that is due in June, there are two things we need  
15 to do. One is evaluate the Medicare Chronic Care Practice  
16 Research Network proposal and in doing that evaluate the  
17 structure and implementation and results of two of the  
18 demonstrations I went over -- the Coordinated Care  
19 demonstration and the Medicare Health Support pilot. I'm  
20 sorry. I keep calling them demonstrations and pilots. The  
21 same thing. In addition to that, we thought it was useful  
22 to look at two other demonstrations that we think bear on

1 that question. That is what we need to do for the report to  
2 Congress in June.

3           These larger issues of what kind of research and  
4 development enterprise, if you want to call it that,  
5 Medicare should engage in is not necessarily part of the  
6 report to Congress. We think that it is hard to pull them  
7 apart because how we approach the question of whether there  
8 should be a Chronic Care Practice Research Network  
9 implicates a lot of these larger issues, but for the  
10 immediate task before us in June, we don't necessarily need  
11 to do that. However, we are taking this up as something  
12 that you might want to look at down the road.

13           DR. MILSTEIN: The second question is, as you  
14 think about this, are you looking more broadly with respect  
15 to alternative methods of making this happen? You know, in  
16 September there was -- I think it was September, or maybe it  
17 was February. February. There was a terrific Health  
18 Affairs paper on the tremendous success they've had in  
19 Germany on moving chronic care performance measures up  
20 quickly. And so if we're going to look at this or any other  
21 proposal -- you know, I guess it is more of a suggestion  
22 than a question, but maybe we should look more broadly as to

1 what is working and then think about how that might be  
2 translated on to Medicare.

3 MR. HACKBARTH: That is, in fact, I think, for the  
4 longer term. We need to do the short-term response to the  
5 specific request, but for our longer-term thinking about  
6 this, I agree with that approach.

7 MS. BEHROOZI: This might be a variation on what  
8 Karen asked, and I feel like it's a dumb question, so maybe  
9 it was answered, what you were talking about, Karen. But it  
10 was kind of like the last thing you said, you know, you  
11 would change what you were doing if you saw that it wasn't  
12 working. I am kind of trying to figure out what the "it" is  
13 that has been studied here. Is it things, is it processes,  
14 or is it entities that have done them?

15 So when you said, Glenn, you know, 500 people at  
16 each place, well, that's different places. Are they doing  
17 different things? Are they doing the same things? Are the  
18 things that they're doing the same?

19 We participated in a study that focused very  
20 narrowly on telephonic follow-up post-physician visit for  
21 men with PSAs over X level, or whatever, and that was the  
22 thing that was being studied. It wasn't how we did the

1 thing. So I'm missing something here.

2 MR. RICHARDSON: I talk a little about it in the  
3 mailing materials. Let me just for the sake of this  
4 discussion give you some examples of the types of  
5 interventions that have been tried in the different  
6 settings.

7 For example, in the Medicare Health Support pilot,  
8 which was focused on a more telephonic case management  
9 approach, there was also, in addition to telephonic care  
10 management, some intensive case management for beneficiaries  
11 identified by the entity as particularly high cost or high  
12 risk of hospital admission. There was patient education on  
13 self-care. If you have diabetes, this is what you should be  
14 looking for; this is how you should be taking care of  
15 yourself. Medication management support --

16 MR. HACKBARTH: These aren't things, though, I  
17 think is what Mitra said. These are categories of things  
18 that can be executed very differently.

19 MS. BEHROOZI: Exactly. Did they all do that same  
20 list of things? Was there any control on that?

21 MR. RICHARDSON: No.

22 MS. BEHROOZI: I didn't think so. You know, it's

1 a combination of sites and types of interventions that we  
2 don't know exactly how they cross-hatch, so you don't know  
3 which things to cross off the list that did not work. Maybe  
4 it is the places you have to cross off the list. And, you  
5 know, it kind of goes to what Arnie was saying. Let's look  
6 at something that has worked and what is it that they have  
7 done, as opposed to, well, you know, this place wasn't good  
8 enough at it and that place didn't use the right combination  
9 and these things didn't work, but we are not sure that they  
10 were all done in all of these places. You know, it is the  
11 discipline of designing the study, I guess, that I'm kind of  
12 feeling like I don't have a handle on it here, and I don't  
13 know that we should do more of it that way.

14 DR. SCANLON: On this point, though, there is this  
15 question of designing something for the real world, and the  
16 real world is going to have variation in it. And so the  
17 question is if you shorten your list, can you develop a  
18 policy that you are only going to get the things on your  
19 short list? Or if you put out this short list, do you end  
20 up sort of getting some of the things that you wanted to  
21 exclude?

22 This kind of goes to your point, Glenn, about

1 being able to only analyze at the site level, if the  
2 demonstration was done well enough, there was enough control  
3 over the variation that we're talking about a policy  
4 intervention, and in the real world it is going to vary.  
5 And we need to know sort of when that variation occurs, does  
6 it result in the intervention being ineffective? Because we  
7 are not necessarily going to be able to go in and say do  
8 exactly this.

9 MR. HACKBARTH: I'm out of my league here in terms  
10 of study design and how businesses do this. But one of the  
11 things that strikes me about this is it's a very academic  
12 model that says you do this at this site, and let's assume  
13 it's well specified. And then you keep doing it for the  
14 next three years, even if you are on the ground there and  
15 think, well, geez, this isn't working. And a business would  
16 say, oh, wait a second, I need to change; this isn't right,  
17 so I've got to tweak the model. But in this academic model  
18 of research, no, you don't change it.

19 DR. CHERNEW: The intervention that they're  
20 testing isn't the clinical intervention. It's the payment  
21 intervention. And then they're allowing the underlying  
22 organizations to do whatever they do because the hypothesis

1 is, if we were to pay -- an example would be capitation  
2 versus not. You would evaluate capitation versus not. You  
3 wouldn't tell people what to do underneath the capitation.  
4 They would do whatever they wanted to do. But the  
5 hypothesis wouldn't be a clinical hypothesis. It would be  
6 capitation versus not. That is what people would be -- you  
7 know, in the RAND health insurance experiment when they  
8 randomized people into different insurance categories, they  
9 didn't tell people exactly what had to happen within each of  
10 those insurance categories. They were testing the  
11 hypothesis if you randomized people into a benefit package,  
12 this is what the impact is, without being able to say  
13 anything about a clinical comparative effect in this thing  
14 underneath. This is the equivalent of that. It's just not  
15 co-insurance as in the RAND health insurance experiment.  
16 You know, the RAND health insurance experiment randomized  
17 people into an HMO. The intervention was the HMO, not the  
18 clinical thing that the HMO did. And, of course, as people  
19 said in that case, that would be generalizable in that case  
20 to one HMO, because that was what they randomized into.

21 No, that wasn't mine. That was just a comment.

22 It's an academic discussion. I can't resist that. I

1 usually don't interrupt.

2 MS. HANSEN: Perhaps I could bring it to another  
3 applied level. One is to kind of address, Glenn, your point  
4 about the size and so forth. I'll just speak to something  
5 that was done. The next one is the question of using other  
6 examples where things do work as well as in studies that  
7 have worked already, and I am curious then, to bring it back  
8 to this proposed project, why representatives of projects  
9 that seem to have worked before in chronic disease  
10 management don't show up in this group, so this whole  
11 selection process of this whole effort, also.

12 I'm just so glad I was born a generation ago, and  
13 that is, you know, I think I lived through this whole demo  
14 project, and I can give you some absolute years of how long  
15 it took to do the PACE project. It was four years of demo  
16 and 14 years of replication and movement beyond that, for a  
17 total of 18 years in order to move it from test to  
18 legislation. So that just gives you anchored, real stuff  
19 that happened with the PACE project. So we got legislation  
20 passed on capitated financing.

21 But the size aspect was interesting because it  
22 relates to these numbers, and when we speak about ACOs

1 having relevance perhaps at the 5,000 level, and then there  
2 are these numbers of anywhere from 300 to 700, with the one  
3 outlier of a larger group, you know, the populations may be  
4 very, very different. Assuming the chronic disease side,  
5 it's multiple chronic diseases going on with many  
6 medications and a lot of care management.

7           So the size ends up small, and if we parallel it  
8 to what nursing home size, if we are going to talk about  
9 that level of frailty, you know, average nursing homes are  
10 no longer than 100. And so it's just we're talking about  
11 apples and oranges when we talk about money flowing to a  
12 population.

13           So I just wanted to perhaps give a reference point  
14 that we may be talking about different populations so that  
15 their size is going to be perhaps looked at differently.

16           Then the other thing is even in the United States,  
17 a couple of other projects that have been trying to do this  
18 on scale are the people we know of, Dr. Eric Coleman from  
19 the University of Colorado and Dr. Mary Naylor from the  
20 University of Pennsylvania, and I think Dr. Chad Boult is  
21 doing some stuff in Hopkins, and there are other people  
22 doing it on the commercial side with Evercare and so forth.

1           So there seem to be existing models that are  
2 dealing with this issue, and that leads me to wonder how  
3 this construct of this proposed network -- I don't see  
4 actually any of these other types of groups that are  
5 involved here. So this whole question of why these seven --  
6 is it 13? -- seven of whom, of course, were in the previous  
7 demo. So it does give me pause to question what this brings  
8 together that's different and moves on further when people  
9 have been at risk financially for other kinds of things when  
10 the payment levers were there.

11           So I do have some pause with the idea of just a  
12 construct of offering 13 systems to come together this way  
13 and not to be at risk also.

14           MR. RICHARDSON: We recently got some information  
15 that was from the group, which we've met with a few times  
16 now -- that came after the mailing materials went out --  
17 that gave a little bit more detail than we had seen before  
18 about what they would be doing. And, specifically -- I  
19 should back up a second. They've actually gotten some  
20 planning grant money from Congress to put the coalition  
21 together and do some research using the data from the  
22 Coordinated Care demonstration, which a number of them were

1 also participants in. And they are looking at those data to  
2 see if they can identify some common specific interventions  
3 that were used in a number of the sites, in addition to some  
4 things that weren't tried but that other research has shown  
5 may be useful, like Eric Coleman's Care Transitions project  
6 and Dr. Naylor's project, and applying -- so the idea would  
7 be if what worked in the different sites or appeared to work  
8 from the data analysis that they're doing, plus these  
9 additional interventions were tried and experimented with  
10 through a network, as they proposed, that that would yield  
11 some result or we would have more information about whether  
12 that particular combination of interventions was successful  
13 or not.

14 MS. HANSEN: This is strictly an editorial  
15 comment. I think that given the fine work that has been  
16 done, and I think some of the findings from the  
17 demonstrations -- and this is so vernacular. You know, a  
18 lot of this is not rocket science, and it's our ability to  
19 follow people during critical transitions. Again, the work  
20 that has been done by -- papers that have been, you know,  
21 juried and so forth, and now being tested in the  
22 marketplace.

1           I guess I just need to feel, you know, what is the  
2 value add with all of this versus the diffusion of available  
3 knowledge and getting it into practice, more like what IOM  
4 will say. From the time you have a finding, you know, does  
5 it take -- I forget how many years -- 13 years, 17 years in  
6 order to diffuse it to really a practice point? Is that not  
7 where the funding, the effort, and the execution really  
8 should be going so that we get more people served rather  
9 than studying the angles again?

10           Again, and I say that I think earnestly only  
11 because having lived this model, lived this stuff for 25  
12 years, I just think that it's time to get on. Like Karen  
13 was saying, get it out there and let's do it.

14           MR. HACKBARTH: Through my bad example, we've sort  
15 of mixed rounds one and two, and maybe even three. This is  
16 a round one? Okay, go ahead.

17           DR. CHERNEW: Did they do a power analysis?

18           MR. RICHARDSON: I don't know.

19           DR. CHERNEW: What's the status of the MCCPRN  
20 proposal? In other words, is it funded? Is it --

21           MR. RICHARDSON: No. The proposal would be for --  
22 it would have to be authorized by Congress, and the proposal

1 would be to create a network like this and authorize funding  
2 for it within CMS.

3 DR. CHERNEW: In thinking through that -- so here  
4 is the last clarifying -- I see two things. The first one  
5 is funding and authorization for an intervention of some  
6 type, of some sort. And then the second one is a separate  
7 funding to evaluate whatever is done. So one activity is  
8 you can't evaluate -- if you're just hanging around the  
9 table here, you can't go out and decide I want to evaluate  
10 the following type of Medicare payment intervention, because  
11 CMS isn't doing that Medicare payment intervention. Right?  
12 That's hard to do. But if CMS was doing any type of  
13 Medicare intervention, like Mathematica and RTI got those  
14 evaluations in a competitive bid, once the actually  
15 intervention was designed in the -- so I'm unsure if the  
16 MCCPRN proposal is both a proposal to change something  
17 Medicare's doing, the payment, and to then give the people  
18 who are running that also the authorization to evaluate it -  
19 - so they're evaluating their own intervention that they've  
20 designed -- or if it's a proposal just to evaluate something  
21 else that's ongoing.

22 MR. RICHARDSON: It's a proposal to come up with

1 ideas about interventions, not payment. I think that that  
2 is -- I'm glad you mentioned that. There would be no change  
3 in the underlying fee-for-service payment system here. The  
4 funding would go to the sites that are carrying out the  
5 intervention. And the funding would also be used to create  
6 this infrastructure to evaluate it.

7 DR. CHERNEW: But what is the intervention? No,  
8 but I'm not even sure what --

9 MR. EBELER: It's an ACO.

10 MR. RICHARDSON: No. The interventions would be  
11 the types of activities that I was describing earlier,  
12 which, again, could vary from site to site. But the  
13 proposal is to as closely approximate it from one site to  
14 the next to reduce the variability so that you had some  
15 confidence.

16 MS. BEHROOZI: This is actually a follow-up. Mike  
17 said that the test here is a test of a payment policy. So  
18 if that's all it is, then line up how you paid, you know, in  
19 each of these programs how you did the payment for the care  
20 coordination work and see which was most effective. I don't  
21 know if that actually correlates. Maybe the PGP is the most  
22 effective, but maybe that's because it's the primary care

1 providers who are involved instead of some third-party  
2 organization based on Boston or Minnesota, or wherever  
3 Health Dialogue is based.

4           The thing is, though, if it's about payment  
5 policy, then payment policy should be set to encourage  
6 efficiency and quality and all of those things, and the  
7 studying of which interventions work seems to be better  
8 housed in this already existing entity, the AHRQ effort.  
9 And one of the reasons for this particular type of thing,  
10 care coordination, or what's been demonstrated, it seems  
11 like to me, through, you know, the evidence that you have  
12 given us and based on the limited evidence that CMS has  
13 released -- I mean, one of the frustrating things in the  
14 paper I think is when you say, well, they haven't really  
15 told us a lot about why it didn't work. But even just, you  
16 know, in our own experience in our organization where we  
17 actually are using Health Dialogue -- full disclosure -- for  
18 care coordination -- and their fees are supposedly at risk -  
19 - is that we've got some members who respond wonderfully,  
20 and their lives are changed and they're grateful to have  
21 somebody to talk to on the phone. And there are some people  
22 who don't want to be bothered, and I see evidence of that

1 here with the self-selection. Educators know that people  
2 learn in different ways, and so, you know, in the health  
3 world it's not much different. People respond to things  
4 differently. So a one-size-fits-all, a mega program, you  
5 know, paying a gazillion dollars and then finding out later  
6 it didn't work because -- you're not quite sure why it  
7 didn't work -- just doesn't seem like the right way to go.  
8 So I would actually not support the whole new bureaucracy  
9 thing.

10 MR. HACKBARTH: We'll count that as the first  
11 comment in round two. Bruce will have the second.

12 DR. STUART: First of all, I thought this was an  
13 excellent although rather depressing chapter to read, and I  
14 think the end is really important in the sense of trying to  
15 pull together what you see and evaluate the evaluations of  
16 the demonstrations. So I think there are some lessons here  
17 that should be learned.

18 As far as this proposal is concerned, obviously I  
19 have not read the proposal, but did they mention PBRN in the  
20 proposal? So they want to do it like PBRN?

21 MR. RICHARDSON: They mentioned them, I think, to  
22 help us understand what they would do.

1 DR. STUART: All right. Well, I've sat in on  
2 several study sections for PBRN, and the way that process  
3 works is the networks are out there. There is money that  
4 comes to the table. AHRQ says, all right, well, we're going  
5 to bid, we have an RFA for ideas, and sometimes they're  
6 rather narrowly defined; other times they're widely defined.  
7 Each of the networks or parts of the network can bid on a  
8 piece of this. They put together a proposal. It's a  
9 research proposal. It's not a demonstration and then a  
10 separate evaluation. It's a research proposal. It's a  
11 thing, a something that is going to be evaluated. And then  
12 that goes through a scientific review process, and the  
13 proposals are scored. And, you know, the good ones  
14 generally are funded, and the ones that aren't so good  
15 generally are not. Nobody's guaranteed any money under this  
16 thing.

17 I will say, however, that the general quality of  
18 the research design -- now, I am not going to push this too  
19 strong, but the general quality of the research design in  
20 that type of a framework -- and this is true in the action  
21 framework as well -- is not as high as it is for other types  
22 of either investigator-initiated proposals or for solicited

1 proposals that go through NIH or AHRQ.

2 DR. CASTELLANOS: I guess the real question is  
3 what did we learn from the demonstration projects to date or  
4 what should we have learned. I am going to take a very  
5 practical approach.

6 I was involved with the Green Ribbon Health  
7 Partnership, the MHS program in Florida. It was a  
8 combination between Humana and Pfizer. And I learned a  
9 little bit during that project. I learned what a silo was,  
10 but it really wasn't a silo. It was a Fort Knox. There was  
11 such a -- this management company stood between the  
12 physician, the patient, and the doctor. You know, it was  
13 pretty evident when they set it up that this was happening.  
14 And we went to them, and we told them that we wanted to get  
15 in, we wanted to be involved. But, of course, they had  
16 their own mind of doing things, and it fell flat.

17 What I'm saying, again, what I learned in this is  
18 something that I haven't heard during this discussion, that  
19 we need to get the physician community involved in this. I  
20 think some of the projects that have been successful, the  
21 large practice group one and the CMS projects, all are  
22 involved with physicians as part of the set-up of the

1 program. If we're going to make any recommendation, I would  
2 hope that we would encourage to have that so there would be  
3 a good care coordination between all providers.

4 DR. KANE: I'm going to go with Arnie's comment  
5 and also Jennie's that we should really look at these kinds  
6 of activities that have already been evaluated in a bigger  
7 scale and longer time and take heart that maybe we can  
8 actually do similar things in the Medicare program.

9 What I learned from this very interesting chapter  
10 was that you don't want to rely on CMS for the information  
11 you need to manage care. They're way too late, it doesn't  
12 do you any good, and it's just way too arbitrary and perhaps  
13 not useful. And so that's what we learned, and I'm not  
14 surprised, and I don't think we need to spend too much money  
15 on it.

16 But I guess the other thing I'm wondering is if  
17 this class of activity could be considered the kind of thing  
18 you'd like to see under comparative effectiveness types of  
19 research whether, you know, this might be viewed just like  
20 any other treatment or protocol, and whether this whole  
21 question shouldn't just be put back into the whole  
22 comparative effectiveness debate, and just say, you know,

1 here is one type of care processes that we would really like  
2 to have considered in the long term, and just stop treating  
3 them as separate. I mean, we didn't hold a lot of policies  
4 that we've implemented to this standard of research. It's  
5 just a way of stalling it, as far as I can tell, stalling  
6 the implementation, and I don't see the point.

7 I don't know if that's helpful, but that's my  
8 opinion.

9 DR. MILSTEIN: I think, you know, being asked to  
10 address this question, as the title of the slide indicates,  
11 is a great opportunity for us to lay out what we think would  
12 be required for a robust R&D capability within Medicare, an  
13 R&D capability that applied not only to Medicare policies,  
14 but also the care manufacturing process, the process by  
15 which you put in certain resources and certain health  
16 emerges. It's that input-output relationship. And I think,  
17 you know, Medicare needs an active R&D function with respect  
18 to both kinds of tests.

19 Who knows whether or not the slow cycle times and  
20 a failure to home in on current parts of the Medicare  
21 program that is working super efficiently and understand --  
22 you know, reverse engineering what that is. But for

1 whatever reason, it doesn't seem to be happening within the  
2 Medicare program and the constraints it faces in  
3 congressional funding and authority. So I just think it is  
4 -- reflecting on the fact that this has not worked very  
5 well, you know, over the last X years, this is a terrific  
6 opportunity for us to say as you look across other  
7 comparable programs, whether they are within Permanente,  
8 within Germany, whatever it is, you know, what do we think  
9 is the best bet for an R&D operation that would essentially  
10 become for Medicare this vision of a learning organization  
11 that is sort of constantly scanning the environment, finding  
12 allegedly better ways of doing things, quickly testing, you  
13 know, with some rigor as to whether or not it is actually  
14 working, and then if it is working, quickly getting the info  
15 out and with some concrete recommendations to Medicare as to  
16 what policies might begin to drive these, advance these most  
17 quickly.

18           Anyway, I'll stop there.

19           MR. BUTLER: I have a little different view on  
20 this in the sense that we're kind of taking some pretty hard  
21 shots at the evaluation model and losing sight of the fact  
22 that, first of all, this is not exactly our competency in

1 this group to comment on this. I think we are all  
2 struggling with understanding what the proposal is and how  
3 it might be better.

4           But, also, I think some of our struggles is that,  
5 you know, chronic care in the elderly is at the heart of  
6 what the whole thing is, and the models are struggling  
7 because nobody is owning it, and so these interventions that  
8 are being proposed are often a nurse coming in and being the  
9 trusted agent to coordinate all this stuff, and no wonder it  
10 is so hard to kind of both put the model together and  
11 evaluate it, because kind of nobody is owning it. And  
12 really, Ron, it is not the -- I mean, doctors care about  
13 this, but it is just all falling through the cracks to some  
14 extent.

15           So one of my comments would be that -- and by the  
16 way, Rush is one of the 13 participants, and I don't know  
17 actually that much about it myself. So that tells you  
18 something about it. But it's a passionate group that is  
19 trying to fill a void, and they're going to go about their  
20 research ways in some way, whether it's through this or  
21 something else. And this may not be the right model to do  
22 it.

1           In fact, Rush is also a participant in an Action  
2 AHRQ Network, and I've also participated myself in another  
3 practice research-based, and one thing is true. They take  
4 time, they're cumbersome, and they don't create results in  
5 an efficient way. What they do do is get an army of  
6 passionate people kind of spreading the word, learning from  
7 each other, and it does create some momentum. But you're  
8 right, it doesn't create real-time, quick results, and that  
9 is just the nature of the model. And whether there's a  
10 place for that in an overloaded CMS agenda to prioritize it  
11 is, I think, something we need to at some point weigh in on,  
12 because as we looked at the various chapters and reports  
13 that we're kind of all throwing up against the wall and  
14 seeing which one sticks, at some point as you do your  
15 summary of the overall interventions that we might recommend  
16 along the continuum, it would be a nice thing for us to kind  
17 of weight these to some extent and say, you know, these ones  
18 might -- if we were to prioritize where we might get the  
19 most leverage, it might be another way to look at this. A  
20 good idea, but in the balance of the rest of the things  
21 going on, maybe the energy ought to be a little bit more  
22 here or a little bit more there, because we don't do that.

1 We just give a series of opportunities which end up in some  
2 congressional thing that still has to be sorted out. And I  
3 think we could help prioritize if we looked at the whole  
4 list of things.

5 MR. EBELER: Two stages. One is commenting on the  
6 proposal. I guess I would be on the side it just strikes me  
7 this is the wrong way to pick either the entity or the  
8 particular design. There's a variety of reasons for that,  
9 but I'd start there.

10 I do think it's a wonderful opportunity to pivot  
11 to your last chart. I'd add three things there. One is I  
12 think the variable we are trying to focus on in the short  
13 term is obviously what is CMS policy levers that we're  
14 trying to change.

15 Second, I think we're talking about two things  
16 underneath that, though. I think we're talking about what  
17 we're calling R&D, which is an academic model which takes us  
18 down one path of design and standards of evidence. I think  
19 the other thing we maybe could be talking about is more  
20 rapid cycle, organizational, and payment change that has a  
21 different standard of evidence but is also something we want  
22 CMS to do. And when we blend the tools and the standard of

1 evidence of those two, we get confused. And I guess I would  
2 encourage us to think about both, because it strikes me,  
3 again, if we're going to pivot of this to talk about sort of  
4 rapid -- really trying to change things, I think we need  
5 both tools in our toolkit.

6 Third, the one thing that is appealing here --  
7 and, you know, maybe we need to say this at some point. We  
8 talk about trust fund funding. There is a point in our  
9 concern about CMS resources where we may need to speak to  
10 financing some of those resources and crossing this bridge  
11 between appropriations and trust fund. I think the only  
12 place -- Bill, correct me if this is wrong -- where we have  
13 crossed that hurdle is in fraud and abuse, and as a result,  
14 we've gotten a lot of fraud and abuse activity.

15 Just at some point we may need to put money behind  
16 the words we're saying, so it strikes me as something I  
17 would at least think about considering here.

18 MR. RICHARDSON: Just a quick fact. The quality  
19 improvement organizations are also funded directly out of  
20 Medicare trust funds.

21 DR. DEAN: Like several have mentioned, I was  
22 troubled by sort of the lack of demonstrated effect. I

1 also, like Peter, need to -- I have sort of a conflict. One  
2 of the organizations in this proposal is the Avera  
3 organization, which I work with quite a bit. But, anyway,  
4 in their defense -- and it isn't really to really defend the  
5 proposal so much, but it speaks to Glenn's concern. They  
6 were very frustrated because they got none of their data  
7 back in a timely fashion. And as they finally got towards  
8 the end of the project and began to get some of the early  
9 data back, they found that there were sub-groups that they  
10 were dealing with where they could show some effect. And  
11 had they had that data on a timely basis, they feel that  
12 they could have demonstrated a much more positive effect.

13 I think that is a fair comment, and it probably  
14 speaks to the broader question that if we are going to  
15 promote projects like this, it should be built in right from  
16 the start that there is an adequate analytic capability on  
17 whoever is doing the analysis to get feedback at a time  
18 where it can really make a difference.

19 The other comment that I would make sort of  
20 follows up a little bit on what Ron said, and that has to do  
21 with the fact that, of the four projects we looked at, the  
22 one that came the closest was the one where these activities

1 were most closely tied with the actual delivery of the care.  
2 And it seems to me that those two have to be tied together,  
3 and closely tied together, if we are going to expect an  
4 effect.

5 DR. CROSSON: I'll make one point that hasn't been  
6 made and then just reiterate quickly some of the others that  
7 already have been.

8 I wanted to just point out that, with respect to  
9 the review of the group practice demonstration project, I  
10 might want to suggest a little skepticism about the  
11 skepticism of the financial impact, because primarily the  
12 time frame is still short. So if you look at, for example,  
13 the question of whether our belief in the cost savings ought  
14 to be obviated by the fact that the coding increased, if you  
15 look at the examples on the bottom of page 28, blood  
16 pressure screenings, foot exams, cholesterol screening,  
17 colorectal cancer screening, and mammography, which are  
18 related to the quality measures, you would expect actually,  
19 if you're trying to improve all of those things, that  
20 several things would happen. Your costs would go up, number  
21 one, but also the identification of individuals with  
22 hypertension or with diabetic foot disease or with

1 colorectal cancer or early breast cancer or whatever would  
2 also increase; and, therefore, the coding would go up.

3           However, the purpose of preventive medicine and  
4 early detection techniques, in addition to trying to save  
5 people's lives and reduce morbidity, is to reduce long-term  
6 morbidity and long-term costs. And all of that is not going  
7 to occur within a three-year time period. So I just want to  
8 make that point.

9           With respect to this consideration of the MCCPRN,  
10 I see nothing in the presentation that would convince me  
11 that we should return a positive verdict on this, for all  
12 the reasons that the staff has raised as well as the issue -  
13 - and I agree with Ron on this, and Tom -- that I think the  
14 preponderance of the evidence and also my own experience has  
15 been that disease management, case management, care  
16 management techniques, the success of them tends to be very  
17 closely related to whether they're actually integrated into  
18 the care delivery as opposed to applied extrinsically. And  
19 I think for that reason alone I would probably view it with  
20 some skepticism.

21           And, finally, on the question of, you know, is  
22 there a better way to do this, I wrote down -- after Arnie

1 talked, I wrote down the term "reverse engineering" also,  
2 which I think is exactly the technique. When some nations  
3 that were developing after the Second World War tried to  
4 figure out how to build an economy, they didn't start from  
5 scratch to build a transistor radio or other forms of  
6 products. They took ones that were in existence, tried to  
7 take them apart, look at them, and make them better, and  
8 apply them to perhaps some new uses.

9 I was also intrigued by the notion that perhaps in  
10 doing this and in thinking where, A, the money would come  
11 from and, B, where the work would happen, the notion of  
12 maybe thinking about comparative effectiveness research --  
13 the definition of that, anyway -- a little bit more broadly  
14 might be useful, because there is a question about  
15 comparative effectiveness of what? Just clinical  
16 interventions, or how the structure of the delivery system  
17 and how the delivery system, for example, is paid impacts on  
18 the cost and quality of health care seems to me legitimate.

19 So you can imagine then, given the interest in  
20 that, that there might be more money available, and that  
21 some of that work could occur in the kind of process that we  
22 would call inside of our own organization operations

1 research. And no offense to academics, but in the  
2 operational realm, problem solving tends to take place much  
3 more quickly. And I think that model that Jack described, I  
4 don't know where that would be done or exactly how it would  
5 be funded or how it would relate to CMS and its R&D  
6 function, but I think it's a good idea.

7 MR. HACKBARTH: Just to pick up on that point for  
8 a second, Mike, the difference is you're playing with your  
9 own money, and when we're talking about potentially paying  
10 for new services -- you know, something that Medicare  
11 doesn't now pay for, we're adding a new code, so to speak,  
12 and a flow of dollars -- then they're playing with somebody  
13 else's money. When you're playing with your own money under  
14 a fully capitated system, then if you make a misjudgment in  
15 your quick movement, you know, you pay the cost. And one of  
16 the things that holds us back in fee-for-service is, well,  
17 we're going to start paying a new line of revenue to a new  
18 set of entities, and if we make a misjudgment, it is going  
19 to be more costs on an already bloated system.

20 I think that's one of the reasons why people seem  
21 to be so hesitant about more quick and dirty analysis. Just  
22 an observation.

1 DR. CHERNEW: First, I'll just say something in  
2 response to Jay's comment. Most preventive care, which I am  
3 extraordinarily supportive of, is cost-effective not cost  
4 savings, even if you go for long periods of time. Peter  
5 Newman has a New England Journal article on that point. So  
6 the idea that doing all these good process things will  
7 eventually save you money and it's just a matter of time I  
8 think sounds a lot better than the evidence would suggest  
9 that it is.

10 That said, I feel extraordinarily strongly that we  
11 should encourage greater use of preventive care in chronic  
12 disease management because our goal isn't to make the system  
13 cheap. We could do that a lot easier. Our goal is to make  
14 the system better in other ways. I think we do have to  
15 address costs, but addressing costs by not providing  
16 preventive care seems like a crazy thing to do.

17 So I think that looking at these results and all  
18 the multiple comparisons suggest that at least what we've  
19 done so far hasn't been a rousing success, and the response  
20 to that has to be we have to try better as opposed to we  
21 have to throw up our hands.

22 And so that leads us to the question of, well,

1 what process should you use? And it's late in the day.  
2 I've been up for a long time. I've had a lot of sugar, if  
3 you've seen the Lucky Charms I've eaten. And so I'll say  
4 this strikes -- this MCCPRN process, which I haven't read or  
5 evaluate in any way so I won't speak to that specifically,  
6 but the process it followed strikes me as amongst the worst  
7 possible processes I could possibly imagine if I wanted to  
8 think of a really bad process.

9 For one -- and I could be completely wrong because  
10 I might not know that process. So, again -- are we done?

11 MR. HACKBARTH: We'll put you down as a maybe.

12 [Laughter.]

13 DR. CHERNEW: There are existing review panels for  
14 how one might fund and evaluate things like that, where in  
15 general you would try to avoid having the people doing the  
16 implementation or the evaluation doing the evaluation of it.  
17 You would tend to have, you know, a lot of other processes  
18 where they might compete broadly against other ideas for  
19 interventions.

20 Now, maybe they've done a great job. Again, I'm  
21 not talking about that particular thing. I might see the  
22 proposal and compare it to others and say this is one that

1 should definitely be funded. There are certainly some  
2 really high-class organizations involved in that, so I'm not  
3 knocking it in any way. But as a process, I think the idea  
4 of having money going through -- we might not be able to  
5 evaluate this, but the idea that the congressional ways  
6 could figure out which ones to do I am more skeptical of. I  
7 think it's crucial that there be more money funded to  
8 evaluation and more authority to CMS to try innovative  
9 ideas. I think other people around the table besides me  
10 could figure out the right processes to do that.

11 I believe strongly that AHRQ should get a lot more  
12 money to support the types of evaluations that they do.  
13 They're reasonably good at having study sections and figure  
14 out what to do. I think a trust fund way to do that  
15 evaluation is fine.

16 One could send that to CMS, through CMS. I am  
17 less comfortable how they would execute that. I think  
18 broadening the idea of comparative effectiveness research  
19 type things to include broad systems interventions is  
20 actually absolutely crucial. And I think more funding to do  
21 that is very important. And I think any MedPAC statement to  
22 that effect would be extremely important.

1           I think that it's also important to understand the  
2   distinction between the evaluation and the design and the  
3   implementation, because I know the people who have been  
4   interested in this competitive bidding stuff for a long  
5   time, and they've become incredibly frustrated because they  
6   can't evaluate a competitive bidding demonstration until you  
7   have some competitive bidding demonstration. There's all  
8   kinds of various road blocks on how to do that. So giving  
9   CMS some flexibility as to what they'd do, if they wanted to  
10   do episode-based payment and things, that I think is  
11   actually crucially important.

12           You're never going to solve the timeline in how  
13   long it takes for the data to be generated and evaluated.  
14   That is just how long it's going to take. But to get it  
15   through the red tape to be implemented I think is crucial.  
16   To have a rigorous, independent evaluation I think is  
17   fundamental. And I certainly think more money to support  
18   those activities and more authority within CMS to conduct  
19   those things is extremely valuable.

20           DR. SCANLON: I think I agree with the majority  
21   that the network idea is something that we should say no to,  
22   but I think we should treat it as an opportunity that we've

1 been asked this question, and we can say, well, there's  
2 really a different question that you should be asking, which  
3 is that we're starved for innovation in Medicare and how do  
4 we get it. And the issue is how do we build the capacity in  
5 CMS to do that. And so if you have \$60 million that you're  
6 willing to spend, we have a place where you could spend it.

7 But it goes beyond sort of the Office of Research  
8 and Development. It's a more fundamental question about CMS  
9 capacity, because I think that -- and this is not total  
10 familiarity with these demos in terms of how they were  
11 operated within CMS. But the idea that there were data lags  
12 and that data lags were a real problem is not a shock given  
13 the state of CMS health information systems or information  
14 systems.

15 This has been a chronic problem forever, and we  
16 can change the timeline in terms of this if we were to  
17 change the information systems and kind of bring them into  
18 the 21st century, because there are all kinds of  
19 organizations that are going to know today what they did  
20 today. CMS, in terms of what claims are paid today and to  
21 be able to know in detail about them, it is going to be  
22 months, if not a year. So that is not something that needs

1 to be the case. We can change that DNA. We can make them  
2 more capable of doing these things.

3 And so it's the idea of we need to invest in the  
4 capacity to administer the program if we're going to get the  
5 kind of innovation that we're talking about here in terms of  
6 research or what Jack was mentioning in terms of short-term  
7 analyses, because you got to have the data closer to real  
8 time.

9 MR. HACKBARTH: Good concluding comment, Bill.  
10 Thank you. John, good work, and we'll talk more about this  
11 next time.

12 Let's move to our final session of the day.

13 We're going to have a presentation by Chris Hogan,  
14 an old friend whom we haven't seen for a while -- Chris,  
15 good to see you -- on the effect of secondary coverage on  
16 Medicare expenditures.

17 DR. SCHMIDT: Let me introduce him, if you do not  
18 know Chris. Last year, you saw a couple of presentations  
19 about Medicare's fee-for-service benefit design and some  
20 illustrative changes to it. And as part of continuing work  
21 on that issue, we're happy to have with us Chris Hogan of  
22 Direct Research, LLC.

1 Chris is an economist with extensive experience  
2 analyzing the Medicare program. He is a former staff member  
3 of PPRC and MedPAC and is currently a private consultant.  
4 And we asked Chris to take a new look for us at the issue of  
5 how the presence of secondary coverage to fee-for-service  
6 Medicare affects beneficiaries' use and spending.

7 DR. HOGAN: Thank you. We're running a little  
8 late, but I can talk fast so let's get right to it.

9 The first slide shows you the scope of what we're  
10 talking about here. I will take it as a given that most of  
11 you understand that out-of-pocket costs reduce health care  
12 use. There is a preponderance of evidence to suggest that.  
13 The Medicare program was designed with co-insurance and  
14 deductibles. But you also know that almost no Medicare  
15 beneficiaries actually pay the full Medicare co-insurance  
16 and deductible amounts. Your own statistics say eight out  
17 of nine in the fee-for-service program have some sort of  
18 secondary insurance.

19 My job today is to remind you of what that does to  
20 total payment in the Medicare program, both, I guess,  
21 throughout the program on the fee-for-service side and, by  
22 reference, to what you pay under Medicare Part C, as

1 empirically as possible. And then although you hired me as  
2 a data analyst, not a policy analyst, I'll just provide you  
3 a little jumping-off point if you want to discuss policy.

4           The proximate reason I'm here is that more than a  
5 decade ago, staff of the CBO and the Physician Payment  
6 Review Commission independently looked at this issue and  
7 came to a pretty solid agreement that secondary insurance  
8 increases Medicare's costs a lot, and that the impact was  
9 largely on Part B services. But last year -- I guess it was  
10 last year -- a paper was published in Health Affairs that  
11 said, no, no, you goofed, you forgot to account for Veterans  
12 Administration coverage and the free services provided by VA  
13 facilities. And if you do that, you get a much, much  
14 smaller impact of secondary insurance in terms of how much  
15 it raises spending. So Rachel called me up and said, "Would  
16 you like to redo the numbers?" And I said, "Fine."

17           I'm going to take three years' worth of MCBS data.  
18 I'm going to compare those who do and don't have secondary  
19 insurance. I need three years' worth because there are so  
20 few beneficiaries who don't have secondary insurance, it is  
21 kind of dodgy to do it any other way. Carefully, I want to  
22 say even tediously, address this issue of Veterans

1 Administration coverage, measure total spending, and anybody  
2 could do that, but probably more interestingly, look at the  
3 mix of services, not only that spending was higher but where  
4 was spending higher when beneficiaries did not have to pay  
5 out of pocket.

6 As a contractor, I can never tell you that it was  
7 easy, but I can tell you it was conceptually  
8 straightforward. I have to figure out who's got what  
9 insurance, throw away the people I don't want to look at,  
10 and compare. That's it. And so that's what I'm going to  
11 do. And when I compare them, I'll adjust for as many things  
12 as I can fit into my regression model in terms of education,  
13 health status, and so on and so forth. Once I've gotten the  
14 file down to the population I want to look at, figured out  
15 what insurance status they have, and done the comparison,  
16 after adjusting for all these other factors, whatever else  
17 is left in terms of the difference in cost between those who  
18 do and don't have secondary insurance, that's what I'm going  
19 to call the impact of secondary insurance. It's sort of the  
20 standard way this is done.

21 Unadjusted, before doing any of those adjustments  
22 for all those factors, the raw numbers show a very large

1 difference in spending. Those who have private secondary  
2 coverage spend about spend about 54 percent more in total  
3 than those who don't. That's a little bit in Part A and a  
4 huge difference in Part B.

5 Now, I can't take that raw number as any estimate  
6 of the impact of insurance because the populations who do  
7 and don't have secondary coverage are just radically  
8 different. So let me quickly go through how different they  
9 are.

10 This is a capsule summary of the differences  
11 between the beneficiaries who have Medicare only and those  
12 who have any private supplemental insurance, and I've  
13 divided it into five sections. I'll briefly describe it as  
14 cost and use, demographics, education, health status, and  
15 income.

16 Briefly, the cost and use section, the little  
17 boxes at the top, is in a nutshell what you're going to see  
18 in the rest of the analysis, that people who don't have  
19 secondary coverage pay a lot more and use a lot less.

20 The demographics, education, and income work out  
21 like this: The population that doesn't have secondary  
22 insurance is more likely to be single, male, minority, less

1 well educated, lower income, and still working. And to me  
2 that profile very much fits the idea of a population that  
3 fits in the notch between being so poor you're on Medicaid  
4 and having had such a good career and so much money at the  
5 end of your life that you have either employer-sponsored  
6 secondary coverage or you can go out and buy Medigap. So I  
7 like to think of them as the working poor of the Medicare  
8 population, is what we are looking at here.

9           In terms of health status, they don't report any  
10 differences in health status to speak of, but the claims-  
11 based health status measure called HCCs, which is on the  
12 chart there, shows a big difference in health status. Now,  
13 maybe that's real, or maybe that's an artifact of the fact  
14 that if 20 percent of these people don't have any claims at  
15 all -- in other words, my data are censored in this regard -  
16 - I'm going to take it as real and factor them into my  
17 analysis.

18           When I go to a regression-adjusted estimate --  
19 this would be sort of the adjusted analog to those raw  
20 numbers -- what I want to show you here and through the rest  
21 of the slides is dollar figures for the people who don't  
22 have secondary insurance and percentage increases associated

1 with having secondary insurance. The middle line is just  
2 about the average for everybody who has secondary insurance.  
3 After I make my regression-based adjustment, total spending  
4 for the people who have secondary coverage is 25 percent  
5 higher, not much in Part A, a whole lot in Part B. And at  
6 this point I could stop. These are just like the results we  
7 got 10 years ago. These are consistent in magnitude with  
8 the National Health Insurance Experiment. But wait, there's  
9 more.

10 I'm going to show you how the mix of services  
11 changes, and all of the succeeding slides are organized the  
12 same way. I'll show you a dollar figure for the people who  
13 don't have secondary insurance. I'll show you a percentage  
14 increase associated with having secondary insurance. And  
15 I'll sort them so the big impacts are always at the bottom.  
16 So in the next set of slides, you want to look at the bottom  
17 and say that's where the additional services show up, is at  
18 the bottom of the slide.

19 Where are the additional services for the people  
20 who have secondary coverage who aren't paying the co-  
21 insurance? They take place in the office, primarily.

22 Who's doing those services? Well, it's mostly

1 medical specialists, to some degree surgical specialists.

2 What kind of -- oh, I'm sorry.

3 DR. MARK MILLER: Chris, if you'll go back to your  
4 first one, the office has the biggest effect, but it's not  
5 zero.

6 DR. HOGAN: Correct.

7 DR. MARK MILLER: I appreciate you going fast  
8 because it's the end of the day, but perhaps just a little  
9 slower.

10 DR. HOGAN: While secondary insurance is going to  
11 increase services across the board to a degree, the biggest  
12 impacts are going to be at the bottoms of these slides, and  
13 that is really -- so it's not as if -- what am I trying to  
14 say? Let me take it the other way.

15 The effects are now uniform. It's not as if  
16 everything goes up 20 percent, 30 percent, 40 percent. What  
17 I'm trying to do is get a handle on what has a price  
18 elasticity, in the jargon of economics, and what doesn't;  
19 what stuff is always going to get provided, and what stuff  
20 is going to get provided more often when it is free to the  
21 beneficiary. That's what I'm trying to get at.

22 And so if you look at site of service, is it big-

1 ticket stuff being done in the hospital or little-ticket  
2 items being done in the physician's office? And perhaps  
3 reasonably, it's little-ticket stuff being done in the  
4 physician's office.

5           If you ask who's doing it, well, it's not your  
6 generalists. It's your medical specialists. Usually the  
7 medical specialists end up being the bad guys in all these  
8 discussions. What a surprise. That's the way they end up  
9 here. I have to be circumspect because I work for people  
10 like that now, but that's the conclusion there.

11           What's being provided, I thought this was  
12 interesting. No difference at all. Top of the chart, no  
13 difference at all in emergency visits, and if I had put in -  
14 - these are the Berenson-Eggers type of service categories,  
15 and there's lots of them, and some of them have too few  
16 dollars in them for me to be able to demonstrate what's in  
17 them. Sometimes I had to aggregate them up to get a stable  
18 enough average. And I've taken sort of representative  
19 sample of all these categories. There's close to a hundred  
20 of them.

21           There's no difference in emergency care, and had I  
22 shown you ambulance rides, for example, no difference in

1 ambulance use. So if it's an emergency, co-insurance  
2 doesn't matter. At the other end of the scale, minor  
3 procedures and endoscopies, well, almost twice as much in  
4 terms of minor procedures for the beneficiaries who don't  
5 pay Medicare co-insurance.

6 I'm hoping you'll get the same flavor out of these  
7 that I did when I went through them. If I went to look and  
8 see what was going on on the inpatient side, it's difficult  
9 to get a simple handle on what inpatient care looks like.  
10 But this flag is already on the claim, so I decided to go  
11 ahead and summarize it. There's no difference in emergency  
12 or urgent admits. All of the additional Part A inpatient  
13 use is in elective surgery, which is almost twice as much  
14 for the patients who don't pay the co-insurance.

15 Finally, there's nothing more elective than  
16 preventive or screening services. They can be delayed, and  
17 you do not really see the bad effects immediately. And  
18 spending for all preventive services on a per capita basis  
19 was just about twice as high for the beneficiaries who had  
20 secondary insurance. And I think that is well documented.  
21 People have shown over and over again that co-insurance for  
22 mammograms suppresses the mammogram rate. Well, there you

1 go. You are looking at it right there. And understand,  
2 please, it's not a huge amount of co-insurance for a  
3 mammogram. It's \$20 or \$30 in the Medicare program, and  
4 that is enough to change the mammogram rate substantially.

5           So at this point, all I've done is show you site-  
6 of-service cuts, and I hope you get the same impression from  
7 this that I do. It's sort of little-ticket, non-emergency  
8 stuff that gets -- and prevention services stuff. I just  
9 want to assure you with one cut based on beneficiaries that  
10 it's not as if you only see these effects for poor people or  
11 you only see these effects for the healthy people or you  
12 only see them for the youngest age as opposed to the older.  
13 You see these effects throughout, and the way to demonstrate  
14 that easily, I think, is to divide the beneficiaries based  
15 on presence of some significant chronic condition.

16           Now, for this slide, I was shooting for the top  
17 five causes of death in the Medicare program, and I also  
18 added decedents as a classic very sick population, known  
19 only ex post. And the bottom is none of the above. The  
20 bottom is people who didn't have any of these conditions and  
21 didn't die.

22           The most important thing to get out of this slide

1 is that the right-hand column is full of asterisks; in other  
2 words, no matter who you were, no matter what sort of  
3 illnesses showed up in your claim stream, it's always the  
4 case that the beneficiaries who basically get their care for  
5 free use more Part B care. And the largest difference, the  
6 largest percentage difference was among what I would call  
7 the "presumed healthy." The people who didn't have any of  
8 these top five killers and who didn't die, they had the  
9 largest difference in spending.

10           So at that point, I want to try and sum up, and  
11 this is hard. This slide kept morphing right up until  
12 yesterday. The first line is always the same. Secondary  
13 insurance raises Medicare's cost substantially, and the key  
14 word there is "substantial." No different from what was the  
15 conventional wisdom 10 years ago.

16           It's difficult for me to get a nice description of  
17 the change in service mix, partly because I don't want to  
18 use any loaded words like "unnecessary" or, you know,  
19 anything like that; and partly because what you see here is  
20 not -- I haven't tested any hypotheses about service mix.  
21 I've just taken whatever targets of opportunity I could get  
22 to try and characterize it. But to me as an economist, if I

1 had to put all those observations in one place and try and  
2 give a succinct mental model, not tested but just the way I  
3 look at it, the people who have to pay their own out-of-  
4 pocket costs, they're more tolerant of small medical risks;  
5 they're less willing perhaps to pay to fine-tune their  
6 health status with modern procedures; but there's no  
7 difference when it comes to life-threatening episodes.

8           Now, having said that, I have failed in my task to  
9 have neutral wording here, because you could just -- as I  
10 said, more tolerant of small medical risks. You could just  
11 as easily have said forced to take more small medical risks,  
12 however you want to characterize it. The real bottom line  
13 is they take more small medical risks. They use less of  
14 these small medical procedures. But when it comes to life-  
15 threatening care, there appears to be no difference.

16           Whatever spin you want to put on the existing  
17 data, the one thing I want you to get out of this is  
18 "strongly" -- out-of-pocket costs can strongly influence  
19 beneficiaries' choices of care. It's not merely 25 percent  
20 in total spending, not merely 50 percent for Part B, but 2:1  
21 differences in use of these services that seem to have, I  
22 would say, a high price elasticity or high sensitivity to

1 co-insurance.

2           With that, let me segue to these two essentially  
3 disposable policy slides.

4           I am not here to give you policy advice, but I  
5 will through and queue up some discussions. I'm sure you  
6 can do this on your own. You don't need me. You can look  
7 at policy either backward-looking for forward-looking, look  
8 back at the existing co-insurance or look forward to  
9 something new you could do.

10           Looking backward, if you could limit secondary  
11 coverage of the existing co-insurance and deductibles, you  
12 would almost certainly save a substantial amount of money.  
13 I did a little back-of-the-envelope as I was coming down  
14 here, and given the algebra of the situation and given my  
15 estimates, 14 percent on average is what I would guess, you  
16 would save that on the fee-for-service side, and presumably  
17 that would reduce your basis for Part C. So the whole  
18 program would come down 14 percent. But if you did that,  
19 you'd probably want to rethink the benefit structure. You'd  
20 probably rethink the fact there's no stop-loss. You'd  
21 probably want to rethink the fact that you charge co-  
22 insurance on services that you want beneficiaries to get,

1 like preventive care. Most preventive care, remember,  
2 didn't exist when they -- the mammogram benefit only came in  
3 the mid-1990s. So when the people set the structure up  
4 early on, they really weren't thinking about preventive  
5 care, although Congress didn't exempt it from co-insurance.  
6 And the high inpatient deductible, interacting with  
7 emergency admissions, it doesn't really seem to do much. It  
8 doesn't deter people from getting most of their admissions,  
9 because most of their admissions are urgent or emergent.

10 But with regard to this notion of limiting  
11 secondary insurance, I can -- I had a little joke I was  
12 going to tell, but I don't dare do it in this audience.  
13 Based on my experience with the Physician Payment Review  
14 Commission and testifying in front of the National  
15 Bipartisan Commission on the Future of Medicare, this is a  
16 really hard topic to discuss. And I'll just say name your  
17 constituency, I'll tell you why they hate it. And it  
18 doesn't go any deeper than that.

19 Going forward, could you introduce a new and  
20 defective co-payment, and here I want to say co-payment as a  
21 fixed-dollar amount so people know ahead of time how much  
22 they're going to owe for a service. So for purposes of

1 discussion, let's make it minor. It's a small, fixed-dollar  
2 amount -- \$10, \$20, \$30; subject to an annual per  
3 beneficiary limit, so we're not going to bankrupt anybody.  
4 Of course, the Congress would have to exclude this from  
5 secondary coverage by statute, as they did with certain  
6 parts of Part D, so the Congress would say nobody can pay  
7 this, it's got to come from the beneficiary; and you would  
8 exempt the usual suspects.

9           If you could get that in place, what could you do  
10 with it? Well, the easy thing would be an across-the-board  
11 fee. It's not very imaginative, but it's fairly safe, and  
12 it would almost certainly save you a little money just to  
13 make beneficiaries think a little bit before going for that  
14 additional service.

15           The alternative would be to try and target it, to  
16 dovetail it with your quality data or to dovetail it with  
17 your financial profiling. But I view that as sort of a two-  
18 edged sword, that if you're going to use this in that way,  
19 you would have to have a fair degree of confidence that the  
20 data you use to pick winners and losers has a very high  
21 signal-to-noise ratio, so to speak, that your low-quality  
22 hospitals, so-called, really are low quality, and your high-

1 quality hospitals really are high quality, because you are  
2 going to move beneficiaries among them.

3 So my final thought for you is let me characterize  
4 these targeted co-payments as a powerful but two-edged  
5 sword, and you would have to think pretty hard before you  
6 tried to implement that in the program.

7 With that, I will turn it over for your  
8 discussion.

9 DR. STUART: If I understand your methods, it  
10 seems to me that you're actually capturing two effects in  
11 your measure of the impact of health insurance. The first  
12 is the one that you really want to get, which is the true  
13 price elasticity and demand. And the second effect is any  
14 unmeasured variance, predilection to use services that is  
15 also correlated with having a Medicare supplemental policy.  
16 And both of those work in the same direction.

17 DR. HOGAN: There's a more detailed discussion of  
18 this in the paper. And your argument is true for the  
19 individually purchased policies, but probably not true for  
20 people who have their employer-sponsored coverage.

21 DR. STUART: Well, I'm thinking about that. That  
22 may well be true, but it's also the fact that if you have

1 somebody that has had good coverage all along, which is the  
2 people who have retiree coverage, then they've developed  
3 styles of demand that are, arguably, going to be very  
4 different from somebody who either does have insurance on  
5 the individual market or not.

6           So, again, I'm not sure that I buy the conclusion  
7 that you're likely to get a big saving from imposing what  
8 looked like fairly small co-insurance upon people who are  
9 currently well insured, in part because of this. So there's  
10 a methodologic issue in terms of that missing, unobserved  
11 variance that leads to insurance. And then the second piece  
12 is people that have insurance and have had it a long time  
13 are probably going to be less sensitive than people who just  
14 didn't have it at all.

15           DR. REISCHAUER: I thought this really was  
16 fascinating and really a good piece of analysis. Just two  
17 little comments.

18           One is, looking at the use of age as a variable  
19 which you control on -- and I was surprised to see that  
20 they're close -- this is in a sense a decision one makes at  
21 age 65, and then there's a price put on delay. And so if  
22 you think of sort of looking at people at age 66, they might

1 answer some of these questions differently, like they might  
2 be considerably more healthy than the ones who choose the  
3 other insurance, but then as you go through time, they  
4 approach the other group in how they look at respect to  
5 health. You know, I think that might have some relevance  
6 here.

7           The second comment is about the looking-forward  
8 policy, and I agree with everything you said about the  
9 politics of making changes in this area. But one way one  
10 could go is, of course, to put a 30-percent excise tax on  
11 supplemental insurance policies than went back into the  
12 Medicare trust funds to pay for the induced utilization.

13           DR. KANE: I'm just curious to know if any of that  
14 excess utilization -- or that utilization by the  
15 supplemental group had any measurable health outcome  
16 differences, whether you were able to test that, whether  
17 there was a difference in morbidity or mortality between the  
18 two groups other than just their utilization differences.

19           DR. HOGAN: Well, their self-reported health  
20 status was about the same. Their health status is as I  
21 reported it on one of those charts, and --

22           DR. KANE: So ones with supplemental, is that the

1 same? It looks like it's slightly -- is the 109 worse than  
2 or better than --

3 DR. HOGAN: The 109 says you are expected to use  
4 more care. You are less healthy is another way to say it.  
5 So it's not clear -- I mean, from my standpoint, from  
6 adjusting the numbers, it was never clear -- what you would  
7 really like me to do is get to the outcomes of care, and  
8 that's a hard thing to do, as you know.

9 I can always say, you know, the health status that  
10 you're looking at presumably should be the long-run health  
11 status. It should reflect whatever outcomes of care they  
12 got over the last five years if their health status hasn't  
13 changed.

14 There was an effect for mortality in here, but I  
15 dismissed it. I looked at it and said I don't believe it,  
16 because it didn't correlate with anything else, that the  
17 population without secondary insurance had a statistically  
18 significantly higher mortality rate in one year, not in the  
19 other two. So I looked at it and said, ah, I'm not sure I  
20 believe that, given the rest of the numbers. I didn't  
21 report it out here, but it's reported in the paper. So I  
22 don't know that you can make a strong health status

1 argument.

2 DR. CASTELLANOS: Really good work and really eye-  
3 opening. You know, we've all looked at, all the Medicare  
4 providers, how we could save money. This is the first time  
5 we've looked at beneficiaries. And we're not going to make  
6 any difference unless the beneficiaries change their  
7 behavior.

8 I'm going to just open a box and ask if you had at  
9 all thought about cost-sharing and what your issues on that  
10 are.

11 DR. HOGAN: Oh, yes, but I've been told that if I  
12 start foaming at the mouth, I am going to have to have my  
13 speaker cut off here. I'm an economist, and to an  
14 economist, "free" is a four-letter word. That is the bottom  
15 line. Joe Newhouse wrote a book -- "Free for All?" -- that  
16 discussed the inefficiency of providing health care for  
17 free. But it's also inequitable to charge high payments for  
18 people who end up being sick. And so it's a real hard  
19 issue.

20 Where I end up personally is that modest co-  
21 payments are probably a not unreasonable thing to charge and  
22 that absolutely free tends to be inefficient.

1 DR. CASTELLANOS: Medicare does have cost-sharing  
2 now. They have it with the ophthalmologists and cataract  
3 lenses, and it's working very well. It's in policy already,  
4 so, you know, I don't know why we are kind of not getting  
5 close to that, or even talking about it.

6 DR. MILSTEIN: This potential manifestation of  
7 noise that you found with higher mortality in one year, that  
8 is the kind of thing that probably is best not left vague,  
9 particularly now that, you know, it has been disclosed. And  
10 I wonder if it might be possible -- I don't know what our  
11 budget is for this analysis, but the software to segregate  
12 claims -- segregate hospitalizations into several  
13 ambulatory-sensitive admission categories. It seems to me  
14 it would be the right place to do this. The software is not  
15 expensive. The analysis is not complicated to do. But I  
16 don't think we should leave that one factoid to linger. I  
17 think we should focus in on what would be a much more  
18 specific signal, which is whether ambulatory care-sensitive  
19 conditions did go up or not -- that is a much more sensitive  
20 signal than mortality -- and then ascertain whether or not  
21 that is or is not a problem with higher cost-sharing.

22 DR. MARK MILLER: I also think that when you start

1 to get into -- you know, I think the level of analysis  
2 that's done here, you can start to delve into these  
3 questions, and then they will immediately trigger questions  
4 from, you know, certain people about more sophisticated  
5 methodologies to start to control for interactive effects.  
6 And these things can get very complex and begin to get more  
7 judgmental as you get into those methods. So it's a  
8 question -- you know, I mean, the first thing we asked Chris  
9 to do was deal with this new analysis that had come along  
10 and said, oh, by the way, the secondary payer effect isn't  
11 that large, which was a shock to a lot of people. And so  
12 that was the first thing he dispatched. And then as an  
13 added bonus, he kind of took us through some of these  
14 effects underneath.

15           It can get pretty hairy methodologically, and I  
16 know we've had -- long ago now -- conversations about how to  
17 kind of go methodologically through those issues.

18           DR. MILSTEIN: It would not require more analysis,  
19 but what are your comments on whether or not your estimation  
20 of -- what was it? -- a 17-percent reduction, a 14-percent  
21 reduction in Medicare spending if this effect were removed?  
22 Any comments on the likely applicability of that finding or

1 relevance of that finding to the Medicare Advantage program,  
2 which is where we are struggling to convert that into a  
3 vehicle for greater affordability. We're not doing too  
4 well. Any comments on the -- since that is a program by  
5 which supplementary benefits are provided, it would reduce  
6 cost-sharing. Is there any opportunity to -- how far along  
7 the study -- it would be interesting to essentially give us  
8 some idea as to whether or not there is an equivalent  
9 savings opportunity that might be achievable in the Medicare  
10 Advantage program via policy changes that might fall along  
11 the lines of some of your policy ideas or the idea that Bob  
12 mentioned.

13 DR. HOGAN: I must say I only brought that up to  
14 remind you that if you managed to bring down the fee-for-  
15 service costs, it would reduce your Part C payments as well,  
16 so that your savings as such would be across the board. I  
17 really haven't given it one inch of policy thought in terms  
18 of the Medicare Advantage side.

19 DR. BORMAN: I have two sort of definitional  
20 questions and one sort of interpretive question. Could you  
21 share with me the differentiation of elective admission  
22 versus urgent.

1 DR. HOGAN: It's a flag on the claims.

2 DR. BORMAN: Yes, I heard you say that.

3 DR. HOGAN: What I did was test it before I used  
4 it, so not shown here -- hospitals don't get paid on the  
5 basis of it, and I don't know the difference between  
6 emergent and urgent. But MedPAR took hip replacements,  
7 found the ones who had fractures and not. Almost all the  
8 ones with fractures were urgent. Almost all those without  
9 fractures were elective. So hip replacement is indeed  
10 intuitively what I expected, and I sort of assumed it worked  
11 about right. I'd have to go look up in a manual to tell you  
12 what the definition is supposed to be.

13 DR. BORMAN: Because I would anticipate that for  
14 the diagnosis that you just described, that would sort out  
15 by diagnostic code. But, for example, the majority of  
16 people who under a cholecystectomy, it's going to be on a  
17 planned admission basis, but it's not something that they  
18 just signed up to do for the fun of it. Probably back there  
19 within the preceding, you know, one week to six weeks, or  
20 somewhere in there, several months, there have been some  
21 episodes of, you know, distress that prompted either  
22 physician visits, emergency room visits, et cetera.

1 Certainly ICD on the diagnosis side is going to be a highly  
2 imperfect way to sort out what's truly elective or not. And  
3 so I would just urge a little caution about this piece.

4 I understand the finding that it is all higher,  
5 and it makes intuitive sense to me as a practicing  
6 physician. But I think as we try and sort of say some  
7 things about the magnitude of the effect, I guess I would  
8 worry a little bit about endorsing this one at this level of  
9 difference, because it is almost a 100-percent increase,  
10 without knowing a little bit more about it.

11 Another one, if you could clarify a little bit, is  
12 how did you place people in surgical specialists who do  
13 interventions like angioplasty but who are not surgeons,  
14 i.e., interventional radiologists, interventional  
15 cardiologists. Was it based on self-designated specialty?  
16 Or is it one a characterization of the kind of service  
17 provided where it sums up in some other system?

18 DR. HOGAN: It's self-designated specialty. This  
19 is a small sample. One more thing, a lot of these measures  
20 are targets of opportunity not because I was trying to be  
21 vague, but because I've got 1,800 people to work with.

22 For example, I wanted to look at total knee

1 replacement as being something that is a clear quality-of-  
2 life improvement and people get it when they hurt a lot and  
3 presumably it's good for you and costs a bunch. And, you  
4 know, there's three in the sample of people. So there was  
5 limited opportunity to do anything on a service-specific  
6 basis.

7 DR. BORMAN: Please know I'm not being at all  
8 critical. This is a wonderful analysis. It's a good  
9 starting point for our thinking. It's wonderful  
10 information. A chunk of it fits my biases, so I'm with you,  
11 okay?

12 [Laughter.]

13 DR. BORMAN: At any rate, if I could ask you about  
14 one interpretive question, and it's on page 9 in here. It's  
15 the chart with the carrier spending by site of service. In  
16 most everything else, at the end as you tried to aggregate  
17 this up, in general the conclusion -- and it seemed to match  
18 up -- was that relatively minor things are where the money  
19 is, if you will, in this. That's why I'm a little surprised  
20 that inpatient versus OPD/ASC, why then is that not more  
21 different? Because the things that would be in OPD/ASC,  
22 generally speaking, will tend toward the minor versus the

1 major. And I would have thought that might have come out to  
2 more of a difference.

3 Is there something that I might be missing here  
4 why those came out so close, basically the same?

5 DR. HOGAN: I can only guess, if you want me to  
6 guess.

7 DR. BORMAN: Absolutely.

8 DR. HOGAN: Surgeon's fees is what I thought that  
9 was, that the difference in admissions wasn't large, but for  
10 the so-called elective admissions, my guess was they were  
11 elective surgeries, and you can get a substantial -- this is  
12 all Part B, you understand. You could get a substantial  
13 Part B payment for a single admission where you wouldn't for  
14 a medical admission, say.

15 DR. BORMAN: I am not following.

16 DR. HOGAN: So carrier spending is only the  
17 surgeon's fees and physician's fees, and so I thought that -  
18 - I noticed that, too: Gosh, look at all that inpatient  
19 spending. Why shouldn't that be much lower? Because the  
20 inpatient dollars were only about -- I'll call it 9- or 10-  
21 percent difference. How could there be a 32-percent  
22 difference? But I think that the inpatient admissions that

1 are excess, that are additional in the population with  
2 insurance tended to be those admissions that had a lot of  
3 Part B services associated with them, such as surgeries, as  
4 opposed to medical admissions where you see a few visits and  
5 a few test interpretations and that's it.

6 So I thought that they were probably more  
7 physician-payment-rich admissions, but I didn't test that.

8 DR. MARK MILLER: Can I ask on this one -- because  
9 this one slowed me down a little bit, too. And it may just  
10 depend on what's in that first row, because, again, you  
11 know, I'm looking for small -- you know, consistent with the  
12 whole thing, kind of small discretionary stuff, more likely  
13 to have a bigger effect.

14 So in that first row, what kind of population --  
15 because I was thinking labs, but maybe that -- and,  
16 therefore, I would have expected a large effect.

17 DR. HOGAN: Man, that's another -- I'd have to go  
18 back and look. I can clarify that.

19 MR. EBELER: Thank you, Chris. I think your  
20 mistake here is you did a little bit of research, and we  
21 want a lot more. And I do think if one went forward with a  
22 policy proposal in this area, you would need to answer all

1 the questions we're looking at. This is really a very  
2 difficult place to go. I can't tell how you adjusted for  
3 MSP, Medicare Saving Program, participants at the low-income  
4 scale.

5 DR. HOGAN: Oh, Medicaid. Yes, Medicaid is  
6 definitely out.

7 MR. EBELER: Right, Medicaid is out. But what  
8 about the MSP program?

9 DR. HOGAN: Medicare secondary payer?

10 MR. EBELER: Savings Program. The low-income  
11 beneficiaries who were above Medicaid, but still get some  
12 subsidies.

13 DR. HOGAN: Oh, I'd have to go back and check the  
14 flags to make sure that they're not in there, but I'm pretty  
15 sure that they were categorized as having public secondary  
16 coverage and would have been omitted. But I have to go  
17 check that.

18 MR. EBELER: Again, I think I'm sort of getting a  
19 sense of differential -- I get a sense of how you -- the  
20 characteristics of the two populations are different, but I  
21 think we would need to know how the impacts differ by those  
22 characteristics, again, if we would go forward. I know that

1 it's easy to list things we want.

2 I think the MA question is important. On the one  
3 hand, you don't worry about this effect in MA because the  
4 costs are internalized. But unless we were very confident  
5 that MA was really working the way it was intended to work  
6 and we were getting a good buy out of it, I think you would  
7 worry about driving people from -- if you pursued your  
8 policy idea, one, I'd be worried about driving people from  
9 fee-for-service and Medigap into MA because it's the place I  
10 can avoid cost-sharing. You know, like I say, driving them  
11 there now is not exactly driving them to a place we're  
12 getting a good buy. So I think we need to think through the  
13 MA thing.

14 I think Bob's idea is interesting, and, in fact,  
15 when CBO looked at this issue, that's the option they put on  
16 the table in their recent options book, which was  
17 interesting.

18 And, finally, when I think through the policy  
19 ideas, your page 2 strikes me as -- if one's going to go  
20 down this road, it's going to take a lot of work. It would  
21 be more beneficial to be thinking through creatively what  
22 and how cost-sharing should work right in the future rather

1 than trying to kind of backward map and figure out how to  
2 change Medigap in the short term. So it just strikes me if  
3 we're going to there, it's going to be very intensive. It  
4 seems to me this is more beneficial.

5           Again, I think that part of this is just a  
6 resource and time question for the Commission.

7           DR. SCHMIDT: Just to advertise, next month we  
8 hope to bring you something that is notionally getting  
9 towards what you were just talking about.

10           MR. BERTKO: Chris, a couple of things. First, on  
11 the VA stuff, to address the question from the last article  
12 in 2008, how clean was your removal of them? Because I know  
13 that in some cases there could be "ghosts" -- that is the  
14 phrase some people use -- in the system. Are you pretty  
15 happy with what you've removed?

16           DR. HOGAN: I was responding to a specific  
17 criticism, so whatever they did I did. I left the ghosts in  
18 knowing full well that the information is partially correct  
19 and partially imputed. And anybody who showed as having any  
20 VA service use of any sort, including drugs -- most of it  
21 was just outpatient drugs -- I tossed them. So it's a very  
22 methodologically ugly thing to do. I would never flag

1 people based on service use. It's just a dumb thing to do.  
2 But it's what I was required to do here.

3 The ghosts didn't seem to matter much. They  
4 seemed to be equally distributed across the categories, as  
5 they should be, and so I just left them in.

6 And there were a lot of things -- when you said  
7 MSP, I thought you were saying Medicare secondary payer. I  
8 checked those, and they were equally distributed. I put  
9 those in. Urban-rural was equally distributed. So there  
10 were a lot of things that I looked at and didn't bother with  
11 because there was enough to mess with. But I didn't think  
12 it made much difference.

13 The VA beneficiaries were concentrated in the  
14 population that has no secondary insurance per Medicare's --  
15 the way they measure it. But they weren't so different in  
16 their spending as to make a huge difference, in other words.

17 MR. BERTKO: Good. I've nagged Rachel probably  
18 for two years to see this study, so I'm glad it came out the  
19 way that I thought it was.

20 The second part was I just wanted to double check.  
21 The 14 percent that you cited is on \$460 billion, so it's  
22 \$60 billion?

1 DR. HOGAN: A and B, and eventually it would  
2 trickle down to C, I guess, so it would be A, B, and C.

3 MR. BERTKO: But it's a big number, \$50, \$60  
4 billion.

5 DR. HOGAN: Yes. In this day and age, it's tough  
6 to say what a big number is, but yes.

7 [Laughter.]

8 MR. BERTKO: You got me. I set you up.

9 Okay. The last one is the co-pay effect that you  
10 alluded to. My actuarial experience has been that going  
11 from zero co-pays such as Medigap to anything is the biggest  
12 effect, and then it's non-linear after that. What comments  
13 do you have on that?

14 DR. HOGAN: That's my impression. I have nothing  
15 to judge that by.

16 MS. BEHROOZI: This is partly because Nancy didn't  
17 ask you to slow down soon enough, so I just am going to ask  
18 you to just -- when you talk about adjusting for  
19 demographics, health status, income, and education, what  
20 does that mean in the context of your observation that the  
21 group without secondary coverage is more likely to be low  
22 income and non-white and, you know, other --

1           DR. HOGAN: Technically, I'm running a regression,  
2 and so I've got both the insurance coverage and flags for  
3 all of these other variables in the regression. In the  
4 right-hand side of the regression is some sort of spending,  
5 and that is it. Anything that I could -- it is a kitchen  
6 sink regression. Anything I could scrape off the MCBS that  
7 looked like it was relevant got thrown in. Most of those  
8 are nuisance parameters, but interestingly enough, if you  
9 want to read the full regression results, the numbers all  
10 looked -- educated people spend more, rich people spend  
11 more. It all sort of worked out right when you see the full  
12 regression results. It all matched my preconceived notions,  
13 anyway.

14           So you are limited, so you have got a few flags  
15 for the level of education, you've got a few flags for the  
16 income. But it's kind of -- I don't want to sound like, you  
17 know, they did it, too. But it's what everybody else would  
18 do with the MCBS is what I did. And the results seemed to  
19 line up well.

20           MS. BEHROOZI: My question, I guess, is not so  
21 much the technical one, but then what the impact of your  
22 observation that the people without the coverage tend to be

1 lower income and non-white in particular, and they're not  
2 people with Medicaid. You know, they're not the people whom  
3 we always can easily classify as low income. They're the  
4 working poor, as you say.]

5           To what degree can you estimate differences in  
6 income having differential impact on what people will spend  
7 if they have to pay out of pocket? And let me say it the  
8 other way. Your 14 percent assumes that a rich person will  
9 be as deterred from spending the \$10 to see the doctor as  
10 the person who makes \$20,000 a year, which makes them  
11 ineligible for any public subsidy, but it means a lot more  
12 to them than somebody, you know, making half a million  
13 dollars.

14           DR. HOGAN: That's a good -- I'm going to give you  
15 two short answers. The one short answer is half. All of  
16 that other stuff explained half the difference in spending,  
17 and what was left was what I assumed was insurance.

18           But your point is well taken in a technical sense,  
19 that my back-of-the-envelope really is a back-of-the-  
20 envelope, and I should have -- I have to think about whether  
21 I can do this or not -- stratified it in some way to get a  
22 tighter bound on that 14 percent. I don't think it would

1 make a huge difference, but I should go look. I didn't  
2 actually estimate -- I didn't say, for example, except for  
3 rich and poor, I didn't estimate different effects by  
4 category of beneficiaries. There's nothing really for me to  
5 get a handle on with that. But the point is well taken,  
6 that if the effects really were substantially different  
7 between rich and poor and everybody else is rich, then if I  
8 knock the co-insurance off, if they have to pay the co-  
9 insurance, it makes such a big difference. In fact, what I  
10 found with the rich and poor analysis that's in the paper is  
11 that they all seemed to have roughly the same elasticity. A  
12 little bit more of an impact on the poor, but not hugely so.  
13 But I get the point. I'm not sure I'm going to do the work  
14 to fix the point, but I get the point.

15 MS. BEHROOZI: I really feel like it's accepted as  
16 such a truism that behavior is affected equally by payment  
17 of dollars. and there's no examination of what that dollar  
18 represents in relation to that person's income status. And  
19 I think, you know, you made the statement, Chris, that it  
20 would be inequitable to charge high co-payments for people  
21 who are sick when they really need to access care.  
22 Similarly, it's inequitable and probably inefficient in the

1 broader sense to charge high co-payments for people to whom  
2 it means more to have to pay that \$10, and then they end up  
3 avoiding necessary care, and then it's a very slight impact  
4 on emergency admissions, but maybe you see more of that as  
5 more low-income people end up not having -- or, you know,  
6 working-poor people end up having no way to cover that cost-  
7 sharing.

8 DR. HOGAN: I like to characterize the Medicare  
9 secondary insurance market as those who need it don't have  
10 it and those who have it don't need it.

11 DR. CROSSON: I hate to ask this but which round  
12 are we in?

13 MR. HACKBARTH: Round one and a half.

14 DR. CROSSON: I'll give you a one-and-a-half  
15 question or observation then.

16 MR. HACKBARTH: Consider this the last round.

17 DR. CROSSON: As I look at this and back away from  
18 it a bit, it just sort of, you know, screams at me and says  
19 what is needed here is something that people are calling  
20 value-based benefit design. So, for example, somehow adding  
21 co-payments or exempting or excepting from supplemental  
22 coverage the co-payments for imaging procedures and some

1 other group of things in exchange, for example, for -- on  
2 the other hand, exempting from the donut hole in Part D  
3 coverage for drugs for diabetes, for asthma, for  
4 hypertension, et cetera, et cetera. So that's the rational  
5 thing.

6 I guess to make it sound more like a part one  
7 question, I will turn to Rachel and say are we -- when you  
8 said we were going to do something next month, is it  
9 anything like that?

10 DR. SCHMIDT: Yes, we will have a discussion along  
11 those lines. We've been working on a draft paper -- and  
12 we'll see where it goes -- that kind of incorporates some of  
13 the material that we've already talked about last year on  
14 some of the problems with the current fee-for-service  
15 benefit design and some of the inequities that are resulting  
16 from it. And we'll include some of the material that Chris  
17 has just presented to you, as well as some discussion of  
18 given his results, what are the implications for future  
19 policies towards, you know, an ideal world of co-pays or  
20 restructured cost-sharing.

21 MR. HACKBARTH: I just want to chime in on this.  
22 This has come up in several different ways. I think it

1 would be very hard, both from a political and a policy sense  
2 to sell the idea of what we want to do is get the existing  
3 Medicare cost-sharing structure to have effect, because it's  
4 so crazy. And what our policy is is to prohibit  
5 supplemental coverage or tax it to reduce it so that we  
6 could have this cost-sharing structure have its effect.  
7 That is not a proposition that I'd want to argue for.

8           And so still enormously difficult from a policy  
9 and political perspective would be to argue for, well, let's  
10 redesign it using value-based benefit design, but make sure  
11 there's still some -- that's plenty difficult, but to try to  
12 reveal the existing cost structure and say this is the way  
13 the world ought to work, that's not a sale that I think I  
14 want to be part of.

15           DR. CROSSON: So are you saying that you don't  
16 think there's any avenue here from a political perspective  
17 we could pursue?

18           MR. HACKBARTH: No, I'm being definitive about one  
19 avenue. Let's not just try to prohibit supplemental  
20 coverage so the existing cost-sharing comes into effect. Or  
21 sort of a milder version of that is, well, let's tax  
22 supplemental coverage so fewer people will buy it, and that

1 will reveal the existing cost-sharing structure.

2 MR. EBELER: So you're differentiating between one  
3 and two, basically, saying the direction

4 MR. HACKBARTH: So if you were going to do it,  
5 you'd have to do the much more thorough redesign using  
6 value-based principles and others to try to come up with  
7 something more sensible. I don't think there's a fast track  
8 on this.

9 DR. SCANLON: In one slide, the whole idea of an  
10 annual limit -- I mean, and there is this huge gift or  
11 benefit that you're giving people when you do put in a  
12 catastrophic limit into Medicare which is missing now. And  
13 the question is can you politically say there should be a  
14 trade-off for that, because that's -- Medicare is bad  
15 insurance, and so the question would be: Are we making  
16 Medicare better? But, you know, we've got to restructure  
17 the entire sort of cost-sharing side to do that.

18 MR. HACKBARTH: Right. And as a basic principle  
19 in insurance design, I certainly believe that that would be  
20 a good trade. But, again, the trade I wouldn't make is,  
21 well, let's do catastrophic coverage and then keep the  
22 existing structure of cost-sharing in place. I'd say let's

1 do a real trade and say, you know, this is the amount of  
2 money we have to spend, let's design it so that it's more  
3 likely to have, A, the quality effects that we want and, B,  
4 equitable effects in terms of low-income people and other  
5 things.

6 DR. CHERNEW: First of all, I think it was two  
7 years ago when Mark and I testified about value-based  
8 insurance design when we came here, something like that, so  
9 I can't tell you how -- first of all, I'm thrilled to talk  
10 about the demand side stuff. I'm even more thrilled that  
11 someone before me mentioned value-based insurance design. I  
12 want to say two things about that.

13 The first thing is it's not clear that all of the  
14 low-value care is this sort of very cheap thing. There  
15 could be a lot of people with very expensive care where  
16 there's a lot of waste. I won't name any clinical areas  
17 here. But I do think it requires more thorough thought as  
18 to how to design this, and I do think that no matter what --  
19 either we go to some broad payment-oriented approach or we  
20 try and capitate or do something else and let people ration  
21 one way, or -- say either/or, or we incorporate demand  
22 mechanisms more, and I think in either case one of the

1 themes of today is some more clinical nuance throughout the  
2 system, be it in payment or co-pay cost-sharing, is really  
3 valuable. And having a system move that way and having  
4 MedPAC say that we need more sophisticated clinical nuance  
5 to get the value we want I think is a wonderful statement.

6           The question I had was really mundane compared to  
7 that wonderful thought, which is, Did you control for  
8 geographic region? I'm a little worried that you have  
9 people without coverage, say, in the South -- there's a lot  
10 of variation geographically in use, and my guess is there's  
11 a lot of variation in supplemental coverage, geographic  
12 variation in supplemental coverage. So in all of these  
13 cross-sectional design things, I know you've controlled for  
14 a ton of individual beneficiary stuff, and I think you  
15 controlled for urban-rural. But sometimes if you had people  
16 in the -- the stereotypical critique would be people in the  
17 South don't have supplemental coverage and the South is just  
18 cheaper, and so you find people without supplemental  
19 coverage spent a lot less. I don't know if that is  
20 controlled for that.

21           DR. HOGAN: It's not controlled for it, but I  
22 looked and there really weren't even urban-rural

1 differences. So as far as I could tell, they were pretty  
2 homogeneously placed across the country, but I can certainly  
3 put in dummies for some level --

4 DR. CHERNEW: Historically, that was the case. It  
5 might not be the case now.

6 DR. HOGAN: The MCBS is a poor design for trying  
7 to look at regional variation in secondary insurance  
8 coverage because it's so clustered. There's only about a  
9 hundred cities. I think that's right. So it's real hit or  
10 miss as to who you've got in there. So it's not clear that  
11 anything will show up -- it's not clear that any expected  
12 geographic pattern will show up, but it's certainly not hard  
13 to reconfigure that to put in dummies for regional.

14 DR. KANE: I'm assuming there was no Part D in  
15 here to -- I'm just wondering if this same population had  
16 differential behavior with Part D only because Part D does  
17 have one place where they all have to experience the same  
18 donut hole and --

19 DR. HOGAN: It didn't exist.

20 DR. KANE: I'm sure it didn't exist, but is there  
21 any way that there could be --

22 DR. HOGAN: It literally didn't exist.

1 DR. KANE: I mean, it didn't exist in that era.

2 DR. HOGAN: Right, right, so I couldn't --

3 DR. KANE: So the other way to think about it  
4 might be, well, what are we finding now about Part D? Is  
5 there a way to take the lessons of how behavior  
6 differentiates by income, education, and even whether or not  
7 -- I don't know if we can link that to whether they have  
8 supplemental coverage or not, but what can we learn from  
9 Part D about how people might behave if they're more at risk  
10 for their drug coverage? Is there any way we can take  
11 those, what we've learned about Part D, even though it's  
12 different years, different people, and apply it to this?

13 DR. SCHMIDT: I think we are still in the early  
14 stages of doing some of our claims work. We have 2006 and  
15 2007 drug claims information from Part D, and we hope to  
16 have some first cuts to look at that data, even by things  
17 like some elements of benefit design, a little later in the  
18 year. And it will take a little more doing beyond that.  
19 We're still trying to figure out how to maneuver some of  
20 these enormous files to get in some of the variables that  
21 you are most interested in.

22 But we are very interested in looking at those

1 questions, and we'll continue to try and work on them.

2 DR. CHERNEW: Part D has some, I think, offset  
3 effects on A and B. Bruce published a paper on the topic, I  
4 think it was on length of stay and health services research.  
5 We actually are working on a paper now in Part D. We find  
6 that at least in some clinical areas you find fewer  
7 hospitalizations in places where people gained more Part D  
8 coverage. But getting the actual Part D data is hard to  
9 get, and the data is not that recent, per earlier comments.

10 But I do think you would find the best evidence  
11 which suggests you would actually get some savings from  
12 better Part D coverage in selected populations. It wouldn't  
13 fully offset the extra drug spend, but it would offset some  
14 of the extra drug spend.

15 MR. HACKBARTH: I think we're done. Thank you,  
16 Chris.

17 We'll now have our public comment session.

18 MR. COBURN: I'm Ken Coburn --

19 MR. HACKBARTH: Before you start, let me just  
20 remind you of the ground rules. Please limit your comments  
21 to no more than a couple minutes and start by identifying  
22 yourself, as you were. If the light comes back on, it means

1 your time is up.

2 MR. COBURN: Thank you. Hi, I'm Ken Coburn. I'm  
3 the Medical Director and CEO of Health Quality Partners.  
4 We're a not-for-profit health care quality research and  
5 development organization. We are one of the two extended  
6 demonstration projects in the MCCD demo, and we're also one  
7 of the sites participating in the MCCPRN.

8 I just wanted to offer two brief clarifying  
9 comments relative to that, and I want to thank John  
10 Richardson, the staff, and the Commissioners for considering  
11 that, and seeing the opportunity to try to accelerate our  
12 R&D work with chronic care in Medicare.

13 Although my side is still participating in the  
14 ongoing MCCD, we see a huge need and opportunity to  
15 accelerate some of the research around chronic care in  
16 Medicare, and the two brief points I want to make are:

17 One issue was raised around why this self-selected  
18 starter group, which I think is a totally valid and  
19 important question. We've spent the last year with  
20 appropriation monies from Congress to do the pre-planning  
21 required to get a uniform intervention that can be  
22 implemented across multiple sites in ways that can be

1 readily adapted to those sites, and we have one more year of  
2 appropriation that we're working with Mathematica Policy  
3 Research and CMS to do that preparation work, the idea being  
4 that on day one of the launch of this, instead of the long  
5 lead time that you all referenced, we would be able to  
6 launch a uniform intervention, best practice model design  
7 across multiple sites and cut off that lead time.

8           The ability to change the membership of this  
9 network is envisioned. It is envisioned in the draft  
10 legislation we are proposing. The Secretary can remove  
11 sites for lack of performance. They can add sites to  
12 augment if they're missing sites that should be  
13 participating and could productively add to that. So I  
14 wanted to clarify that. The starter set is because we're  
15 doing two years of preparation work to be able to have a  
16 model to go out of the block.

17           The other point that I just wanted to make a quick  
18 comment on was in terms of the evaluation, internal-  
19 external. We envision both types of evaluation -- internal  
20 to get accomplished what many of you referenced as that  
21 rapid cycle change, so as data becomes available and changes  
22 in the model can productively be made and studied, that that

1 happens. But we also envision an external third-party  
2 evaluator to look at the long-term outcomes in terms of cost  
3 and quality so that that can be from a policy decision, not  
4 the cake bakers judging their own quality of the cake, but  
5 to have that external evaluation as well.

6 So I just wanted to clarify those in case those  
7 points failed to come across. Thank you.

8 MR. COHEN: Hi, I'm Rob Cohen from Excel Health.  
9 Earlier there was a question about risk adjustment during  
10 the MA discussion, and I just had a two-part follow-up  
11 question or comment.

12 One is, Do we have reason to believe that risk  
13 adjustment overpredicts costs for low-risk persons and  
14 underpredicts costs for high-risk persons? And if so, could  
15 there be substantial policy implications? For example,  
16 could the trust fund lose more dollars if plans  
17 disproportionately enroll healthy beneficiaries similar to  
18 that the trust fund could lose more money if plans  
19 disproportionately enroll beneficiaries in areas with high  
20 fee-for-service payments? So could the trust fund -- and  
21 then the end of that is: Could that also provide a  
22 disincentive to enroll the chronically ill and focus on

1 managing care, if, in fact, there is a bias in risk  
2 adjustment to overpay the healthy and underpay the  
3 chronically ill?

4 Thanks.

5 MR. DRUMMER: Good afternoon. My name is Robert  
6 Drummer. I represent the Promotional Products Association  
7 International out of Irving, Texas. My comments and  
8 questions today aren't necessarily related to your agenda  
9 today, more so to the report you recently released to  
10 Congress, specifically on one of your recommendations  
11 regarding the physicians payment issue and Senator  
12 Grassley's sunshine legislation.

13 Compared to last year's legislation, this year's  
14 legislation and your recommendations supported a \$100 annual  
15 aggregate threshold for doctors and hospitals to report  
16 receipt of gifts and other items of transfer of value. And  
17 we're not sure what, if any, metrics or data or articles you  
18 utilized to come up with that number, that annual aggregate  
19 number, as opposed to at least last year's legislation  
20 provided for \$25 per item de minimis.

21 I have, for example, an ink pen today -- I'm not  
22 sure who made, but it has a logo on it. It's by AFLAC.

1   Essentially, the companies that I represent are companies  
2   that produce these types of items really more so for  
3   advertisements, but not as a "gift." It's not like this is  
4   a Mont Blanc pen. But, nonetheless, those small businesses  
5   that provide these type of logo'd items, whether ink pens or  
6   coffee mugs, feel they'd potentially be adversely affected  
7   by the impact of companies having to make a decision about  
8   whether to go through the administrative burdens of  
9   recordkeeping of all the items that they provide to a doctor  
10   or a hospital in order to keep track and then actually  
11   report once they've reached that \$100 annual threshold. So  
12   that is part of my comment.

13           My question, back to the Commission, is whether  
14   staff or the Commission took into account what is, I guess,  
15   the point of either a de minimis value and/or an aggregate  
16   to determine what would potentially create a conflict of  
17   interest for physicians subject to the intent of the  
18   legislation by Senator Grassley.

19           MR. HACKBARTH: Okay, just for your information,  
20   if you have questions that you want to discuss, the way to  
21   do that is with the staff. They go to great lengths to  
22   receive input from people and respond to questions. We

1 don't do that in this session.

2           Okay. We are adjourned for today. Let me remind  
3 Commissioners what time we start tomorrow: 8 o'clock in the  
4 morning.

5           [Whereupon, at 5:29 p.m., the meeting was  
6 recessed, to reconvene at 8:00 a.m. on Friday, March 13,  
7 2009.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, March 13, 2009  
8:00 a.m.

COMMISSIONERS PRESENT:

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

## AGENDA

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Medical education in the U.S. -- Is it supporting  
needed delivery system reforms?

-- Cristina Boccuti, Craig Lisk

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

2 MR. HACKBARTH: Okay, first up this morning is  
3 medical education.

4 MR. LISK: Good morning. I hope everybody has had  
5 their coffee and tea to get themselves going this morning.  
6 This is our first session since we had a panel back in  
7 October on whether we are training physicians for health  
8 care delivery in the 21st century, and were planning on  
9 having some more sessions in the future and from today.

10 Today, I'm going to start by reviewing some  
11 background information on Medicare support for the process  
12 of becoming a physician and the organization of accrediting  
13 agencies and Medicare subsidy for this.

14 Cristina is then going to discuss findings from a  
15 new study by RAND which MedPAC funded on curricula and  
16 residency programs with a focus on skills needed for  
17 delivery system reform. We will then turn to a discussion  
18 of the disincentives that are in place for non-hospital  
19 experiences during residency and finish with a discussion of  
20 future work topics on this issue.

21 Medicare provides substantial support for graduate  
22 medical education. Over 1,100 hospitals receive Medicare

1 payments in support of GME for approximately 90,000  
2 residents and fellows. Support to hospitals comes from two  
3 payments: Direct graduate medical education payments are  
4 payments made to hospitals for costs associated with running  
5 a residency program such as the salary and benefit costs of  
6 residents, faculty supervisory cost, and program overhead  
7 expenses. Medicare payment for these expenses totaled \$2.9  
8 billion in 2007.

9           The indirect medical education adjustment is a  
10 payment to hospitals for higher patient care costs  
11 associated with being a teaching hospital, such as residents  
12 learning by doing and unmeasured differences in patient  
13 severity. The adjustment is made to inpatient payment rates  
14 and is currently set more than twice the higher patient  
15 care cost associated with teaching activity. These payments  
16 totaled \$6 billion in 2007.

17           Combined, each FTE resident recognized by Medicare  
18 provides hospitals with roughly \$100,000 in revenues from  
19 the program, essentially covering what we might label as the  
20 full direct cost of the residence, Medicare itself funding  
21 that. These funds, however, are fungible and may be used  
22 for other activities other than residency training.

1           At the October meeting in our introduction, we  
2 showed you this graphic on the path to becoming a physician,  
3 which we also discuss in more detail in your briefing  
4 materials. What we focused on in just a little bit is on  
5 the left side on the accreditation process, but if you have  
6 questions on the processes involved, we'd be happy to answer  
7 them at the end of the presentation.

8           The medical education complex in this country is  
9 large. There are over 150 accredited allopathic and  
10 osteopathic medical schools with -- training about 86,000  
11 students, medical students, with about 21,800 first-year  
12 students. There are new medical schools that are opening  
13 and class sizes are growing, so these numbers will be  
14 increasing.

15           Moving on to graduate medical education, there are  
16 over 9,000 ACGME or AOA approved residency training programs  
17 training about 110,000 residents and fellows in this  
18 country. While the vast majority of residents receive their  
19 training in US or Canadian medical schools -- their  
20 undergraduate medical training in US or Canadian medical  
21 schools -- over a quarter are international medical school  
22 graduates, graduates of medical schools outside the United

1 States or Canada. There are over 25,000 residents each year  
2 starting residency programs for the first time.

3 The accreditation of medical schools, graduate  
4 medical education programs, medical licensure specialty  
5 certification, and continuing medical education are handled  
6 by different organizations listed on this slide. As you may  
7 remember, Tom Nasca, from the ACGME, he was responsible for  
8 accrediting graduate medical education programs, was one of  
9 the participants on our panel back in October.

10 So, here we have a slide that shows the different  
11 things that need to be accredited in different accrediting  
12 bodies involving the accreditation and certifying process  
13 along the way to becoming a physician. Within each of these  
14 accrediting bodies are representatives from a number of  
15 other organizations involved in the education process such  
16 as the AAMC, which represents teaching hospitals and medical  
17 schools, and the American Medical Association who are  
18 represented in several of these accrediting bodies, the ones  
19 for medical schools, GME, and continuing medical education,  
20 for example.

21 There's been some cross-fertilization in terms of  
22 the groups, as ACGME and ABIM have worked in a complimentary

1 fashion integrating the core competencies into the  
2 accreditation and certification process. And if you  
3 remember, Dr. Nasca talked about those core competencies  
4 back in October, and we have some discussion of those in the  
5 paper.

6 Dr. Wickham, as you may recall from our October  
7 meeting stated that, with so many players, it makes it  
8 difficult to achieve consensus around system changes or  
9 reform and suggested there might be a role for an  
10 independent body here.

11 So, what does it take to have an accredited  
12 residency training program? Well, first, both the  
13 institutions sponsoring the training and the program itself  
14 need to be accredited. Site visits are performed every two  
15 to five years, and programs must meet the individual  
16 requirements of the residency review committees for  
17 individual specialties with movement to a competency-based  
18 education and outcomes-based education, which Dr. Nasca  
19 discussed at the October meeting.

20 Programs much show how residents have achieved  
21 competency-based education objectives and must also show how  
22 programs are using this information to improve the

1 educational experience of residents.

2 RRC members then review the site visit reports,  
3 then vote on the appropriate accreditation action, which  
4 would include the length of time until the next review.

5 With that, Cristina will talk about delivery  
6 system reform and other topics.

7 MS. BOCCUTI: So, in recent years MedPAC has  
8 recommended several changes to reform the delivery system to  
9 focus on beneficiaries, improve quality, and control  
10 spending. Several are listed on the slide up at the top but  
11 I'm not going to go through them, you've been talking about  
12 them for a couple of years.

13 I will mention that, for delivery system reform to  
14 work, it's crucial for medical education to equip students  
15 with the skills that they're going to need to deliver care  
16 under these new payment policies.

17 Medicare, as a major payer of medical education  
18 and healthcare, has an enormous stake at ensuring that  
19 physicians and healthcare professionals are adequately  
20 trained to provide efficient, coordinated, and high-quality  
21 care. Although accrediting agencies have instituted  
22 standards like Craig mentioned, Medicare has not played a

1 role in fostering goals and objectives in medical education  
2 curricula.

3           Many of you have asked or commented on the  
4 curricula and residency training programs, so we contracted  
5 with RAND researchers to conduct a very interesting study  
6 that I'm going to talk about for the next several slides.  
7 The study consisted of semi-structured interviews with  
8 directors of internal medicine residency programs. All were  
9 conducted by RAND's principal investigator who is a board  
10 certified internal medicine physician. Programs were  
11 selected randomly from a representative sampling frame. We  
12 examined several specific curricular duties within the broad  
13 topics that I listed there on the bottom of the slide, and  
14 we selected these topics for the relevance to delivery  
15 system reform. In brief, the main findings from the study  
16 are that, although most residency programs provide some  
17 training in these areas, there is tremendous variation and  
18 in general curriculum falls far short from that recommended  
19 by experts.

20           The first area we examined here is quality. The  
21 IOM states that physicians must be able to assess the  
22 quality of care they provide and implement changes in their

1 practice for improvement. This process is often referred to  
2 as practice-based learning.

3           The RAND researchers found that while most  
4 residency programs receive some exposure to quality  
5 assurance and system change, only a small share require  
6 residents to complete their own data analysis and data  
7 collection and resulting system change. This is important  
8 because delivery reforms to improve quality such as P4P  
9 demand that physicians really understand the underlying  
10 elements of quality improvement. Evidence-based medicine,  
11 as a tool for practiced improvement and comparative  
12 effectiveness initiatives appeared to be taught more  
13 consistently in residency programs through formal training,  
14 formal sessions and journal clubs.

15           While most programs reported teaching their  
16 residents to use clinical prediction tools such as a  
17 pneumonia severity index, only about a third have IT to  
18 support these tools in clinical practice.

19           Individual physicians work within a complex  
20 arrangement of health care delivery in the US. This  
21 complexity has led to fragmentation in care which has likely  
22 contributed to many hospitalizations for chronic conditions.

1 So, to counter this trend and unsustainable growth in  
2 spending, experts have introduced system-based practice.  
3 This calls for a better understanding of the components and  
4 costs of health care to improve coordination, spending, and  
5 safety. Several of the delivery system reforms that the  
6 Commission has discussed such as medical homes, bundling,  
7 they require providers to have these skills to succeed in  
8 those reforms.

9           RAND researchers found that formal training on  
10 many aspects of care coordination is limited or nonexistent,  
11 particularly in the outpatient setting. For the inpatient  
12 setting, many program directors stated that they have  
13 specific instructions on communicating patient status to  
14 other physicians when they're handing off a patient.  
15 However, less than half have formal instruction on hospital  
16 discharge.

17           This is concerning given the importance of this  
18 has on avoiding expensive readmissions, another area of  
19 recent interest for MedPAC.

20           We found further concerns on the topic of formal  
21 multidisciplinary training. About one-quarter do not have  
22 any formal experience in multidisciplinary teamwork with

1 other health professionals, but rather report that training  
2 on this topic is more informal. Less than a third reported  
3 formal multidisciplinary experiences in the outpatient  
4 setting.

5           Moving on to costs, only about one-quarter had  
6 formal methods for teaching about absolute and relative  
7 costs of diagnostic tests, treatments, and medications.  
8 Among those that did, they seemed to focus on inpatient  
9 costs such as hospital service costs, billing, coding, that  
10 sort of thing. Programs were similarly unlikely to instruct  
11 residents about patient share of medical charges. Among  
12 those that did it was typically during ambulatory  
13 experiences such as in a clinic that uses a sliding scale.

14           On to safety, all programs included some formal  
15 instruction in patient safety issues, for example,  
16 prevention of falls and proper patient identification in the  
17 hospital. However, only about a quarter teach basic safety  
18 design principles as recommended by the IOM. Safety design  
19 principles would be, say, a standardization methodology for  
20 implementing changes.

21           We know from published research that the quality  
22 of communication between patients and their physicians can

1 influence a patient's health outcomes. Thus, to maximize  
2 healthcare effectiveness, it's essential for physicians to  
3 communicate collaboratively with patients, their families,  
4 and other health professionals to determine appropriate  
5 diagnostic treatment and other regimens. The RAND  
6 researchers found that while half covered communication  
7 skills between healthcare providers, more included formal  
8 instruction on how to communicate clearly with patients  
9 about diagnosis and treatment plans. However, when looking  
10 at specific instructional activities, we find that formal  
11 teaching on how to engage in patients in their health care  
12 was rare. This is concerning because it's an integral part  
13 of improving patients' health, yet less than half of the  
14 programs formally trained residents how to counsel patients  
15 on regimen adherence and behavior change.

16           With respect to instruction on communication in  
17 special circumstances, there was somewhat better news. For  
18 example most, but not all, programs reported that residents  
19 received formal instruction on how to communicate  
20 end-of-life issues such as advance directives and most  
21 programs indicated that they have at least one session on  
22 cultural competency.

1           In a previous MedPAC report, we've discussed the  
2 importance of using HIT to improve the quality, safety, and  
3 efficiency of health care. The RAND researchers found that  
4 although all programs provide residents with some exposure  
5 to electronic medical records, in most cases the electronic  
6 medical records is not comprehensive but rather it's more  
7 partial. Some programs reported that none of their  
8 residents had experience with electronic medical records in  
9 the outpatient setting.

10           Lacking components of Health IT include computer  
11 order entry which allows physicians to write orders  
12 electronically for things like patient treatments and  
13 clinical decision support tools were also missing in these  
14 HIT systems, and less than half had experience using HIT  
15 from outpatient coordination functions.

16           Because most health care is provided in settings  
17 other than acute care hospitals, it's essential that  
18 residents gain experience in a variety of settings. The  
19 program directors stated clearly that residents have minimal  
20 training outside of the hospital. So even though most, but  
21 not all, programs include clinic or private practice  
22 experiences, this experience only accounts for a small

1 portion of their total residencies.

2 About half of the programs have their residents  
3 perform home visits and many require experience in a nursing  
4 home or a rehab facility. Many directors reported that  
5 managed-care patients were only a small share of the  
6 patients caseload in the outpatient setting. No directors  
7 reported that their residents have experience in designated  
8 medical homes; however, several directors indicated that  
9 their clinics have many of the features of one.

10 So, hold this thought about non-hospital setting.  
11 I'm going to get back to it in a minute but I want to  
12 complete the findings from the study.

13 RAND researchers reported that, in their  
14 interviews, residency program directors reported multiple  
15 positive and negative factors affecting their ability to  
16 train on the topics that we selected. The presence of IT  
17 was the most often cited resource for facilitating these  
18 topics. Conversely, the absence of IT was the most often  
19 cited barrier. Also, faculty quality and time were also  
20 factors.

21 Which brings me to the next bullet on  
22 institutional support. Residency programs are not always

1 able to compete with their sponsoring hospital on decisions  
2 about faculty hiring and faculty time. Also, Health IT  
3 exposure falls under the category of institutional support.

4 I should also mention that directors viewed  
5 program accreditation requirements as being crucial for  
6 obtaining institutional support for their curricular needs.

7 Directors noted that program locations and  
8 hospital types also provided opportunities and barriers.  
9 So, for example, some programs serve a diverse patient  
10 population but others do not.

11 Program directors also cited the level of  
12 residents incoming knowledge from medical schools as a  
13 factor in program strength, and they also noted a lack of  
14 inherent resident interest in topics, such as care  
15 coordination, is also a barrier, particularly when they're  
16 not a focus of Board certification exams.

17 Finally, program directors reported a dearth of  
18 information on the best educational methods for teaching  
19 residents of these kinds of topics.

20 So, just to summarize, from these interviews the  
21 RAND researchers reported that although most programs  
22 provide instruction on these topics, overall, the curricula

1 falls far short from that recommended by experts such as  
2 those on IOM reports. Of particular concern is the lack of  
3 formal training or enough experience in outpatient care  
4 coordination, multidisciplinary teamwork, awareness of  
5 health care costs, comprehensive Health IT, and patient care  
6 in non-hospital settings.

7           Specific topics that appeared to be covered more  
8 consistently in residency programs were evidence-based  
9 medicine and communicating with patients about end-of-life  
10 care. As I just mentioned, program directors reported  
11 multiple positive and negative factors that contribute to  
12 the circumstances.

13           So, now I'm going to get back to the issue of the  
14 limited time that residents spend in non-hospital settings.  
15 As Craig described, Medicare makes GME and IME patient  
16 payments only to teaching hospitals for medical education  
17 subsidies and residency programs are largely based in acute  
18 care teaching hospitals or medical schools that are tightly  
19 affiliated with teaching hospitals. Accordingly, residents  
20 spend most of their time involved with inpatient care, yet  
21 most of the medical conditions that practicing physicians  
22 confront are, and should be, managed in non-hospital

1 settings such as physician offices and nursing home  
2 facilities and patient homes. This misalignment of training  
3 highlights the need to examine the strong financial  
4 incentives that teaching hospitals face for keeping  
5 residency training in-house.

6           This slide reviews four such financial incentives.  
7 The first is a long-standing issue. Residents provide  
8 valuable services in the hospital, particularly on-call  
9 duties that may include writing timely prescription orders  
10 and conducting patient admissions. Letting residents train  
11 outside the hospital may mean hiring or contracting for  
12 other higher-wage staff to provide these activities. A  
13 second issue is that hospitals lose their direct GME payment  
14 proportional to the time that residents spend off-site in  
15 educational non-patient care activities. This regulation  
16 sounds a little tricky, so I'm going to explain it a little  
17 further.

18           Medicare pays for residents when they are  
19 conducting hands-on patient care, regardless of the setting,  
20 but outside of the hospital Medicare does not pay for the  
21 direct GME component for didactic or non-patient care  
22 activities. For example, Medicare does not count the time a

1 resident spends in an instructional meeting with an  
2 attending unless the meeting occurs within the teaching  
3 hospital's campus. A third barrier to outside placements is  
4 that hospitals lose both their direct GME and IME payments  
5 for time residents spend in settings that do not have a  
6 specified affiliation agreement. So, if a resident spent  
7 half their time in, say, a group practice that did not have  
8 this specific agreement, then the teaching hospital would  
9 only receive payments for half of that residency position.

10           So, what holds up such an agreement? Well, it's  
11 the regulatory requirement that teaching hospitals pay the  
12 outside setting for supervising the resident. It turns out  
13 that office-based physicians often prefer to volunteer their  
14 time rather than be paid by the teaching hospital. I know  
15 that sounds odd, it sounded odd to me, too, but I'll this  
16 further. First, these non-affiliated physicians want to  
17 avoid the paperwork involved with fulfilling that specific  
18 regulation. Also, they enjoy mentoring new physicians and  
19 view it as a professional responsibility. They may also see  
20 it as an opportunity to gain stature by being listed as an  
21 adjunct faculty with the medical school. And in addition  
22 they do, depending on the skills of the resident --

1 non-hospital sites could also gain in some clinical  
2 productivity from residents' care.

3           And finally, for the fourth bullet, to enforce  
4 these policies, teaching hospitals must track all of their  
5 residents' hours at various sites and submit logs of these  
6 to Medicare, which then can be audited. So the opportunity  
7 of this time creates another financial incentive to keep  
8 residents in-house.

9           This presentation has given some background  
10 information on two particular issues in medical education,  
11 curricula and non-hospital training. In forthcoming  
12 reports, you might consider further discussion on policy  
13 changes for these issues, such as ways to establish  
14 requirements or incentives for enhancing particular  
15 curricula and technology in the medical education continuum  
16 and mechanisms for ensuring more residency training in  
17 non-hospital settings.

18           So, to help you or think about and discuss these  
19 issues, we've put up that this slide just to illustrate that  
20 policy options can affect the components of Medicare's  
21 medical education subsidies differently. The top yellow  
22 boxes together represent total IME payments. The bottom

1 blue box represents direct GME payments. The top right  
2 extra box is not empirically derived, as Craig and other  
3 colleagues have discussed in prior meetings.

4 As you know, MedPAC has recommended that a portion  
5 of the IME funds for the extra bucks be used for P4P  
6 initiatives in hospitals. Medical education policies that  
7 you discuss today and in future meetings could also come  
8 from this box or such policies could affect how the funds in  
9 the left-hand boxes are used or distributed.

10 So, with that in mind, here are some more policy  
11 issues for further discussion. I'll give a brief sentence  
12 or two about each, but as you'll see, many could be the  
13 subject of an entire session or chapter, but we thought it  
14 would be useful as a starting place.

15 The first would involve linking Medicare's medical  
16 education subsidies to specific delivery reforms. So for  
17 example, hospitals that accepted bundling and readmission  
18 policies could see perhaps more favorable medical education  
19 payments.

20 Then, for the second bullet -- keeping in mind  
21 that Medicare is the largest contributor to medical  
22 education -- some have formed all payer proposals, and these

1 would explicitly require that other payers join in  
2 Medicare's support.

3 Third, given the interrelatedness of accrediting  
4 bodies that Craig raised, another proposal we've heard is to  
5 have an independent board preside over medical education  
6 funds. Also, the current construction of GME and IME has  
7 some small incentives to promote specific specialties such  
8 as primary care, but these incentives could certainly be  
9 strengthened.

10 Currently, Medicare does not specifically  
11 subsidize nursing education, but many reports show a  
12 significant need for nursing support, as they are essential  
13 professionals for effective and efficient health care  
14 delivery.

15 Given the small number of geriatricians in the US,  
16 some experts, like Chad Boulton, that Jennie mentioned  
17 yesterday, suggest that all physicians be trained in some  
18 aspects in geriatric care.

19 Alleviating student debt through loan forgiveness  
20 policies might be another incentive-based policy to increase  
21 types of physicians and nurses in desired specialties and in  
22 certain underserved geographic areas.

1           Considering Medicare subsidy of \$100,000 per  
2 resident, perhaps Medicare could require some public service  
3 in exchange. And finally, since almost all medical students  
4 become practicing physicians, efforts to increase diversity  
5 need to begin with the medical school admission criteria.  
6 And by diversity, I'm talking about racial, economic, and  
7 geographic diversity.

8           So there is a lot that we covered today and we are  
9 happy to answer your questions about all of this material.

10           MR. HACKBARTH: Thank you and good work. Could I  
11 see hands for first round clarifying questions?

12           MR. GEORGE MILLER: Thank you, Cristina and Craig.  
13 Very good work. I've got a question on the last statement  
14 you made about the demographics. Of the number of medical  
15 students, can you give us a demographic background or do you  
16 have that demographic breakdown currently so we have  
17 baseline to measure when the recommendations promote more  
18 diversity?

19           MR. LISK: Right now, if I recall, in terms of  
20 under represented minorities, which would be Hispanics and  
21 African-Americans and American Indians, there are about half  
22 of what they are in the general population.

1           Part of that also extends, though, from what  
2 happened at the undergraduate college education and also  
3 medical school, but there is some drop-off a from those  
4 populations, and we can provide you more information in the  
5 future on that.

6           MR. GEORGE MILLER: Just a follow up. In part of  
7 the RAND study, did they talk to traditional, historically  
8 Afro-American schools of medicine also?

9           MS. BOCCUTI: That was in the sampling frame.

10          MR. GEORGE MILLER: It was?

11          MS. BOCCUTI: Yes.

12          MR. GEORGE MILLER: Thank you.

13          DR. CASTELLANOS: Cristina and Craig, thank you  
14 very much, and excellent job, and thank you for bringing  
15 back onto the platform. I think medical education -- we  
16 have great opportunities. Just a clarifying question:

17               Cristina, you said we have the opportunity to set  
18 goals and directions for medical education. You were pretty  
19 silent on workforce issues and I see this as a direct  
20 opportunity to address some of the shortcomings in  
21 workforce. I'm just curious if you intend to use that as a  
22 future topic.

1           MS. BOCCUTI: I think it's on this slide, there is  
2 some sense of that in the fourth bullet, when you think  
3 about the mix of professionals. I think that because there  
4 is so much to cover and the Commission has talked a lot  
5 about the delivery reforms that we are first tackling issues  
6 about curriculum and the non-hospital setting that are  
7 somewhat related. And then, I think we're putting a lot of  
8 these topics up to see where the Commission wants us to go  
9 further. It was not focused on in this chapter because  
10 there's just other issues that we've got we should focus on  
11 first.

12           DR. CASTELLANOS: But perhaps you will be talking  
13 about that in the future?

14           MR. HACKBARTH: Ron, when you use the term  
15 workforce, what do you mean? The total number of physicians  
16 being trained or are you talking about specialty mix?

17           DR. CASTELLANOS: I'm talking about everything,  
18 both specialty mix where we have definite shortages within  
19 the physician community and the nursing community and allied  
20 health communities, and I'm also talking about the total  
21 number of the opportunities we have right now. We don't  
22 have enough work power to handle the direction we want to go

1 with medical home, with accountable care organizations. And  
2 if we don't started doing that now, it's going to be 10 to  
3 12 years -- even if we start now -- before we can even  
4 address or solve some of these significant workforce  
5 problems.

6 DR. DEAN: One of the factors that is sometimes  
7 cited as to why hospitals pick the particular range of  
8 residencies that they choose to operate is the amount of  
9 income that the residents actually produce. Do you have any  
10 information about that? It's been argued that that's one of  
11 the negative incentives for primary-care residencies is they  
12 don't produce much income where some of the more  
13 procedurally-based residencies do.

14 Now, the residents and I've had contact with, the  
15 current Medicare rules are so stringent in terms of the  
16 involvement of the attending that I question whether they  
17 can generate all that much. But I wonder, did your study  
18 get at that at all? Maybe Karen, I see, is moving over  
19 there. She probably knows a lot more about this than we do.

20 DR. BORMAN: Just a couple of things that may  
21 relate to what you bring up, I think, Tom.

22 First off, it's important to know that a number of

1 -- other than primary care resident specialty residencies --  
2 cannot exist in the absence of primary care residencies.  
3 For example, you cannot have a general surgery residency at  
4 the institution unless there's at least OB/GYN, internal  
5 medicine, pediatric -- I think it's two of the three of  
6 those. So actually, to some degree, the mix is driven by  
7 what residencies require others to pre-exist. Again, for  
8 example, a pathology residency would require that some sort  
9 of surgical activity go on in the hospital. So, that's one  
10 of the drivers go on.

11 A second one would be, in terms of the supervision  
12 piece, I would suggest to you that is probably is pretty  
13 across-the-board in terms of certainly compliant claims. A  
14 surgery attending is going to be there for the vast majority  
15 of any given procedure, certainly, a percentage equivalent  
16 to office visits. In fact, the only exemption to almost  
17 continuous presence relates to primary care clinics.

18 So, I think that those two things may be decided  
19 but are a little hard to say are a factor in what hospitals  
20 choose to sponsor.

21 MR. HACKBARTH: Could I just ask a follow-up on  
22 that? So, could you characterize the amount of billings

1 that a surgical resident generates compared to an attending?

2 Is there some sort of...

3 DR. BORMAN: First off, a resident can't  
4 independently bill, as you know.

5 MR. HACKBARTH: Right.

6 DR. BORMAN: So to try and -- probably the  
7 function that you can attach a monetary equivalent to in the  
8 Medicare system might be the first assistant payment so that  
9 a case on which there is a resident attending probably  
10 doesn't have a second surgeon.

11 Now, remember that that payment currently is about  
12 16 percent of the intern service part of the surgeon's fee,  
13 so it's a pretty small number, number one. Number two, that  
14 if you went by Medicare's list of procedures for which there  
15 is always an assistant at surgery, it's a pretty small  
16 fraction of those. So, the notion that every operation  
17 would have two surgeons if only residents weren't there  
18 would be a gross overestimation of the contribution. So,  
19 there probably is some contribution to a number of  
20 procedures but the flip side would be that it probably does  
21 add some time and expense by virtue of having residents and  
22 the corollary of students that generally come with it.

1 DR. REISCHAUER: Karen, that would save Medicare  
2 money, having the resident attending, but it doesn't save  
3 the hospital money does it? And the hospital is the  
4 decision-maker, or the medical school is a decision-maker  
5 here.

6 DR. BORMAN: To the extent that a resident costs  
7 more or less than a substitute personnel, it may or may not  
8 affect the hospital bottom line. For example, in our in  
9 first assistant cost more than a resident or so forth, then  
10 it might impact the finance piece.

11 MR. HACKBARTH: So what I'm -- I'll just a frame  
12 question and then we can come back to it later because I do  
13 one interrupt Tom's flow. What would be helpful for me to  
14 understand is the economic impact of having a training  
15 program on the hospital. Obviously, there's the direct the  
16 flow of dollars that comes from Medicare, but I'm talking  
17 about the secondary impact. That's all very murky to me.

18 DR. DEAN: That was basically what I was getting  
19 at, too. I know when we've had family medicine residents in  
20 our practice, if you follow the Medicare rules it's pretty  
21 tough because the rule says that every patient that they  
22 see, even third-year residents who are just about ready to

1 go out and practice, I would have to see those patients and  
2 write a note, even if it's a blood pressure check. I  
3 understand in a way why those rules got there, on the other  
4 hand, they're really restrictive and they really slow things  
5 down and there is a serious question if they have any  
6 educational value. I think it's more of an issue of  
7 preventing fraud and that kind of stuff.

8 I would just add, George, I've got a lot of data  
9 about the makeup of incoming medical school classes and it's  
10 very worrisome. They are becoming more and more majority,  
11 more and more higher income. The minority, rural, and  
12 low-income components of incoming medical students is going  
13 steadily downward which is a very worrisome trend.

14 MR. LISK: It's about I think only 5 percent of  
15 the medical students come from the bottom quintile of income  
16 or bottom quartile, but it's small. Yes.

17 DR. MILSTEIN: In reflecting the degree to which  
18 we think Medicare could and should try to solve this  
19 problem, I reflected on the presentation that I think you  
20 set up for us in November and December from the two expert  
21 medical educators. My memory of that is that, in broad  
22 brush, their observation was that the problems that RAND has

1 done such a nice job of laying out have been visible and  
2 known to most parties including medical educators for quite  
3 awhile. But their message was that energy for change was  
4 the problem. They were very, very candid about indicating  
5 that they were very well aware, as were their colleagues, of  
6 the gap between what is and what would be of greatest  
7 benefit to the public and perhaps the Medicare program.

8           As I begin to reflect on what could we do about  
9 it, one of the things I also remember that the presentation  
10 -- and the two presenters, the point they made was that  
11 there was at least one other source of rescue above and  
12 beyond sense of professionalism on the part of the faculty  
13 which seems to be the problem in this situation. They said,  
14 well, if the boards, the certifying board, were to radically  
15 change the nature of what they test and certify for, that  
16 could be a major source for reform. So, as I reflect on  
17 what we should think about doing, can either of you tell me  
18 whether any imminent major intervention by the boards is  
19 something that we can count on?

20           MR. LISK: There have been changes taking place  
21 like ABIM for the certification of internal medical  
22 residents. It has been trying to incorporate more and

1 actually, in terms of the incorporation of recertification  
2 of physicians and stuff. So, there's efforts going on as to  
3 whether is it enough and how do you end up going about  
4 changing.

5 I think a lot of the problem, too, comes from --  
6 and one of the things is faculty or faculty development --  
7 what is their experience and how do you develop the faculty  
8 for some of these changes as well, so you get some of these  
9 things incorporated in, and that's a difficult thing. If  
10 you don't have the faculty trained to do that, that could be  
11 an issue.

12 DR. CHERNEW: You mentioned this briefly in the  
13 study limitations, but I just wanted to ask about the RAND  
14 study, and that is, I haven't taught residents but I've  
15 taught medical students, and the way in which they're  
16 evaluated matters enormously in terms of what they actually  
17 take in. And so, things are in the curriculum -- like me,  
18 they aren't really in the curriculum in some way because of  
19 the way the program is evaluated. So, I was wondering if in  
20 the RAND study there was any attempt to capture not just the  
21 intensity which you mention a little bit in the limitation  
22 section, but also other aspects of the programs about the

1 incentives -- in the spirit of Arnie's comment -- the  
2 incentives that the students face to actually do well at  
3 these particular things?

4 MS. BOCCUTI: Broadly, I don't think we can speak  
5 to what the feedback was from the instructors to sort of say  
6 whether they told the residents that -- how they motivated  
7 the residents to do better in these areas. We were trying  
8 to just get a baseline on what was really being required and  
9 what was formal and what was informally taught.

10 I didn't get into it enough, I think, but there  
11 are reasons why things should be informally taught versus  
12 formally taught. Some of the skills need to be done during  
13 a hands-on experience, but there's value to making them a  
14 requirement and formally taught in order to show that they  
15 are valued and important.

16 So, I think the most that I could say that there  
17 was a distinction within the confines of the study would be  
18 to say whether there was a formal or informal a focus to the  
19 curricula but there wasn't sort of -- other than the RAND  
20 researchers said, how well does your program, do you think -  
21 - does this. But I think that has so much judgment within  
22 it that it's better to report the actual presence or absence

1 of the activities and then get sort of a general picture.  
2 The final report will be forthcoming and maybe you'll get a  
3 better picture from that, too.

4 Does that answer your question?

5 DR. MARK MILLER: Yes, because the last thing I  
6 think is, when I was trying to process your question is, the  
7 way this is done is pretty much a presence or absence thing  
8 and then a discussion and, depending on which your view of  
9 that is, that means that even if you do something, no matter  
10 how -- if it's not very intense or not very integrated, it  
11 got onto the list. So in some ways you can look at what  
12 happened here as, if there was just something, then it got  
13 counted. Even doing it that way, there was sort of a  
14 conclusion of things falling short. I don't want to  
15 overstate that too strongly, but the other thing that you  
16 said in our conversations and I think you said here today is  
17 that people don't put as much effort into it unless they  
18 feel like it's going to be very much directly part of what  
19 they're tested and evaluated on. There seemed to be  
20 comments like that throughout the discussion. Yes, we do  
21 this, but it doesn't necessarily come up again and again and  
22 something that I'm going to be evaluated on.

1 MS. BOCCUTI: That goes to what Arnie was saying  
2 about the certification exam. Yes.

3 DR. CHERNEW: I was just asking, in the study you  
4 had -- do you have this, are they evaluated on it or how are  
5 there -- that I understand -- it seems like he did -- it was  
6 more of an open-ended discussion. If they mentioned that it  
7 came up, but it wasn't systematically collected by the RAND  
8 researchers.

9 MS. BOCCUTI: Right.

10 DR. SCANLON: Just a quick comment related to  
11 Tom's point on the economics of residency decision. Going  
12 back to our work on specialty hospitals, when we were  
13 looking at DRGs, we maybe need to think about what is the  
14 inpatient revenue impact in terms of a residency program,  
15 because what we saw was there was significant profit  
16 differences between DRGs, not just within a DRG. And while  
17 we've moved it to correct some of that, there is a question  
18 of, historically, what difference that made and what remains  
19 in terms of what the incentives might be.

20 MS. HANSEN: This is more of a question of the  
21 role that Medicare regulation has on any of the curriculum  
22 and the things that we can't do. Tom said certain things

1 you can't do because it's not allowed. So, how much of it  
2 is sorted out to some of the accreditation issues as  
3 compared to what Medicare is specifying?

4 For example, you only get counted if you do  
5 hands-on, for example. And how difficult is that to change?  
6 What level of decision-making is required to be ease that to  
7 make that shift?

8 MS. BOCCUTTI: You mean regulatory versus  
9 statutory? Is that the kind of -- I just want to follow...

10 MS. HANSEN: It could well be. There are  
11 different levels of that. One is the statutory and the  
12 regulatory and then the professional itself in terms of how  
13 it gets defined. But when Medicare has this, is it at the  
14 statutory level or the regulatory level?

15 MS. BOCCUTTI: I would say it's both, but there's  
16 been a lot of regulations over the last decade that have  
17 defined some of the specifics of the non-hospital setting  
18 supervision issues. I think Craig wants to jump in here.

19 MR. LISK: It is, as Cristina said -- it's kind of  
20 both. There is this language that came in the law that said  
21 Medicare should pay in the off-site and went Medicare pays  
22 all or substantially all the residency training program

1 costs. With that language, CMS interprets that as, well,  
2 they really have to pay for almost virtually everything.

3 In the past, though, they allowed for, let's say,  
4 direct GME reimbursement as long as the program was paying  
5 the resident salary in benefits, they allowed it. But when  
6 they changed the regulations to allow IME payments for  
7 residents' time when they were off-site to go to the  
8 hospital, they kind of changed the regulations. This gets  
9 to be a real weedy set of issues that goes on. So, the  
10 regulations kind of change and Congress had put in this  
11 substantially all or all language, and so CMS interpreted  
12 that in one way. So that is where some of the regulations  
13 come into play.

14 So, you have a statute issue from CMS's  
15 perspective. Congress has sometimes put in language saying,  
16 well, that's not necessarily what we mean but it's been in  
17 report language. So it's kind of a quagmire how you deal  
18 with it and who's really responsible, ultimately.

19 DR. MARK MILLER: This is just based on  
20 conversations with you guys and actually -- no, to some  
21 extent, some of the conversations we had with AAMC. My  
22 sense is there's a lot of regulatory underbrush here that

1 could correct some of these problems, particularly the in  
2 and out of hospitals. Probably not all of it, but there are  
3 steps that could be made that would make the situation --  
4 and Cristina, if I'm way over --

5 MS. BOCCUTTI: There are regulatory things that  
6 have changed so that sort of lies within CMS, but some of  
7 the financial incentives even override the regulatory ones.

8 So, I want to be clear that fixing -- let me take  
9 that word back -- changing the regulations may not in and of  
10 itself vastly change the incentives in keeping residents in  
11 the hospital.

12 MS. HANSEN: So, is it possible for future work  
13 with that in mind that there could be a way to outline where  
14 the statutory stuff comes from, the evolving regulatory  
15 kinds of issues that, in and of themselves are probably  
16 conflicting, and then the interpretive side of it which  
17 becomes, frankly, a staff issue sometimes, and then the  
18 financial piece that you just mentioned just so that we get  
19 -- we basically unpacked is a little bit so that we can see  
20 where are the decision points that really will allow us to  
21 do the best policy changes for this. So, from the  
22 accreditation to the payment issues to the regulatory world.

1 MS. BOCCUTTI: Right. We'll try and make that a  
2 little bit more clear in this work. But I think also,  
3 because it's so technical, if we go forward on some of these  
4 ideas, there is a place to really get to the word for word  
5 language and how it might -- because then if the Commission  
6 were to start thinking about changes that those words get to  
7 be -- need to be thought about, too. So, we'll work on this  
8 now but it may also come up in the future.

9 MS. HANSEN: Let me clarify that because I don't  
10 want us to go to the weeds, that level; I appreciate that's  
11 not our role. I think part of it was just for an  
12 understanding of the complexity.

13 But then separately, this may be into round two,  
14 but it just leads so naturally, could we flip it around and  
15 take a look at what are the population needs of the Medicare  
16 population? And all of these initiatives are for the  
17 endpoint of quality, cost-effectiveness, and inclusive of  
18 safety and whatnot.

19 We could do it two ways: One is a structure as it  
20 is. The second one is how patients and beneficiaries should  
21 be getting care in the 21st century and then kind of begin  
22 to see where this is a bit archaic in order to achieve these

1 results. But we take it from a more beneficiary futuristic  
2 population base as to where our goals are meant to be.

3 MR. HACKBARTH: Understandably, we are sort of at  
4 round one and three-quarters, here. Let me just see the  
5 hands of people who have clarifying questions and make sure  
6 we get all those done first.

7 DR. REISCHAUER: I think I'm probably a one-and-a-  
8 half, so you can go to a pure one.

9 MR. HACKBARTH: Jack claims to be a true one here.

10 MR. EBELER: I think I'm a true one. And just  
11 follow up on Jennie's, on this question of regulatory  
12 framework, to the extent that one can get a signal in there  
13 of the regulations that come at you from the payment side  
14 and the regulations that came at you from the Inspector  
15 General side. My impression is that this is a world in  
16 which some cases -- my program does something inappropriate,  
17 the government comes out appropriately on me, but as a  
18 result, Tom and Karen and Peter are filling out forms for  
19 the rest of their life.

20 MS. BOCCUTI: Is there a question?

21 MR. EBELER: The question is that if you follow up  
22 on Jennie's -- that direction would --

1 MS. BOCCUTI: Tom sort of mentioned it when you  
2 are saying about the supervising activities, I thought we  
3 should probably put a little bit more of that kind of a  
4 burden in the chapter because we focus more on financial but  
5 there's sort of the financial -- the opportunity costs of  
6 what it takes to supervise.

7 MR. HACKBARTH: Before we go to round two, I just  
8 want to go back to two things that were raised in the first  
9 round.

10 The questions related to the financial impact of  
11 training programs on the institutions, Peter, I'd like to  
12 hear what you have to say about that. I understand that the  
13 direct dollar flow. What are the secondary effects in terms  
14 of having residency programs on the hospital? What are the  
15 costs and benefits, as it were? If you could say something  
16 about that.

17 Then, the other issue, I was going to ask Karen to  
18 address Arnie's question about what the boards are doing and  
19 how that process is evolving. Peter, do you want to talk  
20 about that?

21 MR. BUTLER: Let me see, I'll do it through my own  
22 specific experience and what occurred 22 years ago when I

1 was a newly-minted CEO of a community hospital, which  
2 affiliated at the time -- the first time I was with Rush and  
3 we inserted 12 internal medicine residents into the  
4 institution. I was highly aware of the formulas at that  
5 time. This won't be a comprehensive answer in terms of all  
6 of the impacts, but I said, I kind of wonder if this GME and  
7 IME is going to pay for the cost of the impact of all of  
8 this. My bottom line was about a wash, but let me give you  
9 some specific examples.

10 I wish I published this because I was using a  
11 second-year master's student in health care administration  
12 to pull together the data as a project. But in the one  
13 month that they occurred -- again, internal medicine  
14 residents are a little different than, say, a radiology  
15 resident. The radiology exams went up about 5 to 6 percent  
16 in volume after 1 month, lab tests went up about 39 percent.  
17 So that's a very visible impact of -- again, this was July  
18 1, new residents coming in the door, encourage to diagnose  
19 and treat patients and maybe it's a community hospital that  
20 wasn't used to having quite the intensity, but you have  
21 these people around the clock. And so on the on utilization  
22 side, it did make it --

1           MR. HACKBARTH: These would fall under the  
2 indirect costs of medical education that IME is meant to --

3           MR. BUTLER: Exactly. There's one very visible  
4 example. And by the way, we need this test that's sent  
5 down, and you don't do it in-house, so you need to bring it  
6 in from somewhere. And some of these things were absolutely  
7 right. And they were further enabled by, say, the faculty  
8 that we now had to pay also to supervise the residents and  
9 they, too, had kind of overall service demands on the  
10 institution which were a different level and a different  
11 expectation than the typical community hospital.

12           And then, of course, the library that the  
13 community hospital had was not sufficient enough and so you  
14 had to have more publications and then you had to have  
15 certain technologies, and it kind of goes on from there. It  
16 really had kind of a cultural impact on the overall  
17 standards of the institution overall.

18           Now on the positive side, while there was  
19 additional costs and utilization, I think the presence of  
20 residents actually helped the care move along faster and  
21 better because the attendings in the community hospital  
22 would come around once a day in the morning and do their

1 thing, and particularly on weekends, you get the residents  
2 around, processes can move. Actually, we had a reduction in  
3 length-of-stay in our institution at that time.

4 Another benefit was that there were certain number  
5 of physicians that were splitters that say, well, you've got  
6 those residents around, now I'm going to admit more to your  
7 hospital. I have a feeling that you give higher quality and  
8 in general there are more people asking questions about the  
9 care than were occurring in a community hospital that didn't  
10 have anybody doing the types of peer review that should have  
11 been done.

12 MR. HACKBARTH: So, what I hear you saying is it  
13 potentially increases your market share, increases your  
14 referrals, makes people more likely to admit at your  
15 institution, and presumably also expands the capacity of the  
16 institution to handle more cases because you have the  
17 resident workforce?

18 MR. BUTLER: Yes, of course, that's injecting  
19 residents in a community hospital, which is sometimes viewed  
20 as very valuable to say -- in downtown academic medical  
21 centers, some of those same community physicians say, I'm  
22 not going to admit my patient down there, it's a

1 bureaucratic morass, the service isn't as good. They may  
2 have expertise but it's not a place -- I don't want to get  
3 on the staff there. So it's very different to have graduate  
4 medical education in the community hospital versus in the  
5 academic medical center, which is a whole different complex.

6 DR. DEAN: I understand that the supervisory  
7 requirements have changed quite dramatically, I think. Am I  
8 right, Karen, in the 20 years, at least, as I remember? And  
9 what's required now, the documentation of supervision. So,  
10 it's a little different environment than you describe.

11 MR. HACKBARTH: Do you want to talk about the  
12 evolution of boards and maintenance of certification?

13 DR. BORMAN: I think that the boards, for a  
14 variety of reasons, have broadened their thinking about what  
15 should be required and what should be evaluated for initial  
16 maintenance of certification and that reflects, number one,  
17 the general competencies presumably apply from the medical  
18 student through the experienced practitioner, number one; so  
19 it's a reflection of that.

20 Number two, it's a recognition of proving that  
21 what all of us who are board certified believe that is a  
22 quality marker, to try to make it more apparent to someone

1 not in what we do, that it is indeed a quality marker, so  
2 the interval, the intensity, of activity that's required.

3 I can only speak to detail from the board on which  
4 I sit, which is the American Board of Surgery. We certainly  
5 have incorporated safety questions. We've incorporated  
6 system questions. We've incorporated ethics questions into  
7 the examination processes.

8 We and multiple other boards, I think, continue to  
9 seek better ways and potentially -- and valid ways, and  
10 there is a big chunk of the problem, of assessing some of  
11 the things that Cristina has brought up here in terms of  
12 interpersonal and communication skills, for example, would  
13 be one. And just to offer an example because I've heard  
14 their presentation, the American Board of Orthopedic Surgery  
15 has a very extensive process that when a diplomate is filing  
16 for recertification, they have to request peer evaluations  
17 that are from a broad variety of people, including chiefs of  
18 service at all of the hospitals that they work, the director  
19 of the OR at all the hospitals for which they work, a  
20 variety of people. So it's not just peer physicians. It's  
21 not your practice partners. It's people who presumably are  
22 in positions where they're aware of not only the medical

1 quality of your work but the nature of your interaction. If  
2 you regularly are unpleasant to the OR staff, it will come  
3 out in the evaluation of the chief or the administrator of  
4 the operating room.

5           One of the problems with that kind of thing and  
6 what the boards struggle with is that occupies 80 percent of  
7 the time of one of the executives of that board, just to  
8 service that process, because of the number of things. So,  
9 it's broadening the base of questioning; it's seeking other  
10 ways to get the input that is not so costly and  
11 time-consuming. Simulation may ultimately play some role in  
12 validating technical skills. For example, the American  
13 Board of Surgery in a couple of years, we will require that  
14 anyone for initial certification will have completed a  
15 number of well-validated skills curricula, including  
16 fundamentals in laproscopic surgery or the FLS curriculum.  
17 So, I would say, on a lot of fronts, the boards are moving.

18           MR. HACKBARTH: What I've seen and ABIM is that  
19 the maintenance of certification work, the development, the  
20 enriching of maintenance of certification is in fact focused  
21 on many these issues about improving actual practice  
22 performance and systems-based improvement and practice.

1 There is a lot of variability among the boards, some are  
2 more advanced in that than others. But Kevin Weiss, who is  
3 the new head of the American Board of Specialties -- the  
4 overall specialty board, his agenda is to deepen maintenance  
5 of certification, make it more substantial, and try to make  
6 it more consistent across the various specialties. That is  
7 sort of another force at work here.

8 MR. LISK: If we're still in round one, I have one  
9 technical issue just to clarify, and that's on the nurse  
10 training issue in terms of Medicare support for nurse  
11 training. Medicare does provide direct GME payments for  
12 hospital-based nursing programs, that's diploma programs. I  
13 just want to clarify that Medicare does provide some small  
14 amount of support for that, but those of the vast minority  
15 of nursing schools.

16 DR. CROSSON: Thank you very much for the  
17 presentation. I thought it was very good and very clear. I  
18 have to admit, when I read the first part of it, it made me  
19 tired and I wondered what I was thinking when I decided to  
20 become a physician.

21 In terms of the focus here for the work, I'd like  
22 to make the case that we strongly consider focusing on the

1 issue of training in non-hospital settings. As you said,  
2 Cristina, there is a lot of things we can do with this. As  
3 we've talked about this over the last few years, I've been a  
4 little queasy about exactly where we could go as a  
5 Commission in terms of making recommendations about the  
6 education process. I think, at least I feel, uncomfortable  
7 about that. But this particular one has some obvious  
8 regulatory barriers that I think we could comment on and it  
9 fits easily, at least for me, and to my conception of the  
10 work that we should be doing.

11 In thinking about it, there is a strong reason I  
12 think, just based on my own experience, for increasing the  
13 amount of time that residents spend in outpatient settings.  
14 You can argue, and I think the paper did very well, what  
15 some of those reasons are. The issue of having exposure to  
16 multidisciplinary coordination of care, certainly, not that  
17 that exists in all practice settings but it certainly does  
18 in some.

19 Obvious things, like the range of problems  
20 addressed -- that's sort of obvious on its face, the kinds  
21 of problems that are dealt with generally in the hospital  
22 are different from those that are dealt with, in general, in

1 the office.

2           The issue of role modeling. I think the role  
3 model in an academic medical center that medical students  
4 and residents are exposed to is quite a different role model  
5 than one is exposed to in a practice setting.

6           And I think all of those things feed into things  
7 like the selection of a specialty but also I think some more  
8 subtle psychological things which can end up influencing the  
9 pattern of practice of medicine for a career.

10           This is sort of an oversimplification, but the  
11 process of a hospitalization, for the most part, and the  
12 mental activities of the physician, are kind of focused on  
13 the diagnosis and treatment. What does this patient have?  
14 How can I figure that out most expeditiously? What's the  
15 proper treatment? And then, when can the patient long? And  
16 that's pretty much it. Now, I don't mean to say that there  
17 aren't follow-ups in clinics and all of the rest of that,  
18 but fundamentally the mental process and the acculturation  
19 of in-hospital training is that: diagnosis, treatment, end  
20 this case. Where the practice of medicine in the office is  
21 really very different from that. It's, in many cases, the  
22 management of the care of the patient over a very long

1 period of time. And properly done, focuses a lot on not  
2 just on diagnosis and treatment, but how to help an  
3 individual maintain their life over a period of time, how to  
4 manage high blood pressure and diet and exercise and how to  
5 do simple things like figure out what to do if you happen to  
6 be over 60 and have a meniscus tear from perhaps playing too  
7 much golf, and sort of like, well, what shoes should you  
8 wear? What sorts of activities are okay, how to know when  
9 you need to stop doing what you're doing, when you should  
10 take anti-inflammatory medicines, all those picky little  
11 things, which, added together, ultimately influence whether  
12 that individual is going to end up requiring higher  
13 intensive and more costly care. And those are things that  
14 you don't really learn in an in-hospital training session.

15           When I came out of my pediatric residency, I was a  
16 real hot ticket. I could put a catheter into a one  
17 millimeter space; It was unbelievable. But two days later I  
18 went into the Navy for two years at the end of the Vietnam  
19 war here at the Bethesda Naval Hospital and I realized,  
20 after spending an hour trying to understand how to put my  
21 uniform on, I realized in the first day or two that I didn't  
22 know anything about how to take care of their children and

1 their parents in the office setting. And I, in fact,  
2 learned the practice of pediatrics in the Navy and not in my  
3 residency training program. Enough of that.

4 I do think, though, that whatever we could do to  
5 help training programs get better reimbursed and to help  
6 interns and residents have more experience in the actual  
7 care of patients in the actual settings where most care is  
8 delivered would be a great contribution.

9 DR. REISCHAUER: Let the records show I was never  
10 a hot ticket.

11 [Laughter.]

12 DR. REISCHAUER: This is sort of a round one and a  
13 round two. The round one is a little refresher course for  
14 me, and that is, if I recall correctly, there is a cap for  
15 residents and we're over the cap. And so, there are some  
16 settings where the institution isn't being reimbursed. It  
17 might be interesting to look at where those are  
18 geographically, what specialties the people are in, and why  
19 that's going on if we want to get insight into the net cost  
20 of these programs or the benefits from them and whether the  
21 residency programs in those settings are significantly  
22 different from others where everybody is under the cap.

1           The round two comment has to do with IT, and I  
2 found that the most interesting part of this, in the sense  
3 that most training programs, post-undergraduate training  
4 programs, produce individuals that, in a sense, are at the  
5 cutting edge of methodology and technology and that's how it  
6 diffuses out into the economics or the sociology or at the  
7 business school profession, is these young people coming out  
8 just saying, I know how to use all these tools and all of  
9 these new methods.

10           What you're showing us here is that that's not  
11 true with respect to medicine and we've just passed  
12 legislation that's going to dump a whole lot of money into  
13 putting IT everywhere. I was wondering whether there was  
14 anything in that or the regulations that try to get the  
15 teaching component sort of where it is in all other  
16 professions and generating cadres of people who are ready to  
17 go and push the frontier, or they're going to come out and  
18 say, wow, now teach me this stuff that's in the office or  
19 that's in your hospital. It dumbfounds me that the  
20 hospitals running the big residency programs don't have all  
21 of the very sophisticated systems in which they train their  
22 people.

1           MS. BOCCUTI: I'll mention a couple things.  
2 First, regarding this stimulus bill you're talking about,  
3 I'm not aware that there's anything specifically for  
4 academic health centers. I think Jeff maybe has looked at  
5 this a little more specifically. It's available for  
6 hospitals, but I don't know that there is a distinguishing  
7 component related to whether they're a teaching hospital or  
8 not. I am getting this means probably not. So, I think  
9 that's a sort of what your question was about. We can talk  
10 more about what the IT similarities are, but I think maybe  
11 we've prepared something. We can talk about that later  
12 off-line.

13           I did want to mention that the VA system does have  
14 comprehensive EMRs. The RAND found that when residents  
15 could rotate through the VA, they did get those experiences,  
16 and that created the bulk of those that had comprehensive  
17 EMR experience.

18           MR. LISK: We focus on internal medicine here.  
19 There are also a lot of family practice programs, though,  
20 that do actually have these systems, and the residents  
21 actually, when they come out of those programs, frequently  
22 actually demand it from the practices that they go into,

1 because all of a sudden, they may have been using those, but  
2 then go into practices or hired by practices that don't have  
3 them or the practices they demand to go into are the ones  
4 that have them.

5 MS. BEHROOZI: Thanks. This was really great and  
6 actually kind of scary in a lot of ways, and Bob made a  
7 point about IT and that shocked me.

8 It does occur me that when we're talking about the  
9 things that, as you said, Cristina, have been so important  
10 in all of our other conversations like care coordination,  
11 communication around hospital discharge, patient  
12 communication, regimen adherence, all of those things that  
13 you've listed, and again, it's scary how little -- what a  
14 small place they seem to occupy in the preparation of  
15 doctors.

16 I know this is about doctor education, but it  
17 doesn't need to be if we're talking about those kinds of  
18 functions, right? Those kinds of functions really don't  
19 need to be always and only performed by doctors. It's good  
20 that doctors know they are important components of whole  
21 patient treatment. And in some settings it may be in  
22 incumbent on the doctor to do these things, but it does seem

1 to me that were in a little bit of a chasing-our-tail  
2 feedback loop kind of thing, because the payment system,  
3 which is doctor-centric, means that it's doctors who have to  
4 perform these functions or they won't be reimbursed. And I  
5 think we need to connect this back to our thinking about the  
6 payment system to be less doctor-centric. It's not just RNs  
7 either who can perform these functions; it can be much more  
8 diverse types of people and people with less expensive  
9 educations to have to support. Health educators, nursing  
10 assistants, and people with far less, as I said, expensive  
11 educations that can do these things. Not that we should  
12 necessarily say doctors shouldn't do these things and  
13 shouldn't know about it but I think that there's a little  
14 bit of a closed mindset that we're within a box, partly  
15 because of the payment system in looking at the educational  
16 issues.

17           But having said that, still, of course, we need  
18 doctors and we need lots of them and we need them to  
19 practice in the right areas and come from places that  
20 represent all of us. It's of tremendous concern how  
21 expensive an education is. Obviously, from the Medicare  
22 side, how much Medicare pays from it. From the hospitals

1 side, they still think they're losing money. They say that  
2 they're losing money even though MedPAC's analysis shows  
3 that the IME is not fully empirically justified.

4 But the students end up with a lot of  
5 uncompensated costs in the form of tremendous loans that  
6 they are only compensated if they choose to go into practice  
7 areas that are lucrative. And I think not only in terms of  
8 loan forgiveness, we should be looking at, or policymakers  
9 should be looking at trying to reduce the burden on students  
10 so that at the going-in end you have more economic and other  
11 kinds of diversity, but at the going-out end you have less  
12 pressure to focus on the lucrative specialties.

13 But also, and this came up in the panel last fall,  
14 if we're not teaching all of these care coordination and IT  
15 and all that good stuff that physicians should have, does it  
16 really need to take so long? Maybe there really is a core  
17 of things that doctors should be learning. And I'm talking  
18 about allopathic and not necessarily making everybody  
19 osteopathic, but that was something that was referred to in  
20 that panel, especially if we're not focusing on all of the  
21 right things.

22 DR. DEAN: Where to start? I have a lot of

1 interest in this topic.

2 First of all, it came up at the whole issue of  
3 what drives the curriculum, and my understanding, both from  
4 talking to medical school folks and talking to my son last  
5 night who is a fourth-year medical student and has a lot of  
6 opinions about these issues, one of the really worrisome and  
7 disturbing parts, although I think it is changing, is the  
8 national boards and that medical students have to pass at  
9 the second- and fourth-year are extremely rigid and  
10 extremely focused on relatively minor bits of information  
11 that students have to memorize.

12 Now, my understanding is that that is changing,  
13 because that has really dictated to faculty to what they can  
14 teach. In fact, my son said that for one course he had a  
15 college classmate who was at the University of Minnesota and  
16 he was in South Dakota. He said his college classmates sent  
17 him his notes, and they were the same thing we got. I had a  
18 student with me from Georgetown a while back and she said  
19 exactly the same thing, the same concern.

20 It really changes, really limits what -- any  
21 flexibility the faculty can have in bringing in some of  
22 these things, especially at an early stage that we think are

1 necessary. Now, my understanding is that's changing and so  
2 hopefully it's been a long time coming.

3           With regard to specialty choice in which  
4 residencies a hospital supports, it certainly seems -- I  
5 back up a minute. I understand that in the undergraduate  
6 area, Medicare doesn't have a whole lot of influence,  
7 although I think it's something maybe we should look at  
8 because what happens in these early years in medical school  
9 clearly has a huge influence on what happens later on where  
10 we are truly interested.

11           But anyway, a few years ago there was a group  
12 called COGME, I think it was Council On Graduate Medical  
13 Education that issued a recommendation which said that, in  
14 order to get Medicare reimbursement, teaching hospitals  
15 would have to have a mix of residencies that was consistent  
16 with the needs and the projected needs in their area. Now,  
17 obviously, that's not a simple thing to project, but at  
18 least it puts some emphasis that there should be some  
19 connection between when public funds are invested and it  
20 should have some relationship to the needs of the area. It  
21 isn't a straightforward thing, because obviously residents  
22 don't always stay in the same area and things change and all

1 that, but it seems to me that some requirement like that,  
2 even though it would have to be somewhat loose, would make  
3 sense.

4 I guess to respond to what Karen was saying, my  
5 impression from the Board of Family Medicine is similar to  
6 hers. I think the specialty boards maybe have been better  
7 at recognizing the needs for some of these changes than  
8 maybe the undergraduate testing activities although, again,  
9 I don't have data to support that.

10 Finally, we've alluded to it already, I am really  
11 worried about the admissions procedures of medical students  
12 and partly who is being admitted and the dead issue that  
13 goes along with that. The cost of medical school is scaring  
14 away many of the people we really desperately want to get  
15 into medical school. And also, it puts medical schools in a  
16 difficult bind, because many of the students come from areas  
17 where they are not guaranteed that they are going to be as  
18 successful as the majority of students that come from  
19 prestigious colleges and so forth; we know they're going to  
20 do well. And so, you understand, if you're in a medical  
21 school's admissions committee, that obviously those folks  
22 are going to stand out. On the other hand, the people that

1 are going to do the things and serve the roles that we  
2 really need to have served are going to come from other  
3 backgrounds and they're going to be a little less secure  
4 students, or a little less than -- going to be a little more  
5 risk on the part of the medical school. You don't blame  
6 medical schools for being hesitant. On the other hand,  
7 we've got to do something to push that forward. Otherwise,  
8 were going to have a complete mismatch in terms of the range  
9 of specialists we have compared with a range of needs we  
10 have.

11 DR. KANE: A couple points, and I think this is  
12 great and gives lots of opportunity for many more meetings  
13 and discussions I'm looking forward to.

14 One thing that's been brought up in different ways  
15 here but a lot of the training that we would like to see  
16 doesn't have to all happen in medical school or residency.  
17 In fact, quite a bit of it I think happens outside of that,  
18 as Jay mentioned, when you get your first real job, but also  
19 through continuing medical education of other activities.

20 I'm at a public health school but we get mostly --  
21 probably two-thirds of our students are physicians seeking  
22 to add to their skills, including IT quality improvement,

1 and all of that. So, I think just saying all this has to  
2 happen in medical school or in residency training might be  
3 too narrow a scope for thinking about that.

4           And now that we've asked all continuing medical  
5 education organizations to be disclosed if they're receiving  
6 pharmaceutical funding, perhaps we should think about ways  
7 that they might be funded to provide more public purpose  
8 types of education around patient education, IT use, quality  
9 assurance, the kinds of topics that are here.

10           I think CME -- I have learned that the average age  
11 of the physicians in my executive ed program are 49 years  
12 old and they are wonderful students; they are lifelong  
13 learners. So, their brains don't go dead for learning after  
14 age 30, and I really recommend that we consider the lifelong  
15 learning opportunities and how can Medicare enhance those  
16 and potentially help either reimburse or foster the kind of  
17 CME that gets us the kind of skills we need. That also  
18 helps to educate the faculty and the older docs who are  
19 serving as role models for younger people.

20           The other issue I'd like to know more about and  
21 maybe have us talk about is that Medicare pays for education  
22 in places where Medicare patients go, particularly the IME

1 which is tied to an inpatient Medicare admission. I've been  
2 doing this safety net hospital work for the Commonwealth  
3 Fund and noting the payer mix for safety net hospitals has a  
4 very low Medicare, 20 percent, 15 percent, and yet the IME  
5 dollars are going to places that have the high Medicare  
6 payer mixes, inpatient. I just wonder if there isn't some  
7 kind of a mismatch when you tie IME to an inpatient Medicare  
8 admission, particularly for communities of the minority and  
9 disadvantaged populations, which don't tend to bring it in  
10 that many Medicare inpatient admissions.

11           It is sort of like a disproportionate share going  
12 out the way it does. I'm wondering if the allocation  
13 formula itself doesn't harm the training grounds where a lot  
14 of our disadvantaged populations go to for their care and if  
15 we shouldn't start thinking more about how to reallocate IME  
16 on a different basis, and I guess that goes also to the  
17 concept of perhaps disassociating the support of medical  
18 education from caring for Medicare patients in the specific  
19 sites but rather having education go to where residents are  
20 educated and not necessarily where Medicare patients are.  
21 I'm not so sure that that makes sense to me, but that's so  
22 tightly linked right now, and I think that's a topic that

1 I'd like to see us explore further in the future.

2 DR. BORMAN: I want to congratulate you on  
3 distilling out nice diagrams about a rather arcane process  
4 of educating a physician. I think it's very important that  
5 people have some literate place to go back to as opposed to  
6 entirely relying on Grey's Anatomy, House, and other  
7 vehicles for what they know about the education of  
8 physicians. It gives me some solace that you've laid that  
9 out.

10 I would point out that you don't have to finish a  
11 residency to get licensed. You have to do one year of some  
12 graduate medical education in order to sit for step three,  
13 which is basically what you're going to need to get a full  
14 and unrestricted license, and on your diagram, you had one  
15 to four years; it was just a little less clear in the text,  
16 I thought. So, I would just clarify that.

17 I'm having a little bit of the problem that Jack  
18 had yesterday in terms of the it that we're trying to get to  
19 here, because I think this is wonderfully provocative. But  
20 I think that, to move it forward, maybe we need to -- and  
21 Jay, I think, touched on a little bit of what is our it in  
22 doing this work and where we do want to go? Because this

1 could be a lifelong project for the Commission, way beyond  
2 any of our lifetimes, no matter how John projects them. So,  
3 I think we kind have to think about that a little bit.

4           If you look at our title, I would support that if  
5 what we're really looking at is education versus delivery  
6 reform, that that starts to take us down a huge -- the big  
7 workforce path consideration of the mix of education,  
8 sophistication, some of what Mitra referred to, and I'm just  
9 not sure that's where we intend to go but that's one place  
10 -- that's the ultimate view of all this, and where to parse  
11 out dollars in support of that.

12           Because I think that, instead, what we're sort of  
13 looking at and that gives me some concern is we think we've  
14 identified the needs over the next 5 to 10 years for some  
15 specific issues within the Medicare program. I'm going to  
16 submit to you that how you educate physicians, at least for  
17 the long-term, may need to have a little longer view.

18           Just to offer you some examples from my own  
19 discipline, when I was a resident and in a fair amount of my  
20 education -- and in fact a good chunk of operative  
21 experience -- related to management of peptic ulcer disease.  
22 Thirty years later, there's a bacteria, H pylori; it's

1 treated. The number of patients that we operate on for  
2 peptic ulcer disease, the natures of the operations that we  
3 do are just vanishingly -- they're hugely different. And  
4 there is some danger in tweaking curriculum to try and  
5 address a need. It would be like -- this is, off the top of  
6 my head, a bad analogy -- a particular plane crash where  
7 judged due to X and we then said every pilot must be trained  
8 in X to some nth degree to the exclusion of something else,  
9 that would not necessarily be a good thing. I think that  
10 one of the things we've got to remember here is that we're  
11 talking about people that are going to practice for 30 or 35  
12 years, and the imperative is to give them a foundation on  
13 which to be those lifelong learners and continue to grow.  
14 We really need to be careful about tweaking for the short  
15 term. I am very concerned every time -- Jay's queasiness  
16 every time I see the curriculum word here and some  
17 implication that we will attempt to manipulate curriculum as  
18 a function of payment policy I think is a slippery slope and  
19 I really, really worry about that.

20 I do think if what we're talking about is how we  
21 best invest the dollars that we are currently putting into  
22 medical education, I think that one of the ways to build on

1 the system we have where the money is in fact going to the  
2 teaching hospitals, is to encourage and incentivize those  
3 entities to be the cutting edge people for us, in terms of  
4 the IT adoption.

5           In fact, Peter and I had a little sidebar, and  
6 most teaching hospitals are farther along than the average  
7 community hospital. Maybe we need to accelerate that, but I  
8 think that tying it to something like that -- faculties and  
9 universities tend to lend themselves to a structure that  
10 could more quickly morph to an accountable care  
11 organization. And should we use -- thinking about this to  
12 incentivize that kind of behavior, I'd much rather see that  
13 than tying it to some measure of how much did we teach  
14 geriatrics in the curriculum.

15           My last comment would be, one of the things that  
16 did trouble me about the study a little bit -- and I think  
17 it's a very fascinating study -- I'd love to see, number  
18 one, to ask the residents the same questions to see what  
19 they think they were taught and perhaps to do a procedural  
20 discipline for a comparison. But you made a lot of  
21 statements about they don't get formal training in this,  
22 formal training in that, formal training in whatever. As

1 was mentioned, some of the more formal piece, that's  
2 undergraduate medical education; that's medical school.  
3 Residency is, in large measure, experiential-based learning  
4 and it's the next step towards adult learning and it's more  
5 effective.

6           So, I want to be real careful that we don't start  
7 to use as a measure how many lectures or things there were  
8 about a given topic as a measure of addressing it. When I  
9 operate with a resident or I'm in clinic with a resident, we  
10 oftentimes talk about how to do those things.

11           Surgery residents, for example, log their cases by  
12 using CPT codes. So, they start learning about some of that  
13 and some of the implications. So, I think we just need to  
14 be a little bit careful.

15           MR. HACKBARTH: That's helpful, Karen. We're  
16 actually at the end of our time on this. I'm going to go  
17 through the rest of the list, but it would be really helpful  
18 if we can convert this into a round two-and-a-half and use  
19 Karen's comment as a jumping off point.

20           We're trying to figure out what the it is here and  
21 even know whether we do anything. So, this is a first very  
22 exploratory discussion. Some of the candidates that are on

1 the table for the it are, should we be trying to alter what  
2 is taught, the curriculum question, who -- we're producing  
3 the specialty mix sort of question.

4           Where they're taught, inpatient versus ambulatory  
5 settings, or the qualitative characteristics. Should we use  
6 these dollars to make sure our new doctors are taught in  
7 institutions that have the latest IT, they're involved in  
8 delivery system innovations, and the like? Those are four  
9 possibilities that I've heard floating around.

10           If, as the remainder of the people make their  
11 comments, if you could say something about where you think  
12 what the it is, that would be helpful.

13           DR. MARK MILLER: I was also keeping a list. I  
14 think there's also the notion of public service and loan  
15 forgiveness requirements either on people coming out or  
16 things to support physicians.

17           There was kind of this question, and it came from  
18 a comment a ways back and it gets to your point of whether  
19 at all. The other thing is, maybe it's not graduate medical  
20 education, maybe it's delivery reform and you use the money  
21 to try to drive this set of institutions in the direction of  
22 delivery reform and teaching or residency training will

1 follow that.

2           And then, finally, just big, really big financing  
3 questions like, are we talking Medicare only or all payer?

4           MS. HANSEN: Well, I appreciate the framing that  
5 both you and Mark did, Glenn, because the it is perhaps  
6 conceptually approached different ways. So it's not about  
7 the general medical education but it's graduate medical  
8 education.

9           So, the delivery system reforms that we're focused  
10 on here belie the fact that behaviors will have to change  
11 that oftentimes are prerequisite with some area of knowledge  
12 and since this is adult education, meaning clinical, my  
13 question is how we can assure the tools will happen.

14           So, the delivery system reform doesn't just happen  
15 by itself. There are some prerequisites along the way. I  
16 have no direct solutions at the moment but I don't want to  
17 forget that. It does need to be thought of maybe  
18 systematically, and to see whether or not some of the  
19 regulatory issues, frankly, get in the way, so that one  
20 consideration of calling it maybe more outcome-based  
21 education for the population of Medicare beneficiaries in  
22 the future as compared to a place-based education which is

1 where it's within the four corners of an institution. So  
2 that may be something as a concept.

3 The only other comment I'll add right now is --  
4 actually it's a question, one, and we can answer it later.  
5 Is licensing kind of consistent across all of the states?  
6 If not, then what does that add to it structurally in terms  
7 of getting the quality of care outcome?

8 And then, finally, whether or not there is any  
9 opportunity from the RAND study to do a part two of it,  
10 because this first RAND study was really the state of  
11 affairs as we know it now. And then, we have graduate-level  
12 practice places of excellence in certain areas of academic  
13 medical centers and so forth. Of the things that we're  
14 looking for in delivery reform, whether it's IT, whether  
15 it's care coordination or transitions of care, is there a  
16 way to understand how those leaders are looking at what's  
17 necessary in order to have delivery reform follow? So, if  
18 there's a way that they can be fleshed out a little bit  
19 more.

20 MS. BOCCUTI: I don't want to take up your time.  
21 I will say we are going to continue working with RAND and  
22 we'll see if we can do a little bit more. The contract is -

1 - we thought we might look at some innovative programs, so  
2 we'll look at that. But I want you all to be able to have a  
3 chance to use up the time.

4 DR. MILSTEIN: Five points. First, as has already  
5 been said, this is a long-tailed problem, right? If you  
6 don't get it right the first time -- we might hope that  
7 continuing education might rise to the job, but it certainly  
8 isn't now. And so, with a fuel great schools exempted, but  
9 it's not happening. Because I think there's some urgency  
10 here, because it's a long-tailed problem, you miss it.

11 I think Jay's comment, maybe a few years ago, was  
12 it takes good delivery systems about two years to remove  
13 wrong contents before you get back to level, so that's  
14 problem one, point one.

15 Point two is that the problem of -- in some ways  
16 you think about where the nature of the absent content or  
17 the missing content on the RAND evaluation, it directly  
18 bears on how much IME costs. If you don't train the  
19 residents, there's no role models around for efficient  
20 workups, if people believe what I believed when I was in  
21 training which is a shotgun workup for the months of July,  
22 August, and September is just fine, then it does cost a lot

1 more. So, a second rationale for moving on this is it  
2 could, I think, substantially reduce the cost of IME.

3           The third point is that I think that the -- I  
4 think this is Ralph Mueller's point -- although I am anxious  
5 to find ways of finding ways of solving the problem of the  
6 mix of residents that we manufacture, I'm not sure this is  
7 the way to do it. I think we have better ways of doing it  
8 having to do with how much we pay different specialties.

9           A fourth point is that the problem runs deep. The  
10 problem is not that -- and many of these -- I suspect that  
11 when these training programs, when they had their exit  
12 conference with RAND, I'm sure they nodded. In my  
13 experience at the two medical schools where I am, where I  
14 play this role of unpaid clinical faculty, the problem is  
15 that there's almost nobody on the faculty who knows this  
16 stuff. And when faculty positions come up, they're not  
17 allocated for these purposes; they're allocated to replicate  
18 who is currently in place. That's reality.

19           So, all that being said, I think we should  
20 consider relatively salient policies to draw attention to  
21 this. This has been known and this problem was signaled in  
22 the IOM blue-ribbon report 11 years ago and we don't have a

1 lot of action and that was acknowledged by the people who  
2 came to testify in December.

3 In terms of the what or the how, we do have a  
4 process now for auditing these residency programs, right?  
5 We have an organization that does that for us. One way of  
6 thinking about this would be to begin to -- not begin to  
7 mandate curriculum, as Karen was cautioning us about, but  
8 rather specify the nature of the disciplines that have to be  
9 part of that auditing and then begin to link the audit  
10 results to how much Medicare pays.

11 DR. CASTELLANOS: I'm sitting here thinking,  
12 what's the it? Medicare really pays for the benefit of  
13 society, for the needs of society and the benefit. What we  
14 really need talk about is a health care delivery system,  
15 which we've been talking about. But we're really focusing  
16 just on the physician. I can't sit here as a physician and  
17 say I'm responsible for this. I'm only as good as the  
18 people that surround me and I need the help of everybody in  
19 the health care delivery system. And I'm sure, Karen, you  
20 feel the same way. Tom, I know you feel the same way. Jay  
21 felt, just like when he finished his residency, he was the  
22 hottest thing available, but you soon came out and realized

1 you didn't know very much and you really had to learn from a  
2 lot of people.

3           So, I know we want to focus on the physician, but  
4 I don't want you to forget that the whole care delivery  
5 system, the hospital administrators, the nurses, the care  
6 coordinators, is as important as a physician in dealing with  
7 the care and the public.

8           MR. GEORGE MILLER: Thank you. I'd like to go  
9 back to the frame you put together and the overall frame  
10 about whether this is under the umbrella of the  
11 sustainability issue or are we talking about investment in  
12 medical education for the future, and it may be a  
13 combination of all of those things. And so, dealing with  
14 these issues we've got to make sure that we understand the  
15 overarching goal and the framework you put this under.

16           One of the challenges I think Bob mentioned is  
17 that there are caps and many hospitals are under those  
18 caps. And then the off-site training is not reimbursed by  
19 hospitals. So, there is some financial pressure there for  
20 those hospitals; Peter illuminated to that.

21           And if my information is correct as I understand  
22 it -- I never worked at a teaching hospital -- but part of

1 the problem is that the capital -- and I think Karen  
2 mentioned that some of the teaching hospitals are further  
3 along on IT and that's because recently they've had  
4 additional dollars for IT and could afford it versus  
5 community hospitals that did not have that. And as I  
6 understand that recently the capital has been decreased, so  
7 there still may be some financial pressure.

8           The other issue I want to discuss going forward  
9 is, I'm concerned about the cultural competencies, the  
10 makeup of medical schools, and still, the disparity issue.  
11 How are we going to deal with that in the long term,  
12 especially those vulnerable hospitals, safety net hospitals  
13 in poorer communities. So, I think the issues of loan  
14 forgiveness and requirements of public service may help  
15 address that issue.

16           Hospital CEOs, whether they're community hospitals  
17 or academic centers are taught, quite frankly, to follow the  
18 money. So, wherever there's financial incentives they will  
19 follow that path and we've got to make sure that we designed  
20 a system that deals with all of these issues.

21           Finally, I am always entertained and appreciate  
22 what Jay talks about, but I would like to introduce just a

1 new acronym is WTMI, when he talked about what he could do,  
2 and that's way too much information.

3 [Laughter.]

4 MR. GEORGE MILLER: Thank you.

5 MR. BUTLER: I won't pass. Having spent my whole  
6 career in academic medical centers, I have to make a couple  
7 comments, but I'll try to be crisp. I have four things I  
8 like and five things I would suggest that would improve  
9 this.

10 First, I like the idea of having a chapter at this  
11 time if we can, even if it doesn't have recommendations. I  
12 think it's a great companion piece at the end of the book to  
13 kind of the reform issues that we've had in the last day.  
14 So if we can get to a point of having a chapter, I'm for it  
15 and I think it gets this issue importantly on the table,  
16 because these are the people that will impact the system of  
17 the future more than any others.

18 Secondly, I like the idea that it looks at  
19 lifelong learning and it doesn't just highlight in the  
20 chapter those years that Medicare is involved in financing.  
21 So, don't lose that.

22 Third, I like the idea that the chapter does a lot

1 of education and I think that it could even do more. I  
2 think that the pathway of how you become a physician is  
3 good, I think the accreditation table really assembles  
4 things nicely, and I think that the text box on the  
5 residency education and how that works is good.

6           What's buried in there that is extremely important  
7 is, in 1999, ACGME took on core competencies required of all  
8 residency programs. I was on ACGME at the time. It is an  
9 extremely tedious but important thing. If you look at those  
10 competencies, which there are five of them, including things  
11 like practice-based learning, systems approach, it's a  
12 perfect vehicle where we perhaps could build on that and say  
13 not what do we want in the curriculum but what are the  
14 competencies that we're looking for. And you have a vehicle  
15 where we could perhaps help find provide some additional  
16 insights into the competencies. So, I would bring that to  
17 light a little bit more as a foundation that we could  
18 contribute to.

19           Lastly, I like the regulatory issue. That is a  
20 theme and there are some early wins. You mentioned if you  
21 go off campus for didactic, you don't get -- if you go to  
22 medical school across the street, it doesn't even count.

1 You can be on campus. But I think there are some early wins  
2 that aren't necessarily financial issues that we could  
3 advance in recommendations fairly quickly and would help  
4 everybody.

5           What could be better? I think the clear  
6 identification of the difference between GME in IME is done  
7 in the textbooks, but right in the front of -- we pay \$9  
8 billion for training. Well, these are very different. You  
9 asked a very important question. We need to bring to light  
10 -- I think even in the chapter -- a little bit more the  
11 mystery around IME. I mentioned utilization and ordering by  
12 internal medicine residents.

13           There's also new technologies. In fact, some of  
14 the kinds of things we're going to discuss in the next  
15 session are often introduced in teaching hospitals more than  
16 any other without reimbursement associated with them.  
17 Whether that's right or wrong, the reimbursement system  
18 doesn't catch up and it doesn't always catch up in the right  
19 way, but that's an added cost.

20           Secondly, when you go and do further work with  
21 RAND, I think programs in internal medicine directors as a  
22 starting point because there are critical. But you might

1 want to go to what is called the DIOs, the Designated  
2 Institutional Officers. They're the people in the  
3 institutions that oversee all of the residency programs.  
4 They are the ones that can create the interdisciplinary  
5 teamwork and issues. So, it's a different position in the  
6 organization that you probably ought to talk to them, not  
7 just one program.

8           Third, I think there's a certain tone of this,  
9 including in the title, that says, we better match at this  
10 year's training to this year's need or health care reform  
11 agenda. So there's a little bit of a tone that should be --  
12 I think this is already said -- that we're training people  
13 for many years out, not just for this year's agenda. So it  
14 needs to be a little bit longer thinking in how that's  
15 presented, and maybe it could be in a different title.

16           The IT thing I like a lot in terms of another area  
17 where we could advance some recommendations sooner rather  
18 than later. I think in the chapter it talks a little too  
19 much about you need to be able to do CPOE or be adept. I  
20 think it misses the point of transforming care.

21           When we put in CPOE, we spent a lot of time with  
22 our residents coming up with 240 order sets that get

1 embedded in the technologies that guide the care that reduce  
2 variations and eliminate error; that's the issue, not having  
3 the technology per se.

4           So, I think the power of engaging residents in  
5 those kinds of guidelines that happen to use technology to  
6 implement them is the issue, not the technology itself. So,  
7 make sure that that's highlighted.

8           And lastly, in terms of the couple of these other  
9 issues that came up, I think that the -- Mark, you and some  
10 like the medical school admission criteria and loan  
11 forgiveness -- I think it's extremely important, I just  
12 don't think it's our domain. I think similarly on the  
13 specialty side, I think we can tweak and influence the mix  
14 of specialties, but I agree with Arnie's comment and then  
15 half of Ralph, I guess. The payment system in the end is  
16 going to do more to put people into the specialties rather  
17 than this piece of the action. We shouldn't ignore it, but  
18 I don't think it should be the heart of what we want to work  
19 on.

20           But overall, I think it's time to bring it forward  
21 as a chapter in time to get some baseline education that we  
22 could advance some recommendations on in the future.

1           MR. HACKBARTH: Okay thank you. This is a good  
2 start and I think we made some progress in giving some shape  
3 to the it, but still much more to be done.

4           The next subject is follow up biologics.

5           Just a word about the schedule. We are starting  
6 about 20 minutes late, but what I'm going to do is extend  
7 this session until 11:15, so we will have just about the  
8 entire time that we had budgeted, and then we will start the  
9 public comment period at 11:15 and have that run to 11:30.  
10 I'm going to have to leave to catch a plane right at 11:15,  
11 but Jack will oversee the public comment period.

12          DR. SOKOLOVSKY: Good morning. Today we're going  
13 to talk about follow-on biologics, an issue that is new to  
14 the Commission, although as you may remember, we have  
15 discussed since the summer putting this on our agenda.  
16 Because the subject is new to us with an unfamiliar  
17 vocabulary and concepts, we're going to spend some time  
18 today going over those key concepts and issues. And I want  
19 to mention at the outset that we convened an expert panel to  
20 help us with this subject by providing their perspectives on  
21 the issues involved, and their insights are in reflected  
22 throughout this presentation.

1           Spending on biologics has been increasing rapidly,  
2    totaling over \$40 billion in the U.S. for 2007, and about  
3    one-third of all drugs currently in development are  
4    biologics. CBO estimates that if the Congress established  
5    an approval pathway for follow-on biologics, the Federal  
6    Government could save as much as \$12 billion over the next  
7    10 years, and much of that things would accrue to a  
8    Medicare. Further, providing a lower-cost alternative to  
9    some very expensive biologics could increase patient access  
10   to needed medications.

11           We're going to present today some of the key  
12    definitions and concepts concerning follow-on biologics or,  
13    as I'll refer to them today, FOBs. First, we'll cover the  
14    difference between biologics and other drugs, and we'll look  
15    briefly at the patent system and the FDA approval process --  
16    two separate processes, but both of which have implications  
17    for when an FOB can enter the market. We'll look at the  
18    issue of data exclusivity, the period of time before a  
19    follow-on manufacturer can submit an application for  
20    approval to the FDA based on the innovator's data.

21           Another key issue for the FDA is to define  
22    standards for approval when an FOB is comparable to the

1 innovator. An even higher standard that we'll talk about  
2 briefly is interchangeability.

3           After this background, Kim will look at FOBs and  
4 Medicare Part B, and Nancy will talk more broadly about ways  
5 in which Medicare could better reflect value in the payment  
6 system.

7           Biologics are drug products derived from living  
8 organisms. Unlike the kind of drugs that most people are  
9 familiar with, these products are large, as you can see,  
10 complex molecules that generally are injected or infused  
11 directly into the body. They include proteins like  
12 vaccines, insulin, and hormones but also products engineered  
13 through biotechnology like many of the new products used to  
14 treat cancer, anemia, rheumatoid arthritis, and MS.

15           Right now there is no expedite pathway for  
16 approval of these follow-on versions of biologics, so the  
17 prices of these new products, which tend to be high to begin  
18 with, have not fallen over time.

19           Biologics are also different from other drugs  
20 because manufacturers cannot produce a follow-on product  
21 that is exactly identical to the reference product. That's  
22 why we talk about follow-ons and not generic versions of

1 biologics.

2           Like all drugs, biologics have safety issues  
3 associated with them. For example, most biologics have some  
4 immunogenicity, which is the ability of the substance to  
5 stimulate the body's immune system, which generates  
6 antibodies. For many biologics, this doesn't result in any  
7 clinically relevant effects, but for others the response can  
8 diminish the efficacy of the product. And in the most  
9 severe cases, immunogenicity can cause severe adverse  
10 reactions in some individuals, including life-threatening  
11 effects.

12           Any biologic has to meet tests of immunogenicity.  
13 However, severe adverse reactions in individuals may be very  
14 rare, and even using large-scale clinical trials for any  
15 specific product, whether it's the innovator or the follow-  
16 on, they may not be big enough to uncover the problem before  
17 a product is approved for marketing. Some analysts have  
18 suggested that post-marketing surveillance for biologics may  
19 be warranted.

20           I need to stop her again and give a little bit  
21 more background. All new drugs, including biologics, go  
22 through two completely separate processes: the patent

1 process, which protects an innovation from competition for a  
2 set period; and the drug approval process, which allows a  
3 drug to be marketed.

4 Different organizations have responsibility for  
5 the patent system and drug approvals. Patents are awarded  
6 under the Patent Act and administered by the Patent Office.  
7 The FDA has the responsibility to approve drugs for sale.  
8 These two processes have different requirements and award  
9 different protections. Examiners at the Patent Office award  
10 patents to any invention on the basis of utility and novelty  
11 and what they refer to as "non-obviousness," which I take to  
12 mean somebody could invent toothpaste, someone else could  
13 invent a toothbrush, but you couldn't get a patent for  
14 telling somebody to put the toothpaste on the brush.

15 MR. EBELER: Don't be so technical.

16 [Laughter.]

17 DR. SOKOLOVSKY: I'm trying.

18 Patent holders can exclude competitors from the  
19 market for a period of 20 years from the date the  
20 application was filed. In the case of drugs, the inventor  
21 generally files for patent protection well before a product  
22 is approved for sale by the FDA.

1           The FDA approves drugs that meet standards for  
2 safety and efficacy. Manufacturers of new products must  
3 support this application with clinical data, safety reports,  
4 manufacturing standards, and other relevant information.  
5 Manufacturers may market their products after they receive  
6 FDA approval, but the FDA also provides extra protection  
7 against generic competitors by awarding a period of data  
8 exclusivity, and that's something I'll talk about a minute.

9           Patent protection generally occurs concurrently  
10 with the FDA approval process. If FDA approval takes a long  
11 time, there are provisions for patent restoration. The  
12 patent process for biologics and drugs in general has a  
13 number of issues that can delay entry of generics or follow-  
14 ons to the market. Some of them are discussed in your  
15 mailing materials. In the interest of time, I'm not going  
16 to go into them now, but I would be happy to discuss them on  
17 question. For the rest of my part of the presentation, I'll  
18 be talking about the FDA process.

19           Two of the very contentious issues in the FDA  
20 process are how long a period of data exclusivity new  
21 biologics should get and what kinds of tests the FDA should  
22 require to determine that FOBs are comparable to the

1 original products.

2           Currently, in cases where a drug's patent expires  
3 before or soon after approval for marketing, an innovator is  
4 granted five years of data exclusivity. That's a period  
5 without generic competition. Data exclusivity is the period  
6 of time after FDA approval before a follow-on or generic  
7 competitor can submit an application for approval to the FDA  
8 that relies on the innovator's data on safety and efficacy.  
9 That means essentially that they don't have to do large-  
10 scale clinical trials.

11           At issue here is how long a period of data  
12 exclusivity is necessary to promote innovation and foster  
13 competition in the biologics market. Some argue that  
14 manufacturers need a long period of data exclusivity to  
15 recoup the development costs of a new biologic. For  
16 example, innovative companies argue that at least 14 years  
17 of data exclusivity is essential to provide adequate  
18 incentive for new inventions. They say investors will be  
19 reluctant to enter this market without the guarantee of a  
20 sufficient period of time.

21           Others argue that lengthy exclusivity provisions,  
22 longer than the five years that's included for generic

1 drugs, would both delay entry of low-cost competitors and  
2 discourage competition. They argue that brand companies  
3 don't have very much incentive to develop new products  
4 without the threat of imminent competition.

5           The second issue is that of comparability. To  
6 approve an FOB, the FDA has to determined that the follow-on  
7 product is comparable to the reference product, and  
8 comparability here means that the safety, the identity, the  
9 purity, and the potency of the FOB is unchanged from the  
10 innovative product.

11           Currently the FDA has comparability protocols that  
12 it uses to assure that when a manufacturer changes its own  
13 product, either by changing the production site or the  
14 process, the new product will be comparable to the old one.  
15 And remember, with biologics, even if it's the same company,  
16 the new product will not be identical to the old one.

17           The protocols outline a series of tests required  
18 on a case-by-case basis to ensure that manufacturing changes  
19 haven't compromised the safety and efficacy of the product.  
20 The FDA determines whether differences between the products  
21 are significant enough to require additional testing.  
22 Sometimes they want some clinical testing to see, for

1 example, how the product affects blood levels and various  
2 tissues, or they want to see the short-term impact of the  
3 product on animals or humans. These tests are clinical, but  
4 they're not the same thing as long-term clinical outcome  
5 studies.

6           At any stage of this process, the FDA may  
7 determine that the two products are not comparable and end  
8 the tests. Analysts disagree about whether the FDA can  
9 improve FOBs based on this case-by-case approach or whether  
10 there should be a uniform series of tests that should be  
11 required of all products.

12           An even higher standard of comparison is  
13 interchangeability. Interchangeability means that an  
14 individual patient can switch back and forth between the  
15 innovative product and the FOB without any clinical effect.  
16 Like if you get a prescription and take it to the drugstore  
17 for a generic drug you don't know which manufacturer has  
18 made that pill that particular time.

19           This is an issue that our expert panel spent a  
20 long time discussing. Analysts disagree about whether the  
21 science currently exists to demonstrate interchangeability.  
22 It's not clear that even if the FDA was given this authority

1 they would use it, but many of our panelists thought the FDA  
2 should have the authority so that when the science does  
3 exist they can make this determination. They also agreed  
4 that comparability was the standard for approval for an FOB.

5 Panelists did note some instances where the FDA  
6 declared biologics interchangeable for public health  
7 reasons, and here they referred to the example of Hurricane  
8 Katrina, where physicians and patients wouldn't have access  
9 necessarily to their usual pharmacies, and so the FDA said  
10 if you need insulin, just get whatever insulin is available,  
11 you don't have to worry about whether it's the same brand as  
12 you were using before. This determination was made despite  
13 the fact that there hadn't been any head-to-head tests  
14 between the products. It was a public health decision.

15 If the FDA designates products as interchangeable,  
16 it will have implications for costs and competition. In the  
17 small molecule market, most states have procedures where  
18 generic product can be substituted for the brand product  
19 without the prescriber having to intervene. With  
20 comparability it would be the prescriber's decision which  
21 product was used. And if the FDA declares that an FOB is  
22 comparable to the reference product, we still assume that

1 the FOB would compete in the market with the innovator and  
2 there still would be savings.

3           Next, Kim is going to talk to you about how  
4 competition might play out with Medicare Part B if FOBs do  
5 enter the market.

6           MS. NEUMAN: Biologics play a large role in  
7 Medicare Part B. The top six Part B-covered drugs in terms  
8 of spending are all biologics. These six biologics alone  
9 account for \$7 billion or 43 percent of all Medicare Part B  
10 spending on separately paid drugs.

11           Follow-on biologics have important implications  
12 for Medicare Part B as they offer potential opportunities  
13 for savings to the Medicare program and beneficiaries.  
14 Lowering the cost of expensive biologics also may increase  
15 access to these products for some patients. The amount of  
16 Medicare Part B savings that are likely to result from  
17 follow-on biologics would depend on a number of factors,  
18 including how follow-on biologics are treated under the  
19 Medicare Part B payment system.

20           Next, I'll discuss how the Medicare Part B payment  
21 system works for drugs and provide an example of the  
22 competitive dynamics that work when generic drugs enter the

1 market and then discuss implications for follow-on  
2 biologics.

3           As you'll recall, most Part B-covered drugs are  
4 administered by physicians. Physicians purchase the drugs  
5 in the marketplace, and Medicare pays them 106 percent of  
6 the average sales price, or ASP. A drug's ASP reflects the  
7 manufacturer's average price for sales to all purchasers,  
8 with certain exceptions, net of rebates, discounts, and  
9 price concessions. Under the ASP payment system, physicians  
10 have the incentive to seek the lowest price available for a  
11 drug because they are paid 106 percent of ASP, regardless of  
12 the actual price they pay for the product.

13           This next slide gets into some of the more  
14 detailed mechanics of how Medicare pays for drugs and how  
15 this affects competition among products.

16           Medicare makes payment for Part B drugs using  
17 billing codes. A billing code typically refers to a unique  
18 form and strength of a chemical or biological entity. All  
19 products in the same billing code receive the same payment  
20 rate based on the volume-weighted ASP for the products in  
21 the code.

22           Generic and brand versions of a small molecule

1 drug are placed in the same billing code, which fosters  
2 competition. Because the payment rate for the billing code  
3 is based on the average ASP for all products in the code,  
4 physicians have the incentive to seek the lowest price  
5 version of the drug available. This in turn causes volume  
6 to move toward the lower-priced products and brings down the  
7 volume-weighted ASP over time.

8           Also, there is a two-quarter lag in the ASP  
9 payment system which further incentivizes use of generics.  
10 Because of the lag, for the first two quarters generics are  
11 on the market, they are paid only based on the higher ASP  
12 for the brand product, which creates a substantial incentive  
13 for generic adoption.

14           For biologics and drugs without generic  
15 alternatives, often referred to as single-source drugs,  
16 coding and payment work somewhat differently. The MMA  
17 required that each biologic and single-source drug be paid  
18 based on its own ASP, not averaged with other products, so  
19 each has its own billing code. The MMA, however, made an  
20 exception for a small number of closely related biologics  
21 and single-source drugs that had been placed in the same  
22 billing code prior to the MMA. The MMA grandfathered these

1 products, requiring that they continue to be grouped  
2 together and paid a rate based on the average ASP for the  
3 products in the code. Note that the FDA has not made a  
4 determination regarding the comparability or  
5 interchangeability of these grandfathered products.

6 This next slide provides an example of some of the  
7 competitive dynamics at work under the ASP payment system  
8 when a generic drug enters the market. This example  
9 illustrates how coding and payment play a role in the degree  
10 of price competition among products.

11 This slide shows four intravenous anti-nausea  
12 drugs in the same therapeutic class that compete with one  
13 another. Each of the four drugs is a different chemical  
14 entity and has its own billing code. In late 2006, one of  
15 the drugs, shown in blue in the chart, went generic. As you  
16 can see by the steep decline in the blue line, there was a  
17 substantial decrease in the Medicare payment rate for this  
18 drug after it went generic as the generic and brand versions  
19 of the drug were placed in the same billing code and  
20 received a payment rate based on the average ASP for all  
21 products in the code.

22 We also saw more moderate declines in the payment

1 rates for the other three drugs in the therapeutic class,  
2 each of which continue to be paid in its own billing code  
3 based on its own ASP.

4           It is important to keep in mind that we would not  
5 expect follow-on biologics to result in as large a price  
6 decrease as we see for generic drugs. Nevertheless, some of  
7 the same competitive dynamics apply.

8           Follow-on biologics are expected to generate  
9 savings for Medicare Part B, and how they are coded would  
10 affect the level of savings. Placing follow-on biologics  
11 and innovator biologics in the same billing code would lead  
12 to more competition and greater savings than if they were in  
13 separate billing codes.

14           Clinical appropriateness of coding decisions,  
15 however, is an important consideration. Placing follow-on  
16 biologics and innovator products in the same code would  
17 create financial incentives for the use of the lower-priced  
18 product. Given some of the safety issues associated with  
19 biologics that Joan discussed earlier, there may be reasons  
20 why financial incentives for the use of the lower-priced  
21 product may not be clinically appropriate in all instances.

22           If policymakers wish to put follow-on biologics in

1 the same billing code as the innovator product, there are  
2 several ways that it could be structured to address the  
3 goals of ensuring patient safety and achieving savings. For  
4 example, placement in the same billing code be contingent on  
5 an FDA determination of interchangeability. Another  
6 potential approach is to permit the Secretary to place  
7 follow-on biologics in the same billing code as the  
8 innovator product after input from an advisory committee of  
9 scientific and medical experts or a public comment process.  
10 A third approach might be to require follow-on biologics and  
11 innovator products to be placed in the same billing code,  
12 but permit the Secretary to make exceptions if there is  
13 evidence that this is not clinically appropriate for a  
14 particular product.

15 As we walk down this list of approaches on the  
16 slide, it is likely that the number of follow-on biologics  
17 and innovator products placed in the same billing code would  
18 increase, and as a result savings would increase. I would  
19 be happy to discuss these approaches in more detail in the  
20 Q&A if there is interest.

21 Now I am going to turn it over to Nancy who is  
22 going to talk about innovative pricing strategies that might

1 improve the value of Medicare payment systems for Medicare  
2 services more broadly, including drugs and biologics.

3 MS. RAY: Implementing a process to approve  
4 follow-on biologics may increase competition and lower  
5 Medicare payment rates for these products. To help Medicare  
6 become a more astute purchaser of health care services,  
7 policymakers could consider other changes. One such change  
8 concerns how Medicare sets the payment rates for biologics  
9 and drugs as well as medical services, devices, surgical  
10 procedures, and diagnostic services.

11 Medicare rarely considers clinical evidence in the  
12 rate-setting process. Consequently, instances exist in  
13 which the program pays more for a service when there is no  
14 evidence showing that it is better than currently available  
15 treatments.

16 Some policy experts have concluded that Medicare  
17 should use comparative effectiveness information when  
18 setting providers' payment rates. Some have also suggested  
19 that Medicare not pay more for a new service without  
20 evidence that shows that it is better than currently  
21 available treatments.

22 Your mailing materials give three examples of

1 pricing mechanisms that would improve the value of Medicare  
2 spending that makes use of clinical evidence. I'm going to  
3 spend a couple of minutes here talking about these  
4 approaches.

5           The first is reference pricing. Payment for a  
6 service under this strategy is often set at the price of the  
7 least costly service among all those that are clinically  
8 comparable. That is, payers cover the cost of the lowest-  
9 priced alternative. Patients can pay the difference if they  
10 and their providers decide on a higher-priced item. The  
11 rationale is that payers should not reimburse more for one  
12 service when a similar service can be used to treat the same  
13 condition and produce the same outcome but at a lower cost.  
14 This concept is a little different than what Kim was  
15 discussing. What we are discussing here is, for example,  
16 two innovator products, two innovator drugs or medical  
17 services, for example, that are in separate codes. One is  
18 more costly than the other, but there is no evidence that  
19 the more costly item produces better outcomes. Reference  
20 pricing could also be used if the decision is made to put  
21 follow-on biologics in different codes from the innovator  
22 biologic.

1 Medicare has some experience with reference  
2 pricing strategies, referred to as least costly alternative  
3 policies that are used to set the payment rate of selected  
4 drugs and supplies. However, a recent court decision  
5 pertaining to drugs might discourage its widespread use.

6 The second strategy is performance-based pricing.  
7 This approach explicitly links payment to patient outcomes  
8 through risk-sharing with providers and manufacturers. This  
9 is also referred to as payment by results. The basis of  
10 risk is the effectiveness of the product as measured by  
11 agreed-upon objective outcomes. This strategy shifts some  
12 of the financial risk from the payer to the provider and  
13 manufacturer.

14 Some have suggested that performance-based pricing  
15 might be particularly appropriate for services and products  
16 that are high-priced but whose clinical effectiveness is now  
17 well studied for all patients.

18 One example is a risk-sharing scheme that began in  
19 2002 in the United Kingdom between the Department of Health  
20 and four manufacturers of products used to treat multiple  
21 sclerosis. The outcomes of about 5,000 patients with MS are  
22 being monitored for 10 years. The price that is being paid

1 for each drug may be adjusted based on the drug's clinical  
2 effectiveness at two-year intervals to ensure that the drugs  
3 remain cost effectiveness.

4           The third pricing strategy is bundling. Under  
5 this approach, providers are paid a set rate for a group, a  
6 bundle of services that they furnish during the treatment of  
7 a chronic disease or illness or during an event, such as  
8 surrounding an inpatient hospitalization. The Commission is  
9 certainly familiar with this strategy. You discussed  
10 bundling all services associated with an inpatient stay in  
11 our June 2008 report.

12           I would like to point out here that widespread  
13 implementation of these approaches might take a change in  
14 the statute. Some researchers have concluded that the  
15 statutes that set forth particular prospective payment  
16 systems and fee schedules would have to be amended before  
17 Medicare could broadly use such pricing strategies.

18           This concludes our presentation. Some of this  
19 discussion of follow-on biologics was complex and introduced  
20 new topics. We are happy to answer any questions you have  
21 about the material we presented this morning and anything in  
22 your mailing materials that we did not present. We are

1 interested in suggestions for topics for future analysis.

2 In April, we will present an analysis of Part D  
3 spending of biologics and discuss how the approval of  
4 follow-on biologics might affect this trend. For the June  
5 report, we plan on including an informational chapter on  
6 follow-on biologics.

7 MR. HACKBARTH: Thank you. I thought I'd see  
8 Bruce's hand up here early. So first-round clarify  
9 questions.

10 DR. STUART: This is a very dynamic market for  
11 biologics, and as you know, the pipelines for these products  
12 among the major manufacturers are fairly deep and long. So  
13 the question here, the first question I'd like to ask, is:  
14 Did you look at the follow-on biologics in the context of a  
15 dynamic market? In other words, it's going to take awhile  
16 for these products to be approved, if FDA gets the authority  
17 to do this. But the market itself is going to continue to  
18 operate in terms of new products coming on the line. Are  
19 the FOBs going to be obsolete by the time they get through  
20 the market? I guess that is really my question.

21 DR. SOKOLOVSKY: I guess that I can't say that  
22 because, as you know, a third of the drugs in development

1 right now are biologics, but we don't know how many of them  
2 will actually make it to the market. So, on that basis, I  
3 don't really think -- as you say, it's a very dynamic  
4 market. I don't think I could answer that.

5 DR. STUART: I haven't read the GAO report. Did  
6 it address this issue?

7 DR. SOKOLOVSKY: It talked about drug development  
8 in general.

9 DR. KANE: I'm finding it a little confusing to  
10 understand quite what the criteria for bundling into the  
11 same billing code options are. So if you look at page 14, I  
12 think, one option is, I guess, to put them in the same  
13 billing code if they're interchangeable; another is to put  
14 them in the same billing code I guess if they're comparable.  
15 And is that middle bullet putting them in the same billing  
16 code on some other basis?

17 MS. NEUMAN: The middle bullet gives sort of an  
18 intermediate option in the sense that you could under the  
19 middle bullet put things in the same code if, for example,  
20 they're interchangeable. And perhaps there may be  
21 circumstances where an interchangeability determination  
22 hasn't been made, but something has been on the market for a

1 fair amount of time, and there's consensus that they're  
2 pretty much the same, and for whatever reason there's not an  
3 interchangeability determination.

4           It would allow the flexibility to sort of take  
5 into consideration the specific circumstances of a product  
6 and, you know, sort of what the common consensus is among  
7 the medical community about its use. So it would give  
8 wiggle room and discretion to the Secretary.

9           DR. KANE: I guess I'm a little uncomfortable  
10 understanding what other type of evidence besides these two  
11 standard -- and maybe a related question is: Does what  
12 other countries do with that drug have any bearing on what  
13 we do? Would that help set the standard that isn't the same  
14 as comparable or interchangeable, but yet it's in wide use  
15 in England or something?

16           DR. SOKOLOVSKY: There are on the market now about  
17 15 follow-on biologics in Europe. The EU, which has the  
18 overall responsibility for approving follow-on biologics,  
19 makes determinations of comparability. It leaves  
20 determination of interchangeability to the individual  
21 countries, and, in general, they are not making that  
22 determination.

1 DR. DEAN: I'm going to say this, but I obviously  
2 could be wrong. The way I organize this to my mind when we  
3 were talking it through is the first one is the highest  
4 standard. It's sort of interchangeability, you only put  
5 them in the same code if there has been a determination of  
6 interchangeability. And that's a fairly high standard. Try  
7 to track your mind back to some of the things that Joan was  
8 saying in terms of being able to determine particular -- all  
9 right.

10 The other two I see as more -- you could use  
11 different determinations, but those are more comparability  
12 standards, and it's just a question of kind of going through  
13 a process and deciding there's enough evidence to put them  
14 into the same code.

15 Is that a fair break between the first and the  
16 second two?

17 MS. NEUMAN: I think that is a fair break, and you  
18 could see a need for sort of the second or third if you had  
19 questions about whether FDA would exercise the  
20 interchangeability determination.

21 DR. KANE: So the second two are sort of ways of  
22 deciding whether they are comparable?

1 MS. NEUMAN: Ways of deciding whether they are  
2 comparable, yes.

3 DR. MARK MILLER: Are you sure, Kim? Because, I  
4 mean, I said that, not you. So --

5 [Laughter.]

6 DR. SOKOLOVSKY: It's the FDA that decides that  
7 they're comparable. This is a coding decision that CMS  
8 would make, and CMS --

9 DR. MARK MILLER: And that's what I was trying to  
10 say. At a minimum, there would be a comparability  
11 determination.

12 DR. KANE: But not by the FDA.

13 MS. NEUMAN: Let me step back for a second. If a  
14 follow-on biologic is approved, assuming there's a pathway,  
15 that would connote that the FDA has determined that the two  
16 products are comparable in terms of safety or efficacy. So  
17 any of the products that there would be consideration about  
18 whether to put in the same billing code or not would have  
19 been determined to be comparable by the FDA. The question  
20 is whether that alone makes you comfortable putting them in  
21 the same billing code or if there are other concerns that  
22 would make you want them to stay in separate codes.

1 DR. KANE: Okay. So step two and three are really  
2 just ways to avoid having a comparable put in the same  
3 billing code if there are concerns that are beyond the  
4 comparability determination.

5 MS. NEUMAN: Yes.

6 DR. CROSSON: My question of clarification was  
7 exactly the same as Nancy's.

8 DR. CHERNEW: I had a question about Slide 16,  
9 and, in particular, were you intending these to go well  
10 beyond biologics and be a broad discussion of Medicare  
11 payment policy that could be used in Part A or Part B? Or  
12 is this ways of thinking about it just within the context of  
13 prescription drugs?

14 MS. RAY: More broadly, Part A and Part B.

15 DR. CHERNEW: I'll save my round-two follow-up  
16 question.

17 MR. BUTLER: Just another clarification, because  
18 the chapter is titled "Biologics," and you do get into in  
19 the end the pricing for new technologies. So you use, for  
20 example, IMRT and CTA which are really not biologics per se,  
21 or we could go back over drug-eluting stents and some of the  
22 other things and how those have been handled.

1           What is your thinking about how that fits with the  
2 rest of the discussion around biologics? Because they're a  
3 little bit different. They're both important, but...

4           DR. MARK MILLER: It's always complicated trying  
5 to organize the material that we go through here. There has  
6 been some discussion on at least a couple of these  
7 strategies in the past, the reference pricing strategy and  
8 the bundling strategy for sure. Biologics introduces  
9 another place where it was a good place to talk about these  
10 kinds of tactics.

11           The middle one, although you might potentially  
12 apply it to other things, my sense -- and, again, because I  
13 am not as close to this as you guys -- is pretty much that  
14 one has been talked about only in the drug world that I'm  
15 aware of.

16           So I think what we're trying to do is we're trying  
17 to do a couple of things here. Biologics and those follow-  
18 on biologics matter to Medicare, and it's probably worth  
19 knowing what they are, number one. Number two, there are  
20 some very specific Part B issues that might pertain. Then  
21 there are some broader payment strategies that we should be  
22 talking about generally that could very much play a role in

1 the biologics world but probably go past that.

2 I see your point that these may have different  
3 permutations depending on what we're talking about. We're  
4 just trying to organize it close to something where you can  
5 get your head around it and go, oh, I see what these  
6 concepts -- how they could be used.

7 DR. REISCHAUER: This might be more a question for  
8 Bruce or some of the physicians here than you folks, but  
9 comparing biologics to small molecule drugs, is the  
10 effectiveness of any biologic more likely to vary with  
11 genetic makeup than is the case with small molecule drugs?  
12 Because we could be on the cusp of a period where we're  
13 going to say, well, you know, all of us have the same  
14 condition, but biologic A is best for me and biologic C is  
15 best for Bruce, and so sort of trying to lump together just  
16 before we get to the scientific application that says this  
17 is not appropriate may be not the way to go.

18 DR. SOKOLOVSKY: If no one else wants to take a  
19 crack at that, I will give -- a couple of years ago, you may  
20 remember, we did a mandated report on physicians that used  
21 Part B drugs, and one of the examples was rheumatologists.  
22 There are four biologics -- well, actually, there are four

1 Part D biologics and two Part B biologics that  
2 rheumatologists use, most of them in the same class called  
3 TNF inhibitors. I was told virtually to a person by the  
4 rheumatologists that all of these drugs essentially perform  
5 the same purpose; there isn't a particular reason to favor  
6 one over the other going in, but that each one of them won't  
7 work for a certain percentage of people, and if you move  
8 them to another one, it may work. So that implies a certain  
9 -- I don't know that I want to compare it to small molecule  
10 drugs, but it certainly supports the idea that there is a  
11 some individual reaction that's important to take into  
12 account.

13 DR. MARK MILLER: The thing that I try to carry  
14 around in my head is, again, it goes to the  
15 interchangeability and the comparability. If you could get  
16 to an interchangeability standard in the sciences, you know,  
17 is in question. That notion there is it's getting a lot  
18 closer to what a generic is.

19 But setting that aside, because the standard may  
20 be a very high and hard to hit, is the question of  
21 comparability. And there the difference one way -- and you  
22 said this -- is whether you go to the pharmacy and somebody

1 simply just substitutes a drug or one biologic for another,  
2 you wouldn't be doing that. In a comparability situation,  
3 your physician would be making that decision.

4 DR. CROSSON: Just a little bit on Bob's question,  
5 there's two moving pieces here. One is for the small  
6 molecule drugs which say -- let's say it contains 20 or 25  
7 atoms; the generic drug has got same 20 or 25 atoms.  
8 They're the same. So then you have genetic diversity in the  
9 population in the sense of how one person versus another  
10 person responds to that group of 25 atoms.

11 The issue here with respect to the biologics is  
12 you've got molecules of perhaps hundreds or in some cases  
13 thousands of amino acids all combined in a ball of yarn like  
14 that diagram suggested. And it's possible to construct --  
15 as a matter of fact, it is most likely that when others try  
16 to construct the same molecule, they're going to have, say,  
17 a few amino acid sequences that are different.

18 It is possible, although I don't know that there's  
19 any evidence, that those differences between the two  
20 molecules that are slightly different could play into the  
21 genetic differences that are present in the population, even  
22 for more simple formulations of pharmaceuticals. But I

1 don't know that there's any evidence that it's more likely.

2 DR. DEAN: Just to follow up on the same thing,  
3 what Joan said is certainly right, but it's also true of a  
4 lot of small molecule drugs. It's true of non-steroidal  
5 anti-inflammatory drugs, it's true of antidepressants. So  
6 there is a lot of variation. I think we just really don't  
7 understand it, I mean, just on the verge of -- but I would  
8 suggest that I think it's true of all drugs.

9 MR. HACKBARTH: I am struggling -- and we're going  
10 to get to round two here in just a second. Maybe this is  
11 the first round two. I am still struggling with the  
12 question of where MedPAC might enter into this conversation.  
13 It seems to me, if I understand this correctly -- and I may  
14 not -- that there are a bunch of issues for the FDA about  
15 how it deals with follow-on products in this area and very  
16 important questions to be answered there. And then there's  
17 a series of questions about how Medicare would pay for  
18 biologics and, more broadly, new technology of various  
19 types.

20 I understand that focusing on biologics gives us  
21 an example of broader "How do we pay for new technology?"  
22 questions. But given how many moving parts there are in

1 biologics, I wonder if it's a good case for us to be using  
2 to address the Medicare new technology questions. That's a  
3 question, not an answer, but that's what I'm struggling  
4 with.

5 Let me see hands for round two.

6 DR. STUART: This is partly a question -- well, a  
7 comment and then a question. There is one opportunity  
8 that's not on here, and that's coverage determination. So  
9 you decide whether you're going to cover it or not.

10 Now, this is certainly a very underused aspect of  
11 at least drug coverage under Part B. But that's not to say  
12 that it can't be done, and there are some other countries  
13 that have done this with biologics. What that comes back  
14 to, then, is having a mechanism for determining  
15 comparability, which is really what were kind of struggling  
16 with here.

17 That leads to my question. Of the \$1.1 billion in  
18 stimulus funding for comparative effectiveness, \$400 billion  
19 of that ended up in NIH, and \$300 billion is going to be in  
20 AHRQ, and \$300 billion is at the discretion of the  
21 Secretary. My question is: Has there been any talk about  
22 that \$300 billion being funneled in some way for comparative

1 effectiveness that might lead ultimately to coverage  
2 decisions under Medicare? I know this is an atomic issue.  
3 It's a huge issue, but you're closer to it than I am.

4 MS. RAY: Just to clarify, the comparative  
5 effectiveness funding totals \$1.1 billion; \$400 million goes  
6 to NIH, \$300 million goes to AHRQ, and \$300 million is at  
7 the discretion of the Secretary.

8 This slide and the mailing materials were designed  
9 not to be comprehensive but just to provide examples. I  
10 think we focused on payment as opposed to coverage because  
11 of concerns raised in the past with coverage and trying to  
12 include value in the national coverage decisionmaking  
13 process. And that leads to a yes and no decision versus on  
14 the payment side where you don't have that same yes or no  
15 decision.

16 In terms of the \$1.1 billion funding in stimulus  
17 and the coverage, I think it remains to be seen how that  
18 goes.

19 DR. MARK MILLER: My take on the second part of  
20 your question would have been -- I mean, they're going to  
21 motivate studies, and those studies may potentially shed  
22 light on coverage decisions. But I don't know that there is

1 a hard linkage between the money and coverage decisions. I  
2 think the money is directed more towards studying things.

3 DR. STUART: I'm sure there is no direct linkage.  
4 It was simply a question about whether the discretion is  
5 likely to lead to some efforts to clarify what is a very  
6 messy area here. And I frankly would put coverage  
7 determination in there even if you don't spend a lot of time  
8 talking about it, because I know private insurers, private  
9 payers, are looking particularly at some of these new  
10 chemotherapy agents that are coming down the line.  
11 According to the trial, it gives you another week to live as  
12 opposed to the next best agent. You know, are we going to  
13 pay for that? So I think it ought to be on the table.

14 MR. HACKBARTH: Nancy, can I just ask one more  
15 round-one question? The CBO had in its Options Book a  
16 policy related to biologics. In fact,, the President's  
17 budget also has one, and they have some specific number of  
18 savings, \$9 billion or something over 10 years. Is that a  
19 proposal or the CBO option about changing the FDA process,  
20 or is it about changing Medicare payment, or some  
21 combination of the two?

22 DR. SOKOLOVSKY: It reflects both the FDA and the

1 coding issues that Kim brought up, depending on your  
2 assumptions what the savings would be. One range of  
3 assumptions is what are you assuming about data exclusivity.  
4 Another set of assumptions are about this coding issue that  
5 Kim is talking about.

6 DR. KANE: It would be interesting to know -- for  
7 these biologics that may be harder to get generic  
8 substitutes for, for a variety of reasons -- how they're  
9 priced in other developing countries and how our average  
10 sales price relates to that. I am not saying necessarily  
11 that Medicare should go negotiate directly around the price,  
12 but perhaps the global developed country average sales price  
13 should play our role or have an influence over. I would  
14 just like to know what that differential is, if there is, in  
15 fact, a big differential, and that we might want that to  
16 inform our decision on how much we're willing to pay.

17 You know, maybe we are using -- ASP works when  
18 there is a competitive market, but when there isn't one, it  
19 doesn't work, and some countries might even be looking at  
20 what's a reasonable ROR or how long should we leave it on  
21 the market before we arbitrarily say that.

22 I just think we're trying to price this thing when

1 there's clearly some scientific reasons why there is no  
2 competitive market, and we shouldn't remove from the table  
3 the option of saying, okay, when there's no competitive  
4 market, we're going to use more regulated or administrative  
5 pricing mechanisms. I would like to see us explore that if  
6 we can.

7 MR. BERTKO: I'd like to have us, I think, be  
8 perhaps on two levels. One, the spending on this is already  
9 high, and I think a third of the new drugs in the pipeline  
10 do come on, some portion of them. It is probably going to  
11 get higher much faster. These are very expensive drugs, as  
12 I think we know -- \$10,000, \$50,000, \$100,000 for a course  
13 of treatment. And so the thought would be should we be as  
14 the Commission generally supportive to the FDA of speeding  
15 up the process somehow. I'm not sure I know how to specify  
16 it, but just that we would lend our support.

17 Then, secondly, I think you guys have laid out  
18 some nice options there in terms of the payment principles,  
19 and this was one where I think we really need to pound  
20 through, particularly on drugs. As far as I know, there's  
21 really no other cost control mechanisms out there today, as  
22 I think Bruce or Nancy were saying. When the drugs come in,

1 we pay for them, that's it. And so anything we can do to  
2 support the cost controls I think is worthwhile.

3 MS. BEHROOZI: It occurred to me, Glenn, that --  
4 by the way, I learned a lot from this. Thank you so much,  
5 and I'm so impressed with how much you guys know about this  
6 obscure corner of the world, becoming less obscure actually  
7 as we spend more money on it. I was thinking, as you were  
8 saying, Glenn, what is it that MedPAC should be thinking  
9 about in terms of Medicare payment policy. It struck me  
10 it's either rather narrow; it's, you know, whether we should  
11 include various drugs in the same code; or it's really  
12 broad, like should we reform the entire payment system.

13 As I was thinking about this, I was thinking about  
14 our problems and paying for biologics, and what we've been  
15 doing is taking them off our physician fee schedule and  
16 moving to specialty pharmacy management by our PBM. And so  
17 it does seem to me that we are constrained by the fact that  
18 these are Part B drugs rather than being able to put them  
19 into Part D where, no, Medicare can't negotiate; so far  
20 Medicare is relying on the innovation of private payers.  
21 Well, maybe we should let them innovate about biologics, and  
22 I bet they'd be a lot less -- they'd feel a lot less

1 constrained by just paying ASP plus 6 percent versus an  
2 entirely new payment structure. I bet they'd come up with  
3 ways to determine comparability, step therapy, all kinds of  
4 things that are imposed in the private sector that we're not  
5 talking about here.

6 MR. HACKBARTH: Although part of what I thought I  
7 hear John saying is that private payers feel powerless in  
8 this case.

9 MR. BERTKO: I agree. Step therapy is there, but  
10 once the drug is indicated, you're done. You just pay  
11 \$100,000.

12 MS. BEHROOZI: Well, except, like I said, we've  
13 moved it out of the physician payment fee schedule that we  
14 use, which is based on Medicare, into a specialty pharmacy  
15 where there is some negotiation going on by the large PBMs  
16 that have a lot more pricing power certainly than we do.  
17 And I anticipate that they will be innovating and be more  
18 aggressive about things like their own version of  
19 comparative effectiveness and things like that, as we do  
20 with other drugs.

21 I thought the point that Jay made was so  
22 important. It's not just biologics where people say that

1 there are differential impacts on people. Right now we have  
2 reference pricing for generics, and there are still  
3 physicians and there are patients who say, yes, but in this  
4 particular case, I need this brand drug. And we have a  
5 clinical review process to make exceptions, which was  
6 referred to in the paper as a possibility.

7 So I feel like we could be treating biologics a  
8 little more like other drugs except we don't deal with drugs  
9 in Medicare, except for Part D.

10 DR. CROSSON: Thank you. I'd like to compliment  
11 you, the staff, particularly Joan, on this presentation.  
12 It's one of the more complex, I think, technical things that  
13 we've taken on in the time I've been on the Commission. As  
14 usual, you have made it seem simple. So thank you for that.

15 The other thing is I think it is something that we  
16 should take up. We have thought a lot about this, made some  
17 cost projections of our own, given the state of the  
18 technology. And I would have to say, just based on our own  
19 cost estimates, the ones that we saw in the paper are  
20 somewhat of an underestimate based on what we think is going  
21 to happen, at least over the next 10 years.

22 The question is what do we want to do, you know,

1 if we are going to move towards recommendation, how  
2 technical do we really feel that we can get here? I'm not  
3 sure, I think we have some more thinking to do.

4           It would seem to me that if I were thinking about  
5 recommendations right now, it might be something like, well,  
6 given the potential impact on the Medicare program and our  
7 responsibility for trying to guard that as a fiduciary, we  
8 might decide to conclude that there probably does need to be  
9 a pathway for the approval of biogenerics without  
10 necessarily saying exactly what that would be. Because I  
11 guess that's one of the questions, whether there should be  
12 one at all or not. I would certainly come down on the side  
13 of there being one.

14           Second, something that might have to do with  
15 whether or not Congress should consider the necessity of  
16 expanding in any way the authority of the FDA -- perhaps it  
17 doesn't need to be, but examining and expanding the  
18 authority of the FDA to deal with this new complexity of  
19 issues. Whether or not there needs to be some sort of case-  
20 by-case work done or not would be part of that.

21           And then, lastly, the issue of the marketing  
22 exclusivity period. I guess maybe we might say something

1 along the lines that as Congress considers the issue of the  
2 marketing exclusivity period, it should take into  
3 consideration, among other things, for sure the impact on  
4 the cost of the Medicare program, the cost of these drugs in  
5 terms of out-of-pocket costs for Medicare beneficiaries, and  
6 then also perhaps even the impact of these on out-of-pocket  
7 costs for non-Medicare beneficiaries because there is a  
8 derivative cost. Many of these drugs are put into the  
9 highest-cost tier by insurers, and when you're talking about  
10 drugs that cost \$100,000 a year, 25-percent co-payment,  
11 pretty soon it adds up to real money. So there are economic  
12 issues that go beyond the Medicare program.

13           So I have been thinking about us ending up  
14 somewhere in an area like that.

15           DR. CHERNEW: I'm struggling with the scope of  
16 this in a specific way. I see three topics that are sort of  
17 spinning around. One of them is biologics, which is a range  
18 of issues. One of them is Part B drugs, which certainly  
19 includes biologics but is definitely not limited to just  
20 biologics, and that has a separate set of issues of how we  
21 pay. And the third is all new technology.

22           So first let me say I think how we pay for all new

1 technology, which is a fascinatingly important question, I  
2 think needs to be somewhat beyond the scope of how we deal  
3 with this. I think there is a lot of -- I think that's  
4 going to differ in different areas. I think applying this  
5 to new imaging is just somehow different than applying it to  
6 new services that might be a new medical service or a new  
7 clinical service. It's just different. I think it's too  
8 hard to think about how to think about some of your Slide 16  
9 concepts across the whole array of different types of new  
10 technologies. And some of the things, like bundling, is  
11 important for things well beyond issues of new technology.  
12 So I think that, in my mind, just has to be separate.

13 I think the Part B focus versus the biologics  
14 focus again illustrates this complex problem we commonly  
15 have, which is we're organized A, B, C, D, but we think  
16 about disease and services, and we often get confused.

17 So I like discussions about how we might solve  
18 some of the problems and rationalize across the programs  
19 where we have issues, and I think this issue of what  
20 consumers pay matters a lot.

21 What makes this interesting to me is there are  
22 some really fundamental questions that arise in this case

1 technically that have ramifications and also some  
2 philosophical issues. One of them that hasn't been raised  
3 very much is many of these biologics, I understand, are  
4 designed for a very small number of people and that they  
5 tailor treatment in very specific ways for very specific  
6 people. They'll look at exactly your cancer, your type of  
7 cancer, and they'll do the genetic testing and decide this  
8 is the right one for you, more so than I think they've done  
9 for others. They have a lot of small market biologics -- I  
10 believe that to be true -- which has ramifications for  
11 price.

12           What often happens, I believe, in those cases is  
13 they can demonstrate in some cases there is some measure of  
14 better quality. How much better quality, whether it's a  
15 week or a month, is a separate issue. But I think  
16 throughout this it raises the question of how we decide to  
17 pay for quality. And my opinion regarding some of these  
18 things, for example, when we talk about coverage, I think  
19 coverage is particularly clunky in these areas because you  
20 might find some subsets of people for whom it works, but if  
21 you cover it, it's hard to limit it to just those people.

22           I think this is an area where there is a strong

1 role for aspects of consumer incentives as we talked about  
2 before. I think we have to think about novel designs. I  
3 think we have problems with across-the-board cost-sharing.  
4 I think we have problems with coverage limits, because many  
5 of these people are going to hit their coverage max, and  
6 then everything is free about that. On the other hand, I  
7 think really would make none of us feel still good -- I know  
8 would make me feel horrible -- if we had a system where you  
9 had to pay 25 percent of all specialty drugs when there were  
10 some that were really, really high value in certain people.

11 So I think this is really going to challenge our  
12 sense of how we use consumer incentives to allow people to  
13 decide they want something that we don't want to pay for,  
14 how we decide what quality we will pay for.

15 The last related point that I want to make, which  
16 I think is a wonderful change from the last several meetings  
17 we've had, is we often have discussions around the table in  
18 a paradigm of what does it cost, what should we pay, how do  
19 we did the margin right? And as the medical education  
20 discussion illustrated and as this discussion illustrated,  
21 our discussions are actually much more broad about how we  
22 can make the health care system better for Medicare

1 beneficiaries, and then particularly in the medical  
2 education discussion, overall how can we make the health  
3 care system better, which, of course, would benefit Medicare  
4 beneficiaries?

5 I think that broader paradigm is actually really  
6 useful in thinking about how we go forward and how we do  
7 this. And I think as we talk going forward about payment, a  
8 payment paradigm that is fundamentally based on what's the  
9 cost of this, how shall we pay for it, is different than a  
10 paradigm that is broader. And I enjoy and I think it is a  
11 better role in some cases if we can, recognizing our more  
12 limited charge, to have that broader paradigm.

13 DR. CASTELLANOS: We all wear a lot of hats, so  
14 let me wear a physician hat for a second. I think we're a  
15 little out front. I think we need the science before we  
16 talk about reimbursement, and I think we all agree on that.  
17 Whether interchangeability and compatibility are consistent,  
18 we need the scientists to help us. So before we think about  
19 reimbursement, we really need the help from them.

20 Again, with the physician hat, Mitra, you  
21 mentioned about drugs and Medicare. Well, these drugs are  
22 Part B drugs, and these come directly out of the SGR. And

1 every physician, whether he's a pediatrician or a primary  
2 care director or a urologist, pay for this under the SGR.  
3 So if the oncologist is using these billion-dollar drugs, it  
4 affects every physician and his reimbursement.

5 This has been brought up on several occasions. I  
6 don't need to beat up on the SGR. We've all thought about  
7 taking this out. But it does affect that.

8 I guess the big point I want to make is that we do  
9 need to look at reimbursement. Urology was directly  
10 involved with a Part B drug called LHRH agonists. And we  
11 were getting paid under AWP. And it was outrageous the  
12 money we were making. I didn't set the rules up, but did I  
13 collect the money? Yes. But it was outrageous, and we as a  
14 committee made some decisions and did the right thing. And  
15 I think we can do the same thing for these drugs, too.

16 I really believe that we have the ability to make  
17 some changes to correct some of the inadequacies or  
18 inaccuracies in the reimbursement system.

19 DR. MARK MILLER: Can I ask one thing? Ron, in  
20 your opening comment, you said policy needed to wait for  
21 science. And then in your last two examples, you suggested  
22 -- yes, policy needed to wait for science. And then your

1 last two examples kind of pointed to the need for  
2 reimbursement to address some of these issues.

3 DR. CASTELLANOS: I guess the point I was making,  
4 we first need science for the policy as far as whether these  
5 are interchangeable or not and whether they can be used.  
6 But once they are approved, then we need reimbursement  
7 policies. And I think we have that ability to do it, and we  
8 have done it.

9 DR. MARK MILLER: [off microphone] So you're not  
10 asking us to wait on making those decisions?

11 DR. CASTELLANOS: I'm talking as a physician.  
12 Before I use these drugs, I want the science first. But we  
13 should be working at things together.

14 DR. STUART: This is a follow-up. I think it has  
15 implications for what you're talking about. The  
16 reimbursement is going to forth regardless of the science,  
17 and Mitra was indicating that what she sees is that these  
18 drugs are being put -- they're taken out of the medical  
19 side, they're put on the drug side, they're a specialty tier  
20 and presumably very high co-insurance. No? All right.  
21 Well, but this is -- I don't want to steal your thunder for  
22 next month because you're going to be talking about this.

1 But to the extent that these drugs are on the D side, they  
2 are increasingly being put on specialty tiers, and I think  
3 you said the average reimbursement rate is somewhere around  
4 33, 35 percent.

5 Well, the difference between D and B is that D has  
6 a company. And so, in essence, when you take one of these  
7 very expensive drugs, if somebody is in the standard plan,  
8 the price doesn't matter, because you just zip right up to  
9 the catastrophic cap almost instantly; whereas, if it is a B  
10 drug, there is no maximum. And then it becomes the issue  
11 of, well, what does the Medicare supplemental plan do, what  
12 does the employer plan do.

13 John, maybe you can answer this -- well, I know  
14 you can answer it better than I can. That is, what are the  
15 supplementary payers doing with respect to Be coverage for  
16 biologics?

17 MR. BERTKO: The answer is pretty much as I  
18 indicated before. You run through as many things as Mitra  
19 said -- and step therapy in particular -- and then you pay.  
20 And they use specialty pharmacies, but even the specialty  
21 pharmacies -- you're right, Mitra, they do try to negotiate,  
22 and I'll emphasize the verb "try" as opposed to "achieve"

1 negotiated prices.

2 DR. STUART: I was thinking in terms of patient  
3 cost-sharing.

4 MR. BERTKO: They pay.

5 DR. STUART: So they'll just pay. All right.

6 MR. BERTKO: They have to just pay.

7 DR. STUART: So there is no move that you see  
8 toward D is doing in terms of segregating these into a  
9 separate your tier with higher co-insurance that would not  
10 be paid by the supplemental policy.

11 MR. BERTKO: Well, there are very few people in  
12 Medigap D coverage, so that's very small. And if you're in  
13 an ESI, employer-sponsored insurance, retiree fund, then you  
14 most likely have a regular four-tier cost-sharing with the  
15 25 percent. But that's becoming increasingly -- well, it's  
16 diminishing.

17 MR. HACKBARTH: But if it's a B drug as opposed to  
18 a D, they're just paying all the cost-sharing?

19 MR. BERTKO: Yes. In a supplement, if it's a  
20 Medigap B, they're just paying. And probably, as far as I'm  
21 aware of, most of the Medigap payers use relatively few  
22 specialty pharmacies. I mean, compared to what Mitra's

1 group does, they're on top of the game, and these guys are,  
2 let's say, slow.

3 MS. BEHROOZI: If you're talking about Medigap,  
4 then you're talking about wrap-around payments, so you've  
5 got two different payers in the mix. So that's another  
6 problem, another issue. If you move it to the drug payment  
7 side, you've got one payer, and that's where you have some  
8 negotiating power. And maybe it hasn't proved effective  
9 yet, but there's more opportunity when you've got one payer  
10 paying from whatever dollar they pay from, then splitting it  
11 between two -- just, you know, as a theoretical model. I  
12 understand it hasn't played out yet.

13 MR. HACKBARTH: Although if it's a B drug, one of  
14 the payers is Medicare, which has lots of power -- not  
15 necessarily used at this point, but it has the potential to  
16 have more market power than any individual private carrier.

17 MS. BEHROOZI: Sure, as long as we're paying ASP,  
18 whatever that is, at 106 percent, as you said, no power  
19 being exercised.

20 MS. HANSEN: This is related to the Part D side.  
21 Did I recall -- and I forget whether it was this time or  
22 before -- that the people who are dual eligibles or they're

1 covered, that the use of biologics has been  
2 disproportionately higher for them?

3 DR. SOKOLOVSKY: You're absolutely right, yes, and  
4 that is some of what we're going to present next month.

5 MS. HANSEN: It struck me when we talk about the  
6 co-pay with somebody paying the 25 percent, or whatever it  
7 is. But when you are on Part D and you're subsidized, the  
8 beneficiary doesn't necessarily have a co-pay. And so there  
9 seems to be some corresponding disproportionate use of the  
10 biologics with the people who don't have a co-pay.

11 DR. SOKOLOVSKY: Just to clarify, they do have a  
12 co-pay but it's much --

13 MS. HANSEN: It's much smaller.

14 MR. HACKBARTH: Any other questions, comments,  
15 suggestions for direction?

16 MR. BUTLER: Just to reinforce that Mike's point  
17 that the direction we're headed towards a narrow focus, I  
18 vote for that.

19 DR. STUART: I think narrow is good, too.

20 This is a question that you may have addressed  
21 here, but I didn't see it, and that is, how does the VA pay  
22 for biologics?

1 DR. SOKOLOVSKY: That's a very good question, and,  
2 unfortunately, it didn't occur to me until yesterday, so I  
3 can't give you much clear data. But I wanted to see if the  
4 PA used any formulary process for those rheumatoid arthritis  
5 drugs, the TNFs, which, as far as I could see, Part D plans  
6 have all of them on their formularies, although it's not  
7 actually a protected class. But for all the various reasons  
8 that we've talked about, they have them all.

9 The VA, as a plan that has a national formulary  
10 and is much stronger in using them, I wondered if they had a  
11 formulary, but I found that cover them all as well. But  
12 what they pay I don't know.

13 DR. STUART: But you're planning on adding that to  
14 the chapter?

15 DR. SOKOLOVSKY: Yes.

16 MR. HACKBARTH: Thank you very much. Good job.

17 Now we will have our public comment period.

18 The ground rules are please first state your name  
19 and organization and limit yourself to no more than two  
20 minutes.

21 MS. TODD: Good morning. My name is Laurel Todd.  
22 I'm Director of Reimbursement and Economic Policy at BIO,

1 the Biotechnology Industry Organization. We appreciate the  
2 opportunity to comment this morning.

3 BIO is the largest trade association to serve and  
4 represent the biotechnology industry in the U.S. and around  
5 the globe. BIO represents more than 1,200 technology  
6 companies, academic institutions, state biotechnology  
7 centers, and related organizations in the U.S.

8 BIO strongly supports the creation of a regulatory  
9 approval pathway for biosimilars and believes that Congress  
10 should pass the right bill as soon as possible. This  
11 legislation should be based on sound science and recognize  
12 that biologic products are fundamentally different from  
13 traditional small molecule drugs in their complexity,  
14 development, and production processes, and that biosimilars  
15 are not generic drugs.

16 In addition, BIO believes that such a pathway must  
17 fully address both how to ensure patient safety and how to  
18 maintain incentives that spark continued investment that  
19 leads to future medical advancements and breakthroughs.

20 One of the many important positions that BIO has  
21 articulated during the legislative discussions surrounding  
22 the establishment of a regulatory approval pathway for

1 biosimilars relates to interchangeability and the importance  
2 of maintaining the physician/patient relationship. As the  
3 FDA has noted on numerous occasions, there is a known  
4 significant risk to repeatedly switching between products  
5 and a resulting negative impact on both patient safety and  
6 effectiveness.

7           Therefore, in light of the current scientific  
8 limitations on the ability to make determinations of  
9 interchangeability, and because it is critical to protect  
10 patient safety, BIO agrees with the FDA's position that  
11 patients should not be switched from the innovator  
12 biological product to a product that is only similar and  
13 vice versa without the express consent and advice of the  
14 patient's physician, and legislation should not allow for  
15 determinations of interchangeability at this time.

16           BIO has worked with legislators in Congress for a  
17 number of years to ensure that these critical goals are met  
18 by any biosimilars legislation. BIO looks forward to  
19 working constructively with MedPAC, as we have with  
20 Congress, as MedPAC reviews the many complexities of a  
21 regulatory biosimilar approval pathway, as well as the  
22 implications for the Medicare and Medicaid programs

1 following the passage of a new regulatory pathway.

2 Thanks.

3 MS. BIRMINGHAM: Good morning. My name is Maya  
4 Birmingham. I'm a Senior Assistant General Counsel with  
5 PhRMA. I'm representing PhRMA today and would like to thank  
6 you for the opportunity to present a short statement  
7 concerning follow-on biologics in Medicare.

8 As many of you know, PhRMA represents the  
9 country's pharmaceutical research and biotechnology  
10 companies which are devoted to inventing medicines that  
11 allow patients to live longer, healthier, and more  
12 productive lives.

13 It is in this spirit that PhRMA supports  
14 establishing a pathway to approve follow-on biologics that  
15 is science-based, open and transparent, puts patient safety  
16 first, and promotes incentives for innovation.

17 As you were all discussing today, there has been  
18 much discussion about the appropriate abbreviated approval  
19 pathway for FOBs. However, there is little consensus and  
20 much controversy about the correct approach. Just this week  
21 Chairman Waxman introduced new FOB legislation, which raises  
22 more questions than it answers.

1           While we are still reviewing the legislation, we  
2 believe that there are a number of patient safety,  
3 regulatory, clinical, and intellectual property issues that  
4 remain unresolved. The resolution of these issues is  
5 critical to understanding the market and reimbursement  
6 implications of any proposed changes.

7           Consequently, it is difficult to speculate whether  
8 and to what effect coverage and reimbursement policies, how  
9 they may affect pricing and competition. For that reason,  
10 PhRMA believes that it's premature for MedPAC to make  
11 recommendations before the regulatory approval pathway for  
12 FOBs is appropriately designed, described, and defined.

13           However, once a pathway is established, we firmly  
14 believe that market dynamics should be given time to play  
15 out before Congress and/or regulatory entities intervene and  
16 formulate policies that may result in unintended  
17 consequences.

18           Thank you very much.

19           MS. FISHER: Hi, Karen Fisher with the Association  
20 of American Medical Colleges, AAMC. We represent all of the  
21 medical schools in the country as well as all of the major  
22 teaching hospitals.

1           We, too, were glad to see the Commission interest  
2 and discussion on medical education and the role of delivery  
3 system reform. It's obviously something that we're paying a  
4 lot of attention to within the academic medical center  
5 community.

6           Let me first say that we really appreciate  
7 Cristina and Craig's efforts to meet with us, and Mark and  
8 the other staff, and have dialogue about a lot of these  
9 issues. That's been very helpful.

10           The one thing I would say is that it is important  
11 to remember that a lot of the people who do this work, and  
12 the program directors, and the DIOs that Peter Butler  
13 mentioned are really committed to educating people for the  
14 future and looking forward at delivery system reforms.  
15 There is a lot of effort and emphasis on core competencies  
16 by the accrediting body and by academic medicine to do  
17 exactly what you folks are talking about, and that is to set  
18 people up for lifelong learning to be able to deal with the  
19 changes that are going to come about in medicine throughout  
20 their whole careers.

21           It is important that that be a major focus.  
22 That's why our association is very much behind the ACGME

1 core competencies and we're involved with that. Many of our  
2 members are devoting a lot of time and effort and cost to  
3 implementing those core competencies.

4 So we do urge the Commission to look at those core  
5 competencies, to opine on them, to see if you think they're  
6 going in the right direction or not. Because a lot of our  
7 members are spending effort on that and we would not like to  
8 see a parallel process go in opposite directions. It's not  
9 the right message to give them.

10 We do appreciate and met with MedPAC staff on the  
11 RAND study and the survey. Part of the problem -- and we're  
12 part of the problem with it, too -- is that there's not  
13 enough information about what's going on in the 9,000  
14 residency programs. We need to do a better job.  
15 Twenty-seven gives you some information. It's not enough.  
16 We're going to be going out to our GME leaders and asking  
17 them questions similar to what the RAND study asked and  
18 we're happy to work with MedPAC staff to get more  
19 information in that arena.

20 Let me finish up with the non-hospital site issue  
21 on the regulatory side. We do think that's an area where  
22 the Commission could make some major impact to the

1 regulatory agency about the regulations that are going on.  
2 It is demoralizing for our GME people who are trying to  
3 place people out into these settings to see the regulations  
4 that they must go through to be able to do that, and for me  
5 to get questions on the phone saying our residents are  
6 training in school-based clinics. They're going out to the  
7 jail. They want to go out to public health departments.  
8 They want to ride along with the ambulance people. What do  
9 we have to do there?

10           The incentives are so negative in that area that  
11 it's quite demoralizing. Despite the fact, though, that  
12 they're still doing it, in part because they think it's  
13 important and in part because the accrediting bodies say you  
14 must do it. So they're going to do it. But it's  
15 demoralizing and I think the Commission could make some real  
16 progress in that area by saying something to CMS about the  
17 necessity of some of these regulatory burdens.

18           Thank you.

19           MR. HACKBARTH: Okay, we're adjourned. See you in  
20 April.

21           [Whereupon, at 11:07 a.m., the meeting was  
22 adjourned.]