indeed, the evidence to date suggests that when drug coverage for dual eligibles switched from Medicaid to Medicare, the prices for their drugs increased significantly.[5]

It's on the basis of such logic that Obama's recent proposal can be justified. A policy requiring that drug manufacturers offer subsidized Medicare beneficiaries the same prices that Medicaid pays represents an intervention in a segment of the Part D market that does not appear to function as a competitive market. Legitimate concerns do arise when such interventions are advanced. First, prices may be set too low, which would reduce financial returns on research-and-development investments so that companies won't make adequate investments in developing new products. The Congressional Budget Office (CBO) argued in a 2011 budget options report that the President's ideas "would not significantly reduce the incentive to develop 'breakthrough drugs' because those drugs could be launched at prices high enough to largely offset the rebate." The history of antipsychotic drugs, a drug class that has been especially reliant on Medicaid, suggests that innovative activity would not be dampened. Between 1994 and 2005, before Part D was implemented, roughly 70% of antipsychotics sold were paid for by Medicaid. If Medicaid prices were too low, one would have expected to see low levels of innovation, but more than 90 molecules in the class were under development during that period — a robust level of activity.

The proposed policy also raises concerns about cost shifting, because linking Medicaid prices to best private prices creates incentives for drug companies to offer fewer rebates to private payers and possibly to launch new drugs at higher prices. Nevertheless, the CBO and others estimate that there would be large net savings if the President's proposal were adopted.

The President has put forth an idea that promises important cost savings to the nation while preserving drug coverage for a vulnerable population. The approach obtains savings without undermining incentives for developing important new medical treatments. The anticipated side effects would be outweighed by the size of the estimated budget gains. This is as close to a win–win solution as we can get.

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Lessons from the Physician Group Practice Demonstration — A Sobering Reflection

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In early August, the Center for Medicare and Medicaid Services (CMS) announced the results of the Physician Group Practice (PGP) Demonstration project. Although the headline of the press release was glowing — "Physician Group Practice Demonstration Succeeds in Improving Quality and Reducing Costs" — the reported information suggests more mixed results.[1] These results should dampen unreasonable expectations, particularly in terms of potential savings, for accountable care organizations (ACOs), which were modeled after the PGP demo.

The demo resulted from a directive by Congress in 2000 to test ways to encourage physicians who were part of traditional (fee-for-service) Medicare to provide higher-quality care at lower cost and to be rewarded for doing so with a share of the savings they produced. The demo began in 2005 (the first sobering fact is that it took so many years to get it started) and included 10 large PGPs. All were multispecialty groups, many with well-known names, such as the Marshfield Clinic, Geisinger, Park Nicollet, and Billings; two were

associated with academic medical centers — the University of Michigan and Dartmouth.

Physician groups in the demo received their regular Medicare payments for services provided to beneficiaries but could also share in the savings generated as long as they met certain quality metrics and exceeded a savings threshold of 2%. Thirty-two quality goals were used, most of them process measures related to coronary artery disease, diabetes, heart failure, hypertension, and preventive care. The savings threshold was calculated by using the per capita expenditures for a comparator group in the same geographic area and adjusting for the case mix and severity of illness.[2]

The demo ended at the end of 2010, and a 2-year PGP Transition Demonstration began in January 2011. All 10 PGPs are participating in the follow-on demonstration, which indicates their continuing commitment to providing improved care at lower cost. In the Transition Demo, CMS responded to some of the criticisms that had been raised by participants in the original demo. Two of the more important changes are the use of a national benchmark rather than a local comparator group and the assignment of patients to a PGP on the basis of services provided by primary care physicians rather than services provided by physicians in any specialty. In addition, CMS is now using a prospective risk-adjustment mechanism rather than concurrent risk adjustment. Some new quality measures have also been added.

But it's the financial results reported by CMS that make the PGP news sobering — especially given the length of time most of these physician groups have been operating and the high regard in which they're held.

There is definitely some good news. The PGPs did very well on the quality metrics during all 5 years of the demo. In the fourth year, all 10 groups met at least 29 of the 32 quality goals. By the fifth year, seven groups achieved benchmark-level performance on all 32 measures, and the remaining groups did so on at least 30 measures. In addition, the PGPs increased their quality scores on diabetes, heart-failure, and cancer-screening measures by at least 9 percentage points over the 5 years. Although there has been some criticism suggesting that there was too much "teaching to the test" and an overemphasis on process rather than outcome measures, the quality results are worth applauding.

The savings are another matter. Even with all their experience, only two of the PGP participants were able to exceed a 2% savings threshold the first year of the demo, and only half managed to surpass that threshold after 3 years. Even within this group, the shared savings varied widely among the PGPs. The Marshfield Clinic earned about half of the total savings; Michigan, Dartmouth, and St. John's each earned about 15%; and Geisinger earned about 5%. It's important to understand why only half of these 10 experienced PGPs were able to achieve the 2% savings threshold — partly because the results are unexpected and, more important, because of what they suggest about the likelihood of success for ACOs. The minimum savings threshold that CMS has proposed for ACOs is also 2% (or 3.9% for plans with fewer patients), but plans will have to share losses as well as gains by year 3.

The PGPs have suggested that some of the challenges they faced derived from design issues — the way the comparator groups were constructed, the ways patients were attributed to PGPs, and the risk-adjustment mechanism used. Most of the PGPs were in low-cost geographic areas to begin with, which made it more challenging for them to find savings than it might be for ACOs in high-cost areas. Some also argued that there might have been changes taking place in the comparator group that might have lowered its risk profile but would not have been picked up through the use of concurrent risk adjustment — especially in areas where the only quaternary care facility was the PGP site, a situation that would result in artificially lower costs in the comparator group. There was also some concern about the risk-adjustment mechanism that was used in the demo, the Hierarchical Condition Categories, which CMS uses for the Medicare Advantage program. The follow-on Transition Demo will use an age-, sex-, and cost-matched population control, which is what is used in most commercial markets.

There were also complaints that CMS did not provide data to PGPs in a timely manner, which made it hard to know which patients were being attributed to a PGP (although this problem would have applied to all groups). Given the difficulty that many of the experienced PGP participants had in meeting the 2% savings threshold, the proposed rule for ACOs released by CMS in late March is perplexing.[3] The ACOs will have to meet benchmark levels on an

even larger set of quality metrics than the PGPs did. The requirement for a 2% savings threshold in the PGP demo was used to make sure that the savings realized were not just "statistical noise" — that is, normal variation. The proposed ACO rule also includes such a threshold, plus a 25% set-aside, and perhaps most important, a requirement that all plans take "downside" risk (that is, share in losses as well as gains) in year 3. These requirements are likely to be particularly troublesome unless CMS provides data in a more timely fashion, since the plans may just be getting information on their year 1 experience when year 3 begins. The potential for retrospective assignment of patients to ACOs on the basis of their use of services (although this aspect of the ACO model may be changed in the final rule) could make ACOs liable for the behavior of patients that they didn't even know were part of their population mix at the time when services were being provided.

It is not unusual for the government to want to protect itself from unexpected financial risk, but the proposed rules seem inconsistent with the hopes that have been pinned to ACOs as a viable alternative to both traditional Medicare and traditional managed care. Perhaps it would have been better to use an enlarged pilot to try out the ACO concept on a larger and broader mix of groups than was in the PGP demo but that would still be limited and selective; that approach would have placed the government at only minimal financial risk. Or perhaps the final ACO rule will reflect a better balance between protecting the government from undue financial exposure and encouraging newly formed groups to provide care in ways that can both improve quality and reduce costs. In any case, the PGP demo has made it clear that such a feat may be harder to accomplish than some had thought.

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