

NATIONAL QUALITY FORUM

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MULTISTAKEHOLDER INPUT ON PERFORMANCE
MEASUREMENT FOR RURAL SMALL-PRACTICE AND
LOW-VOLUME PROVIDERS
RURAL HEALTH COMMITTEE

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THURSDAY
FEBRUARY 5, 2015

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The Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Kelly Court and Ira Moscovice, Co-Chairs, presiding.

PRESENT:

KELLY COURT, MBA, Co-Chair
IRA MOSCOVICE, PhD, Co-Chair
ANN ABDELLA, Chautauqua County Health Network
MICHAEL BAER, MD, AmeriHealth Caritas
Pennsylvania
TONYA BARTHOLOMEW, OTR, Platte Valley Medical
Clinic
JOHN GALE, MS, Maine Rural Health Research
Center, University of Southern Maine
AARON GARMAN, MD, Coal Country Community Health
Center
GREGORY IRVINE, MD, St. Luke's McCall Orthopedics
Clinic
JASON KESSLER, MD, Iowa Medicaid Enterprise
JASON LANDERS, MBA, Highmark West Virginia
BRUCE LANDON, MD, MBA, MSc, Harvard Medical
School
JONATHAN MERRELL, RN, BSN, MBA, IA, Profound
Knowledge Products, Inc.
GUY NUKI, MD, BlueWater Emergency Partners
KIMBERLY RASK, MD, PhD, Alliant Health Solutions

ROBERT RAUNER, MD, MPH, SERPA-ACO
SHEILA ROMAN, MD, MPH, Consultant
SUSAN SAUNDERS, MSN, CNM, WHNP-BC, Rush Health
CNM, American College of Nurse-Midwives
STEPHEN SCHMALTZ, MS, MPH, PhD, The Joint
Commission
TIM SIZE, BSE, MBA, Rural Wisconsin Health
Cooperative
BROCK SLABACH, MPH, FACHE, National Rural Health
Association

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer
SEVERA CHAVEZ, Project Analyst
MITRA GHAZINOUR, Project Manager
ANN HAMMERSMITH, JD, General Counsel
KAREN JOHNSON, Senior Director
MARCIA WILSON, MBA, PhD, Senior Vice President,
Quality Measurement

ALSO PRESENT:

GIRMA ALEMU, MD, MPH, Health Resources and
Services Administration
MARTIN RICE, RN, MS, Health Resources and
Services Administration

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

2 9:00 a.m.

3 MS. JOHNSON: So, good morning
4 everybody and thank you and welcome to
5 Washington, D.C. and NQF and the Rural Health
6 Committee.

7 We appreciate very much your coming
8 and being with us in these two days. I think
9 we're going to have some interesting discussions,
10 we're going to learn some stuff from each other
11 and hopefully, we're going to enjoy ourselves as
12 well.

13 So, that's one of my goals.

14 Let me very briefly introduce the NQF
15 team. I'm Karen, I know we've corresponded back
16 and forth several times. And then we have Mitra
17 and Severa, I'll let them say hi. And then I'll
18 also ask Helen and Marcia to say hello this
19 morning.

20 Mitra?

21 MS. GHAZINOUR: Hello everyone. This
22 is Mitra Ghazinour. I am a Project Manager at

1 NQF supporting the work of various projects
2 including Rural Health and just wanted to welcome
3 everyone to today's meeting.

4 Thank you.

5 MS. CHAVEZ: Good morning everyone.
6 This is Severa, I'm the Project Analyst for this
7 project. In addition to this Rural Health
8 project, I also support our data project and
9 Medicaid development.

10 Thank you.

11 DR. BURSTIN: I'll add my welcome as
12 well. Helen Burstin, I'm the Chief Scientific
13 Officer here at the National Quality Forum. I'm
14 delighted you could join us.

15 It's really -- this was a very fun
16 committee to actually assemble, as you might
17 imagine, since you wanted a blend of those who
18 are doing it, those who study it and those who
19 live it.

20 So, I think hopefully we have
21 succeeded and have a great mix of methodologists
22 and those who live and breathe Rural Health. So,

1 we're really looking forward to your input.

2 DR. WILSON: Good morning. I'm Marcia
3 Wilson. I'm the Senior Vice President for
4 Quality Measurement and I'm delighted to have
5 everyone here and very much looking forward to
6 this discussion.

7 Thank you.

8 MS. JOHNSON: And I'll hand it over to
9 Kelly and Ira to say hello and introduce
10 themselves and take us into the meeting.

11 CO-CHAIR COURT: Good morning. I'm
12 Kelly Court, I'm the Chief Quality Officer at the
13 Hospital Association in Wisconsin.

14 CO-CHAIR MOSCOVICE: And Ira
15 Moscovice, I'm a professor at the School of
16 Public Health at the University of Minnesota and
17 run the Rural Health Research Center and this is
18 a topic of real interest to us. Welcome.

19 MS. JOHNSON: Okay, so the charge for
20 the committee today, we have a really broad area
21 of rural health issues and measurement. But our
22 charge is really to try to make recommendations

1 to CMS for mitigating challenges in performance
2 measurement for rural providers.

3 So, with that broad scope, we really
4 want to narrow ourselves down a little bit and we
5 want to consider these issues through the lens of
6 engaging providers in CMS P4P programs, or pay-
7 for-performance programs.

8 So, there's a lot of interesting
9 things that we can talk about in terms of QI and
10 we'll probably touch on those things, but we are
11 really thinking as much as we can at that P4P
12 accountability piece of things.

13 And we are going to very much talk
14 about the low case-volume problem. It's a
15 problem that we all know about. It's a problem
16 that really was the top issue that everybody
17 mentioned in all our pre-work and some of our
18 earlier discussions.

19 So, we are going to start our major
20 discussions early this afternoon about low case-
21 volume and then we'll branch out from that to the
22 other challenges.

1 And, Ira, would you like to go ahead
2 and go through our meeting objectives for us and
3 --

4 CO-CHAIR MOSCOVICE: Sure. We have
5 four meeting objectives. The first is to
6 finalize the consensus set of measurement
7 challenges for discussion.

8 Then we want to make some
9 recommendations regarding measures appropriate
10 for use in CMS pay-for-performance programs for
11 rural hospitals and clinicians. So, we're
12 looking at a broad range of providers.

13 We want to make recommendations to
14 help mitigate measurement challenges including
15 the low case-volume as was just mentioned.

16 And finally, what NQF does in these
17 panels which is really important is to identify
18 what are the measurement gaps for both in this
19 case, rural hospitals and clinicians.

20 So, we have an important set of
21 meeting objectives and we'll march through them
22 in order today.

1 CO-CHAIR COURT: So, we'll go over the
2 agenda quickly.

3 A couple of housekeeping items before
4 we start. You all have a microphone in front of
5 you and so there is a little button to press to
6 speak so we'd ask that when you do speak, please
7 press the speak button and it'll show up red on
8 top here because it's being recorded, so we want
9 to be able to hear.

10 And then when you stop speaking, turn
11 that off because only a couple microphones can be
12 on at a time.

13 The other thing we'll do to kind of
14 control the conversation is if you have a comment
15 or a question or input, if you put your table
16 tent up like this, then we know -- Ira and I will
17 do our best to try and make sure we get people's
18 inputs in order.

19 The restrooms are past the desk where
20 you came in and then to the right, and there's
21 refreshments in the back.

22 And Karen and Mitra and the staff will

1 kind of help keep us on track today.

2 So, the first item we're going to talk
3 today about today is kind of setting the stage,
4 so putting some context to our work. Then we'll
5 take a break mid-morning about 10:30.

6 Then we're going to jump right in to
7 our work really talking about trying to get
8 consensus on those overarching measurement
9 challenges.

10 So, we have some pre-work that
11 everybody did. There's some themes in there so
12 we want to narrow those down.

13 And like Karen said, we want to make
14 sure that we focus our discussion today on
15 measurement and measurement as it relates to
16 potential P4P.

17 So, there's a lot of challenges we all
18 deal with every day, but we'll try to stay
19 focused on the measurement issues.

20 And then after that, we're going to
21 move into some discussion and possible solutions
22 related to low case-volumes which is, I think,

1 probably going to be our number one challenge,
2 obviously, bubbled up in the pre-work like Karen
3 discussed.

4 And then there's going to be
5 opportunity for public comment and then we'll
6 take a lunch at 1:00.

7 And then this afternoon, we're going
8 to talk about potential solutions and I think
9 that's really what we're here to do is not just
10 talk about what's wrong because I think we all
11 know that, but what can we offer up as potential
12 solutions.

13 We'll take a break about 3:00 and then
14 this afternoon, we're going to break out into two
15 different groups. One group really focusing on
16 the physician practice side clinical kind of
17 issues and then the other group will focus on
18 hospital issues, again, related to --

19 The solutions may be different for the
20 two different groups, we'll do that this
21 afternoon.

22 Then we'll finish up with a report out

1 from those breakout groups. We'll have an
2 opportunity for public comment again and then we
3 will summarize and adjourn about 5:30.

4 MS. JOHNSON: Thank you, Kelly.

5 And right now, we're getting ready to
6 do introductions and Ann, our General Counsel, is
7 going to walk us through that.

8 But before, Ann, I hand it over to
9 you, I would like to introduce Marty Rice. Some
10 of you know him, maybe not everybody does, but
11 Marty, would you like to say a welcome to
12 everybody?

13 MR. RICE: I just wanted to thank
14 everyone for coming today.

15 I'm with the Office of Rural Health
16 Policy and we thought this was a topic when we
17 proposed it that was really relevant to the rural
18 community. And it seems for the last few days,
19 it's been getting a lot of traction at the last
20 conference that we were at.

21 I think Patrick Conway was made aware
22 of the project and I've gotten a ton of emails

1 about briefing him now about it.

2 But, there's going to be somebody else
3 taking over this project from me and we're going
4 to make sure you have somebody who's really great
5 from ORHP.

6 And I'm going to Medicaid in the next
7 two weeks. So, I wish everybody the best of luck
8 and I'm going to really thank you all for joining
9 us. Not the best place to be in the wintertime
10 sometimes, but I think we've got better than
11 average weather.

12 MS. HAMMERSMITH: Good morning
13 everyone. I'm Ann Hammersmith, I'm NQF's General
14 Counsel. And as Karen said, I'm going to lead
15 you through the introductions and the disclosures
16 of interests.

17 We combine those because we find it
18 saves a little time so that you can go ahead and
19 do your work and get into the meat of the
20 meeting.

21 I'm going to summarize for you what
22 we're looking for and then we'll go around the

1 table and ask you to introduce yourselves and
2 disclose.

3 You received a form from us, a fairly
4 lengthy form, where we asked you about your
5 professional activities. And what we'd like you
6 to do is not summarize the form, not summarize
7 your CV, but to disclose things to your fellow
8 committee members and anyone listening on the
9 phone if you are engaged in something that's
10 directly related to the subject matter before the
11 committee.

12 I realize that Rural Health is a very
13 large issue. So, use your judgment in what you
14 disclose. We're particularly interested in
15 whether you have grants, you're doing consulting
16 or research in an area that's directly related to
17 what's before the committee.

18 Just because you disclose does not
19 mean that you have a conflict. Part of the
20 reason we do this is in the spirit of
21 transparency and openness so that everyone knows
22 where everyone else is coming from.

1 I also want to remind you that you sit
2 on the committee as an individual. Sometimes
3 people will say, I'm Susie Smith and I'm here
4 representing the American Academy of Fill-In-The-
5 Blank and actually, that's not the case.

6 You don't represent your employer, you
7 don't represent any professional group that
8 you're associated with. You don't represent any
9 group or individual who may have nominated you to
10 serve on the committee.

11 So, with that, let's go ahead and go
12 around the table, introduce yourselves and tell
13 us if you have anything to disclose.

14 We'll start with the Chairs.

15 CO-CHAIR COURT: So, again, Kelly
16 Court and I don't have any conflicts or anything
17 to disclose.

18 CO-CHAIR MOSCOVICE: Ira Moscovice and
19 we have a substantial number of grants from the
20 federal government dealing with Rural Health
21 Quality which is presumably why we're here. So,
22 anyhow, that would be it. But I don't think it's

1 a conflict of interest.

2 DR. IRVINE: I'm Greg Irvine, I am an
3 orthopedic surgeon in McCall, Idaho. I have no
4 conflicts except that I practice medicine in a
5 rural community.

6 DR. NUKI: My name is Greg Nuki, I'm
7 an emergency medicine physician and I also don't
8 have any conflicts other than I'm the partner in
9 a group that practices in rural emergency
10 departments.

11 DR. LANDON: Bruce Landon, I'm a
12 professor of Health Care Policy and an Internist
13 up at Harvard Medical School. My conflict is
14 that I don't practice in a rural area.

15 DR. GARMAN: My name's Aaron Garman.
16 I'm a physician in Beulah, North Dakota in an
17 FQHC. I serve on the Commission for Quality and
18 Practice for the AAFP. Other than that, I have
19 nothing to disclose.

20 DR. RAUNER: Bob Rauner, a physician
21 from Lincoln, Nebraska and two hats, one is
22 Medical Director of a rural physician-led ACO

1 with 12 clinics in Nebraska that, of course, uses
2 NQF measures for our incentive programs.

3 Second, I sit on a legislative policy
4 group that sets medical home standards and
5 develops quality measure sets for the State of
6 Nebraska.

7 DR. BAER: Good morning, Mike Baer
8 from Pennsylvania. I am a family doc. I work
9 with AmeriHealth Caritas. I'm a network medical
10 director in Pennsylvania and we have a lot of
11 rural areas there. I have no conflicts.

12 DR. ROMAN: Sheila Roman, I'm an
13 endocrinologist and part-time attending at Johns
14 Hopkins University. I have no conflict, but I
15 did work until just about a year to date for the
16 Centers for Medicare and Medicaid Services for 14
17 years and saw them transfer themselves from
18 public reporting to pay-for-reporting to pay-for-
19 performance.

20 And I just want to reiterate that I'm
21 here representing myself and not the agency at
22 all.

1 MR. LANDERS: Jason Landers, I'm Vice
2 President of Medicaid Markets for Highmark West
3 Virginia. I now manage a joint venture project
4 between Highmark and 23 FQHCs in West Virginia
5 which, obviously, derives a large percentage of
6 their income from grants.

7 CO-CHAIR COURT: Could you turn on
8 your mic, please? There you go.

9 MR. MERRELL: Is it on now? I guess
10 I was holding it down.

11 Jonathan Merrell, President of
12 Profound Knowledge Products, Incorporated out of
13 Oklahoma.

14 I think my disclosures at this time
15 are important. I'm also a faculty at the
16 Institute for Healthcare Improvement.

17 Until six weeks ago, I was the Vice
18 President of Performance Improvement at OCHIN,
19 Incorporated in Portland, Oregon which is an
20 organization, a health center controlled network
21 by definition that provides Epic EMR to FQHCs,
22 CHCs and others. We have about 4,500 physicians

1 using our customized Epic platform.

2 I'm also preparing to do quite a bit
3 of work in the next few months with the Indian
4 Health Service out of Portland Area Office.

5 And I'll just be clear at this point,
6 again, that I won't be representing the agency of
7 the Indian Health Service. So, thank you.

8 MS. BARTHOLOMEW: I'm Tonya
9 Bartholomew from Saratoga, Wyoming and my husband
10 is a physician and I am the practice
11 administrator for a small rural clinic. We serve
12 about 2,800 patients out in the middle of nowhere
13 and I have nothing to disclose.

14 DR. RASK: Kimberly Rask, I'm an
15 internist and I'm the Medical Director for the
16 CMS-funded Quality Improvement Organization for
17 Georgia and North Carolina.

18 And we do technical assistance to
19 hospitals and physician practices for quality
20 reporting and work with some more critical access
21 hospitals on flex grants.

22 MR. SLABACH: My name is Brock

1 Slabach, I'm the Senior Vice President for the
2 National Rural Health Association. Formerly, a
3 critical access hospital administrator in
4 Southwest Mississippi. We also ran four
5 provider-based rural health clinics.

6 I work for the National Rural Health
7 Association and we have some contracts with the
8 Federal Office of Rural Health Policy and I will
9 not be representing the association nor those
10 grant programs.

11 MR. SIZE: Hi, I'm Tim Size, Executive
12 Director of the Rural Wisconsin Health Co-Op and
13 we're a collaborative of 39 rural hospitals,
14 mostly CAHs, about six to eight tweeners.

15 About 90 plus percent of our budget is
16 shared services but we're well known for advocacy
17 which is a lot of what I do.

18 Programs, I think things I'd like you
19 to be aware of kind of under disclosure, I don't
20 think I have any conflicts, but under disclosure,
21 we have a number of quality reporting programs,
22 so obviously, decisions of this group eventually

1 could affect that work.

2 We also are involved in contract
3 negotiations on behalf of our hospitals with
4 payers and increasingly in pay-for-performance,
5 so decisions here could affect that work.

6 And then I'm also on a quality
7 committee of a local insurer which is very
8 engaged with this type of metrics.

9 MR. GALE: John Gale, I'm from the
10 University of Southern Maine and the Rural Health
11 Research Center and we have some federal funding
12 to develop quality measures, but there's no
13 conflict.

14 DR. KESSLER: Jason Kessler, I'm a
15 pediatrician and the Medical Director for the
16 Iowa Medicaid Enterprise. I am contracted to the
17 State, but I'm actually an employee of Telligen
18 which is the Iowa Quality Improvement
19 Organization, QIO. I think they've changed what
20 they actually call it now.

21 But Telligen does some work with
22 quality measurement and quality improvement in

1 rural practices and the Iowa Medicaid Enterprise
2 has contracts and grants from CMS and the
3 government for rural health programs and quality
4 measurement programs.

5 MS. SAUNDERS: I'm Susan Saunders.
6 I'm a Certified Nurse Midwife and Women's Health
7 Nurse Practitioner in the rural Southeast. And I
8 have no disclosures.

9 MS. ABDELLA: Good morning, I'm Ann
10 Abdella from the Chautauqua County Health Network
11 and the Chautauqua Region Associated Medical
12 Partners. I don't think I have anything that's a
13 conflict.

14 Through the network, we are a HRSA
15 grantee. I sit on the Board of a local FQHC, so
16 we get funding from there.

17 And also, I think part of my
18 involvement in this committee has to do with the
19 fact that I'm the Treasurer for the local Chamber
20 of Commerce that works with the Manufacturers
21 Association. So, they have no conflict, but they
22 have a lot of interest in this topic.

1 DR. SCHMALTZ: Hi, I'm Steve Schmaltz.
2 I'm a Senior Statistician for the Joint
3 Commission in their Division of Health Quality
4 Evaluation.

5 The Joint Commission is a
6 subcontractor on a grant with CMS for performance
7 measure development and a number of the measures
8 that the Joint Commission has developed are used
9 by critical access hospitals.

10 MS. HAMMERSMITH: Thank you for those
11 disclosures.

12 Mr. Alemu, would you like to introduce
13 yourself?

14 DR. ALEMU: My name is Girma Alemu.
15 I am with HRSA and I work as a public health
16 analyst.

17 MS. HAMMERSMITH: Thank you.

18 Before I leave you today, just want to
19 remind you that if during the meeting you think
20 you have a conflict, you think someone else has a
21 conflict and they're not speaking up, or if you
22 think someone's behaving in a biased manner, we

1 ask you to bring that to our attention.

2 Our conflict of interest process
3 doesn't work without your participation and
4 cooperation and we don't want you sitting there
5 in silence if you think something is up.

6 So, if you think there's bias, you
7 think there's conflict, you can always approach
8 your Chairs, who will approach NQF staff, you can
9 approach NQF staff, and of course, you are always
10 welcome to bring it up openly in the meeting
11 itself.

12 Do you have any questions of me or of
13 anyone else based on the disclosures?

14 Okay, thank you.

15 MS. GHAZINOUR: So, I just would like
16 to provide a brief overview of the project.

17 So, in September 2014, the Department
18 of Health and Human Services contracted with the
19 National Quality Forum to convene a
20 multistakeholder committee to provide
21 recommendations on how to address measurement
22 challenges for rural providers, particularly in

1 the context of pay-for-performance.

2 The rural health providers of interest
3 for this project include critical access
4 hospitals, rural health clinics, community health
5 centers, small hospitals, small practice offices
6 as well as clinicians who serve in these
7 settings.

8 So, as part of this effort, NQF
9 conducted an environmental scan and to help
10 inform the committee's deliberations and the
11 primary goals of the environmental scan were to
12 identify performance measures and quality
13 measurement programs that are currently on their
14 way and would apply to rural providers as well as
15 to identify and describe both measurement
16 challenges and solutions for rural health care
17 providers for payment purposes and to identify
18 key measurement of gap for rural health.

19 So, the committee could use this
20 environmental scan as context to provide
21 recommendations regarding how HHS can mitigate
22 measurement challenges in payment incentive

1 programs for rural providers and also identifying
2 the best -- the most appropriate measures to be
3 included in these programs.

4 And lastly, to identity development
5 resources that could be best directed toward
6 filling those measurement gaps.

7 So, this is our time line. As
8 mentioned earlier, the project started in
9 September and we held a call for non-committee
10 rural health nominations and we received many
11 wonderful nominations and the committee was
12 seated in mid-December.

13 And immediately after, we held our
14 first web meeting which was to orient the
15 committee members to the project and also to seek
16 your input in terms of the priority areas that
17 you would like to discuss during today's meeting.

18 So, after today's meeting, NQF will
19 draft a report which will contain your
20 recommendations and, again, in March -- March
21 19th, we're going to hold another web meeting for
22 you to review the draft report and to provide

1 comments to us.

2 And on April 15th, we'll submit the
3 draft report to HHS and in June/July, we will
4 post the draft report for a 30-day public comment
5 period and, again, we're going to convene the
6 committee via a web meeting in July to review and
7 respond to public comments.

8 And the final report will be submitted
9 to HHS in September.

10 Now, I would like to turn it over to
11 Karen.

12 MS. JOHNSON: Thank you, Mitra.

13 So, I know you guys heard that stuff
14 before, but we wanted to make sure it's in front
15 of your mind what you're up to here.

16 We wanted to give you a little bit of
17 the insights that we found from our environmental
18 scan and from the pre-work that you guys did as a
19 committee.

20 I don't think any of this will be news
21 to any of you. It was a little bit new to me and
22 to NQF. We have not done a lot of work in the

1 rural health area.

2 My interest actually is because I am
3 from the Central Appalachian Region. I grew up
4 about 20 minutes from the Cumberland Gap. So, I
5 understand what's going on. Our local hospital
6 closed last year. The doctor that my parents
7 visit actually quit the clinic that he worked in
8 because he didn't like the EHRs and having to
9 work with EHRs and he went out and started his
10 own practice, but he does not take insurance.
11 So, that's a very -- it's difficult.

12 So, I understand, at least from my own
13 personal perspective, some of these issues.

14 But these are the ones that bubbled up
15 from talking to you and from doing quite a bit of
16 reading and looking at reports and such.

17 So, one of the biggest things is the
18 limited availability of the health care
19 providers, including the specialists as well as
20 the post-acute care providers.

21 Along with that is the limited
22 emergency response options that are a part of

1 life in rural America.

2 Also, very closely related is the
3 geographic isolation. So, that really -- the
4 first thing I think of is the transportation
5 issues and I'm sure that there are other things
6 as well that go with that isolation. But, I
7 think it really has an impact on measurement.

8 There is limited hours of operation
9 for many providers including ED docs and
10 pharmacists. There is, and I know it well, the
11 patient characteristics, SDS factors, health
12 status and health behaviors.

13 Again, I'm from a part of the country
14 that our health behaviors aren't so great and we
15 have a very -- the cultural status for looking at
16 health care provision is sometimes a little
17 different than in other parts of the country, a
18 very independent streak, so there's a lot of that
19 out there.

20 I think the other thing that's really
21 interesting and it's my bottom point there, it's
22 heterogeneity. I know about my area, Rose Hill,

1 Virginia, but I know that's very different than
2 Nebraska and Wyoming and these other places. So,
3 that heterogeneity makes things difficult in
4 terms of measurement.

5 We have the workforce capacity that
6 many of you talked about a lot on our web
7 meeting. And that really comes up in measurement
8 because of the IT expertise that's needed as well
9 as the QI expertise. And I think one of you
10 mentioned in your pre-comments, the pre-work that
11 you did that you're the doctor and the plumber
12 and the IT guy and the QI guy. So, we get that.

13 The low patient volume, we've already
14 talked about and we're going to talk about that a
15 lot today.

16 And then finally, the lack of
17 resources. So, it's resources, financial as well
18 as workforce, et cetera.

19 So, part of our environmental scan was
20 to dip our toes into some of the different QI
21 programs that are out there. So, we were trying
22 to look at measurements and QI programs, a very

1 large scope.

2 So, we didn't hit everything but we
3 learned a little bit about the various CMS
4 programs and Mitra's going to walk us through a
5 couple of those later on today.

6 We know that CMS has the very
7 successful QIO programs that have recently
8 changed, so I'm not quite sure how they're going
9 to morph given the recent changes.

10 Medicaid, there's a lot of work going
11 on in Medicaid, particularly from the Medical
12 Home Initiatives that Medicaid is doing.

13 We have a lot of work from HRSA in the
14 MBQIP, is it QIP, is that how you say that?
15 MBQIP? Okay. And that program for CAHs trying
16 to help with measurement there.

17 Telehealth programs, we've pulled that
18 out because that's very -- or at least I think
19 it's important. It'll be you guys to talk about
20 telehealth and importance for measurement there.

21 Private sector P4P programs, there's
22 at least 40 throughout the country. So, lots of

1 employers, health plans, et cetera are doing P4P,
2 so that is not new. CMS is not the only entity
3 that's doing P4P.

4 And then finally, there are a lot of
5 regional QI collaboratives that have bubbled up
6 over the country. Probably more in urban areas,
7 but they have their own ways of measuring things,
8 their own measurement sets, that sort of thing.

9 So, we did get some specific feedback
10 from folks. We talked just one on one with a few
11 different people, some of you around the table
12 and then a few that aren't around our table.

13 We learned that state regulations can
14 actually impact which measures are used in
15 programs and Pennsylvania I think is one and
16 Minnesota are the two that come to mind. I'm
17 sure there are others.

18 The low case-volume problem is known.
19 Nobody's surprised about this. And different
20 folks try to solve it in different ways,
21 including I talked to someone from one of the
22 large insurers and they don't worry too much

1 about, at least for their specialists where the
2 low volume problem is really big and even more so
3 in rural areas.

4 They look at a lot of structural
5 measures as a way to assess quality of their
6 physicians. So, a different way of thinking
7 about it.

8 Even though the low case-volume
9 problem is known and it definitely impacts
10 reliability of measurement, particularly for P4P
11 or other kinds of accountability programs, that
12 really doesn't impact the ability to provide
13 clinician-specific feedback.

14 So, what that means is, you know, you
15 can still learn even if you only have three cases
16 of whatever and different groups are providing
17 that feedback.

18 And then finally, we have some
19 indication that employers in rural areas may not
20 be as focused on quality measurement as other
21 purchasers.

22 So, we tried to do a scan for measures

1 and don't get too upset about this number, we
2 found 1,265, way more than what there really is.
3 We realize that there's a lot of duplicates in
4 the list. And part of that is to some extent, it
5 just shows how difficult it is to try to find
6 lists of measures, especially if people change
7 titles or tweak them just a little bit.

8 So, 1,265, we limited it down a little
9 bit but still, our list is still a little bit too
10 long, to a little over 200 hospital-specific
11 measures and a little over 400 clinician-
12 specific.

13 I've actually tweaked that a little
14 bit more and narrowed it down a little bit more,
15 but the take home from that is if we need it
16 later on today and we want to look at some of
17 these measures, we can pull up this spreadsheet.
18 We may not need to get into the weeds of
19 individual measures, we'll see how that goes.

20 The other thing that I learned and we
21 have Ira and John who know very much about this
22 and I'm sure you could talk about this more as

1 the day goes on, but they have through the work
2 with HRSA, they've done some work on rural
3 relevancy. So, they've actually looked at
4 different measures that are being used pretty
5 much in the CMS programs, I think.

6 And in various years, they've looked
7 at those to see if those measures seem to be
8 rural relevant or not. So, they started out
9 looking at small hospitals back in 2004, updated
10 their work in 2010/2012 somewhere in there and
11 then John's work with RHCs is ongoing.

12 And we actually tagged measures with
13 results of their work in our Excel spreadsheets
14 of measures.

15 Based on their work mostly, but also
16 just looking overall and thinking about the
17 National Quality Strategy and some of those kind
18 of things, some of the gaps and measurement that
19 we found in the scan have to do with medication
20 safety and reconciliation.

21 Surgical checklist, there actually are
22 some surgical checklist measures out there, a

1 couple of them. But, more in the ambulatory
2 surgical centers. So, we, you know, we might can
3 talk about that if we need to later.

4 There's not much in advanced care
5 planning.

6 Shared decision making is very much
7 missing from all of those measures. And then, so
8 far, I did not see measures around telehealth and
9 telemedicine.

10 So, I'm sure you guys will know a lot
11 more gaps. Again, these are the ones that I
12 found as we were doing our environmental scan.

13 Now this, this was my attempt at
14 trying to put some order around all of these
15 issues. And you'll notice that all these boxes,
16 you don't have to try to figure this out. This
17 is, you know, me trying to mind map a little bit
18 here.

19 Some of these are challenges, some of
20 these are issues. I didn't put everything on the
21 table. But what I was trying to do, and what I
22 convinced myself of, and this is not really a

1 surprise, is that a whole bunch of these things
2 are really intertwined.

3 So, as we go through the day, we're
4 going to talk about low case-volume. Right? But
5 as we talk about low case-volume, we may need to
6 talk about risk adjustment because there are some
7 methodologies, I believe, if I understand
8 correctly, that can help in the low case-volume.

9 Measure selection also impacts the low
10 case-volume problem. If you are only looking at
11 measures of things that everybody does, for
12 example, a screening measure, then you might not
13 have a low case-volume problem.

14 So, again, this is just to illustrate
15 probably to myself more than anybody else, that
16 all of these things are very much intertwined and
17 that we will be talking about different things,
18 even though we're going to try to be systematic
19 throughout the day, we'll be hitting a lot of
20 these different points as well.

21 And then finally, I know everybody was
22 just dying to know what the pre-meeting exercise

1 results were. So, I asked you to do two things
2 for me.

3 The first time, I just asked you to
4 give me your top five of different challenges and
5 you did that and we combined those and we really
6 abbreviated those to a large extent because many
7 of you really gave me some meaty feedback on
8 that.

9 But then, I collected those and pulled
10 what seemed to be the big ones off of your list
11 and then asked you to rank those.

12 So, not surprisingly, we have low
13 case-volume was the one that was ranked highest
14 on the scale of one to ten. And then you see
15 across, and if you kind of squint your eyes, you
16 can probably read some of that.

17 At the very end, you have the
18 aggregation, the level of analysis piece and the
19 attribution. So, that didn't seem to be from
20 your perspective as big the problem or challenge
21 as the other ones.

22 But I think interestingly, there's not

1 a lot of difference there in between the, you
2 know, 7.6, 6.4, there's not a lot of difference.

3 A lot of people see these as a lot of
4 problems. So, again, just a real quick feedback
5 of what you were able to provide us for the pre-
6 work that you did and I do thank you for sending
7 all of those in.

8 Okay, with that, I'm going to hand it
9 back to Mitra so that she can remind us one more
10 time of the various CMS programs that we need to
11 keep in mind.

12 MS. GHAZINOUR: Thanks, Karen.

13 So, I just would provide a brief
14 overview of CMS Quality Improvement programs that
15 are directed towards hospitals and clinicians and
16 are also relevant to this project.

17 So, to drive improvement in health and
18 health care, CMS has administered a variety of
19 quality improvement programs for hospitals such
20 as the programs that are listed on this slide.

21 And the first quality improvement
22 programs that CMS has implemented are pay-for-

1 reporting programs. And on top of the list, we
2 see Hospital Inpatient Quality Reporting Program
3 and followed by Hospital Outpatient Quality
4 Reporting Program which requires hospitals to
5 provide quality data on a set of quality measures
6 to CMS and failure to do so will result in
7 reduction in their annual payment updates.

8 And also we have quality reporting
9 programs for Ambulatory Surgical Centers.

10 And a subset of measures from the
11 hospital IQR and hospital OQR programs are
12 reported publically on the Hospital Compare
13 website which is -- the Hospital Compare website
14 provides information on how well hospitals
15 provide the recommended care to their patients.
16 And also informing patients or consumers choices
17 in regard to their health care decisions.

18 And so, CMS has been shifting from
19 pay-for-reporting to pay-for-performance and now
20 we have Hospital Value-Based Purchasing program
21 which provides incentives to hospitals that meet
22 or exceed their performance standards.

1 And moving on to the next slide. So,
2 here, we attempted to show the relationships
3 among CMS hospital programs. And so, CMS in its
4 effort to align programs, tries to include same
5 measures across programs and we see here that
6 measures for hospital-acquired conditions,
7 reduction program and measures for hospital
8 readmissions reduction program are from the IQR
9 program as well as the measures for the value-
10 based purchasing.

11 So, the measures for the value-based
12 purchasing program are selected from IQR,
13 however, they need to be reported on the Hospital
14 Compare for one year in order to be included in
15 the value-based purchasing program.

16 And moving on to the next slide. So,
17 again, we see here CMS quality programs for
18 clinicians and we see the Physician Quality
19 Reporting System which is a pay-for-reporting
20 program and it started as a voluntary program for
21 clinicians to report measures from a menu of
22 measures, a set of measures, and they would get

1 incentivized for reporting a selected number of
2 measures.

3 However, that is changing now this
4 year to -- the incentive is changing to payment
5 adjustments or reductions.

6 And for some of the -- actually, all
7 the measures in the PQRS also are going to be
8 included in the Physician Compare for public
9 reporting and also in the value-based payment
10 modifier which is a pay-for-performance program,
11 and it evaluates physicians both on the quality
12 of care that they provide and the cost of care.

13 So, the next slide also shows the
14 relationship across the clinician programs and
15 the measures need to be valid and reliable in
16 order to be reported on Physician Compare. And
17 also similar to the relationship between IQR and
18 VBPM measures need to be in PQRS for a year
19 before they can be used in VBPM.

20 So, under critical access hospitals
21 can report measures on a voluntary basis through
22 the physician -- through the Hospital Compare

1 website. They are excluded from reporting though
2 IQR and OQR because they're not paid under the
3 hospital prospective payment system.

4 And some small hospitals also may not
5 be able to report on some of the measures because
6 of low case-volume. And the same situation is
7 for the clinicians who serve in rural health
8 clinics and critical community health centers.

9 And because they are not paid under
10 the physician fee schedule, they're excluded from
11 PQRS and other clinician programs. And also solo
12 practitioners also and small practices, they also
13 have issues regarding reporting on some of the
14 measures because of low case-volume.

15 So I think that was the quick summary
16 of federal programs. I'm just handing it back
17 over to Karen.

18 MS. JOHNSON: Thank you, Mitra.

19 So, the next piece of our morning is
20 really to get a little primer from several of you
21 about some of these settings.

22 Now, I realize that many of you may

1 know all of this stuff already, but maybe not
2 everybody knows some of the details of some of
3 these different settings.

4 So, I've asked a few of you to give us
5 maybe a five, seven, eight minute, whatever you
6 need to do, primer on the settings.

7 So, we'll just go through, let's start
8 with Susan, who's going to talk to us about
9 Critical Access Hospitals.

10 MS. SAUNDERS: All right, Critical
11 Access Hospitals, they are limited to 25 beds or
12 less. They can designate like up to ten beds for
13 other services such as rehab, swing beds,
14 psychiatric. They are required to provide 24-
15 hour emergency care.

16 Some states will designate as
17 necessary provider. They need to be 35 miles
18 from other hospitals, although some states waive
19 that and it can be less.

20 The surgery aspect is minimal-type
21 surgeries because admissions are 96 hours or
22 less.

1 In regards to how they're paid in
2 revenue, of course, they were left out, as was
3 mentioned, they're left out of the Medicare
4 prospective payment system. But they are
5 reimbursed at 101 percent of Medicare reasonable
6 charges or costs.

7 They are subject to Medicare A and B
8 copays and deductibles. With telehealth, they're
9 subject -- they receive 80 percent of the
10 reimbursement. And then they can have HPSA
11 incentive payments for the physicians or
12 providers.

13 They also are able to participate in
14 the Meaningful Use or, you know, EHR incentives.

15 They can have some other incentives as
16 far as teaching incentives, things like that.

17 The current measurements that are
18 going on, you know, as stated, they were excluded
19 from IQR and OQR type measurements. They can
20 report voluntarily to Hospital Compare. However,
21 you know, the fact that the reporting is
22 voluntary, it may not be consistent, you know, or

1 representative of all Critical Access Hospitals.

2 They did participate in the Medicare
3 Beneficiary Quality Improvement under HRSA which
4 looked at things like outpatient ED transfers,
5 pneumonia, acute MI.

6 And then they have many of the private
7 pay-for-performance measures as well as regional
8 quality measures.

9 Some of the challenges in Critical
10 Access Hospitals, you know, is the availability
11 of staff, especially when you get to specialists
12 looking at pharmacists, dieticians, that kind of
13 mix, IT, you know, those people and individuals
14 can be very hard to recruit and retain.

15 You also, in your general education
16 experience staffing mixes can vary. Often times
17 if they're geographically locked or secluded, you
18 may, you know, the further you move away from
19 that academic environment, you kind of lose that
20 culture of knowledge acquisition and, you know,
21 from that regard.

22 Also, just implementation, the

1 importance of quality measures, you know, the
2 implementation, the tool kit in which to do that
3 can be challenging.

4 Because they are secluded and, as
5 Karen mentioned, the heterogeneity of rural
6 areas, your patient demographics can vary, you
7 know, and quite largely. You also have that low
8 volume less predictable kind of population.

9 Some of the key details, the quality
10 measurements, I think we've kind of now mentioned
11 several times is that low case-volume, you know,
12 across the board, the lack of data.

13 The measures that I think we look at
14 for rural health, they need to address what rural
15 health does, the triage, stabilization,
16 transport, you know, the front line kind of
17 measures.

18 And then, you know, some of the
19 measures required mandatory reporting on items
20 that are really not applicable to Critical
21 Access.

22 MS. JOHNSON: Thank you.

1 And, I don't know if anybody has any
2 questions for Susan. It looks like Tim does. So
3 Tim?

4 MR. SIZE: More of a comment and the
5 first one might be a bit of a quibble.

6 There is a very much a controversy
7 around the 96 hours being an average or a cap.
8 It for many years has been an average. CMS, and
9 it's a long complicated story, recently
10 reinterpreted their position to say it was a cap
11 that is being very much pushed back on.

12 So, a lot of CAHs, in fact, do have
13 significant amount of surgery because they work
14 and have been working on an average. Just a
15 small quibble.

16 And the second thing is, and I would
17 have mentioned earlier, it fits anywhere in the
18 conversation, but I'm very much a fan of what the
19 National Quality Forum has done by raising up the
20 SDS issue and its impact on compliance and
21 outcomes.

22 And I think that affects all of our

1 provider categories and I hope that -- I'm not
2 sure we have re-discuss everything that NQF's
3 already doing, but I think we certainly had a
4 couple of key points needed to cite that -- well,
5 it's not a unique role, it has a disproportionate
6 impact on small providers in any of these
7 categories.

8 Thank you.

9 MS. JOHNSON: Thanks, Tim.

10 Anybody else have any questions about
11 CAHs?

12 DR. LANDON: Can you put a little bit
13 more meat on the bones about the 101 percent of
14 sort of usual customary fees or whatever and how
15 much that equates to?

16 MS. SAUNDERS: I'm not sure I know how
17 to answer that because I'm not really an expert
18 in Critical Access. It was just some of the data
19 that I pulled.

20 I think there are individuals at the
21 table that could probably better answer it.

22 MR. SLABACH: I'll do the short

1 version, I could probably talk all morning on
2 reimbursement by costs.

3 I'll give a little bit of history that
4 in 1966 when the Medicare program started, all
5 hospitals were cost-based reimbursed. And then
6 in 1983, we had the Prospective Payment System
7 which reverted to that program for all hospital
8 payment. And then in 1997, we went back to
9 Critical Access costs. We went back to cost-
10 based reimbursement for Critical Access Hospitals
11 at 101 percent of costs.

12 I will point out that due to cost
13 reporting methodologies, that's really never 101
14 percent of costs, it's really more like 94 or 95
15 percent of costs. When you start to exclude some
16 of what's considered customary and reasonable in
17 terms of Medicare's eyes for what constitutes
18 costs.

19 So, the cost of care is what
20 determines -- your payment is based on cost not
21 on your diagnosis. So, there's no upper payment
22 limit as it were in terms of how those costs

1 shake out. So, you could have low volumes that
2 are basically your overhead is spread out over
3 low volumes.

4 And in this case, it corrects for that
5 because you're getting reimbursed on costs, not
6 on a set fee for each diagnosis.

7 Now, if you have any questions to kind
8 of go down further, I'd be happy to answer those.

9 DR. LANDON: Do you have any sense for
10 an average diagnosis of what the payment for a
11 typical Critical Access Hospital is versus what a
12 payment under DRGs would be for, you know, a
13 hospital in the nearest local city?

14 MR. SLABACH: The answer is yes, but
15 it's variable based on region and parts of the
16 country, as we know. But I would say that most
17 of your Critical Access Hospitals -- well, all
18 your Critical Access Hospitals are paid on a per
19 diem and those run anywhere from \$1,500.00 to
20 \$3,000.00 per day and that's how they're paid on
21 an interim basis.

22 And you can compare that then with

1 your average DRG payments for basic diagnosis and
2 you could come up, in some cases, it could be
3 more and some less. So, it's really hard to
4 generalize in terms of the relationship there.

5 MS. JOHNSON: Bob?

6 DR. RAUNER: General follow-up
7 question for that, Brock.

8 So, for example, since your costs --
9 say your costs are stable for three years but
10 your volume went from 90 to 110 to 100. Your
11 reimbursement would be the same in the per diem
12 essentially ratchets up and down based on your
13 volume for the most part? Maybe that's over
14 simplified.

15 MR. SLABACH: No, that's a very good
16 way of saying it. And basically, the costs, I
17 look at it like a tax return. At the end of the
18 year, your costs are based on your audits, are
19 adjusted according to various things.

20 So, another thing that will impact it
21 is not only volume but case mix or patient mix in
22 terms of the types of patients you have in your

1 facility.

2 So, if your Medicare volume declines
3 from 60 percent to 40 percent, then your costs
4 are going to go down accordingly.

5 And so, you could either have an
6 underpayment or an overpayment each year to
7 Medicare and, believe me, as a hospital
8 administrator, you never want to have an
9 overpayment that you have to pay back because
10 Boards don't tend to understand that very well.

11 MS. JOHNSON: And I have one question
12 for you guys who really understand CAHs. I want
13 to make sure that I understand.

14 Do you guys do Part A claims? And
15 then physicians who work there, do they do Part B
16 claims for Medicare or not?

17 MR. SLABACH: Hospitals bill Part A
18 for their -- CAHs bill Part A for their services
19 and those claims are all based on hospital-based
20 claims.

21 Physician claims, now this can start
22 getting very complicated.

1 Yes, if they're not working -- they
2 are Part B claims for physicians working in a
3 Critical Access Hospital unless the Critical
4 Access Hospital opts for Method II billing. And
5 then if they do Method II billing, you get your
6 fee plus 15 percent.

7 MS. JOHNSON: Okay, thank you.

8 And I wanted to know because some
9 measures are claims-based and I was just trying
10 to understand are those measures even applicable
11 for CAHs?

12 MR. SLABACH: Well, part of the
13 problem for a lot of our hospitals right now is
14 that if you have -- if you're in a rural health
15 clinic as a physician, you may have only a small
16 portion of your claims that are Part B. And so,
17 now we're understanding that they are going to be
18 penalized on PQRS for that small sliver of claims
19 that they have.

20 So, in a Part B arrangement, and it's
21 really unfortunate, it's a problem of regulation
22 and we're trying to work on this, but you could

1 get -- they're going to get dinged on the PQRS
2 for not reporting based on the fact that they
3 have those small number of claims.

4 MS. JOHNSON: Okay. And one thing, as
5 you do your tag, can you -- there you go, thank
6 you.

7 Michael? Thanks.

8 DR. BAER: This goes back to the
9 telehealth comment, the 80 percent.

10 Telehealth is only paid by CMS in
11 certain areas, the health physician shortage
12 areas and it is my understanding that anybody who
13 gets reimbursed by CMS only gets reimbursed at 80
14 percent.

15 So, it's not really discriminatory, is
16 it? Is that -- I mean that comment about the 80
17 percent, because they don't pay 100 percent to
18 anybody for telehealth.

19 For the E&M codes, because in an urban
20 area, they don't even pay for telehealth. So, in
21 effect, it's kind of reverse disparity meaning,
22 you know, for those who are not in a shortage

1 area, they can't bill telehealth.

2 So, it's actually a benefit for rural
3 areas, but CMS doesn't pay 100 percent to
4 anybody, they just made a decision since it's
5 telehealth, we'll give the, you know, the
6 originating site X and we'll give the receiving
7 site Y and that was 80 percent.

8 MR. SLABACH: So, if I could, I'll
9 respond.

10 The facility -- there's what's called
11 the facility fee that a Critical Access Hospital
12 or rural health clinic can bill and then you
13 combine that with the Part B fee that the
14 physician gets and it basically is supposed to
15 equal out so that 80 percent -- yes, so the 80
16 percent combined would come up with a total fee.

17 DR. BAER: Right, but there is no 100
18 percent for payment for the physician E&M portion
19 of that, right.

20 MS. JOHNSON: Okay, Bruce? And then
21 we're going to have to go on to our next setting.

22 DR. LANDON: Sorry, can I get back to

1 that question about the sort of hospital claims?

2 Are you doing a typical, you know, UB-
3 92 and putting in the same diagnoses and all?
4 And more importantly, since you're not really
5 getting paid based on those, is the accuracy of
6 the diagnostic coding at a Critical Access
7 Hospital going to be the same as a hospital where
8 it's actually determining which DRG you fall
9 into?

10 MR. SLABACH: You've hit on a very
11 important topic and very astute because one of my
12 big passions over the years has been, as a
13 hospital administrator, we had certified coders.
14 I had very rigorous attention to detail in terms
15 of coding our claims. And we had a case mix
16 index in our facility that was close to one, a
17 little over one.

18 But I have a lot of colleagues who
19 don't pay attention to this at all and I'm not
20 being disparaging, it's just that they -- since
21 they're not paid based on their diagnosis and the
22 accuracy of their coding, it's not a big deal.

1 And so, they'll have case mix indexes that are
2 much, much lower than that.

3 And so often you'll find that the
4 acuity in these facilities is higher, it's just
5 that the coding isn't as robust and so you get
6 the kind of a suppression of what they're
7 actually doing versus what their codes suggest.

8 MS. JOHNSON: Thank you.

9 Let's go on to our next setting.
10 We're going to do Rural Health Clinics and that's
11 John.

12 MR. GALE: Thank you.

13 The Rural Health Clinic program is
14 probably -- is one of the oldest if not the
15 oldest rural support program for primary care
16 providers. It dates back to 1997 -- 1977, excuse
17 me.

18 And the program was designed
19 specifically to address geographic access for
20 Medicare beneficiaries and Medicaid enrollees.

21 It does that through the provision of
22 more volume appropriate cost-based reimbursement

1 for Medicare services, originally Medicaid
2 services and that has transitioned from straight
3 cost-based reimbursement to originally cost-based
4 Prospective Payment System from Medicaid, so it
5 was designed to try to cap their costs.

6 There are probably -- there are over
7 4,000 Rural Health Clinics located in 45 states.
8 And there are some challenges for their
9 participation and some of them are -- some of
10 it's an understanding issue because Rural Health
11 Clinics are certified and designated by CMS and
12 they have to be located in a non-urbanized area.
13 They have to be located in a shortage area either
14 HPSA, medically-underserved area or a Governor
15 designated shortage area. They tend -- and
16 they're paid on a cost-basis.

17 They tend to be confused with
18 Federally-Qualified Health Centers which have
19 somewhat similar designation criteria.

20 The challenge being that they're not
21 alike. RHCs aren't eligible for 330 Funding for
22 the uninsured and in they're not nearly

1 homogeneous in terms of their organizational
2 structure as FQHCs.

3 They can be for-profit privately owned
4 clinics. They can be privately owned clinics.
5 They can be municipally and county government
6 owned, state government owned. And they can be
7 501(c)(3)s.

8 And so, we tend to think of them --
9 it's harder to move the industry or that
10 population because they're all very different.
11 And in many ways, they act much more like small
12 private physician practices than they do an
13 organized delivery system. So, that's the
14 challenge first off.

15 The second part is that they're --
16 RHCs are paid under the Medicare B Trust Fund,
17 but they're paid using Part A methodology. So,
18 they submit UB claims to Medicare A for their
19 reimbursement and they go through the same
20 reconciliation process at the end of the year.
21 They get a Prevacid rate.

22 They are capped. They're paid for a

1 defined package of services which is generally
2 the provider and the professional component of
3 physician services, the evaluation and management
4 codes for osteopaths, they get paid. That
5 includes the manipulation codes, the R&T codes,
6 some procedures.

7 And a basic component of laboratory
8 services, there are six, hematocrits, urines, the
9 sort of basics.

10 And so, they are paid and they submit
11 it and they get a calculated Prevacid rate and
12 that's settled at the end of the year.

13 And I think Brock was saying this, it
14 is true that certain services fall outside of the
15 defined package of Rural Health Clinic services
16 are billed to Part B. So, some of the more
17 extensive diagnostic services, if they're doing
18 some procedural activities, services and even
19 inpatient care. So, if they're providing
20 inpatient services, that's not considered an RHC
21 component.

22 So, they get -- those services get

1 billed on the 1500 to Part B, the rest of the
2 services get billed to the parties but paid
3 eventually and reconciled to Part B.

4 The big challenge in terms of
5 reporting because of the UB issue, the bulk of
6 their services aren't billed using CPT code, they
7 use the revenue codes. They submit CPT codes
8 primarily to commercial carriers, some Medicaid
9 programs, depending on the state regulation
10 process.

11 So, they are getting caught in this
12 PQRS penalty because certain things are being
13 billed but not the bulk of what they do. So, as
14 a result, they have not been eligible to submit
15 the lion's share of their work through PQRS and
16 participate where that's claims-based.

17 They've been left, I don't know if I
18 want to say left out, if that's the right term,
19 some of the other programs like Meaningful Use,
20 they are typically, which doesn't makes sense for
21 them to consider Medicare Meaningful Use
22 Incentives because of that issue.

1 But they can qualify for Medicaid if
2 they have 30 percent or more of their volume
3 attributable to what's considered needy patients,
4 SCHIP, Medicaid and the uninsured.

5 And there's probably much like
6 Critical Access Hospitals, they are struggling
7 with staffing issues. They're struggling with
8 resources. We're beginning to see that in terms
9 of Electronic Health Record Adoption, they're
10 increasing their utilization, VHRs and
11 implementation.

12 Probably rural providers or family
13 docs are increase -- they're probably the fastest
14 increasing group in terms of adoption. They're
15 not quite there with everyone else, but they've
16 been moving along more rapidly from a lower
17 baseline.

18 But we're seeing inconsistent quality,
19 if you will. Some have old legacy systems and
20 what we're finding from some of the providers
21 that we talked to is that even though they may
22 have a certified system, that doesn't necessarily

1 mean what we think it's going to. They're not
2 able to get the codes out. So, if you have
3 standard codes, standard quality measures, they
4 may not all throw out the same information.

5 Questions?

6 MS. JOHNSON: That's Bob. Can you --
7 yes, do your tag over towards -- there you go,
8 Bob.

9 DR. RAUNER: Actually, this was the
10 perfect segue between these two things. Because
11 I think this is critical understanding the
12 incentive problems in rural because of this A/B
13 hybrid billing system that has resulted.

14 So, I actually was working for a
15 couple of years for our regional extension
16 center. About half of the rural physicians in
17 Nebraska were in effect written out of the
18 Meaningful Use Incentive program because this
19 Part A, Part B issue that John just talked about.

20 And it messes up everything from PQRS,
21 it even messes up the Medicare Shared Savings
22 Program, ACOs in rural areas that I have a direct

1 conflict with, of course, because it made it, I
2 think made it impossible for us to make a bonus
3 actually because of these -- all this mess up
4 here.

5 And I think, and no offense to the
6 folks who are Washington people, if Washington
7 had a better understanding of this, we could fix
8 a lot of these rural problems because this A/B
9 distinction messes up most of the incentive
10 programs whether it's PQRS, Meaningful Use, ACO.
11 And until they get around this A/B division, it's
12 fundamentally unsustainable.

13 And Aaron and I were talking about
14 this before this meeting started because he's in
15 that limbo world where he actually does the FQHC
16 but even that is really messed up in rural
17 because there's a 30 percent threshold and many
18 people can't make the 30 percent Medicaid
19 threshold in rural.

20 In Nebraska, it even got to the point
21 where even the urban pediatricians couldn't make
22 the 30 percent Medicaid and so even urban

1 pediatricians were written out of Meaningful Use
2 because of these different limitations.

3 And so, this A/B thing is really,
4 really, really important to solve.

5 MS. JOHNSON: Ira?

6 CO-CHAIR MOSCOVICE: So, I'll be
7 speaking as a member of the committee now.

8 I think a couple of issues got raised
9 by a couple of speakers that I'm hoping the
10 committee can deal with as we go through the next
11 day and a half.

12 And it's basically the exclusion of
13 CAHs or Rural Health Clinics or other kinds of
14 providers you'll hear from whether it's mandated
15 reporting, differences in, you know, how they're
16 going to get paid.

17 And, you know, my observation is that
18 many providers think, well, if I don't have to
19 report, that's good. You know, it's one less
20 hassle.

21 But, from my perspective, when we
22 exclude rural providers from the programs that

1 are coming, it's a huge issue. And so, I'm
2 hoping that the discussion we have over the next
3 couple of days can at least start to grapple with
4 that and make some recommendations to CMS where
5 we think it's appropriate to try to include rural
6 providers in these programs.

7 MS. JOHNSON: And Bruce?

8 DR. LANDON: So, could you elaborate
9 more on why the A/B issue is problematic for
10 constructing budgets for ACOs?

11 You know, for instance, in urban
12 areas, we now are able to get around that issue
13 with our community health centers who have the
14 same A/B issue. And, you know, at the end of the
15 day, the budget's the budget whether it's a Part
16 B or a Part A part of it.

17 Does it have something to do with how
18 the growth rates are determined? Can you -- I'm
19 a little confused on that.

20 DR. RAUNER: And I may not get this
21 completely right because we are still struggling
22 with this. I finally got to talk to Medicare

1 actuary recently about this, so with our ACO, and
2 again, I have a direct conflict with this one,
3 just disclosure again.

4 We've had a 15 percent reduction in
5 our hospitalizations over the last two years but
6 no reduction in our costs and we're trying to
7 figure out why. Well, we think the reason is,
8 back to this volume issue, is though the
9 hospital's volume has been reduced, their costs
10 were not reduced so their per diem just went up
11 accordingly.

12 And then that, because no cost was no
13 changed, us as an ACO, we got no credit for those
14 reductions. Yes, that's that.

15 The Meaningful Use was the A/B issue
16 because literally most -- so we have a Rural
17 Health Clinic. For example, they do most of
18 their stuff but it all goes through Part A. But
19 your Meaningful Use Incentives are based on
20 meeting a threshold of Part B.

21 No, this goes back to the actual
22 individual Rural Health Clinic and why they could

1 not get Meaningful Use Incentives. Yes, but
2 almost every program, there's a unique A/B thing
3 that messes it up whether it be Meaningful Use,
4 PQRS, ACOs.

5 And until the federal policy fully
6 understand that, all these things, they work,
7 say, in Philly but they don't work in, you know,
8 Minot, North Dakota because of these issues.

9 MS. JOHNSON: Brock?

10 MR. SLABACH: This has been a great
11 discussion. I will point out and add a little
12 bit to John's commentary that there are free-
13 standing Rural Health Clinics that are -- and
14 then there's also provider-based Rural Health
15 Clinics. So, there's two very distinctly
16 different reimbursement structures for each.

17 In a free-standing, they are subject
18 to an upper payment limit which is amended,
19 hopefully, annually to some kind of economic
20 index. This year, it was a whole one percent, so
21 they went from 79 AD to AD 16 per visit.

22 And so, if your costs are more than

1 that, then that's all just down the cracks, as it
2 were.

3 For provider-based, there is no upper
4 payment limit. So, those are clinics that are
5 owned and operated as departments of hospitals
6 either Critical Access Hospital or a PPS hospital
7 50 beds or less.

8 And so, those have a different payment
9 structure and sometimes that does have an impact
10 on ACOs. And the problem for us in our rural
11 settings is not withstanding the problem for the
12 ACOs, these are all designed as safety net
13 programs to ensure the access.

14 So, if you remove that -- in other
15 words, if you remove the effects of no cost
16 decreases, then they're not going to be able to
17 have enough money to keep their overhead in place
18 to be able to support those structures.

19 So, there's the rub between one level
20 of payment policy in terms of incentives to the
21 ACO and the safety net concerns that we have
22 between rural and those payment programs.

1 And so, there's some conflicts as you
2 start layering these programs up.

3 MS. JOHNSON: John?

4 MR. GALE: One small clarification on
5 the provider-based caps, it's 50 beds and higher.
6 Provider-based clinics owned by hospitals with 50
7 beds and higher are subject to a cap. It's
8 anything under 50 beds, 49 and smaller.

9 My understanding is, and here is the
10 challenge, is that most clinics and most MIS
11 systems used to do billing, they are entered in
12 based on the CPT codes. So, actually that
13 information is extractable. It's just a matter
14 fo the claims submissions.

15 So, and in some ways, I have to say to
16 be honest, the political calculation has been
17 made when PQRS is being developed, Medicaid
18 meaning -- Medicare Meaningful Use.

19 Whether or not it's worth fighting to
20 get them included in some ways because they're
21 not eligible for the incentives, they're also on
22 the downside not subject to the penalties down

1 the road.

2 And in looking at the two Medicare and
3 Medicaid reimbursement incentive payments, as
4 long as they're eligible -- as long as they meet
5 the 30 percent threshold, the Medicaid incentive
6 payment is actually more beneficial financially
7 for claims.

8 So, I mean there are so many things
9 that they can fight for and they make some
10 decisions about what makes sense and what, in the
11 long run, is best for them.

12 MS. JOHNSON: Okay, Tonya?

13 MS. BARTHOLOMEW: I just wanted to
14 give you some hardcore data.

15 We were just this summer dropped our
16 Rural Health Clinic status because my costs of
17 taking care of a Medicare patient was around
18 \$132.00 and my reimbursement from Medicare was
19 \$79.00. You can't keep the lights on, and we're
20 an independent -- we were an independent rural
21 health.

22 MS. JOHNSON: Okay, great discussion.

1 You know, part of me thinks that this
2 may be a little tangential but maybe not. I
3 think we probably need to understand some of
4 these reimbursement issues a little better.

5 And I'll be coming back to you later
6 because some of what you said was over my head
7 and we'll get the details before we publish
8 anything.

9 But, let's go to CHCs and Aaron is
10 going to talk about CHCs.

11 DR. GARMAN: Thank you all.

12 Well, the FQHC program has actually
13 been around since 1965, so we're celebrating our
14 50th year of service.

15 FQHC is our nonprofit community-
16 directed providers that have to have a Board of
17 Directors, community Board of Directors that
18 composes at least 50 percent of their Board.

19 As of 2013, there were 1,200
20 organizations with 9,170 delivery sites. FQHCs
21 served almost 22 million patients in 2013.

22 So, when we all get together and talk,

1 we're the largest health care delivery system in
2 the United States.

3 About 50 percent of FQHCs are rural.
4 The origination is to provide access and
5 affordable care to the underserved and uninsured.

6 There's a huge push currently for
7 FQHCs to follow 19 program requirements, one of
8 which is a robust CQI program. I've got the
9 other 18 if you're interested, but I don't think
10 you will be.

11 At FQHCs, obviously, there's a wide
12 range of services that can be provided. In rural
13 areas such as myself, we do prenatal care and
14 primary care. We cover emergency rooms. We
15 cover the hospital. We cover the nursing home.
16 We provide hospice care.

17 So, we have many hats and are pulled
18 in multiple directions. I think that's one of
19 the big challenges for rural providers is that
20 it's great to talk about being able to sit down
21 and talk about quality measures if you have the
22 time to do it.

1 But which quality measures do you talk
2 about? Do you talk about those that you're
3 providing at the CAH? Or do you talk about those
4 that you're providing at the FQHC? Or do you
5 talk about those that you're providing at the
6 nursing home? Where do you give your time?

7 As an FQHC, we do a lot of reporting,
8 but I'll go into funding first. We are funded
9 with federal grant dollars. We have a
10 noncompeting grant that we have to fill out an
11 application for every year. And then every three
12 years, we have a competitive grant.

13 Both Medicare and Medicaid are
14 reimbursed as flat fees. Medicare is billed
15 through Part A and lab and x-ray components are
16 billed through Part B. Medicaid, again, is a
17 flat fee.

18 Other insurance is typical fee-for-
19 service. We also get other grant dollars if you
20 provide other services such as behavioral health,
21 you can write for other grants.

22 Some benefits for being an FQHC

1 include FTCA coverage. However, with FTCA, we
2 also have gap insurance because we don't
3 necessarily trust FTCA coverage. And also, we
4 have a 340B drug plan which is a great product
5 for our patients.

6 Measurement, we utilize -- every year,
7 we have to fill out a UDS or Uniform Data Set of
8 measures sponsored by the Bureau of Primary
9 Health Care. That follows the National Quality
10 Strategic Plan.

11 And that goes through demographics
12 which are cross-linked for all unique patients.
13 The quality measures include entry into prenatal
14 care or early entry into prenatal care, childhood
15 immunizations prior to the third birthday,
16 cervical cancer, weight for adults and kids,
17 tobacco use, pharmacological therapy for asthma,
18 CAD and lipid-lowering therapy and ischemic
19 vascular disease.

20 One of the other measures or other
21 programs that we have is VFC, so vaccines for
22 children and also commercial products provide

1 quality measurements that we have to comply with
2 or should comply with.

3 But the problem gets to be that all of
4 these measures have little different tweaks. So,
5 our UDS, for instance, we have to report all of
6 our A1Cs less than nine and for everything else,
7 it's A1Cs less than eight.

8 For immunizations for UDS, it's all
9 kids up to their -- prior to their third
10 birthday. For everything else, it's kids up to
11 their second birthday.

12 So now, when we do these measures, we
13 have to duplicate them multiple times and run
14 data on multiple different fields to be able to
15 figure out where we're actually at.

16 Other challenges, and I am the plumber
17 of the group, I am the one that fixes the toilets
18 in my facility, and so, you know, I shingle the
19 roof and fix the toilets and do what you have to
20 do to make a go of it. But, weather is a
21 challenge, trying to get patients into the clinic
22 can be a very big challenge.

1 And staffing, you know, staffing is a
2 huge issue, especially in rural North Dakota with
3 the oil that's filtered into the western part of
4 the state, we lose a lot of people to the oil
5 fields. And so, trying to find quality people
6 that can work in a clinic is very challenging.

7 The rural health institutions, the
8 CAHs in our area, really have significant
9 challenges with that. And it's very interesting
10 that despite the increase in volume, pretty much
11 all of the Critical Access Hospitals in the
12 western half of North Dakota have lost money
13 every year since the oil came into play. They're
14 seeing a lot more volume, but they're not getting
15 paid for it.

16 So, that is FQHC in a nutshell.

17 MS. JOHNSON: Thank you.

18 I have one question for you, Aaron.
19 You talk about FQHCs, and I understand that there
20 are different types of clinics that fall under
21 those. There's the community health centers and
22 then there's some migrant centers and some other

1 ones.

2 Do we need to make a distinction for
3 our work here and talk solely about CHCs or is it
4 once you understand rural FQHCs, it's --

5 DR. GARMAN: That's a very good
6 question and I do think there are some
7 distinctions.

8 As far as funding, I don't believe
9 there are. As far as measurement, I don't
10 believe there are. But, it's very challenging
11 for our migrant centers and also our centers who
12 have a large homeless population to be able to
13 capture data.

14 I mean if somebody doesn't have a
15 place to hang their hat, no home, how do you
16 capture that? So, it is a big challenge.

17 MS. JOHNSON: So, the biggest
18 challenge is the patient population and the
19 difficulties there. Okay.

20 Marty?

21 MR. RICE: So, one thing that isn't
22 brought up much is that we have an all voluntary

1 military and a lot of the military folks come
2 from rural communities to seek a better
3 opportunity.

4 A report that we did a couple of years
5 ago, what we found was is that when someone,
6 unfortunately, gets injured in war and has become
7 disabled, the VA takes care of that injured
8 person, the injured military person.

9 But the family is not covered under
10 the VA health care. So, where does the family
11 from, you know, go to seek medical health care,
12 to seek hospital care, to seek dental care? If
13 maybe their breadwinner is not able to work and
14 usually, it's federally qualified health centers,
15 rural health centers, Critical Access Hospitals.

16 So, to put a face on some -- you know,
17 when we talk about safety net, we also have to
18 look at the people who are involved within the
19 safety net. And some of them, unfortunately, are
20 kind of stuck and they get great care at these
21 facilities.

22 But I just wanted to bring out the

1 military, even though VA takes care of the
2 military person, the families are taken care of
3 in their communities.

4 Thank you.

5 MS. JOHNSON: Okay, Michael?

6 DR. BAER: Two questions. One, the
7 FTCP, that's the Federal Court Claims Act, and so
8 you actually have a -- so that's medical
9 malpractice?

10 So, if you work in a FQHC, you don't
11 need to have malpractice, but you say you cover -
12 - you carry a gap coverage for that?

13 DR. GARMAN: Correct, because the
14 issue with FTCA, Federal Tort Claims Act, is
15 essentially, it's free malpractice insurance for
16 those practitioners in a FQHC.

17 The problem gets to be when we fill
18 out our scope of service which is a form that we
19 have to fill out for the federal government, we
20 list all of the services that we provide.

21 Well, on there, it doesn't say
22 anything about me seeing a kid at a basketball

1 game for a sprained ankle.

2 It also gets really gray when I leave
3 my center and I go to the hospital and provide
4 care to a patient who's not a health center
5 patient. Who covers that?

6 So, that's why I said I don't really
7 trust it. It's a great program and it benefits
8 me tremendously, but there are gaps in that and
9 that's why we have to have gap insurance.

10 Thank you.

11 DR. BAER: The second question, can
12 you compare and contrast, if you can in any quick
13 way, what's the difference between an FQHC and an
14 FQHC lookalike?

15 DR. GARMAN: FQHC lookalikes have to
16 fulfill all the requirements of an FQHC that's
17 practicing. The only difference is lack of grant
18 funds.

19 DR. BAER: Say that again?

20 DR. GARMAN: They don't get the grant
21 dollars. So, as an FQHC, we get grant funds
22 every year and an FQHC lookalike does not.

1 They've applied, they go through all the motions,
2 they have to do all the reporting, but they don't
3 get grant dollars.

4 DR. BAER: What's the advantage of
5 doing that?

6 DR. GARMAN: Of being an FQHC
7 lookalike?

8 DR. BAER: Yes.

9 DR. GARMAN: Increased reimbursement,
10 perhaps, but not --

11 DR. BAER: What about the 840B
12 pharmacy stuff?

13 DR. GARMAN: 340B?

14 DR. BAER: 340B.

15 DR. GARMAN: 340B pharmacies,
16 essentially, what happens, and this gets a little
17 bit complicated, but we, as an FQHC, are able to
18 procure pharmaceuticals from a large company such
19 as McKesson, for instance for a discounted rate
20 compared to what anybody else could get them for.

21 In turn, when we use our local
22 pharmacy, when our pharmacist goes to -- when we

1 prescribe those medicines and our patients go to
2 pick those up, if they have insurance, that
3 medication is sold at the usual customary rate,
4 whatever that is across the nation, normal
5 customary fees. So, we make a little bit more
6 money on that, no our end.

7 And then, every patient coming to the
8 health center fills out insurance or financial
9 information. If they fall into the Federal
10 Poverty Guidelines, they can qualify for
11 discounted care either at our center, which is
12 one of the benefits, or at the pharmacy. So,
13 they can receive a 100 percent discount of their
14 pharmaceuticals at the pharmacy based on the 340B
15 drug program.

16 And the way that that money is made up
17 is that small margin that we make up when we
18 purchase those pharmaceuticals. So, it's really
19 McKesson or the other large entities, the
20 pharmaceutical companies, that are essentially
21 taking that hit.

22 As an insured patient, you don't take

1 the hit, you pay what you'd pay no matter where
2 you go. As an uninsured patient, you get the
3 benefit but the money is made actually in the
4 small margin that we make on the drugs.

5 MS. JOHNSON: Kelly?

6 CO-CHAIR COURT: Aaron, you talked
7 about 19 program requirements that includes a
8 robust quality program and you talked about UDS
9 with quality measures.

10 So, who requires those? Where does
11 that data go? And what do they do with it?

12 DR. GARMAN: The Bureau of Primary
13 Health Care tracks the UDS form and it's done
14 yearly. And it's a very robust form and it's a
15 very robust amount of data.

16 This is just the quality measures.
17 There's also financial measures that we have to
18 gather, but that goes to HRSA and to the Bureau
19 of Primary Health Care.

20 CO-CHAIR COURT: And then, what do
21 they do with that data?

22 DR. GARMAN: They -- well, that's a

1 very good question.

2 Some of it is political, they use it
3 to say, hey, look how good our health centers are
4 doing. And I think that translates up on The
5 Hill as far as funding for health centers because
6 the quality metrics that we have obtained do show
7 significant improvements in care and also lower
8 costs for our patients.

9 But, it's also a measure of how the
10 program is doing as far as accountability for the
11 program. So, when somebody else in the federal
12 government comes up and says, well, we don't like
13 this program, how is it doing? You've got the
14 data to support how well your program is doing.

15 CO-CHAIR COURT: And is that the same
16 thing as your 19 program requirements?

17 DR. GARMAN: No, totally different.

18 CO-CHAIR COURT: Where does that come
19 from and what happens to that data?

20 DR. GARMAN: That's really not so much
21 data. The 19 program requirements are things
22 like you have to have open access scheduling.

1 You have to have a CQI program. You have to have
2 appropriate staff in place. You have to have a
3 place for your patients to go if they don't -- if
4 your center is closed. Those are the 19 program
5 requirements.

6 CO-CHAIR COURT: Don't the FQHCs,
7 though, submit other measures like diabetic
8 measures, immunization measures, to a central
9 repository somewhere?

10 DR. GARMAN: That's part of the UDS
11 measures.

12 CO-CHAIR COURT: Oh, okay. Thanks.

13 DR. GARMAN: Yes. It's a huge
14 process.

15 DR. LANDON: Those are not patient
16 level, though, I think they're aggregate.

17 MS. JOHNSON: Okay, great.

18 Now, I know we're at our time for
19 break, but I think we should go ahead and finish
20 this setting.

21 So, Tonya's going to tell us a little
22 bit about small practices. Yes, she didn't know

1 she was going to, sorry.

2 MS. BARTHOLOMEW: Let's see, what do
3 you want to know?

4 Small practices, I think in our
5 initial webinar it was mentioned that those are
6 the practices that we're really trying not to
7 leave behind through these quality measures.

8 And there are so many things that we
9 need to empower these practices with in order to
10 keep up with the times, to keep up with the
11 quality reporting.

12 A lot of them, at least in our state,
13 are being encouraged to Become Patient-Centered
14 Medical Homes for quality measure reporting.

15 We just received our Level 3
16 recognition, so I'm really proud of that,
17 especially with three providers and an
18 occupational therapist filling out the
19 application.

20 A lot of the small practices are in
21 conjunction, Rural Health Clinics. Like I
22 mentioned, the reimbursement rates aren't

1 supporting the costs of providing for these
2 patients.

3 Currently, transportation is a huge
4 ordeal, telehealth is a huge ordeal. I'm trying
5 to get that -- the specialists to cooperate with
6 these small clinics to get our patients that
7 access to the rheumatologist or the infectious
8 disease specialist. It is a real challenge, even
9 though they can sit down at their desk and easily
10 see the patient and charge an E&M code.

11 I think, as far as the quality
12 measures, it's kind of a chicken and an egg
13 scenario. In order to afford to pay that person
14 to run the data reports, to contact the patients
15 and to gather that quality reporting
16 measurements, you have to have that financial
17 background to support that person to do that.

18 But often times, that financial
19 incentive or background does not come until after
20 you do that quality reporting measurement.

21 So, I think small clinics often times
22 rely on a lot of philanthropy, to be honest with

1 you, to keep the doors of the clinic open, to
2 keep access available for patients and, in turn,
3 report quality measures.

4 So, I think that is one of the biggest
5 challenges then is to how do you recruit these
6 small practices? It's been mentioned before here
7 this morning, time. It's when the physician is,
8 you know, fixing the toilet, going out to do an
9 end of life care visit, cramming 20 patients in a
10 day.

11 How do you find time to do this
12 quality measure reporting and what is most
13 important? What is going to be useful in helping
14 these patients achieve better health? And that's
15 what it comes down to.

16 So, I think there's just a ton of
17 challenges within that.

18 And then, of course, we've already
19 mentioned the staffing issues. Living in a small
20 town of 1,700 people, to find someone who's
21 competent and reliable and able to do this kind
22 of stuff is very difficult.

1 MS. JOHNSON: So, thank you.

2 Kelly?

3 CO-CHAIR COURT: Thanks, Tonya.

4 I've struggled with trying to figure
5 out what's the difference between a rural primary
6 care -- as it relates to measurement -- a rural
7 primary care practice with three providers from a
8 nonrural primary care practice standalone with
9 only three providers.

10 So, it would seem to me, and so help
11 me understand, wouldn't they all have the same
12 kind of resource constraints and, you know,
13 clinical island, if you will? So, what makes it
14 different in rural?

15 MS. BARTHOLOMEW: Well, you're not
16 operating under an umbrella of administrators as
17 a standalone clinic. If I'm understanding your
18 question correctly, we are not -- we don't belong
19 to -- we're not owned by a hospital, we're not
20 owned by an umbrella of entities where maybe they
21 do have a practice administrator to provide me or
22 they do have an IT person to provide me.

1 But truly, a standalone, you are out
2 in the middle of nowhere, 40 miles away from the
3 nearest other health care provider, you're it.
4 You've got to figure it out and you don't have
5 someone to go to to do those things and solve
6 those problems for you.

7 MS. JOHNSON: Okay, I wasn't paying
8 attention to who got their flag up first.

9 DR. BAER: Oh, it was a quick
10 question.

11 So, a town of 1,700, you have 2,800
12 patients in your practice, so is everybody in
13 your town in your practice? And what's the
14 radiance from which they come?

15 MS. BARTHOLOMEW: Pretty much
16 everybody in our town is in our practice. They
17 come from at least a 40 mile radius on a regular
18 basis. So, in Wyoming, you've got weather
19 conditions to contend with, so that, again, that
20 telemedicine is a huge component of what we need
21 to do for our patients.

22 MS. JOHNSON: Aaron? Oh, sorry, Bob?

1 Whichever.

2 DR. RAUNER: Well, one, I credit Tonya
3 to get to Level 3 NCQA, the paperwork slug of
4 that in your size practice is huge. So, kudos to
5 you for that.

6 My group is essentially almost 12
7 versions of Tonya's and that's partly literally,
8 we formed the ACO not because we wanted to the
9 ACO, because we want to do all of that and we
10 have no way to pay for it.

11 The way to pay for it was to get an
12 advance payment to basically fund myself and an
13 IT person to help the clinics do that because
14 that's the critical problem in rural areas.

15 It's not a sample size because I would
16 bet her husband sees more patients and has a
17 bigger panel than most urban people. So, it's
18 not a sample size at the clinic level issue, it's
19 a capabilities, having someone who has the time
20 to pull quality measures out of a really badly
21 designed EHR which most of them are for this type
22 of thing.

1 And so, it's really what they need
2 more than anything else, I think and correct me
3 on this, is they need people who can do this
4 stuff because they don't live in Saratoga
5 probably.

6 And then having somebody who has the
7 time to do that stuff. So, that our IT person,
8 she actually goes to one of our smallest clinics
9 and literally can dial in from her basement in
10 her bunny slippers to the Broken Bow Clinic and
11 pull this stuff for the clinic so, Tess, who's
12 our version of you, doesn't have to do it.
13 That's literally the biggest issue.

14 So, the quality from a small practice
15 is not the sample size, it's the staff, the time
16 and the payment because fee-for-service doesn't -
17 - if actually a Patient-Centered Medical Home may
18 hurt them financially on fee-for-service unless
19 they get per member home out there or something
20 like that and you may clarify some times.

21 But I know you guys well, because I
22 used -- I grew up about 150 miles from you.

1 MS. BARTHOLOMEW: Yes, currently, the
2 Patient-Centered Medical Home is killing us
3 financially because of the time it has taken to
4 fill out the application, the time it takes to
5 negotiate with the payers, but then it still
6 comes down to those quality measures and how are
7 we going to use those quality measures.

8 However, my patient care coordinator,
9 she answers the phone, she runs telehealth and
10 that's the key thing with the rural clinics is
11 that nobody has just one job, it is just so much
12 multitasking and those staff are really hard to
13 find.

14 MS. JOHNSON: Aaron?

15 DR. GARMAN: I would like to speak a
16 little bit to your question, Kelly, as far as
17 what's the difference? Why three docs in an
18 urban environment versus three docs in a rural
19 environment?

20 Well, right now, today, there's nobody
21 seeing my patients because I'm here. And my
22 partners are busy.

1 The other thing is, when I am there,
2 I'm there seeing patients but also I have to go
3 over to the hospital to see an ER patient. I
4 have to cover my patients in the hospital. I
5 have to cover the patients in the nursing home,
6 might have to go make nursing home rounds. I
7 might have to go for a hospice meeting. There's
8 nobody else to do that.

9 So, it's not like a larger city where
10 you have hospitalists, you have people to do
11 those jobs. We are those people that do those
12 jobs. There's nobody else.

13 So that, I think is the biggest
14 difference is we're pulled in 15 different
15 directions all the time. And if one of those
16 things is reporting, which one do you think? Is
17 Bob's heart attack going to take precedence over
18 PQRS measures? Yes, it is.

19 And I've got to still fix the toilet.

20 MS. JOHNSON: Guy?

21 DR. NUKI: I was actually going to say
22 exactly what Aaron said, so I almost turned my

1 sign down.

2 But I just wanted to add one thing,
3 that does make for a low volume issue, though,
4 because if you are acting as the hospitalist,
5 delivering babies and seeing diabetics in your
6 clinic, the number of diabetics is going to be a
7 little bit less even though you're probably
8 seeing more patients, you're the obstetrician,
9 you're the hospitalist, you're everything else.

10 So, it does actually end up causing a
11 problem with numbers.

12 MS. JOHNSON: Ira?

13 CO-CHAIR MOSCOVICE: So, just a couple
14 of responses to Kelly.

15 The first is, I'll speak for the Twin
16 Cities. There are very few three physician
17 practices. Now, maybe on Park Avenue in New
18 York, you have concierge doctors who are solo,
19 don't take insurance. But, there's been such
20 consolidation in the system that there's very few
21 small practices in major metropolitan areas.

22 But I think the points that have been

1 raised really point out that we have states and
2 Wisconsin's one, our state, Minnesota, and there
3 are other states where it's a network that you're
4 a part of and that's where you get the support.
5 Or it's a QIO and the rep that they have that's
6 providing the kind of support needs.

7 These practices can't do it on their
8 own and what we, I think, need to figure out is,
9 you know, what are the vehicles? What are the
10 strategies so that every state has the ability to
11 help, you know, practices like that. And then,
12 how that feeds into the quality issue is the
13 larger issue.

14 But, they can't do it alone. We're
15 not going to be able to figure out a government
16 program that's going to help every small
17 practice. We need to figure out strategies that
18 allow others to network with those facilities.

19 And, you know, you hear this and it's
20 just, you're sitting here, you know, beyond
21 belief saying, if you don't live in those small
22 towns. I mean, they're saying what it really is.

1 Tonya's writing grant proposals, doing OT and God
2 knows whatever else.

3 And we need to figure out a way so
4 that the kinds of services that a good network,
5 the good QIO, a good hospital association, how we
6 get that available in every state so that small
7 practices can survive.

8 MS. JOHNSON: Marty?

9 MR. RICE: Health care isn't my first
10 profession. My first profession was accounting
11 and one of the interesting things about going
12 into becoming an Advanced Practice Nurse as an
13 adult, if you kind of look at the business
14 process of it.

15 And I think that one of the things
16 that we need to look at as health care
17 professionals and people in public health is that
18 even though the practice of medicine is the same,
19 we all give good care, we hope.

20 But the workflow is going to be
21 different in every setting and I don't think we
22 always look at the workflow. And you can't, even

1 though the medicine is practiced the same, we
2 have to look at how it's actually practiced in
3 that setting to make judgments and to set
4 measures of how those outcomes come about.

5 MS. JOHNSON: Brock?

6 MR. SLABACH: Just a couple of quick
7 comments.

8 First of all, I think that the
9 statistics are noting at least in rural
10 communities around the country that about between
11 75 and 80 percent of physicians are now becoming
12 employed by hospitals or health systems.

13 So, the market, I think, has kind of
14 taking -- having an impact in the very problem
15 that you're talking about because those system
16 resources are necessary to do the very things
17 that we're talking about here.

18 Secondly, for recruitment, by
19 definition, most of all of these places that
20 we're talking about are in what's known as Health
21 Professional Shortage Areas, or HPSAs. And by
22 definition, there's not enough providers for the

1 population served.

2 And I have physicians in my hospital,
3 in our clinics that say 70 patients a day.

4 I will point out that also in that
5 context, most rural emergency rooms see over 50
6 percent of their volume as primary care visits.

7 So, you have access being received
8 through the emergency department in these
9 communities, which we all know isn't the best
10 source of care, but it is, of course, if it's the
11 only source for many of these folks, that's
12 another backstop, if you will.

13 And so, that's why we're particularly
14 distressed over 47 rural hospitals that have
15 closed in the last four years, we're projecting
16 another 283 probably over the next couple of
17 years that are in very similar situations.

18 So, as we start to project here, I
19 think, and again, it's important to understand,
20 that sometimes the market works, sometimes it may
21 not work so efficiently in these issues and we
22 have to be conscious of the fact that there are

1 stresses in these local communities that do
2 produce those kinds of reactions that we're
3 seeing.

4 MS. JOHNSON: Jason?

5 MR. LANDERS: This is kind of a
6 question and kind of a question to you in general
7 and maybe a bigger question to the group.

8 But, I've been on the practice
9 administration side and on the payer side
10 establishing PCMHs and now I'm on the Medicaid
11 side paying for all the Medicaid care.

12 But, one of the common things that
13 come up, especially when I was establishing PCMHs
14 was the time to mine out data from their EMR.

15 Someone talked about poorly
16 constructed EMRs, and not only the time, but the
17 expense because often you have to have custom
18 reporting to draw the right reports out.

19 And in deference to my neighbor here
20 who was on the epic side, it seems that the big
21 winners in the Meaningful Use money were the EMRs
22 themselves because they had federal dollars

1 coming in to pay for those.

2 And yet, they've established a system
3 where there's no commonality in reporting and
4 there's additional fees to develop reports. I
5 would think that bringing more -- putting more
6 emphasis on the reporting from the EMRs and kind
7 of creating a very common and some method of you
8 write one report for PCMH or UDS measures or PQRS
9 and it works across platforms.

10 I mean as I talk to people like you,
11 that's really the one thing is I go to them and
12 I'm wanting my five measures for Medicaid, West
13 Virginia Medicaid reported out and I've got, you
14 know, 300 providers in West Virginia that are
15 small providers and the one or two docs and
16 you're in OT. But I mean it could be an MA or
17 whoever that is kind of charged with getting us
18 that information.

19 They don't have time, they don't have
20 the money and that's really the barrier for
21 getting good data back.

22 So, am I kind of on to the problem or?

1 MS. BARTHOLOMEW: Absolutely, and it
2 goes back to what Aaron was saying is that he
3 reports on the same measures but they're tweaked
4 a little bit. The hemoglobin A1C is eight for
5 one place and it's nine for another place. And
6 that's the problem that we're running into is all
7 of these little entities have their own little
8 programs but these providers have to almost
9 develop these fingers that, you know,
10 specifically report on this program and
11 specifically report on that program.

12 And again, it comes back to time and
13 resources and money and I've actually been
14 working with the Wyoming State Medicaid Program,
15 this is probably -- I should probably say this,
16 should have so this is the disclaimer, to design
17 the Patient-Centered Medical Home attestation
18 form and their big push is we want practices to
19 participate.

20 So, we need to make these measures the
21 same as what other people are asking for because
22 otherwise, then you do lose money and you don't

1 want to do the quality reporting if you're having
2 to report on the same things in different ways.
3 It's a huge problem.

4 MS. JOHNSON: I want to have Tim then
5 Kim and then Jonathan and we need to look at the
6 clock, unfortunately. And Helen, I'm going to
7 get you in here, too. We need to stop, have a
8 hard stop at 11:00 so we can have a short break
9 and we still have to talk about small hospitals.

10 MR. SIZE: I'll try to be quick and
11 it's just an observation and, Karen, I compliment
12 you on so quickly helping us bring out all the
13 complexity of this topic.

14 And I'm just going to make it a little
15 worse, I think, by reinforcing a couple of
16 threads.

17 I think Brock may have been the first
18 person to mention the word market and a lot of
19 the conversation that I've heard before
20 underneath it had more of a frontier tinge or
21 maybe I misheard.

22 Most rural population is adjacent

1 rural and easily within driving distance of
2 aggressive urban outreach and health plan or
3 system.

4 I've got three meetings with insurers
5 coming up in the next three weeks that we've
6 invited in terms of pay-for-performance measures
7 because we desperately want to have a mechanism
8 to show our people can do the work and are doing
9 the work.

10 So, this conversation isn't just about
11 Medicare. In our state actually, and I think
12 we're somewhat of an outlier, I think we're
13 beyond 50 percent of our Medicare population is
14 in Medicare Advantage. And notwithstanding all
15 the complexity we can get into around ACO
16 development, Medicare Advantage is not going away
17 in my mind.

18 So, the commercial side of this
19 conversation is very important to some of us and
20 that we not be left behind because I think if
21 we're left behind the metrics, our practice sites
22 will be left behind as more and more people

1 migrate away from them.

2 So, I just wanted to make our complex
3 conversation just a bit more complex.

4 MS. JOHNSON: Tim?

5 MR. SIZE: You're welcome.

6 DR. RASK: Tonya, I have a quick
7 question.

8 When we were talking about the rural
9 health clinics, we talked about some of the
10 billing issues and that made it around the Part A
11 versus Part B which is a problem for reporting
12 for PQRS.

13 Now that you're a small off practice
14 and not an RHC, does that problem go away?

15 MS. BARTHOLOMEW: We report for
16 Meaningful Use and PQRS and Patient-Centered
17 Medical Homes.

18 But, I do want to say I think we're
19 the exception to small clinics. Most small
20 clinics are still using paper charts. Most small
21 clinics are not reporting quality data.

22 So, I think our challenge here today

1 is how do we reach out to those clinics and make
2 it feasible for them to do this? Because their
3 quality measures, they're going to make a
4 difference in the cost-effectiveness of health
5 care.

6 MS. JOHNSON: And Jonathan and then
7 Helen?

8 MR. MERRELL: Yes, I just wanted to
9 first give rebuttal to Jason about his comments
10 toward Epic, but --

11 Actually, I wanted to really go into
12 talk about a little bit more about the history of
13 Health Center Controlled Networks and the
14 commonality of many of the programs that we've
15 talked about through HRSA.

16 And the history behind the Health
17 Center Controlled Network was in about 2002/2003,
18 HRSA issued a series of grants to start the HCCN,
19 the Health Center Controlled Networks, which were
20 essentially small organizations that would
21 provide electronic medical record, data
22 aggregation and reporting and quality improvement

1 services for FQHCs and CHCs and RHCs.

2 Has anybody heard of these programs?
3 The HCCNs? Is anybody a part of one or use one?
4 I'm kind of surprised, again, there's, you know,
5 pushing 5,000 docs now on OCHIN's version of
6 Epic, in almost 22 states now, in 22 states by
7 the end of 2015, several million outpatient
8 visits. So, we can see the number of the
9 percentage.

10 I think 50 percent of FQHC visits go
11 through OCHIN Epic. I think that's the size and
12 the scope of OCHIN's Epic.

13 Now, you know, Epic is not Epic is not
14 Epic from one organization to another. So, all
15 5,000 of these physicians are using one
16 customized instance of Epic.

17 So, whenever I get that power of data
18 that's comparing apples to apples to apples, and
19 as the Vice President of Performance Improvement,
20 I would work with our FQHCs and so I know 22
21 state Medicaid programs. I know hundreds, maybe
22 thousands of payer organizations that can turn a

1 definition of hemoglobin A1C as many possible
2 ways as possible.

3 And it was my obligation at that
4 Health Center Controlled Network at OCHIN to get
5 that reporting out the door for that organization
6 so that they can get reimbursed or that they can
7 participate in local quality improvement efforts,
8 HRSA, state, local or federal quality improvement
9 efforts.

10 So, I think whenever we talk about
11 those resources and identifying those resources,
12 if you're an FQHC, a CHC, an RHC and you are not
13 participating or partnering with the Health
14 Center Controlled Network, you need to really
15 look at that.

16 And I'm not selling OCHIN and I no
17 longer work for OCHIN, but there's 60 other
18 Health Center Controlled Networks across the
19 country. They're great resources and that's why
20 HRSA's fond of funding to get the HCCNs off the
21 ground.

22 MS. JOHNSON: Thanks. And Helen?

1 DR. BURSTIN: Just to make a brief
2 comment about some work we've been doing with CMS
3 and all the medical directors of the large health
4 plans through AHIP on alignment.

5 And so, it's actually really
6 interesting to hear that that is a particular
7 issue in the rural areas as well.

8 And it'd be helpful to try to get a
9 sense of, are the unique issues in contracting in
10 the rural areas with health plans, that might
11 actually color our discussions between CMS and
12 the health plans around alignment.

13 Are there specific kind of programs
14 that are more likely to be part of the health
15 plan, private health plan, environment or even,
16 you know, for example, some of the public
17 programs as well?

18 We've done some work as well as part
19 of the initiative called Buying Value. We've
20 looked, for example, at the state measure sets
21 across 26 states, an analysis that Mike Bailey
22 and Associates did for us we'd be happy to share,

1 that overwhelmingly showed, you know, I think it
2 was about 1,300 measures used across 26 states
3 just internally within states.

4 Huge disagreement within states across
5 programs as well as between states and a lot of
6 what they called tweaking of measures. They say
7 they were using the NQF endorsed measure but
8 they'd lop off the second weight or they would
9 change the population.

10 So, we've really been interested in
11 this issue of both comparability but also this
12 issue of alignment.

13 So, if there are ways we could really
14 learn about specific issues in the rural
15 community, make sure that they're part of those
16 discussions ongoing, it'd be really valuable and
17 I hope valuable for you as well.

18 MS. JOHNSON: And we have five minutes
19 before I'm going call a hard stop and let us take
20 a bathroom break here.

21 But, Greg, you were going to tell us
22 about small hospitals, so let's talk about that

1 and I'm sure we can come back and do some of
2 these additional questions when we come back.

3 DR. IRVINE: I'll try to keep it brief
4 so everybody can get to the bathroom.

5 I'm going to talk about this from a
6 very personal point of view. I'm a surgeon that
7 works at a Critical Access Hospital. I'm so
8 naive, I don't even know when Karen asked me to
9 do this what the difference between a Critical
10 Access Hospital and a small hospital is. We are
11 a small Critical Access Hospital.

12 I work in small rural hospital in the
13 mountains of Idaho. We are 150 miles from any
14 other hospital. I have patients that come to see
15 me on snow machines.

16 We are the main health care provider
17 for West Central Idaho, the only health care
18 provider as a community access hospital.

19 I came there four years ago, allegedly
20 to semi-retire. I came from Portland, Oregon
21 where I was in a large group practice and got
22 burned out and thought I was coming to nirvana.

1 I found I just stepped in to a much different set
2 of problems and that's partly why I'm here
3 because rural hospitals are floundering.

4 My hospital has 12 beds, two operating
5 rooms, emergency room, we do obstetrics, we have
6 lab and imaging, we have no ICU. We do infusion
7 services. We're staffed entirely by primary care
8 providers except for one general surgeon and one
9 orthopedist, family practitioners and internists
10 in mid-levels.

11 We have some part-time traveling
12 specialists that come to visit us, mostly to go
13 skiing from time to time.

14 And we have unique challenges in our
15 Critical Access Hospital and I'm not an expert on
16 reimbursement. I'm not an expert on acronyms and
17 I don't pretend to be. I fix bones and joints.

18 The unique challenges that I have in
19 my hospital are recruiting and training
20 providers, especially nurses. Fully half of our
21 nurses now are doing reporting functions and the
22 other half are doing patient care. That's

1 untenable, it can't last, but we're pulling
2 nurses constantly to do reporting functions to
3 try to stay up with our reporting.

4 We have a widely disbursed patient
5 population. I have farmers and ranchers that
6 drive two and three hours to see me. I get
7 patients from East Oregon, Eastern Washington,
8 the mountains of Idaho and so on.

9 That patient population is very
10 challenging to manage. If I operate on somebody
11 from one of those ranches out in the middle of
12 nowhere, I frequently never see them back again.
13 I think they take a set of needle-nose pliers and
14 take their staples out and then they're done.

15 These are independent, self-reliant
16 patients. They are not people who are interested
17 in follow-up. They're not interested in AICs.
18 They're interested in getting back to their ranch
19 and getting on their tractor and doing their job.

20 We have very small numbers, low
21 denominators. My nurses are collecting data for
22 quality measures for six patients a year that's

1 sent somewhere that we don't know what's done
2 with that data and if you look at that data, it's
3 meaningless. It has absolutely no impact on
4 patient care. It's siphoning resources. It's
5 creating problems.

6 This critical access designation in
7 our hospital does allow us, having come from an
8 urban center, I discovered when I came to a
9 Critical Access Hospital, that I wasn't subject
10 to PQRS or DRGs or Joint Commission and I have
11 in-house rehab where I can rehabilitate my
12 patients in the house. Those are definite
13 advantages for me as a practitioner. It's a
14 world of difference.

15 But there are a new set of problems
16 that we just outlined.

17 I thought I'd use one quick example
18 and then you can get to the bathroom, of sort of
19 my very close in look at quality measurement.

20 We discovered after I came to Idaho
21 four years ago that we have a zero percent
22 surgical site infection rate and we wanted to

1 know why. In fact, the system that we work with
2 wanted to know why we have a zero percent.

3 Was it that we were using antibiotics
4 within an hour? I did that in Portland and I had
5 a very average surgical site infection rate in
6 Portland.

7 Was it because I use clippers rather
8 than a razor to prep the patient? Another SCHIP
9 measure. Well, I did that in Portland, too.

10 Was it because I was such a great
11 surgeon? I'm pretty much the same surgeon I was
12 in Portland.

13 Was it because we avoided hypothermia?
14 No.

15 Was it because we had tight diabetic
16 control? Probably not.

17 We discovered that the reason that our
18 surgical site infection rate is zero is that we
19 have a comorbidity index and we're operating on
20 patients who are healthy and have a BMI of under
21 35 and are great candidates for surgery. And
22 that's the main determinate as to the surgical

1 site infection rate. That's how you pick your
2 patients.

3 Well, all the other folks that don't
4 meet our comorbidity index go elsewhere. They
5 have to, I don't have an ICU. I don't have
6 specialists. I don't have ID guys, so I send
7 them to Boise and they get operated there and
8 they get their SSIs down there.

9 So, we have to look a little bit at
10 what we're measuring, what we're doing and that's
11 what I hope we can accomplish this next couple of
12 days.

13 MS. JOHNSON: Great, any burning
14 questions for Greg?

15 Okay. If not, let's come back, I'll
16 give you a quick break. Let's come back at 10
17 after 11:00 by this clock.

18 (Whereupon, the above-entitled matter
19 went off the record at 10:58 a.m. and resumed at
20 11:11 a.m.)

21 CO-CHAIR COURT: Okay. So our next
22 book of business, if you will, is we're going to

1 spend -- we're going to take about a half an hour
2 here. So, we're just a little bit behind. We're
3 going to try and catch up.

4 What we want to do here is reach
5 consensus on the four or five main issues that we
6 are going to want to focus the rest of our time
7 together in the next two days trying to create
8 some possible solutions to.

9 So, there's great discussion about the
10 challenges and there's some themes here. And
11 many of the themes match what we all submitted in
12 our pre-work. So now we need to kind of narrow
13 down the list, and that will be the focus of our
14 solution creation. And if we get to others, that
15 would be great.

16 One thing that I want to -- had kind
17 of a personal observation and maybe challenge us
18 to think about is, all of our discussion today
19 was relative to the challenge from a provider
20 perspective.

21 So, as we do our work, we should also
22 be thinking about what patients want, need,

1 deserve so that we don't become so provider-
2 focused that we lose track of the patients.
3 That's why we all do what we do every day.

4 So, I think that's an important
5 perspective to keep and I think it's designed for
6 us to be provider-focused because that's what we
7 all do, but let's not forget our patients.

8 And we know we're going to talk about
9 low-case volume next and possible solutions to
10 that. So we've got the work from the homework.
11 So, alignment, data collection. And it sounds
12 like there was a lot of theme around resources,
13 lack of systems related to data collection, use
14 of this, you know.

15 So we've got all this data, but so
16 what? What are we, you know, the measures might
17 not be meaningful. How do they get used? And if
18 it's just collect data for data's sake, that's an
19 interesting administrative exercise that takes us
20 away from doing what we all want to do every day.
21 And then there is issues related to how the data
22 gets used.

1 One issue that I thought is not really
2 on this list that came out in many of the
3 discussions this morning was challenges related
4 to how rural providers bill. So the whole Part
5 A/Part B, that was -- I had never thought about
6 it like that, you know. CPT codes, not CPT codes
7 and I get lost in some of that, but, you know,
8 the current national federal programs are based
9 on billing systems that don't support that. So,
10 to me, that was a new issue.

11 So I'm going to open it up here. I
12 think Karen is going to help us take notes or --
13 let's try and figure out which are the additional
14 four or five things that we really want to say,
15 yep, these are the things that we think are most
16 important to work on first.

17 Go ahead, Bob.

18 DR. RAUNER: Okay. I'm still trying
19 to think through this in my own head, too. So,
20 and maybe this may be a little jumbled, but one
21 of the things I see as an issue is that the
22 measures that a health system insurance plan

1 looks at are different than the measures that a
2 real hospital wants to look at, and, yet, are
3 different than the measures that a clinic wants
4 to look at.

5 I think that's part of our challenge
6 here is that we're -- we've got three different
7 groups in the room who have three different
8 perspectives.

9 So do we want to try and solve each
10 person's, or do we want to find at least some
11 measures that unite all three?

12 One I would posit out there actually
13 is a medication reconciliation, since that's
14 literally our number one quality focus area
15 because we have so many problems in that world,
16 you know.

17 I'll finish with an anecdote. One of
18 our newest clinics started -- we were trying to
19 get the buy-in on the whole medical foam, care
20 coordinator thing and the way that we have it now
21 because in the first two weeks they ran into
22 three med errors, two of which were potential

1 readmissions.

2 One was a patient who was on Coreg
3 6.25, got mistranscribed in the ER at admit to 25
4 -- so quadruple their beta-blocker dose -- and
5 went home with that, because nobody ever bothered
6 to reconcile that with the home meds.

7 They -- their first -- that was Day 2
8 of the care coordinator starting her job doing
9 transitional care work. And that was the, you
10 know, Day 2 ran into that one. So, wow, maybe
11 this is a good thing to do.

12 Second, the next week ran into two
13 issues. One was a Lisinopril Thiazide that got
14 mistranscribed to just Lisinopril. So, didn't
15 get her Thiazide. Maybe not as big a deal. But
16 when they brought her back in, her weight was up
17 six pounds.

18 Maybe that's minor, but several days
19 later, again, similar issue where it was the
20 patient didn't restart her on Lasix. And that
21 patient was up 10 pounds and symptomatic.

22 And so, within two weeks, we have

1 absolute buy-in from those two care coordinators
2 because they found it that quick. So, med
3 reconciliation is such a huge issue that I think
4 can unite to hospitals and clinics because they
5 have decent sample size for that.

6 They may not have surgical size
7 because they may not have enough surgical sites,
8 but they have a lot of admissions and med rec
9 applies to almost all. So, hopefully that makes
10 sense.

11 CO-CHAIR COURT: So, let me help
12 trying to put some framework around that as it
13 relates to measurement for P4P.

14 Is it the lack of alignment of
15 measures between the ambulatory side and the
16 hospital side, or that the people or
17 organizations are using the same measure with a
18 different definition for different purposes?

19 How do we frame that issue as it
20 relates to measurement for P4P?

21 DR. RAUNER: Yeah. Well, in the
22 hospital I'm not sure if that actually is an

1 incentive measure at this time.

2 However, in Medicare Shared Savings
3 Program, I think it's the first of the 22, is med
4 rec. In the first two years it was med rec, but
5 only post-discharge. But this year they have
6 changed it to just every single visit, which we
7 like because that's what we started doing.

8 You've just got to do this every
9 single time, not just post-discharge, because
10 it's such a common problem.

11 So, I think it should be added to a
12 lot of hospitals' incentive measure because it's
13 so important. Because if we both have financial
14 incentives for it, we'll both focus on it.

15 And to do it well, there needs to be
16 better interchange between the hospital and the
17 clinic because so frequently people get admitted,
18 especially when it's a rural patient who goes to
19 the urban hospital. They just never bother to
20 even talk to us to find out whether that med list
21 was right or wrong or not.

22 And that's probably the most common

1 errors I've seen in things, and I can give you
2 lots of stories on that of falls from excess
3 beta-blockerage because there just is not that
4 communication from the urban center back to the
5 small-town family doc to make sure those meds are
6 right, which leads to people being on two beta-
7 blockers at the same time and whatever formulary
8 switches and all that.

9 So, I think med rec needs to be like
10 -- if you're a quality chasm, I think that is the
11 number one source of medical errors in the
12 country.

13 So, does that answer? Sorry.

14 CO-CHAIR COURT: So, Greg, you're
15 shaking your head. So, help us.

16 DR. IRVINE: Well, and I think one of
17 the real problems here is that we are -- a lot of
18 us are caught in the no-man's land between EMR
19 and paper charts.

20 A lot of rural hospitals are still
21 using paper charts, including mine, but our
22 clinics are using the EMR.

1 And a lot of these med rec issues and
2 so on relate to inability to transfer data in a
3 seamless fashion from one setting to another.
4 And things get missed when you do that.

5 And until we can have a seamless
6 integrated EMR that truly can communicate with
7 other hospitals, other systems, I'm beginning to
8 think that might be a pipedream. But until we
9 have that, we're going to have that problem.

10 CO-CHAIR COURT: Brock.

11 MR. SLABACH: Oh, thank you. Just a
12 quick comment and follow-up. 83 percent of
13 critical access hospitals have attested to
14 meaningful use Stage 1. So, a lot of them are on
15 information systems and they do the medical
16 reconciliation process.

17 CO-CHAIR COURT: Is it Michael?

18 DR. BAER: Yeah, Mike. So, our job
19 right now is to maybe look at this and look at
20 the categories in which -- so, I'm thinking I'm
21 hearing what this discussion is about is use to
22 improve care.

1 So, I would agree that, in addition to
2 low volume, you know, the measures should be that
3 we agree upon should be in the use-to-improve-
4 care category.

5 Is that what we're doing? Is that the
6 --

7 CO-CHAIR COURT: Right.

8 DR. BAER: -- the goal?

9 CO-CHAIR COURT: Right.

10 DR. BAER: So, that -- I'm voting for
11 that. And I think this is -- kind of speaks to
12 that category.

13 CO-CHAIR COURT: And so, is that
14 better summarized in that -- do we think if the
15 measures are meaningful to the practices that we
16 have in the rural setting, they would be used, or
17 do we not have the resources and infrastructure
18 in place to use them as well?

19 DR. BAER: My statement for that is
20 what I'm hearing is if there is good medication
21 reconciliation whether it's EMR or paper or
22 whatever, you know, the category of use to

1 improve care, we would improve care. It's not
2 necessarily that they have to have an EMR. So --
3 or does it have to have, you know, alignment.

4 I don't see this as an alignment
5 issue; I see it more as this is patient outcome.
6 We don't want to have these readmissions for, you
7 know, quadruple the Coreg dose, which could cause
8 a fall.

9 So, I would just say that that's one
10 category that we might want to consider for our
11 final list.

12 CO-CHAIR COURT: So, let me restate it
13 though. Is the problem that we don't use the
14 measures, or that the measures that we have don't
15 matter?

16 Ann, or if you guys got an answer to
17 that question?

18 DR. NUKI: So, I want to find out what
19 altitude we're flying at, at the moment. From a
20 30,000 foot point of view, to answer your
21 question, clearly if you ask your doc to spend
22 four hours a day doing data extraction and they

1 see no meaning, you're never going to get it;
2 it's not going to happen. And it's bad for
3 patients, because that's four hours they're not
4 taking care of patients.

5 So, if you want to focus on patients,
6 which is what I think we all want to do, it's the
7 whole purpose of doing this, the measures have to
8 mean something.

9 If they don't or if it becomes just a
10 game, then it's not going to help anybody. It's
11 not going to help the patients.

12 And the physicians or the providers,
13 all the providers in the rural areas are going to
14 see that and say, we're just doing this to get
15 dollars, it's just a game, it's not helping our
16 patients. So, clearly they have to mean
17 something.

18 You have a great story where somebody
19 in three days found out that doing this is, you
20 know, with the med reconciliation was meaningful,
21 but are we sitting here now trying to come up
22 with measures and the details of those measures,

1 or are we trying to look at a system by which we
2 build those measures upon?

3 CO-CHAIR COURT: I think it's the
4 latter, right, Karen? So, we're trying to create
5 categories of major problem that then there can
6 be activity.

7 We can start it, but there will
8 probably have to be a lot of follow-up activity
9 to start to find solutions to those problems then
10 which will, you know, I guess we get to nirvana.

11 MR. RICE: So, the genesis for this
12 project was simply to look at measures that are
13 valuable in rural health settings.

14 I think it's a different issue that if
15 it's -- there's different concepts for measures.
16 But we looked at the measures and how the numbers
17 that those measures were counting, the
18 denominators, and they weren't representative of
19 the care.

20 We all know that rural health settings
21 provide great care, but the measures don't --
22 aren't -- the measures that were developed, in a

1 lot of ways, were made for high-volume urban
2 settings.

3 So, I think the project pretty much
4 surrounds how does it apply to a rural setting?
5 What are the gaps for measures?

6 I would leave out -- the IT issues are
7 the IT issues. We all know this. EHRs are what
8 they are. We've made a lot of progress and --
9 but there's still some things that aren't working
10 great.

11 But if we can look at the actual
12 concepts of the measures, what do we want to
13 measure in a rural community?

14 One thing we know is there's a lot of
15 transfers from critical access hospitals to
16 larger facilities, you know. Is that an
17 applicable measure? We use that in MBQIP, but
18 it's not being used in Hospital Compare.

19 So, I'll throw that out to try to
20 center it a little bit.

21 CO-CHAIR COURT: I think Ann was next.

22 MS. ABDELLA: Yes, I've been leaping

1 up and down in my seat.

2 In the spirit of full disclosure, I
3 forgot to mention that I run a small rural
4 accountable care organization that's part of the
5 Medicare Shared Savings Program, but we don't get
6 any money. We've been doing this all on our own
7 time.

8 And I think Bob's my new best friend
9 because we have a lot in common, but I think
10 there is -- I think it's an issue of alignment.
11 I would vote for that one.

12 In the spirit of looking at total
13 patient care and putting the patient in the
14 center of all of this madness, there -- we have
15 wrestled for years trying to move toward clinical
16 integration and trying to figure out how do we
17 come up with common performance measures with
18 payers that get the physician activity lined up
19 with what the hospital is doing.

20 And the one piece in this that I think
21 we could -- we should be talking about, and there
22 are probably others, is we're not mentioning

1 skilled nursing at all and you all have measures
2 related to that.

3 And I get frustrated in these
4 conversations because it's so hospital-driven
5 than physician-driven, and it's as though that
6 care is delivered in that vacuum, and it's not.

7 There are a number of community
8 services and resources that have got to come into
9 play in order to make sure that we're delivering
10 good quality care. And that's a whole other
11 conversation. And that's this version like 4.0
12 down the road when we get to the broader
13 population health measures.

14 But I think that alignment between the
15 ways that we can make sure that we link something
16 that physicians are doing and specialists are
17 doing, that hospitalists are doing and then
18 hopefully we can bring skilled nursing into this,
19 that makes sure that we've all got the oars going
20 in the same direction.

21 And med rec is -- that's the big one
22 that we obviously have an opportunity to tangle

1 with. But when you're dealing with CVD, you
2 know, you've got people who've got chronic heart
3 disease in the primary setting, in the cardiology
4 setting, in the hospital setting and in the rehab
5 setting. I just think there's some opportunity
6 for alignment there.

7 CO-CHAIR COURT: I don't know who's
8 next. So, Tim.

9 MR. SIZE: Two things. One, I just
10 wanted to reinforce what Marty said. I mean,
11 this isn't about what might be a good idea for us
12 to do in our home court. It's actually we're
13 here to make recommendations to Department of
14 Health, Human Services, CMS about what we think
15 is reasonable for them to use as metrics.

16 And maybe that sounds like the same
17 thing, but to me it isn't. I think, so it's
18 focusing on what we think is a credible set of
19 behaviors for the federal government to kind of
20 model where they haven't been doing it to date.

21 So, I come at this in a sense of
22 having been left out of a very rapidly moving

1 train that's trying to document the care that's
2 being done.

3 And I think increasingly we're going
4 into a time where if you can't show you're not
5 doing good, unless you have zero zero choices,
6 you're 500 miles from whatever, you'll be getting
7 more and more to choose to go elsewhere. So
8 that's how I frame the issue.

9 I'm not a quality guru. I'm more of
10 a rural system co-op guy. So, I did ask people
11 back home kind of the answer to the question I
12 think you're making.

13 Definitely in the first four columns
14 make good sense to me and I think the way we said
15 it back home was four filters we're looking for,
16 for this conversation.

17 The first is metric obviously
18 evidence-based in support to achieving the triple
19 aim. And maybe all metrics claim to do that, but
20 I think some have a claim that's more valid.

21 Second, the data is already likely
22 being collected or not onerous to begin

1 collecting. So, I think it's the collection
2 issue.

3 Third is germane to low-volume
4 clinics, hospitals, nursing homes, what have you.
5 And the fourth, the likelihood it is or could be
6 publicly reported and uses part of a value-based
7 purchasing scheme.

8 I mean, so that's four key filters I
9 think for anything we do going forward,
10 hopefully.

11 CO-CHAIR COURT: Bob.

12 DR. RAUNER: You kept asking questions
13 and I kept wanting to say yes because it's so
14 broad.

15 So, I think one way of looking -- if
16 you can find measures that solve -- that address
17 multiple bars on the graph -- so, you know, in
18 addition to like med rec, for example, flu
19 vaccination. That crosses so many different
20 things.

21 One of the problems with quality
22 measures is every focus group wants their

1 measure. Well, if you have a heart failure
2 measure, an asthma measure and blah, blah, blah,
3 that works for a health system. It doesn't work
4 for the small hospital, because they only have
5 two of this and four of that.

6 Well, if you can blend it altogether,
7 that works better for us and that's why we --
8 internally, that's why we use them that way.

9 So, a flu vaccination gets around low-
10 case volume because it applies to everybody above
11 six months.

12 Alignment, just like the med rec being
13 such a disparate problem because there's no
14 common med list because of all kinds of reasons,
15 similar problems with flu shots.

16 It sounds simple. Either you got it
17 or you didn't, but flu shots are given everywhere
18 and nobody talks to any, you know, Wal-mart is
19 the worst right now, you know.

20 So, the hospital will tell us when
21 they get a flu shot, but Wal-mart won't tell us.
22 So, how do you track that well, which leads to

1 the data collection problems.

2 You have to have things work, things
3 combine somehow. Both obviously are huge for
4 improving care. They apply, they address gaps,
5 they're risk adjustment irrelevant because they
6 apply to everybody.

7 So, if we can find measures that work
8 for everybody, that might be one of the solutions
9 to the either is it this or that.

10 Well, if we can find measures that cut
11 across and address the low-case volume, fix the
12 alignment so we work more together and so impede
13 that kind of stuff.

14 CHAIR COUNT: Yeah, I had thought
15 about that, too, that -- I think part of the
16 problem right now is measures tend to be disease-
17 specific. And in a rural setting, you only have
18 a few of those.

19 And so, then you get to that quickly
20 where there needs to be more cross-cutting
21 measures, you know. And PQRS has started to
22 address that with those measure groups.

1 Tim, did you still -- we're going to
2 have to coach Tim at lunch. Marty, did you --

3 MR. RICE: So, think about, you know,
4 we're worrying about what the measures are out
5 there.

6 I'm pretty basic. Don't worry about
7 the measures that are out there now. Tell us how
8 you do business. We'll find the measures.

9 What are the concepts that you work on
10 within your hospitals? How do you actually
11 practice medicine?

12 And then let's come up with the
13 measures from there, because you're not -- the
14 measures that are already created may or may not
15 work for you, but the way you practice medicine
16 is what's important right now and how it's
17 practiced in a rural community.

18 CO-CHAIR COURT: Ira, you've got to
19 poke me because I don't see you there.

20 CO-CHAIR MOSCOVICE: All right.

21 CO-CHAIR COURT: Thank you.

22 CO-CHAIR MOSCOVICE: So, Marty sort of

1 stole a little bit of my thunder. But what we
2 should be doing, I believe, is exactly what Marty
3 says. Basically, if we can give CMS a list with
4 bullets that basically say here are the 10, 12
5 core principles behind a set of measures.

6 And I think, you know, responding to
7 Guy, if we had some examples, that would help,
8 but obviously you're not going to develop a list
9 of 82 or 200 measures. That's down the road,
10 hopefully.

11 But if we can hone in, and I think we
12 have started honing in on some of the key
13 principles, and if we can give any specific
14 example, it would really, really help.

15 CO-CHAIR COURT: Greg.

16 DR. IRVINE: I'm going to say
17 something fairly radical. And in the next couple
18 days you may learn that that's kind of my MO, but
19 instead of us talking about a top-down approach
20 from CMS, why not a bottom-up?

21 Why don't we empower hospitals,
22 clinics in small towns to develop their own

1 quality measures, submit them to CMS, get them
2 approved and then do something that's meaningful
3 for that site?

4 We are such a diverse group. We have
5 so many conflicting needs. Why can't that be the
6 case?

7 Medicare came up with some fairly
8 radical exceptions for critical access hospitals,
9 for example, in the Medicare area exempting us
10 from DRGs and things like that.

11 Why can't we have a bottom-up approach
12 where we design our own quality improvement?

13 CO-CHAIR COURT: I think there's been
14 some attempt, a start at that with the QCDRs --
15 so, we get all these acronyms -- which is a way
16 for an organization that's already collecting
17 measures to get measures approved for PQRS so
18 that the clinical specialty registries have done
19 that. So, there's a little bit of start of that
20 on the ambulatory side.

21 Jason.

22 DR. KESSLER: In the spirit of

1 discussion here, I'm going to disagree with a
2 couple of statements that were just recently made
3 in that, in particularly looking at the issue of
4 alignment if we start inventing a lot of new
5 measures, doesn't that complicate the whole issue
6 a lot more?

7 Doesn't that -- doesn't it, you know,
8 doesn't it defeat the purpose of trying to, you
9 know, trying to have -- trying to have people not
10 digging out new things to measure and to be able
11 to report the same things just once or twice
12 instead of having to, you know, well, we've got,
13 you know, A1C, seven here and eight here and nine
14 here or whatever.

15 Isn't there some logic to, you know,
16 using existing measures, looking at measures that
17 are being used already for other purposes and
18 seeing how they apply or how they don't apply
19 rather than, you know, just kind of looking at
20 high-level means and saying, well, let's make up
21 a new measure for what we're seeing here?

22 CO-CHAIR COURT: Guy.

1 DR. NUKI: Well, I'll actually answer
2 your question first, Jason. I think the problem
3 with that is, is that we've shown that it hasn't
4 worked.

5 All these measures have been out there
6 and rural hospitals, rural clinics and providers
7 have basically said these measures aren't going
8 to work for us.

9 Now, we could tweak them and then that
10 would be, you know, Tweak 8.3 and -- but I'm not
11 sure that's really the way to go.

12 I think it sounds like we're here to
13 kind of take a step back and look at the bigger
14 picture and how do we frame -- how do we frame
15 this.

16 I was sitting here and, you know, one
17 of the things that I do is we do a pay-for-
18 performance for our company with the hospitals
19 that we contract with.

20 And so, we pick, you know, goals for
21 the year, we go through it with the CO, they get
22 approved. And then if we meet those, we make

1 more money. And in a private group, that's a
2 good thing, and there's different ways to break
3 that out.

4 One of the ways, you know, that we've
5 done is through ACGME's core competencies. You
6 can use that. We use that sometimes as a
7 framework.

8 I was just sitting here and there's --
9 I look at it and there's -- if we want to -- what
10 we're trying to do is improve the care, because
11 that's what the patients want. We'll be a little
12 paternalistic. I think patients want better
13 care.

14 And so, if we're trying to improve the
15 care, I would break that into two areas. One is
16 areas of risk, and areas for improvement. And,
17 you know, the example of the med rec is an area
18 of risk, clearly.

19 Any time you have transitions of care,
20 all of that whole around transitions of care is a
21 huge area of risk.

22 Someone had mentioned about

1 transports, you know, transfers out. Well, is
2 that a good thing, or a bad thing? Because,
3 personally, I'm trying to decrease our transfers
4 out of our hospital.

5 Because every time I put someone in an
6 ambulance and send them, their family is driving
7 two hours through the woods in snowstorms to go
8 visit their family.

9 And I had a patient -- I'll just -- I
10 think stories -- this is a very meaningful story
11 to me. A woman with twins who decided she was
12 going to go and get her OB care not with me at
13 our hospital, but at the big medical center and,
14 you know, she had some complications and all that
15 was fine.

16 And the babies were born early. And
17 the dad was driving and was killed in an
18 accident. I mean, it was a two-hour drive
19 through the woods, through a snowstorm. And now,
20 these babies don't have a dad.

21 Well, that wouldn't have happened if
22 they had been delivered at our hospital. So,

1 we've got to really think is that good, or bad?
2 I mean, is decreasing what we can do at critical
3 access hospitals good, or should we increase it?
4 I don't know the answer, but we need to think
5 about that.

6 Areas of improvement, overuse of
7 services, really looking at outcomes. Hemoglobin
8 A1C is not an outcome. Renal failure is an
9 outcome from diabetes. Access to care, that's
10 huge.

11 If you said to a community hospital,
12 if you can provide more primary care providers,
13 we'll give you more money, that gives more money
14 to actually improve the care.

15 They'll be able to pay those doctors
16 more, because they're getting more money for
17 having better access.

18 Community as an entire system, I spent
19 a lot of time trying to get our mental health
20 service people to talk to us in the emergency
21 department. And they're like, really? You want
22 to meet with us? Of course we do. We interact

1 with you all the time.

2 And then coordination of care within
3 the hospital. So, those are just some of them.
4 Those are just the first five minutes.

5 There's got to be ways that we can
6 look at how we can mitigate risk, how we can
7 improve things and put -- and make the measures
8 real so that -- and meaningful for rural areas.

9 However, I think what Greg said is a
10 really good point. They've got orthopedics at
11 his hospital. Another hospital might have no
12 orthopedics, but two urologists.

13 So, you can't put something --
14 surgical wound site infection for a urologist is
15 going to be really low. They're doing everything
16 through the urethra.

17 So, you can't -- how would you
18 compare? I don't know how to do that.

19 CO-CHAIR COURT: Bob.

20 DR. RAUNER: I got to follow up on a
21 couple of things. One was Jason's thing. I
22 actually think that part of our problem isn't

1 that we don't have enough measures. I think our
2 problem is we have too many measures.

3 So, for example, we have 22 through
4 the Medicare Shared Savings Program. We really
5 only focus on five of them, because we think
6 those are the ones that are important. And then
7 some of them, I think, are, frankly, stupid.

8 I don't -- we're not going to waste my
9 doc's time on doing a stupid measure because -- I
10 won't go into that, which that might make people
11 mad, but -- so, one, I think we need to constrain
12 on what's really important. It's a
13 prioritization issue as much as anything.

14 Now, I use the example of Peter
15 Pronovost's central line bundle. It wasn't
16 incredibly complicated. It was five measures,
17 and one of them was wash your hands. It's not
18 rocket science.

19 If you do a couple things really well,
20 the other things will take care of themselves.
21 So, I think part of the problem with Medicare
22 Shared Savings program and, frankly, most federal

1 programs, there's too many measures.

2 So, if we could prioritize because
3 every -- they're all given equal weight. Blood
4 pressure control I think is one of the most
5 important measures, but it's no more important
6 than any others, some of which I think are
7 wasteful and a waste of our time.

8 If I were going to add anything, it
9 actually would go away from quality measures to
10 what Guy just said. Things like measuring
11 continuity of care, access to care and
12 coordination of care.

13 I think those are the three most
14 understudied things in healthcare right now and
15 there's not financial incentives for them. If
16 anything, there's financial disincentives for
17 most of them.

18 CO-CHAIR COURT: Ira.

19 CO-CHAIR MOSCOVICE: These have been
20 some really good comments. I think we're getting
21 to where we need to be.

22 In response to Jason, I think you

1 raise a good issue, but the challenges -- and I
2 think, you know, I'll point this out for CMS and
3 for NQF. The other -- the pushback has been,
4 well, you can't start new measures that are
5 really different, because we have a limited
6 amount of resources and we want people to have
7 the same set of measures that they're looking at.

8 What we've done in the work we've done
9 in the past, is to say, here's a core set that we
10 can all agree everybody wants. And now, there's
11 extra modules.

12 You're doing surgery, you got a
13 surgical module that we can -- you're doing
14 urology, it -- you're doing orthopedics, so you
15 have the modules that are specific to the
16 individual environment.

17 And I think if we have a small core
18 set, and then say let's really individualize to
19 some extent at least in some broad areas -- if
20 you're doing obstetrics, you know, fine, we'll
21 have that kind of -- that's one way of looking at
22 it.

1 I think the important thing is for us
2 to come up with these -- we've had some good
3 ideas, some basic concepts. And if we can break
4 through to CMS that it really is a different
5 environment, an alignment doesn't mean every
6 measure is going to be exactly the same for all
7 institutions and providers.

8 If we can get them over that hump,
9 then I think we can start trying to
10 individualize, but it can't be one set of
11 measures for every, you know, all 1,300 critical
12 access hospitals.

13 And the problem, by the way, when you
14 don't have comparable measures is people start
15 raising -- it's two-tiered, you know. We have
16 two tiers of medicine now and rural is not as
17 good, and that's just simply not true.

18 Different doesn't mean not as good,
19 and we need to be able to figure out a way to get
20 that point across to CMS.

21 CO-CHAIR COURT: Okay. I think Karen
22 and I kind of conversed here. Let's get the last

1 three comments here and then we're going to wrap
2 this up. And then we're going to move more into
3 our problem-solving, because it sounds like we
4 have consensus around kind of the big key bucket.

5 So, John.

6 MR. GALE: I was going to make a
7 similar point in that we know the rural health
8 clinics that we have worked with, they have a
9 different -- part of their practice patterns are
10 such that they may not be able to refer patients
11 as easily to other services.

12 So, they hold onto folks with
13 behavioral health issues and treat them longer in
14 the clinic. They hold onto other patients they
15 can't get out for other services.

16 Unfortunately, you can't capture
17 everything that they're doing that's that
18 different. So, we in working with our group
19 defaulted on really trying to target what was the
20 most important benefit. And also obviously up
21 front, the lowest hanging fruit.

22 At some point, clinics haven't been

1 reporting consistently to any sort of external
2 quality measurement system. So, we have to bring
3 them along relatively gently.

4 In the beginning, we wanted five
5 measures as a core set that we were asking any of
6 our demonstrations to test. And then we gave
7 them a set of optional measures that may have
8 been more reflective of their practices. So, for
9 us, it was really about the importance, how
10 important it is to measure it.

11 We've got two patients that you're
12 holding onto for behavioral health service. We
13 really want to do a good job for them, but does
14 it make sense to measure them? No.

15 You've got diabetes. You've got a
16 variety of very common chronic illnesses in these
17 practices. How useable can they do something
18 about it?

19 At the end of the day, we want them to
20 make a difference in their practice. So, they
21 really have to have something that is much more
22 actionable.

1 Can they collect it and does it pass
2 the straight-face test if you want to compare
3 rural health clinics to the performance of
4 primary care providers in an FQHC or a small
5 physician practice or hospital clinic?

6 So, for us, it was really a matter of
7 trying to find measures that -- who have captured
8 the essential, most common services and look at
9 some of the process of care measures.

10 For me, meaningful use was sort of an
11 interesting process. It was a lot less about
12 technology in some cases, but actually making a
13 statement about the things that providers should
14 do.

15 A provider should be reconciling
16 medications from a new patient coming in or going
17 elsewhere regardless of whether they have an
18 electronic health record, but put it in one
19 place. And so that was the type of thing that we
20 looked at.

21 CO-CHAIR COURT: Tim.

22 MR. SIZE: Yeah, I very strongly agree

1 with what Ira said and John just said. I'd go
2 back to what you said earlier, Kelly, about let's
3 remember the patient perspective and I would
4 reference a meeting I was at here in town next
5 door Monday with an accountable care
6 organization.

7 And one of the strong themes I heard
8 from a lot of the people who spoke is ACO gives
9 them an opportunity to begin to address a serious
10 problem for many of them, out migration.

11 And out migration is about people
12 making choices where they can. And I, you know,
13 as now a senior citizen and lots of friends more
14 and more using the medical system, and then as a
15 parent and a grandparent, I can tell you, I mean,
16 what they're interested in is show me you are as
17 good as my alternatives.

18 That's the fundamental question and
19 that's why I'm kind of libertarian, we all do our
20 own thing, but that's not going to cut it for
21 what I think the market need is.

22 And I think Ira -- and Ira and I go

1 back a long way. And for me to say I totally
2 agree with Ira is almost unprecedented, but I did
3 agree with his summary, you know.

4 If we think about a core, then we can
5 build around that. And for those who can only do
6 the core, they do the core, but at least that
7 would give me as a patient or my family the
8 ability to compare.

9 CO-CHAIR COURT: And Brock.

10 MR. SLABACH: I guess a couple of
11 important questions maybe more than an answer in
12 terms of a statement.

13 I think are we going to be agreeing on
14 the significant population or portion of our
15 providers that are exempted from any reporting
16 requirements?

17 In other words, are we going to
18 address the issue of voluntary versus mandatory
19 in terms of recommendation to CMS?

20 Secondly, I think that another
21 important thing or a question is the process
22 under which these measures down the road are

1 selected and how is that going to be established.

2 And I think one of the suggestions I
3 would make, just to answer my own question now,
4 is the Measures Application Partnership, there is
5 a MAP for about every single category of
6 providers.

7 And I'm wondering if we would
8 recommend a MAP for small-volume providers, or
9 however we want to style that, to then begin the
10 selection process through a multi-disciplinary
11 group of people to be able to select the specific
12 measures that we would then start using down the
13 road.

14 Because I think we're starting to talk
15 about a lot of individual measures and we're
16 getting into the weeds, if you want to call it
17 that, in terms of discussion. And from a bigger
18 picture level, I think we have some policy issues
19 that are going to be more valuable or more
20 important, I think, in terms of whether it's
21 going to be successful. And that is 1,332
22 critical access hospitals that don't report

1 mandatory and rural health clinics that are
2 exempted from all of these PQRS and other
3 programs.

4 CO-CHAIR COURT: And Helen.

5 DR. BURSTIN: I just want to quickly
6 respond to the suggestion, Brock. I think it's a
7 really interesting one.

8 So, for those of you who don't know,
9 NQF convenes something called the MAP, the
10 Measures Application Partnership, where we review
11 over 20 different federal programs to make
12 recommendations to CMS about which measures to
13 use for which program. So, for example, we do
14 that across all the hospital programs.

15 We don't currently do it for these
16 programs, because they're not part of the puzzle
17 of what gets reviewed. I think it's a really
18 interesting idea.

19 We would have to think carefully about
20 who is on that work group, obviously, because
21 you'd want to make sure you have the right kind
22 of input into that.

1 Part of that process is not just that
2 CMS puts forward measures, but usually there's a
3 process, to go back to Dr. Irvine's point
4 earlier, where people can suggest the measures
5 potentially as part of this process of what
6 should be considered under the measures under
7 consideration.

8 So, there might be an interesting
9 angle for us to follow up with what CMS said on a
10 particular and maybe Marty going back to CMS
11 could be very useful here.

12 DR. IRVINE: I just want to quickly
13 respond to Tim. I agree a hundred percent that
14 patients should be empowered to make decisions
15 about where they get their healthcare based on
16 data, but you have to be very careful about the
17 data they're getting.

18 In this era of the connected Internet,
19 patients in the State of Idaho have discovered
20 that our little critical access hospital of 12
21 beds and an emergency room has a zero percent
22 surgical site infection rate.

1 And we have actually had medical
2 tourists coming to our hospital because they say,
3 well, that's where I want my surgery then.

4 And I, you know, and they come in with
5 a BMI of 40 and I send them away because they
6 don't meet our comorbidity index.

7 So, you have to be very, very -- and
8 that's just an example of how you have to be
9 cautious about how data is reported, because
10 sometimes what creates an affect isn't what you
11 think created the affect.

12 DR. RAUNER: Totally agree.

13 CO-CHAIR COURT: Okay, Ira. This is
14 the last comment.

15 CO-CHAIR MOSCOVICE: I think it's
16 essential, in response to Brock, that we do deal
17 with the voluntary versus a mandatory issue.

18 If you aren't collecting data and
19 participating in these programs, then you can't
20 measure quality. And so, I think it's the first
21 -- I'm hoping one of the first bullets is we
22 think, however we feel as a group, that either we

1 should remain voluntary or should be mandatory.

2 If we make it mandatory, we're going
3 to have some people who aren't going to be so
4 happy with us, obviously. But, to me, if you
5 don't measure, the rest of this is not going to
6 happen. So, I think that that's essential.

7 CO-CHAIR COURT: Yes, go ahead.

8 DR. ALEMU: I, too, totally agree with
9 what Ira said. As Karen mentioned this morning,
10 we know that there are a lot of measures out
11 there for different programs.

12 In some cases, some people complain
13 that there are too many measures out there. And
14 when we listen to some other people doing
15 different, you know, committee meetings, they say
16 there are some areas where we don't find
17 measures.

18 So, when we look at now the project,
19 what we need to do is to look at using measures
20 which are out there. I think Karen has already
21 mentioned that there have been a voluntary scan
22 of the measures which are out there.

1 We have talked about the challenge the
2 rural population is facing, rural providers are
3 facing in reporting, in collecting data for
4 quality improvement. All these issues we have
5 discussed now to some extent.

6 And what we would like to see is which
7 measures are, from those which are out there,
8 which ones are the most relevant ones which could
9 resolve the problem or the challenge which we are
10 facing in the rural area.

11 And another point which hasn't been
12 mentioned is if we think there are areas where
13 there is no measure available, but that could be
14 available to us, the Committee is charged to come
15 up with recommendation, you know, the concept
16 areas.

17 We lack some measures in some specific
18 concept areas which are relevant to the rural
19 providers or to the rural settings. So, that is
20 one of really the recommendations which we need
21 to think about.

22 And after having a collective search

1 concept, we can recommend CMS to develop
2 measures. That is really the most important
3 outcome of, you know, this group. So,
4 identifying core measures, identifying gaps and
5 making recommendations.

6 So, I think I just want to highlight
7 that we can also recommend areas which are really
8 not covered until now, which we think there are
9 gaps. So, I just want to highlight that point.

10 CO-CHAIR COURT: Okay, Sheila.

11 DR. ROMAN: I agree with a lot of the
12 comments that have been made that I think where
13 we should be focusing is from a patient
14 perspective and on patient safety and ways to
15 improve the care of patients so that they stay
16 healthy and we meet really the three pillars of
17 the chair.

18 And I'm going to, I guess, be
19 tangential a little bit here, but I think that
20 providers want to be compared to providers that
21 they see are like them rather than like the mass.

22 And I wonder if we should be thinking

1 of a critical access hospital compare and
2 thinking about it from that perspective as we
3 think about measures in core groups and modules,
4 which I also agree with.

5 CO-CHAIR COURT: Okay. I'm going to,
6 I guess, I am chairing this, so I get the last
7 word. Sorry, Tim.

8 (Laughter.)

9 CO-CHAIR COURT: So, two thoughts. I
10 agree with Ira. I think patients deserve that we
11 move into an eventual mandatory system, but it
12 has to be done in a way that doesn't create
13 unintended consequences and deteriorate the
14 safety net that's been set up because rural
15 access is really important. And a lot of
16 patients get rural care, but they deserve good
17 care. And so, I think we need to move into a
18 meaningful system.

19 I think there is a lack of measures
20 that are meaningful and reflect what really
21 happens in the rural setting.

22 And so, I would hate to see us just

1 trying to choose from the measures that are
2 already there.

3 And so, I think there are -- we need
4 different measures. Otherwise, we wouldn't have
5 these problems that we're already in.

6 So -- and I'm not sure if that's the
7 work of this group or to think about how -- what
8 would be the guidelines to create meaningful
9 measures like a MAP or whatever. Perhaps that is
10 where we would better spend our time.

11 Because I think if we start talking
12 about individual measures, we will be here until
13 Christmas, and I have to go home.

14 DR. BURSTIN: Just one quick comment
15 on that. I think that's a great point. You're
16 obviously not going to develop measures at this
17 table.

18 I do think there is very much a need
19 to identify the core measure gaps of what you
20 think. If there is a need for a measure to be
21 developed, what it could be with some level of
22 specificity like don't say care coordination and

1 continuity. Those sound wonderful. We have
2 lists of gaps that say that.

3 Something perhaps more specific that
4 really gets into what's unique and special about
5 the rural community space, I think, would be
6 really important.

7 And then lastly it is also really, I
8 think, an opportunity to do something we've been
9 affectionately referring to as "prospecting for
10 measures". I guess that's kind of a rural term.

11 What's out there in your communities
12 that people are using for internal QI that have
13 really worked? That clinicians and patients and
14 others have actually found valuable. That
15 perhaps we could try to bring some of those up
16 and bring some of those into measures that --
17 rather than it being top-down, some of it really
18 bringing in the ideas of what's been effective on
19 the ground and bringing that forward to try to
20 get those developed into national standards that
21 could be part of these kind of programs.

22 CO-CHAIR COURT: Okay. So, time

1 check. We're going to move into the next
2 section. And, Karen, do you have --

3 MS. JOHNSON: Yeah, and let me
4 interject. We have a pretty good list now. What
5 we want to do with that list is just make sure
6 that when we leave tomorrow at 2:00, that we have
7 addressed at least those things on that list.

8 If we end up having extra time, we can
9 certainly talk about other challenges, but the
10 idea of trying to come up with at least the top
11 few things that we want to do is just to make
12 sure that we don't talk all day and not end up
13 with some recommendations. So, never fear.

14 And we also have -- we didn't point
15 these out earlier, but we do have these big -- I
16 call them big post-it notes back here. We can
17 have that as a parking lot issue.

18 If there's something that you just
19 feel like is burning and you don't want us to
20 lose it, put it on those notes. We won't lose
21 it. And we'll come back to it.

22 I think now I don't know if anybody

1 wants to just stand up and stretch your legs for
2 a minute, but we have about an hour or so before
3 lunch and we want to start talking about
4 potential solutions for the low-volume problem.

5 And I'm going to tell you guys what we
6 found in our environmental scan just to get us
7 started. And I think our methodologists, who
8 have been pretty quiet so far, will probably have
9 a lot to say in this session particularly.

10 But what we know is it's not a new
11 problem. Programs are excluded, oftentimes
12 because of a threshold or maybe because of
13 reliability.

14 So, reliability measures is very
15 important when you talk about accountability
16 applications.

17 So, there's been lots of solutions
18 identified, you know. We can talk about all of
19 these things, and I don't know how you want to
20 best do it. Maybe talking about pros and cons.
21 Maybe -- I'm sure there's things that you'll come
22 up with that aren't on this list, but we've

1 already addressed the broadly applicable
2 measures.

3 That's one way to get around that
4 problem is, you know, look at things that, you
5 know, that everybody is seeing.

6 Thinking about indicators that don't
7 have a typical denominator just in terms of how
8 do you construct measures.

9 Pulling your data, there's lots of
10 ways across years, across providers. That's, you
11 know, using networks or some other conglomeration
12 of providers, perhaps, or even across settings.

13 We saw the idea -- and I think Bob has
14 addressed it a little bit, but maybe not in this
15 way -- grouping across settings. There's some
16 things that you, you know, some things are
17 outpatient measures versus inpatient measures.
18 And that's almost an artifact almost at the, you
19 know, how you -- the claims are created, but it's
20 the same stuff.

21 Composite measures, that's a little
22 weedy, but that is one way that you can increase

1 your denominator size if you create composite
2 measures in particular ways.

3 There's statistical approaches. This
4 starts really getting in the weeds, but there are
5 approaches where you can do this hierarchical
6 modeling and be able to pull in some information
7 from the average. And that kind of helps out the
8 small numbers problem.

9 And then obviously in reporting, there
10 are things like, okay, we know we have a small
11 volume problem. Let's be sure that we include
12 additional information so that people understand
13 what's going on. Let's show those CIs, which we
14 don't usually see. That sort of thing.

15 And then finally stratification,
16 comparing like to like, would be potentially
17 another way to think about small volume problems.

18 So, again, I just wanted to put this
19 out as stuff that as we were going through our
20 readings, these aren't new. You may have new
21 ones in addition.

22 And with that, I'm going to hand it

1 over Ira to facilitate this session.

2 CO-CHAIR MOSCOVICE: So, this is a
3 simple problem. We'll figure it out in 5 or 10
4 minutes and be able to go to lunch early.

5 Obviously, it's a complex problem.
6 I'll just offer a couple comments, and then we'll
7 open it up for suggestions. And particularly, as
8 we say, some of the methodologists who are here
9 can offer their comments.

10 When we offer our thoughts, remember
11 one of the objectives of the meeting was to make
12 recommendations regarding measures appropriate
13 for use in CMS pay-for-performance programs.

14 So, it's a little bit more complicated
15 when you say, okay, let's look at the low-volume
16 issue, but not just with respect to the quality
17 measure, but we're linking it to a pay-for-
18 performance or reimbursement system and just
19 think about that as you go through these.

20 Because the notion of, for instance,
21 pulling data across years, well, maybe I can get
22 enough sample size in three years, but guess

1 what? Payment systems aren't set up to not pay
2 anybody for three years. You got to figure out
3 on an annual basis how you're going to do that.

4 So, I would just, you know, that's one
5 thought about how it -- in the back of our minds
6 we need to take that into account.

7 There are obviously a whole host of
8 other approaches, and I would just say we've
9 tried in our work to use some of these
10 statistical approaches. I mean, we did a couple
11 papers on using article modeling, invasion
12 modeling, and came up with suggestions about how
13 you could actually do that.

14 And what is involved is saying we're
15 going to use your hospital's data, but then we're
16 going to look at all the other hospitals that are
17 sort of similar to you doing similar stuff.
18 We're going to use their data, we're going to
19 pull it together, and we'll come up with a more
20 reliable estimate.

21 Practically what happens is you do ten
22 out of ten cases perfectly and then say, you

1 know, it's not really 100 percent in your
2 hospital, it's really 88 percent.

3 If you do five out of ten, you know,
4 perfectly and have five that you don't, and then
5 say, you know what? It's not 50 percent; it's
6 really 75 percent -- yeah, that looks much
7 better. So, there's those kinds of issues that
8 really underlie all this.

9 So, it's a complicated issue, but
10 we're trying to look at, and I doubt that we're
11 going to come up with the solution, because
12 smarter people than all of us have been trying to
13 deal with this for decades.

14 But if we can once again come up with
15 a series of bullets that underlie recommendations
16 for where CMS is, how they should move forward, I
17 think that would be really helpful.

18 So, we'll open it up for discussion
19 and just put your signs up as you feel fit. So,
20 we'll start with Greg.

21 DR. IRVINE: Yeah, the problem as you
22 point out, Ira, is that with the low denominator

1 issue is it can make you look worse than you are,
2 but also it can make you look a lot better than
3 you are, as we've proved.

4 And, you know, I'm not sure how to
5 solve that problem; I'm not a statistician. I'm
6 sure there's statistical ways to deal with that,
7 but we're going to keep bumping into this issue
8 of trying to use small numbers to make big
9 decisions, including how you're going to pay
10 people for what they do.

11 And I think we're going to have to
12 think much, much more radically about, you know,
13 what do we do about PFP? Because if you pay
14 people to perform, they will perform. They will
15 give you a performance. They'll do what you ask
16 them to do, but you may not get what you want.

17 CO-CHAIR MOSCOVICE: Any thoughts
18 about how you would define "radically"?

19 DR. IRVINE: Going back to my bottom-
20 up, I think that paying people, perhaps small
21 hospitals, to design quality systems that makes
22 sense in their setting looking at various metrics

1 within that system that makes sense. Offering
2 that as a project for a year and saying if you
3 meet your own defined goals, you can do that,
4 you'll get paid for that.

5 I don't know any other way.

6 CO-CHAIR MOSCOVICE: How does that get
7 you around the small number issue, though?

8 DR. IRVINE: Well, what we're looking
9 at is not necessarily making a project that
10 doesn't use numbers, it looks at processes. It
11 looks like -- at access to care it looks at more
12 perhaps fuzzy and esoteric goals, but goals that
13 are very important to the community.

14 We've recently at St. Luke's McCall
15 begun trying to augment -- we realized as an
16 organization that our behavioral health services
17 were horrible. And we tried to augment
18 behavioral health by recruiting practitioners, by
19 setting up clinics, by dealing with that as a
20 problem in the community.

21 If we had set that up as a CMS goal
22 saying we want to improve behavioral health in

1 this community because Valley County, Adams
2 County, Idaho County, which are the three
3 counties we deal with, have no competent mental
4 health providers and we want to work on that,
5 finding funding, doing what's necessary to get
6 community buy-in and so on, we can do a better
7 job of that.

8 And if then we can show CMS that we've
9 done that, then that makes some sense.

10 CO-CHAIR MOSCOVICE: And so Greg has
11 raised the issue of focusing perhaps more on
12 population health measures rather than specific
13 individual health measures.

14 I'm just wondering if people -- how
15 people feel about the utility of that and whether
16 it's an area that we can move down.

17 Yeah, Bob -- oh, Steve.

18 DR. SCHMALTZ: Well, I guess the
19 problem with population measures is the
20 attribution question.

21 So, if you have a good population-type
22 measure, how much of that is due to the

1 particular critical access hospital or rural
2 health center?

3 And if you're reimbursing the rural
4 health center for a good community measure, are
5 you giving enough credit, or not enough credit,
6 where it's due?

7 CO-CHAIR MOSCOVICE: One of my
8 reactions is in some ways in rural environments
9 we can deal with that a little bit better than in
10 urban environments where there's all sorts of
11 different programs.

12 We've been hearing about the isolation
13 and sort of -- particularly looking at smaller
14 practices. And so, in some sense particularly if
15 they're certified as a primary care medical home,
16 you would think we might feel a little bit more
17 comfortable. There are some advantages to doing
18 stuff in rural environments.

19 Okay. I have Bob, and then I have
20 Sheila and then Marty. So, Bob.

21 DR. RAUNER: Okay. Two comments. One
22 is on the question of pay-for-performance. The

1 pay sometimes leads to bad, unintended
2 consequences, unfortunately.

3 I'm actually coming to the point where
4 I think we don't need the pay-for-performance.
5 All we need is public reporting.

6 I'm too close. Whoops. Sorry.
7 Because it turns out physicians and nurses are so
8 competitive they hate to not look good publicly
9 and that that actually is enough to drive
10 performance.

11 So, maybe if you don't have the pay so
12 tightly connected you avoid some unintended
13 consequences.

14 Kind of like Cleveland Clinic puts all
15 its stuff out to the world partly because it
16 drives their own people to do a good job because
17 they know the whole world is going to see how
18 they do. That actually turns out to be more than
19 enough incentive.

20 The second, back to the population and
21 some of these issues. I'll just -- because we've
22 been on -- this has been an issue for us the last

1 two years. That's why we drilled down to five
2 measures.

3 And that's why we focused on five at
4 the ACO level; med rec, influenza, pneumonia
5 vaccination, blood pressure control and diabetes
6 control, because they're broad enough, the sample
7 size is big enough and I'm pretty convinced that
8 if you do well in those five, you do pretty well
9 in most of the others as well.

10 There's enough cross-correlation that
11 the processes those fix pretty much fix many
12 other issues, too.

13 And in terms of prospecting for
14 something new, the only other thing we add to
15 that actually right now is percentage of our
16 patients who have had an annual wellness visit.

17 It's real easy to track and I think
18 it's also again reflective of the process and the
19 prevention and mentality of the docs. So, that's
20 kind of what we've got around some of those
21 things.

22 CO-CHAIR MOSCOVICE: Sheila.

1 DR. ROMAN: I'm just thinking about
2 how the methodologies in the pay-for-performance
3 programs have been set up. And generally they
4 have been set up by domains and percentages on
5 domains and come up with a performance score by a
6 variety of methodologies in all of the pay-for-
7 performance projects -- programs that are up and
8 running.

9 And I'm just wondering if we can put
10 our heads together and think of domains that
11 would be applicable to the rural environment and
12 address the low-case volume issue, one of them
13 being patient experience with care, perhaps, or
14 population health measures and then maybe those
15 process of care measures that are broad enough to
16 actually have sufficient case volume.

17 CO-CHAIR COURT: So, I think the
18 domains idea is the right idea, but in the
19 current pay-for-performance programs there's a
20 serious flaw in if you don't have enough measures
21 in one domain, then the other domains get
22 weighted more heavily. And so, it becomes very

1 perverted.

2 And so, if we want to recommend
3 something about domains, we have to have
4 something to guarantee that we don't get the
5 situation there is now where no measures here,
6 then all your weight is on two measures over
7 here. So, the domain process is not designed
8 well.

9 CO-CHAIR MOSCOVICE: And so, what we
10 can do as a recommendation is be as specific as
11 possible to how we change that.

12 The other action I would say is -- you
13 mentioned patient experience with care. And this
14 is where the voluntary versus mandatory comes in.

15 We know, on average, rural looks
16 better than urban any way you look at it usually
17 for patient experience with care. So, you'd have
18 to be foolish not to report.

19 Yet, there are still so many rural
20 providers that don't for all the reasons earlier,
21 you know, how difficult it is just to do this,
22 but that's one area where you know you're going

1 to look better. On average, we know that across
2 the U.S. and still it's not -- and so, that
3 notion of mandatory versus voluntary is
4 important.

5 I'll come back to this side. I want
6 to go to this side of the table for a while. And
7 so, I had Kimberly first and -- I forget your
8 name, Wyoming, but -- Tonya.

9 MS. BARTHOLOMEW: That's all right.

10 CO-CHAIR MOSCOVICE: And then Tim and
11 then we'll come back to this side. So, why don't
12 we start with Kimberly.

13 CO-CHAIR COURT: Use your microphone,
14 please.

15 DR. RASK: Two thoughts. I really
16 like the idea of focusing on pay-for-reporting.
17 If we think we have measures that have
18 significant analytic issues with them because of
19 the low-volume piece, there is a benefit exactly
20 as you mentioned to reporting to competition to
21 drive that keep you from some of the perverse
22 incentives of tying payment to it.

1 The second piece is that as I hear a
2 lot about, you know, what makes rural providers
3 different and especially some of the rural health
4 clinics and critical access hospitals in terms of
5 their payment strategies, they are being paid and
6 supported in a way to provide a necessary
7 community function which is accessibility to
8 care.

9 So, that's the social good of what
10 they do. It would make a lot of sense to have
11 measures then that capture that.

12 Are they meeting the community good
13 for which they are being treated in this special
14 way for doing that?

15 At the same time, it's problematic to
16 add -- to then put things like coordination of
17 care measures on them if they are not being paid
18 in such a way to be able to support the actual
19 delivery of coordination of care services that
20 are particularly needed in their setting.

21 And as an example that does not apply
22 to the rural health, but I've been involved with

1 two states' Medicaid Waiver DSRIP programs where
2 they're really trying to broaden some of what
3 their Medicaid providers who are taking care of
4 low-income, very challenged communities.

5 And so, they held back their DSRIP
6 payments and asked them to be working with other
7 community providers and improving coordination.
8 And then tied their payment as to whether or not
9 they were able to achieve certain improvements in
10 patient outcomes that were dependent upon kind of
11 a voluntary building of things.

12 And so, there was such a big
13 disconnect over time in terms of when the data
14 was collected and in terms of reality as to
15 whether they could deliver services that they
16 were not being paid to deliver, that it just kind
17 of makes the whole thing an exercise.

18 Now three years into it, what they're
19 basically doing is falling away from most of the
20 measures and coming into can you write a good
21 plan about what you were going to do. And if it
22 checks off everything on the planning list, then

1 we'll say, yes, you implemented a program.

2 So, you know, I think it's just that
3 issue of coming up with the alignment between
4 measures. And if it's going to be for payment,
5 being sure that the payment system is actually
6 paying people to do the things that your measure
7 wants them to do.

8 CO-CHAIR MOSCOVICE: And that might be
9 one of the -- outside the core, one of the
10 modules that really is much more specific,
11 perhaps, to rural than urban that we push in
12 terms of getting CMS to change the way they
13 perhaps think about things.

14 So, why don't we -- we'll go to Tim,
15 and then we'll go to Tonya.

16 MR. SIZE: Maybe at the risk of saying
17 the obvious, but I haven't heard it said and just
18 to get on the record, and I'm not a metrics guru,
19 but there's a distinction, I think, very relevant
20 to low volume between outcome and process
21 measures.

22 And obviously you got to have higher

1 volume to have validity on the outcome side, I
2 think. Whereas I think on the process measures
3 if it's the right thing to do, it's the right
4 thing to do with one patient, two patients or
5 three patients.

6 And while I understand the attraction
7 to outcome measures and I understand why the
8 field is going that way, I think we need to make
9 a statement that one way we need to think about
10 addressing process measures is a belief that the
11 research is there to say that people who do this
12 kind of process, they have good outcomes.

13 And we don't burden in a crazy way low
14 volume and say, well, you got to redo the
15 research every time you do an outcome report.

16 And then I do think that is something
17 that's rural-specific and low volume is the way
18 to do it.

19 And I think where we -- that's not to
20 say we shouldn't give up looking for those things
21 where we can show good outcomes, but I think
22 process measures will retain -- will be longer --

1 are still relevant in the rural areas and we need
2 to be clear and unapologetic about that.

3 CO-CHAIR MOSCOVICE: Tonya.

4 MS. BARTHOLOMEW: What I'm hearing is
5 everything that's a component of a patient-
6 centered medical home model of care, it captures
7 patient experience, it captures access to care,
8 it captures quality measures.

9 And going back to what Greg said, it
10 captures quality measures that are designed by
11 the entity as, you know, for example, for my
12 patient-centered medical home, I got to choose
13 what I wanted to define as a high-risk patient.
14 And I wrote a process, how am I going to define
15 this patient? How am I going to measure outcomes
16 on this patient and am I going to do it, and then
17 report on those quality measures.

18 That would really encourage us to take
19 a look at that model of care, because I think it
20 encompasses every single thing that we're talking
21 about today in a realistic and useable way.

22 And that's what all of these data and

1 these metrics are about is how can we use this to
2 improve our patient care.

3 CO-CHAIR MOSCOVICE: I want to come
4 back to this side. I have Guy and Aaron and
5 Jonathan at the end. I think Jonathan actually
6 had his sign up the longest. Why don't we start
7 and we'll work back this way.

8 MR. MERRELL: Yeah, I just wanted to
9 be explicit. I think we've kind of tiptoed
10 around some of the metrics on the population side
11 of the house, but I want to be explicit in
12 considering social determinants of health metric
13 selection.

14 The National Quality Strategy that HHS
15 has set forward and the work that the National
16 Association of Community Health Centers has done
17 in the last two years in conjunction with HRSA in
18 selecting social determinants of health metrics,
19 I think, is important for consideration of this
20 group.

21 We all know that zip code has a lot
22 more impact to outcome of morbidity and mortality

1 than genetic code does in our current setting.
2 So, I think being explicit with social
3 determinants of health and considering that for
4 selection is going to be important especially for
5 alignment, because those things are going to be
6 added to us in the future. Thank you.

7 CO-CHAIR MOSCOVICE: I don't know,
8 Helen, if you have any comments in terms of the
9 work NQF is currently doing in that area. How do
10 you see it intersect, I mean, the rural folks
11 feel that that's an important issue. But other
12 than stating that, is there -- the work that NQF
13 is currently doing, is there a way for this to
14 fit into that?

15 DR. BURSTIN: I think so. I mean, I
16 think the more we get some clarity as to what's
17 unique that we can build into the current work I
18 think it would make sense, yeah.

19 CO-CHAIR MOSCOVICE: Okay. We have
20 Aaron and then Guy.

21 DR. GARMAN: Well, I think there is
22 already some standard out there for a model that

1 utilizes some of this fluffier stuff to develop
2 guidelines for a program to go forward.

3 And that's -- again, I'll refer back
4 to these 19 program requirements for a community
5 health center. And I'll read them and not all of
6 them, obviously, are applicable, but the first
7 one is a needs assessment.

8 So, in my center we had to go through
9 with all of the surrounding communities, all the
10 players, sit down and come up with what does our
11 community actually need? Well, there's a good
12 measure, I think, determining what your community
13 needs.

14 Required additional services. So,
15 preventative services, enabling health services,
16 behavioral health services, do you have those
17 items in place for your community?

18 Staffing requirements, are you
19 appropriately staffed? Accessible hours of
20 operations and locations. After hours coverage.
21 Hospital admitting privileges and continuum of
22 care.

1 For us, we have sliding fee discounts.
2 A quality improvement assurance plan and that --
3 basically there are several guidelines regarding
4 that, but it requires us to report that on a
5 continuous basis to our project officer of items
6 that we actually measure that are important for
7 us and for our patients.

8 Key management staff. Contractual
9 affiliations and agreements. Collaborative
10 relationships. Financial management and control
11 policies; billings, collections, budgets.
12 Program data reporting systems. So, can you
13 manage your data?

14 The scope of our project and then
15 board issues like board authority and board
16 composition.

17 There's also conflict of interest
18 policy as well, but at least those first few I
19 think would be very applicable to what we're
20 trying to do here today.

21 CO-CHAIR MOSCOVICE: Guy.

22 DR. NUKI: I think most of what I said

1 was -- but just to try to reiterate and also to
2 address something that Bob said and Tim, I
3 actually think we could -- I know just enough
4 statistics to understand that it's actually a
5 bunch of voodoo to try to take bad data and try
6 to make it look good using statistical analysis.
7 So, I think we should give up. I don't think
8 that you are going to solve that problem.

9 So, what you're hearing and what I'm
10 hearing is that what we really need to do is have
11 measures that don't have -- we don't have to
12 worry about the low-volume issue.

13 The other thing is, is that when it
14 comes to pay-for-performance, I mean, there's a
15 huge amount of data out there that shows
16 individuals are not going to change their
17 behavior based upon giving them money. As a
18 matter of fact, you may have the exact opposite.

19 If you ever listen to Daniel Pink or,
20 you know, the whole daycare scenario, all of that
21 sort of stuff, using -- telling individual
22 physicians that you're going to get paid

1 differently to perform on a statistical grid
2 definitely isn't going to work, but systems will.

3 If you go to a CEO and say you're
4 going to get more money if you implement these
5 systems, that works.

6 So, I think, you know, I'm just
7 reiterating, I think, what everybody has said
8 which is we need to look at pay-for-performance
9 not in the traditional sense that all of these
10 other measures have been, but really more like
11 things that Aaron had just talked about.

12 CO-CHAIR MOSCOVICE: Okay. We'll come
13 back. My co-chair here has a comment.

14 CO-CHAIR COURT: So, a couple
15 potential solutions. I think we need more
16 measures that are cross-cutting, you know, that
17 apply to here's things every patient should get.

18 And I -- other than the immunizations,
19 there's not very many of those because then, I
20 mean, it's things every patient should get.

21 And then I think we need to get on the
22 record that there has to be a system where you

1 have to have, you know, pick -- you've got to do
2 eight measures. I don't know what the number is.

3 And then the hospital or the clinic is
4 free to choose the measures that most apply to
5 them. They're more likely to use them and it is
6 meaningful to the patients they serve.

7 The other thing I think CMS needs to
8 think about is I think the reason that many rural
9 providers don't do CAHPS, either HCAHPS or CG
10 CAHPS, is because right now it's mandated that
11 you do it through a vendor. And those vendors
12 are very expensive.

13 And so, on the hospital side they
14 developed the cart tool which is a free tool for
15 submitting your process measures.

16 And I think the CAHPS need something
17 similar so that the cost to these vendors isn't
18 prohibitive to collecting patient experience,
19 because I think it's really important. And it's
20 the measures the patients really understand.

21 CO-CHAIR MOSCOVICE: Okay. I've got
22 John and Jason.

1 MR. GALE: I do want to sort of pick
2 up on one point that was mentioned earlier about
3 the idea of creating program-specific compare
4 subgroupings, you know, CAH or Rural Health
5 Clinic and I have to say I am not a fan of that
6 idea for the express reason we've got two sets of
7 issues.

8 First, it sort of creates a secondary
9 tier issue, you know. A different reporting
10 category.

11 And the second is that critical access
12 hospital status, rural health clinic status,
13 federally-qualified health center status and all
14 of these support programs are designed to
15 stabilize the facilities. They don't really
16 change the way medicine is practiced.

17 So, if I am sitting in a rural
18 community and the idea is transparency and I can
19 either make a difference -- I want to choose a
20 provider -- I want to see a primary care provider
21 at some level. I could care less if they're an
22 FQHC or an RHC or anyplace else.

1 And the second is we want to make sure
2 at least for purposes of value-based reporting
3 there is some consistency across the delivery of
4 services regardless of the site.

5 CO-CHAIR MOSCOVICE: Okay. I have
6 Jason, then Brock.

7 DR. KESSLER: I have somewhat of an
8 outside-the-box, but perhaps half-formed idea
9 that I want to kind of throw out for discussion
10 of the group.

11 But before I do that, I want to just
12 take a step back and kind of think, you know,
13 thinking about these measures from the
14 perspective of patients.

15 What matters and what's important to
16 patients is maybe a good way to focus on things,
17 but, you know, it's fair to say patients will
18 find information out there and they really don't
19 know what it means.

20 I know from, you know, what I know
21 about looking at data, that a good data person
22 can take data and make data mean just about

1 anything they want it to.

2 So, I tend to be very skeptical about
3 looking at data just in terms of making decisions
4 about, well, how good is the healthcare, or how
5 good is this institution, this community, this
6 provider.

7 Looking at the different types of
8 measures that are out there currently, most
9 measures have a numerator and a denominator and
10 crank out a rate.

11 And then we have P4P programs that
12 based on where this rate is, you know, you might
13 stand to get such and such amount of money for
14 that. And I almost think that's overthinking a
15 little bit for a lot of these types of things.

16 If rather than rate measures we
17 started looking at just, for lack of a better
18 term, pass-fail measures where, you know, there's
19 not so much data behind it, but it's a question
20 that you can answer yes or no, that may actually
21 produce some meaningful information for people,
22 you know, whether it be consumers, patients or

1 payers of P4P types of programs that they can use
2 to judge -- I guess that's what we're really
3 looking at is judging the quality of care that's
4 delivered.

5 I don't necessarily know how to do
6 that. I don't have specific ideas of yes or no,
7 pass or fail types of measures, but that might be
8 one way we could look at it.

9 So, I just throw that out for
10 discussion if anyone wants to comment on it.

11 CO-CHAIR MOSCOVICE: Okay. We have
12 Brock and then Marty.

13 MR. SLABACH: A couple of things.
14 And, Kelly, I like the discussion on some of the
15 specifics around, for example, HCAHPS.

16 One of the things that I think would
17 be appropriate to address is the issue of
18 exclusion of patient populations from those
19 surveys.

20 So, for example, patients discharged
21 to nursing homes are not eligible. Well, this
22 just decreases your population of patients that

1 can answer the questionnaire.

2 So, rural-specific -- or rural-
3 sensitive processes at least would, I think,
4 maybe help providers to become more alert to
5 using those systems.

6 And the reason they don't use it is
7 not necessarily only because it's so expensive.
8 It's because they get poor responses or response
9 rates and it's not as meaningful.

10 So, for example, in my institution we
11 had two systems. We had the HCAHPS system and
12 then we had our internal system that we used for
13 patients that were discharged and we gave them
14 the survey before they left the building. And
15 that was far more effective for us than what we
16 got back from the HCAHPS vendor a month or two
17 months later.

18 Second, I'm thinking back in terms of
19 issues in my hospital and our clinics that
20 probably produced the best performance
21 improvement. And it's not -- and we did all of
22 the quality reporting. We were Joint Commission

1 accredited. We did all of that and that all
2 helped and it was all part of the processes that
3 we did to improve care.

4 But when we did AHRQ's culture patient
5 safety survey and used that tool within our
6 facility, and we did it, I think, every two years
7 if I'm not mistaken, this was an incredibly
8 powerful tool to improve the safety culture of
9 our institution and making us, as leaders, aware
10 of our vulnerabilities and gaps that we have
11 within our system of our caregivers.

12 I'm seeing the same evidence now with
13 TeamSTEPPS through AHRQ and the processes that
14 that includes in terms of problem-solving.

15 And I think that goes back to the
16 point that was made just a second ago in terms of
17 pass-fail. So, that could be some of the
18 programmatic things I think that they pass so
19 that if they do this and they're engaging in that
20 process, it could be helpful.

21 The last thing I'll make a comment on
22 is stretching ourselves to thinking ahead. And I

1 like the conversation about population health
2 because we can sit and comment about all of the
3 existing metrics like whether or not we, you
4 know, get the correct antibiotic within four
5 hours of a patient arriving to the emergency room
6 and diagnosed with, you know, respiratory
7 disease.

8 Those are important and I'm not going
9 to reduce those, but we need to be looking ahead
10 at where -- what's going to be important ten
11 years from now for populations and for how --
12 where do we see medicine going? And the ACO
13 model, I think, is a good example.

14 And how do we prepare the future of
15 our rural providers and incenting them into
16 systems that are going to get us to where we're
17 going and not just looking behind and asking them
18 to continue in kind of performing on things that
19 they should have hopefully done a long time ago,
20 but we need to be stretching them forward. So, I
21 guess I'll stop there.

22 CO-CHAIR MOSCOVICE: Yeah, I think the

1 latter point is a good point. And rather than
2 just looking at existing, where are we heading,
3 my bias has always been if you're looking at
4 population health as a concept, we should be able
5 to do that better in rural starting with we can
6 define the population better and also hopefully
7 could develop programs that would be not having
8 to fight against lots of other programs. So, I
9 think that's an important comment.

10 We had Marty and then Bob.

11 MR. RICE: So, I think Jason made a
12 good point. Maybe we're looking at these
13 measures so broadly that you can't really break
14 it down.

15 We look at attribution. We look at,
16 you know, can you take attribution out of a
17 measure? I don't know whether you can or you
18 can't, but maybe there's different types of
19 measures we need to look under different
20 categories like measures for consumerism that we
21 should just look at and separate it from
22 everything else.

1 Process of care, population health,
2 they're all kind of subcategories. And when you
3 lump them altogether it gets so confusing. To
4 tell you the truth, I start getting confused. I
5 don't know whether there's an answer to it
6 because when you put everything together, you
7 really can't build a measure for these large
8 topics. It's hard to wrap your arms around it.

9 My arms are short. So, I can't wrap
10 my arms around anything. So, but it's tough
11 concepts. How do you, you know, how are you
12 going to look at this?

13 And then when you add attribution into
14 the mix, it just gets to the point where it's
15 almost hopeless.

16 So, is there subtopics -- and this is
17 probably more for Kelly and Ira, you know. Would
18 it be better to break this down into subtopics
19 and just look at the specific areas? And then
20 look at the practice of care within those areas.

21 I don't know. I'm just kind of
22 throwing that out there.

1 CO-CHAIR MOSCOVICE: I like the idea
2 of -- I don't think we can avoid all the work
3 that's going on. We have to address is that
4 relevant for rural or not.

5 And if many of us are concluding that
6 certainly all of it's not relevant and there are
7 alternatives for how we might look at this in
8 rural and we need to discuss those alternatives
9 and proposing that to CMS, hopefully they could
10 opt into saying one or two of those areas, let's
11 really demonstrate and see if it really works.

12 So, the concept of not just being
13 boxed in with where we are, I think, is what I'm
14 hearing time and time again. And hopefully we
15 can get some more details as we go along.

16 So, I have Bob and then Stephen.

17 DR. RAUNER: Actually, I'm going to go
18 back to Brock's comment about HCAHPS and CCAHPS.
19 And it's really a question I'm hoping one of you
20 guys in the room can answer for me.

21 I was thrilled that that was part of
22 the ACO measures and that we would be judged on

1 customer service. I think that is really, really
2 important.

3 And I was real excited about it and
4 then I started looking into what the CCAHPS
5 includes and how it was actually administered.

6 Had some suspicions, and the
7 suspicions were confirmed when I actually saw the
8 ACO results of both us and everybody else in the
9 country in that our numbers are all within one or
10 two points of the mean.

11 We're essentially statistically
12 equivalent to just about everybody, and so is
13 almost everybody else, which, to me, says is this
14 a fundamentally flawed survey?

15 And my suspicion is that it is because
16 what happens is they ask the entire, I don't
17 know, 70 some questions and they're calling, you
18 know, 85-year-old Aunt Tilly on the phone at
19 random. And by the time she gets to Question
20 Number 7, I think she's answering four all the
21 time.

22 And so, I guess does anybody know

1 enough about the CCAHPS to know whether this is
2 the explanation for why almost all the ACOs are
3 statistically equivalent to each other on patient
4 experience?

5 And of course they're actually dingling
6 us all because you have to get 90th percentile to
7 get full credit.

8 Is this a fundamentally flawed
9 problem, unfortunately, where it's like a
10 perfectly sampled worthless data problem?

11 Can anybody answer that?

12 CO-CHAIR MOSCOVICE: Bruce, are you
13 responding to that?

14 DR. LANDON: I mean, so there's always
15 been certainly problems with CAHPS surveys and
16 the power of the CAHPS surveys to discriminate
17 among different institutions and whatnot. It's
18 not completely strong, but --

19 CO-CHAIR COURT: Can you talk closer
20 to your microphone?

21 DR. LANDON: It's not all that strong,
22 but this is very sort of scientifically valid,

1 well-developed.

2 And we've actually published a paper
3 looking at just the pioneer ACO program looking
4 at first-year results and actually found
5 improvements in two domains of CAHPS that were
6 pretty relevant in -- to ACOs just among those 33
7 organizations that were -- 32 organizations that
8 were participating for that year. So, there is
9 some power there.

10 DR. RAUNER: I think it's something
11 that's probably valid on the multiple system
12 level, but I think it may lose its power on the
13 individual ACO level because it's so much
14 regression of the mean and so much -- I think
15 there's probably -- so, I don't know if maybe I'm
16 getting too weedy.

17 DR. LANDON: I guess I don't know in
18 detail the sample sizes that they specified for
19 each one of the ACOs, but I assume that they're
20 using similar sample size requirements that they
21 use for MA plans and the like which are, you
22 know, reasonably adequately powered.

1 You know, clearly, you know, pioneer
2 ACOs are larger than MSSP ACOs, but the MSSPs
3 still have to have 5,000 patients if they're
4 sampling. If 600 of them and get 50 percent, it
5 should be adequate power.

6 CO-CHAIR MOSCOVICE: Stephen, so we
7 want you now to defend statistics and explain --

8 (Laughter.)

9 CO-CHAIR MOSCOVICE: -- that it is
10 valuable and can be useful.

11 DR. SCHMALTZ: Well, Jason mentioned
12 pass-fail measures and we actually have those.
13 They're called structural measures. And they
14 tend to be less useful than other types of
15 measures, but I think what you need to look at is
16 the information content of the measures you have.

17 So, the larger the sample size, the
18 better for proportion-type measures, and -- but
19 proportion-type measures have less information
20 than continuous-type measures.

21 So, if you could find a good
22 continuous-type measure, I think that would be

1 the ideal because you'd need smaller sample sizes
2 to show meaningful differences.

3 But for proportion-type measures which
4 are most of our process measures, you do want a
5 larger sample size and you can't really get
6 around it statistically.

7 You just have -- if you have poor
8 information from a measure, it's not going to
9 help you to try to move everybody toward the
10 middle.

11 You're not going to detect meaningful
12 differences. And what you want to do is improve
13 care by detecting meaningful differences and
14 acting on those.

15 MR. MERRELL: So, with the continuous
16 measures, so why has it been a challenge in
17 general to come up with those kinds of measures?

18 Are they more difficult to collect, or
19 do you have any examples maybe that might be
20 relevant for rural that could be used?

21 DR. SCHMALTZ: Well, the emergency
22 room measures, I think, is an example.

1 MR. MERRELL: The time measure. The
2 timing measures.

3 DR. SCHMALTZ: The timing measures.
4 The problem with timing measures is you can have
5 these big outliers that really skew your results,
6 but here is a case where statistics can help as
7 far as giving more meaningful comparison values.

8 MR. MERRELL: And we sort of know that
9 timing issues in emergency departments in rural
10 areas in general are not the same as they are in
11 urban areas.

12 DR. BURSTIN: I think also it would be
13 helpful if you could give an example of a
14 proportion measure versus a continuous measure.
15 I'm not sure everybody is on the same measurement
16 page.

17 DR. SCHMALTZ: Okay. A proportion
18 measure, an example of that would be given
19 aspirin at arrival for AMI patients.

20 CO-CHAIR MOSCOVICE: So, the percent
21 of patients who would get that as compared to the
22 emergency department, how long did it take a

1 patient to see -- to be served or how long did
2 they wait to get transferred out or whatever?

3 DR. SCHMALTZ: Which is a more precise
4 measure.

5 CO-CHAIR MOSCOVICE: Right. I have
6 Bruce -- okay. Marty, is yours still up? Okay.
7 Bob, though, definitely has a --

8 DR. RAUNER: Just this goes right back
9 to that. So, for example, the -- all these, and
10 actually I have our ACO with a whole bunch of
11 other ACOs. They're all percentage measures.

12 And if I calculate the confidence
13 intervals right, they're all plus or minus five
14 percent just like your typical political poll.

15 All of these are within that plus or
16 minus five percent because they're those
17 proportion measures. And that's why I think
18 unfortunately they are discriminatorily helpful
19 for an ACO, because they're all within that
20 plus/minus four, five percent like any --

21 DR. LANDON: But don't forget --

22 CO-CHAIR COURT: Microphone, please,

1 Bruce.

2 DR. LANDON: It's just pay-for-
3 reporting.

4 DR. RAUNER: Yeah.

5 DR. LANDON: So, no one is actually
6 trying to --

7 DR. RAUNER: But they're going to be,
8 though.

9 DR. LANDON: I understand, but, I
10 mean, so we've done a bunch of analyses of sort
11 of the most prominent early commercial ACO
12 contract, which is the Blue Cross and Blue Shield
13 of Massachusetts Alternative Quality Contract.

14 CO-CHAIR COURT: I'm sorry, Bruce. We
15 can barely hear you. Can you get closer?

16 DR. LANDON: We've done a bunch of
17 papers on the first sort of large commercial ACO-
18 like contract which is the Blue Cross and Blue
19 Shield of Massachusetts Alternative Quality
20 Contract.

21 And in a paper what we just published
22 a couple of months ago, Zirui Song is the first

1 author, control comparing to national benchmarks.
2 We actually showed substantial improvement
3 particularly in the outcomes-type measures like
4 control of diabetes, control of cholesterol,
5 control of blood pressure, which I've actually
6 never seen those measures that responsive to
7 anything before.

8 CO-CHAIR MOSCOVICE: My colleague
9 Kelly.

10 CO-CHAIR COURT: So, two thoughts. I
11 think there is a nugget in what Brock said before
12 about current measures that might need to be
13 repurposed. And it's probably through the
14 denominator definitions, because there is
15 exclusions in defining the population that might
16 not fit with rural.

17 And so, that's excluding patients that
18 maybe don't need to be excluded. So, that might
19 be a way to repurpose existing measures.

20 And then just a question. Maybe this
21 is a really dumb question, but has anybody
22 studied what these different providers do a lot

1 of? I mean, because that's the high volume
2 stuff, you know.

3 So, when I used to be a hospital
4 quality director, when you chose measures it was
5 high volume, high risk, problem prone.

6 And so, it seems like there should be
7 data that says this is what these organizations
8 do a lot of. And then that would maybe be a
9 place to naturally look.

10 And then I think from a patient's
11 perspective, these programs should be aligned in
12 measuring the same things because they don't know
13 if they're in an ACO or a FQHC or what all those
14 other letters are.

15 And so, you know, hopefully it should
16 be aligned to things that matter to patients and
17 it shouldn't be different for the different
18 programs.

19 Now, perhaps the payment incentive
20 needs to, you know, needs to be better aligned.
21 I don't know, but seems like the measure should
22 be converging on something similar.

1 CHAIR MOSCOVICE: So, we -- and I
2 actually have the data. I had our folks just get
3 the latest numbers we had at least in terms of
4 critical access hospitals and the volume. And
5 there's about 1300 plus critical access
6 hospitals.

7 And if you say how many have -- meet
8 the definition of, say, having 25 patients over a
9 year, there's maybe 10 measures totally that have
10 a couple -- there's two to three -- at least 200
11 of the critical access hospitals have it. So,
12 most of the measures you just simply don't have
13 the volume. So, we have that.

14 I don't know on the physician side or
15 clinic side if you have any data like that, but -
16 -

17 CO-CHAIR COURT: But that starts from
18 the -- let's look at the existing measures versus
19 --

20 CO-CHAIR MOSCOVICE: Yeah.

21 CO-CHAIR COURT: -- what do they all
22 have in common. Or if we had cross-cutting

1 measures, again, things that every patient should
2 have. Like medication reconciliation would be a
3 good example.

4 CO-CHAIR MOSCOVICE: Yes, fair enough.
5 Guy.

6 MR. NUKI: I just want to caution you
7 about the repurposing of the measures. Because
8 if you make a little -- that's making a little
9 tweak. It's another complexity. People will
10 then try to compare -- you can't compare it to
11 the untweaked measure and I think that that's the
12 wrong direction to go in.

13 I think it's, you know, your volume
14 through the emergency department, yeah, I mean,
15 that happens to every patient. Med
16 reconciliation happens to every patient.

17 But when you try to bring it down to
18 disease, a specific disease process, I don't
19 think -- I think it's going to be almost
20 impossible to get enough volume on any single
21 disease process and certainly not across enough
22 of the hospitals to really compare.

1 CO-CHAIR COURT: Yes, I totally agree.
2 And I think that's part of the flaw is that
3 approach to measure selection has been a disease
4 process, but what if you said these are things
5 every orthopedic patient, surgical patient should
6 get, or patients with chronic disease should have
7 this, patients, you know, with well, you know,
8 well patients in the clinic setting should get
9 this.

10 When you get to disease-specific, the
11 numbers get small so quickly.

12 CO-CHAIR MOSCOVICE: Bruce, you sound
13 like you want to respond directly or --

14 DR. LANDON: Well, I'm jumping in a
15 little bit. I mean, I don't think -- the
16 potential solutions aren't rocket science.
17 They're sort of, you know, you can collect
18 measures over a longer period of time, you can
19 create bundles of measures that, you know, are
20 sort of combined together, or you can create
21 bundles of institutions that are combined
22 together to increase sample size.

1 And I think those are the sort of
2 issues that we should debate in this room in our
3 recommendations.

4 And as I thought about it, I mean, the
5 extent to which we can potentially encourage, you
6 know, small hospitals and small practices to come
7 together in their quality improvement and
8 reporting activities might be a reasonable
9 solution in that, you know, they can share best
10 practices, try to sort of all pull for each other
11 and whatnot.

12 That might be more effective than, for
13 instance, saying, all right, we're just going to
14 get together all of your measures in completely
15 disparate areas, or we're going to measure your
16 care over the last three years which doesn't
17 capture any sort of improvement. So, just want
18 to get that on the table.

19 CO-CHAIR COURT: So, just back -- I'm
20 not a fan of big time frames, because the
21 measures drive improvement and that's what we
22 want to happen.

1 And if you -- yeah, and so if you're
2 -- and value-based purchase is a really good
3 example. Now with the hospitals, they're getting
4 penalized on something that happened three years
5 ago and that's wrong.

6 CO-CHAIR MOSCOVICE: Greg had a
7 comment.

8 DR. IRVINE: Pulling data between
9 small hospitals, I think, is probably not going
10 to work because of the issue that we've talked
11 about, the providers have talked about so much
12 today, and that is time and expense.

13 We just don't have time and we don't
14 have the money to be able to do those things,
15 period. So, pooling data is extraordinarily time
16 consuming and difficult and expensive.

17 I had -- I asked my -- one of my
18 nurses who does nothing but extract data for
19 these kinds of things, to extract me some data to
20 bring to this meeting.

21 This is actually data for the Federal
22 Office of Rural Health Policy for Marty.

1 CO-CHAIR MOSCOVICE: Marty is leaving.

2 DR. IRVINE: These were part of the
3 Medicare Beneficiary Quality Improvement Project,
4 the MBQIP which I had never heard of, but it's
5 something that our hospital spent a lot of time
6 doing.

7 We looked at Phase 1 measures for
8 small hospitals. We're looking at discharge
9 instruction lists for congestive heart failure
10 patients. And then later on evaluation of left
11 ventricular function. And also getting blood
12 cultures in the emergency room for patients that
13 were admitted with pneumonia prior to receiving
14 antibiotics. For fiscal year 14 we had six
15 cases.

16 One of the problems with that was that
17 in the pneumonia cases we actually had 14, but
18 several of them were -- had other diagnoses. So,
19 they were excluded. So, that's that exclusion
20 issue.

21 Then Phase 2 came along looking at
22 acute MI. For fiscal year 14 we had eight cases.

1 For antibiotic timing in the operating room which
2 is also a SCIP measure, we had lots and lots of
3 cases, but it's also a SCIP measure and something
4 we do all the time. Every time really doesn't
5 need to be measured.

6 Phase 3 was the pharmacist
7 verification of the med rec which was within 24
8 hours of admission and ER department transfer
9 communication which had seven elements. And she
10 said the data extraction out of the paper record
11 which we still have because there were subset
12 elements within those seven elements that had to
13 be measured, took a total of 153 hours of nurse
14 time to extract that data.

15 Hugely time consuming, hugely
16 expensive. The data that was derived from that,
17 I dare to say, was probably relatively
18 meaningless and that's what we're struggling
19 with.

20 CO-CHAIR MOSCOVICE: Other comments.
21 Tim.

22 MR. SIZE: Yeah, in all respect I

1 don't think -- let me try to say it more
2 positively.

3 (Laughter.)

4 MR. SIZE: We are in a point of
5 transition away from paper to electronics. I
6 don't think we leave here with a report that
7 assumes it's got to work for paper.

8 I think it's got to as we -- I thought
9 as a society, have been doing to try to create a
10 glide path for us all to get from paper to
11 electronic, but, I mean, I feel your pain. But,
12 I mean, you've got to become electronic.

13 DR. IRVINE: It ain't going well in
14 small hospitals, I'll say that.

15 MR. SIZE: Well, I actually work for
16 39 small hospitals --

17 DR. IRVINE: Well --

18 MR. SIZE: -- and they are either all
19 there or about to be there.

20 DR. IRVINE: I'll amend that. It's
21 better for primary care. I'm coming at it from
22 another perspective where we're struggling and

1 it's very difficult.

2 MR. SIZE: And I don't want to be
3 disrespectful about that struggle. I just think,
4 and it's the complexity of this conversation --

5 DR. IRVINE: Right.

6 MR. SIZE: -- we need to address where
7 most people are likely to be, but also address
8 with needed care sites that are much further --
9 have a much further journey yet to go.

10 CO-CHAIR COURT: I'm just going to
11 jump in here. Some of those same issues, doesn't
12 matter if it's paper, electronic, I mean, those
13 MBQIP ED transfer measures are way labor
14 intensive whether it's electronic or paper. So,
15 I think the design of the measures is critical
16 when we think about the resources needed to
17 collect it.

18 And I'm not sure there's input from
19 providers about what's it going to take to
20 collect measures in a system that don't have a
21 lot of resources to -- because your nurses
22 collecting the measure is not working on

1 improving it.

2 DR. IRVINE: Well, they're also not at
3 the bedside taking care of the patients, which is
4 where they need to be.

5 CO-CHAIR MOSCOVICE: So, I must
6 reflect on the fact that the measure developer is
7 sitting right next to you. And so, we don't have
8 enough time to talk about it now, but I sort of -
9 - where we're heading is electronic and it should
10 work electronic a lot better than paper.

11 We have 10 minutes left. I'd say
12 let's look at the screen here. And if people
13 have some specific thoughts, we can wheel through
14 these pretty quickly.

15 But in terms of, you know, we have
16 talked about broadly applicable measures, the
17 screening measures and so forth.

18 Are there other examples, specific
19 examples you can think that would help staff in
20 terms of giving some information, providing some
21 information on the kinds of measures that would
22 be useful or broadly applicable so we're not

1 looking at a specific condition now, but
2 everybody who comes in, for instance, would be
3 looked at. So, you'd have a larger denominator.

4 Any thoughts on that or --

5 MS. ABDELLA: Well, I think that what
6 I wanted to say before was we have an opportunity
7 here to look at some measures that really get at
8 the root of some of the health issues that we
9 have in rural communities.

10 We know that we have tremendous burden
11 of heart disease, obesity, diabetes. And so,
12 looking at measure sets that get us potentially
13 working as communities in front of the care.

14 So, I guess some screening measures
15 for things like BMI, referrals to services, you
16 know. Maybe there's composite scores that come
17 for certain patients.

18 But I think looking at definitely
19 having some component of screening that moves our
20 whole rural set, I mean, everything that we're
21 talking about is all about treatment. It's after
22 the horse is out of the barn.

1 And that's never going to get us
2 anywhere in rural if we don't start measuring
3 performance based on getting in front of that and
4 keeping the barn door locked.

5 CO-CHAIR MOSCOVICE: Okay. Stephen.

6 DR. SCHMALTZ: Right now measurement
7 is pretty much a separate process as far as
8 collecting the data. But I think as we go
9 forward in the future, think about measures that
10 can be obtained as a byproduct of care.

11 Now, moving to the EHR, I think we're
12 kind of moving in that direction although we're a
13 long way of getting there, because you still
14 have to look at the workflow of the physicians
15 entering in the data, but I think working with
16 that might --

17 CO-CHAIR MOSCOVICE: Any example that
18 comes to mind?

19 DR. SCHMALTZ: None that come to mind.

20 CO-CHAIR MOSCOVICE: Okay. Brock.

21 MR. SLABACH: As a hospital
22 administrator, I can't believe I'm actually going

1 to say this, but this -- when the hospital
2 readmission reduction rate program went into
3 effect several years ago, I was highly suspicious
4 of it and its impact and what it was going to do
5 to our hospitals.

6 And I'll have to say that I was
7 pleasantly surprised about the reaction in the
8 hospital industry and the improvement that has
9 been made on that.

10 And if you look at the statistics
11 since 2010 or 2011, the number of patients
12 readmitted has just plummeted within a 30-day
13 period.

14 It did incent hospitals then to begin
15 to look outside of their own four walls to
16 discover ways that they can keep patients from
17 becoming a readmit statistic. And they've
18 developed partnerships and all kinds of
19 collaborations to be able to make that happen.
20 And it was all because of that one simple program
21 that was implemented on the payment system that
22 provided those incentives.

1 So, I think we do respond to
2 incentives. I think those incentives if they're
3 structured correctly work and if they have policy
4 outcomes.

5 And so, I guess that's a measurement
6 that I think that does work and it can be applied
7 fairly universally.

8 CO-CHAIR MOSCOVICE: I have Bob and
9 then Bruce.

10 DR. RAUNER: I'm going to say I'm a
11 big fan of the population health measures
12 provided they're done correctly.

13 So, for example, we have picked child
14 obesity screening counseling as one of our
15 measures across the ACO regardless of plan,
16 actually.

17 The downside though, again, I think,
18 Kelly, you said make sure that they're clinically
19 useful meaning one of my big frustrations with
20 the MSSP is what they've selected you're supposed
21 to do for obesity screening and counseling and
22 also for blood pressure screening and counseling

1 makes no clinical sense to me.

2 So, for example, every time someone
3 has an elevated blood pressure, you're supposed
4 to counsel them and arrange follow-up. But what
5 if they showed up on December 30th with a back
6 spasm and their blood pressure is 140 over 90?
7 I'm not surprised at that and I'm not going to
8 arrange screening and counseling at that time,
9 but they're holding us accountable for what I
10 think is really an asinine way to measure it.

11 So, I really like population health
12 measures as long as they're implemented
13 correctly.

14 CO-CHAIR MOSCOVICE: Okay. Kelly.

15 CO-CHAIR COURT: So, things that
16 should happen for every patient. They should
17 have a timely assessment, you know. So, they
18 should leave the hospital with a discharge
19 appointment.

20 So, if we looked at the Medicare
21 conditions of participation which regulate
22 hospitals, there is, you know, specific

1 categories in there, but what happens now is the
2 measures are like way over here and then
3 hospitals are regulated on a whole different set.

4 So, I mean, could there be thought of
5 looking through the -- the areas of the COPs and
6 saying, okay, you know, it's an area for thinking
7 about measures.

8 There's things that you have to do for
9 surgical patients, but that's not what we're
10 measuring in surgery. So, it's just a thought
11 about creating some kind of framework.

12 CO-CHAIR MOSCOVICE: And so, I think
13 the balance we're going to need to think about
14 over the next day plus is, so, there is an awful
15 lot of focus on non-outcome measures that I'm
16 hearing. And I think that's valuable.

17 It can't be, I think, at the exclusion
18 about, you know, sort of that balance how we do
19 that and make it relevant for rural, I think, is
20 certainly important.

21 So, we have at least one minute before
22 lunch, but why don't we give that minute back to

1 our chair here.

2 Karen.

3 MS. JOHNSON: Okay. So, thank you
4 very much. We're going to be thinking about what
5 you said. We may come back and tweak it just a
6 little bit more if not later on today or
7 tomorrow, maybe in the next few weeks.

8 I definitely didn't hear as much as I
9 would have liked to have from our health plan
10 partners. Curious as to what you guys do to take
11 care of this low-volume problem. Is it the
12 structural measures that we've heard about? Is
13 it the broadly applicable measures? So, we'll
14 come back.

15 In the meantime, looks like lunch is
16 served. So, we have a 30-minute lunch break.
17 We'll start back up at 1:30. Thank you.

18 (Whereupon, the above-entitled matter
19 went off the record at 12:57 p.m. and resumed at
20 1:35 p.m.)

21 CO-CHAIR COURT: Okay. We're going to
22 reconvene here. So, our next big agenda item here

1 is Discussion of Potential Solutions for
2 Overarching Challenges. So, if we go back to our
3 objectives, and I keep touching base with Karen
4 here, Ira and I do, to make sure that we get done
5 what we're here to get done. So, we're going to
6 really try and really focus now on solutions,
7 because I think we have a pretty good common
8 understanding of what our challenges are.

9 And then we're going to -- after we
10 have this initial discussion, then we're going to
11 break out into -- we think it still makes sense
12 to break out into the two groups, so group
13 focusing on physician issues, and another group
14 focusing on hospital issues. And we're going to
15 try and focus that breakout session on the
16 measurement gaps, or areas that we really need
17 measures for that we don't have. And probably not
18 specific measures, but areas of measures, so
19 we'll get to that.

20 So what we want -- the things that
21 kind of bubbled up that we think make sense to do
22 some problem-solving around, we'll try and do

1 them in order here, is the -- so be thinking
2 about your thoughts. So, level of analysis. Okay.
3 So, for the physician practices is that -- should
4 a P4P program be at the physician level, at the
5 clinic level, at a system level, at a network
6 level, at some other new creative thing we
7 haven't thought about yet, or you maybe thought
8 about.

9 We also want to talk about -- spend a
10 little time talking about solutions related to
11 alignment. I think we had a lot of comments about
12 the cacophony of measures, and different
13 programs, different organizations using same or
14 similar measures for same or different things, so
15 we want to spend time on that.

16 I want to spend a little time talking
17 about peer groups, so if CMS is going to create
18 P4P for the groups we're interested in, and I
19 assume they are eventually, and if we can inform
20 them so it's done better, I think that's our
21 goal. So, what would we suggest related to peer
22 groups?

1 And then we also want to spend some
2 time talking about if there's a -- or not if,
3 when there's a P4P program I'll assume for rural
4 providers, how would we want that program to be
5 designed? So, what are the attributes of a good
6 program design? So, we'll spend some time on
7 that, as well.

8 And I think that's going to be maybe
9 the harder one, and maybe the other things we
10 talk about will lead us to that, so then if
11 there's anything else we haven't covered, we'll
12 get there.

13 So, let's talk first about level of
14 analysis. So, if there's P4P for rural
15 physicians, rural hospitals, at what level --
16 what level of analysis do we think makes the
17 most sense? Please.

18 DR. RAUNER: Surprise, surprise.
19 Actually, one thing that actually Tonya and I
20 were talking about on break, that actually
21 patient-centered medical home, a lot of these
22 leads back to that, so if you don't have enough,

1 for example, measures for X, focusing on being
2 that is just as useful, I think, sometimes.

3 Another thing that I think is a
4 potential solution is if you're doing this, if
5 they can exempt you from what I might consider a
6 legacy CMS program. A few years ago we had ERX,
7 Meaningful Use, PQRS, none of which aligned with
8 each other, but if you're doing Meaningful Use,
9 you're pretty much doing most of the other two,
10 so why couldn't one exempt it from another? And
11 it took them a while to get to that point.

12 Actually, I think we're there now again where
13 Meaningful Use Stage 2 went off the rails, and
14 what we're doing with ACO and medical home is way
15 more meaningful than what Stage 2 Meaningful Use
16 is. So, if we could get out from underneath Stage
17 2 and not have to worry about that ball and chain
18 and focus on ACO and medical home, we could do a
19 lot more, but now we've got this extra bit of
20 overhead stuck here. So, if we want to talk about
21 process, I think focusing on being a value-based
22 entity like a patient-centered medical home is

1 one of the big buckets that could help.

2 And then back to measures, you know,
3 I think going back to the population level
4 measures like flu shots, med rec, the BC
5 screening which apply to most of your population,
6 you're good.

7 CO-CHAIR COURT: Within that value-
8 based entity?

9 DR. RAUNER: Yes.

10 CO-CHAIR COURT: Okay. Other thoughts
11 about how a provider -- so, the ambulatory side,
12 what that unit should be?

13 DR. LANDON: I think this gets back to
14 sort of the issue we were talking about before.
15 Again, there's sort of relatively limited options
16 for doing these things. And to the extent that
17 whatever system that comes into play provides a
18 path or incentives toward, you know, aggregating
19 across providers and sites probably makes the
20 most sense. I think we were actually talking a
21 little bit before how, I guess, he knows two
22 different markets, and in one of them, even

1 though there's still a lot of practice sites that
2 have solo or two-person places, they've kind of
3 affiliated with either community access hospital,
4 critical access hospital, or a system or whatnot
5 that helps them a little bit with sort of having
6 some common infrastructure and whatnot that can
7 be used. And to the extent that whatever system
8 that we develop or recommend on the ambulatory
9 side is aligned with moving in that direction,
10 that will probably be helpful for these places.

11 CO-CHAIR COURT: So, Bruce, how would
12 that get implemented? I mean, what would -- so,
13 clinics, I'll just call them clinics, would self-
14 define some kind of network if they didn't belong
15 to a --

16 DR. LANDON: I think --

17 CO-CHAIR COURT: You know, Wisconsin is
18 so different because they're integrated systems
19 and everybody is in a network, so if you're not
20 in Wisconsin, how would you do that?

21 DR. LANDON: So, there's -- I mean, I
22 think -- and I'm just thinking out loud here, so

1 someone who knows more please correct me. So,
2 there's probably --

3 CO-CHAIR COURT: Into your mic, too, so
4 we can hear.

5 DR. LANDON: So, there's probably two
6 options. So one is, you know, we need to -- for
7 stability we need to have, you know, 5,000
8 accountable patients, or 10,000, whatever it is.
9 And there's an average of X patients for clinics,
10 so we need five or ten of your sites to aggregate
11 together and you can report together. And you
12 choose it yourself, or we'll choose it for you.
13 And I imagine that places will want to choose it
14 themselves, so there's, you know -- relatively
15 locally, so there's a big patient-centered
16 medical home demonstration program being run by
17 CareFirst, which is the Blue's plan in Maryland,
18 D.C., and Northern Virginia. Obviously, those are
19 places that are not particularly rural, although
20 there are some rural areas in Maryland that they
21 cover. And for their smaller practice sites they
22 actually -- they impose -- they put them together

1 themselves. But, you know, my own feeling is that
2 places would rather choose their partners than be
3 told who their partners are. But, you know,
4 again, implementation can be difficult.

5 CO-CHAIR MOSCOVICE: So, how does that
6 play into pay for performance? So, in other
7 words, you join a group of other clinics. I would
8 join the highest performing group, obviously, if
9 I'm going to be part of that. The whole group
10 gets a payment increase, decrease, whatever. Is
11 that how that works?

12 DR. LANDON: Yes. So, again, so this
13 isn't like, you know, you've got this really high
14 performing 15-member group, and you're aligning
15 your single practice with that. It's that, you
16 know, there's these 10 practice sites that aren't
17 big enough on their own to become -- you know, to
18 report, but we'll put them together so there's
19 not -- it would be hard to know that, but you
20 certainly can say, you know, I'm choosing to
21 align with this guy because I think he has good
22 systems in place and does things well, and

1 everyone thinks he or she is a good doc. So, in
2 terms of sort what they're actually getting --
3 this program is actually a very interesting
4 program, but they have these patient-centered
5 medical homes which, again, are either single
6 sites within larger sites. They have different,
7 you know, groupings. And then the smaller sites,
8 they put them together, and they're actually
9 responsible for TME, in addition to quality
10 measures. So, they're doing, you know, very --
11 sort of very serious kind of consequences for
12 what they're doing.

13 CO-CHAIR COURT: So, would you see that
14 -- those sites that would come together to have
15 geographic -- some geographic proximity, or could
16 you have a practice in Florida, and a practice in
17 California, and somebody in Wyoming?

18 DR. LANDON: Well, you know, from a
19 program perspective, to me it doesn't make sense
20 to do this unless you can actually create, you
21 know, working on the ground synergies. And I
22 don't see that happening if you are putting your

1 practice in Florida with one in Kentucky.

2 CO-CHAIR COURT: Go ahead, Ann.

3 MS. ABDELLA: She saw me jumping again.

4 And idea that we've been wrestling with to that
5 point, and I think it's supported by some work
6 that the National Rural Health Association had
7 been working on, and maybe HRSA around the idea
8 of virtual patient-centered medical homes, so the
9 idea of the patient-centered medical home, I
10 think there's a lot of kumbaya in the room about
11 -- from a primary care perspective for those of
12 us who are doing this work. We think this is as
13 good as it's probably going to get for our
14 lifetime. So, the virtual patient-centered
15 medical home would be that opportunity for
16 providing some of those data collection supports
17 and, you know, helping get their care management
18 pieces together and reporting in some kind of
19 aggregated way. And I think there is potentially
20 a rare opportunity right now in this window of
21 time with the TCPI Initiative that CMS is funding
22 through CMMI across the country to look at

1 bringing along small and solo practitioners. And
2 they're trying to build that infrastructure now
3 to get them up to speed.

4 There's also a huge press on --
5 certainly in my state, in New York, and I know
6 others to bring primary care up to advanced
7 primary care as part of Medicaid redesign. So,
8 there's a lot of stuff going on right now that's
9 kind of desperate to figure out how do we bring
10 along these solos. Honestly, is that a rural-
11 specific issue? I can't speak to it because the
12 world I live in is only rural, but just some
13 thoughts.

14 CO-CHAIR COURT: Great. Jason.

15 DR. KESSLER: I don't know that this
16 is, you know, an ideal situation, but it's at
17 least an example of something I'm aware of that
18 has worked. This began in the State of Colorado.
19 We don't have anybody from Colorado here? Okay,
20 so no one is going to correct me if I completely
21 screw this up. And I believe there's one other
22 state that's doing it, and Iowa has been looking

1 at it, but what they did is they divided the
2 state up into regions based on population. And,
3 you know, there some process of putting somebody
4 in charge of each region which was, you know,
5 some sort of contract procurement thing. But,
6 basically, each region became its own level for
7 measuring the data so that each -- and it's based
8 on population that they divided up the regions.
9 But each region, even competing organizations
10 within a region, the idea was that each region is
11 measured. It's just an example of a way of
12 leveling the field for measurement across the --

13 MS. MOORE: Do you think that would
14 work, though, for pay for performance? So, if I'm
15 a high performing primary care, and I know
16 there's a not so great practice down the road,
17 and I get grouped with them, and my pay is based
18 on their -- driven by their -- I'm not sure
19 providers -- how would that work?

20 DR. KESSLER: Well, I don't know for
21 sure. I know that, you know, they kind of -- with
22 the procurement that went along with it, there

1 was one organization per region that was sort of
2 in charge of coordinating the effort, and then,
3 you know, distributing the pay for performance
4 results of what they did. So, whether those, you
5 know, master organizations subdivided out
6 different things in their regions, or how they
7 managed that, I don't know.

8 CO-CHAIR COURT: Okay. We're going to
9 come back over here and then go back across. I
10 think Guy was next.

11 DR. NUKI: I have a little bit of
12 concern about putting these clinics together, and
13 it's around two reasons, one of which is if
14 you're going to look at geographical similar
15 areas, a lot of rural areas aren't going to have
16 any choices. It's going to be the clinic that's
17 45 minutes away, and then the solo practice guy
18 who's 85-years old and should have retired at the
19 age of 30. That, you know, like well, they're the
20 only people that I can work with, and so that's
21 one problem.

22 The other thing is, I think it's just

1 going to end up being regression to the mean. I
2 mean, if I'm a really good provider, and I'm not
3 getting rewarded for that because the other
4 providers aren't, I'm going to stop trying. And
5 if I'm a bad provider, and I'm getting rewarded
6 some because the other people are really good, so
7 why should I change? I like the way I practice.
8 So, I don't think that it's going to change the
9 behavior. I mean, it's just -- it's going to move
10 money around, but I don't think it's going to
11 give us an improved quality of care. I don't
12 think it's going to help our patients any, unless
13 those disparate clinics all decide okay, we're
14 just going to join an organization, Kaiser. We're
15 going to all be employed by the hospital or
16 something like that, and I think that most rural
17 providers, some of them are there because they
18 don't want to be part of a massive organization.
19 So, I think putting this together like that is -
20 I mean, it statistically makes sense, but I don't
21 think it's going to work.

22 CO-CHAIR COURT: So, Guy, would you be

1 a proponent then of the level of analysis and
2 being a penalty incentive is at the provider
3 level, individual provider?

4 DR. NUKI: Actually, I'm not. I think
5 that the level of analysis should be at the
6 provider level so that you can -- but you've got
7 to create, obviously, measures that are
8 meaningful, you know, with a low volume,
9 everything. I think the pay for performance
10 should be at a different level.

11 I think tying all of the quality
12 measures to money is not necessarily going to
13 change behavior. And, as a matter of fact, I
14 mean, there's science out there looking at this,
15 lots of it, and it says this is a bad idea. I
16 don't know why U.S. businesses and U.S. -- you
17 know, why we keep looking to try to do this, but
18 it doesn't work.

19 Does everybody know the day care
20 situation that I referred to? Okay. Well, assume
21 somebody doesn't. Very quickly, they had a day
22 care, parents were showing up late to pick their

1 kids up. They decided okay, the day care said
2 this is a problem, we need to prevent this from
3 happening, so we're going to charge parents an
4 extra \$25 if they pick their kids up late. So,
5 they said this should solve the problem. Parents
6 don't want to have to pay that. So, they did it,
7 and actually the rate went up. Okay, and then
8 they said oh, geez, that didn't work. Let's get
9 rid of it, and the rate went up even higher. And
10 if you look at it, basically parents were saying
11 you know what 25 bucks for an extra hour at work,
12 it's worth it. I'm going to stay. And then when
13 they took the penalty away parents were like hey,
14 you know what, now I don't have to pay the \$25. I
15 might as well just make it two hours.

16 So, I think -- that's a real world
17 situation. I think that we really need to think,
18 really think are we just going to try to use
19 money to change behavior? And I don't think
20 you're going to do that with physicians. It's
21 kind of what I do, I try to change behavior of
22 physicians. Money doesn't work. I think it does

1 work in systems, as I said before. So, anyway,
2 that's my two cents.

3 CO-CHAIR COURT: Okay. I think Bob was
4 next.

5 DR. RAUNER: I'm actually going to go
6 back to Bruce's question here, because that
7 essentially is how we formed. Although it says
8 ACO on my business card, we're not really an ACO,
9 if you consider ACO to be a big, vertically
10 integrated system. What we really are is a loose
11 federation of patient-centered medical homes with
12 a support structure that does IT and quality, and
13 other stuff. And it helps us band together and
14 negotiate as a group so we can get people like
15 Ken to listen to us. But that's essentially how
16 we formed. And we're not -- we're geographic --
17 along the I-80 corridor north and south, but we
18 hopscotch around because sometimes there's a
19 practice, frankly, I wouldn't want them part of
20 us because I think they suck. They're practicing
21 run up the bill medicine, and I don't want them
22 with us.

1 And then from a level of analysis, we
2 do need that pool because now as 12 we have, you
3 know, 14,000 Medicare patients. That's enough to
4 be a risk pool, actually. And then internally we
5 actually don't -- I -- we don't -- from my level
6 discriminate between the physicians. We leave
7 that up to the practice. They're a team. If they
8 ever got a bad actor in their shop, it's their
9 job to fix it. It's not our role to go in and say
10 you need to fire Dr. So and So. Because, frankly,
11 we don't -- I don't think -- like you said, I
12 don't think we need to give them money. If Dr. So
13 and So sucks compared to his peers, he's going to
14 fix it, or eventually he's going to get booted
15 off the island. I don't think we have to throw
16 dollars around to make him do that. If everybody
17 agrees that controlling blood pressure is a good
18 thing, and some guy has 70 percent, the other has
19 30, they're going to fix it, or eventually
20 they're going to kick him out, or -- I don't
21 think you have to pay him \$10 more than the other
22 guy.

1 Now, eventually, what's going to get
2 awkward in our ACO is we do have written in so
3 that if we do get a bonus and it gets
4 distributed, there will be some quality criteria.
5 And that's when the rubber is going to -- things
6 can get ugly, you know, if this clinic misses out
7 on 100 grand and so and so drug them down. It's
8 not my problem, it's the clinic's problem. And
9 it's going to be funny to see -- not funny, but
10 it will be weird to see how that happens. But I'm
11 actually totally for this loose affiliation of
12 medical homes approach because it's working well
13 for us, at least so far, anyway.

14 CO-CHAIR COURT: It sounds, though,
15 that --

16 DR. RAUNER: And it ends that way, too,
17 I think.

18 CO-CHAIR COURT: -- an important part
19 of that design would be it's the provider's
20 choice to either do that or not do it with the
21 groups they're interested in being affiliated
22 with. Is that --

1 DR. RAUNER: That's good, because if
2 some people don't want to change, fine. But
3 they're going to make less, if they're okay with
4 that. And if patients want to keep going to those
5 guys or gals who have crummy results, well,
6 that's their choice. It's a free country.

7 CO-CHAIR COURT: So, we're going to do
8 Mike, and then Greg, and then come over to John.

9 DR. BAER: Yes, you answered some --

10 DR. RAUNER: Sorry, I didn't mean to --

11
12 DR. BAER: No, no, not you. I think --

13 DR. RAUNER: The comment about getting
14 you to listen.

15 DR. BAER: Oh, no, I wasn't listening
16 to you. What did he say? No, what I wanted to
17 say, I really like Bruce's idea of affiliations.
18 I wouldn't -- but I would couch it in the sense
19 that, you know, if those practices who otherwise
20 would not qualify would only be in the pool to
21 affiliate, meaning, you know, you have an ACO
22 here. They're already affiliated. They don't need

1 to be in that pool, but as a payer right now --
2 and just to let you know, we're a small payer in
3 a large pool of payers in Pennsylvania.

4 But one of the things that we struggle
5 with are those practices -- let's just say, in
6 Pennsylvania, you know, we have a big pot of
7 members who qualify for Medicaid, and they're cut
8 up amongst nine different managed care
9 organizations. I am one of those managed care
10 organizations, so we have practices who are --
11 whether they're a PCMH, or whether they're just
12 a solo practitioner in rural Pennsylvania, they
13 don't want to affiliate with an ACO, or
14 Geisinger, or UPMC, some of the gorillas in
15 Pennsylvania. They want to stay local, and they
16 want to stay independent, so this would really be
17 good for them.

18 And I agree -- your comment about what
19 do you do after you get the money? I think it
20 would have to be an aggregate analysis, but then
21 have the ability to have group level or provider
22 level results so it can be distributed, however

1 that loose affiliation would like to do it.

2 CO-CHAIR COURT: Okay, Greg.

3 DR. IRVINE: I want to agree with what
4 Guy said, number one, is that physicians are
5 poorly motivated by financial reward. They'll
6 take an hour of free time over 200 bucks any
7 time. And we've had great trouble in our
8 organization motivating people with money, but
9 they're very easily motivated with extra time. If
10 they can have time with their family, that's
11 extremely valuable.

12 CO-CHAIR COURT: So, how would you
13 build that into a P4P program?

14 DR. IRVINE: I don't know, give them
15 hours. I honestly don't know. I think it's very
16 difficult to do P4P. I'm part of a big vertically
17 integrated group at what I would call an evolving
18 ACO. We're not really an ACO either, but we're
19 trying to be, that is dominated by the largest
20 health care system in the State of Idaho, and
21 with delusions of grandeur. But they don't get
22 rural health care, and I think that's where I got

1 into it with Tim earlier, was the one reason we
2 don't have electronic medical records on our
3 inpatient side is the hospital -- you know, we're
4 kind of out there somewhere and they'll get it to
5 us eventually, but not right now. Whereas, your
6 cooperative clearly, you know, takes care of the
7 rural health care. We're kind of -- we're at the
8 back of the pig, as they say in Nebraska.

9 And I think we have to be careful if
10 you look at large vertically integrated groups
11 that happen to have sort of tag along rural
12 health care providers incenting the big groups
13 thinking you're going to get everybody because
14 the rural providers are, as I said, often left at
15 the back of the pig.

16 CO-CHAIR COURT: Okay, John, and then
17 Tim, and Jason. Your microphone.

18 MR. GALE: Thank you. I tend to be a
19 little nervous about the collaborations, not
20 because they're bad things, but because I think
21 we have to understand what we're trying to
22 accomplish with pay for performance. If one

1 appropriate goal is to have enough transparency
2 that an individual and a patient can make a
3 decision about where they're going to go for
4 their health care, aggregating up to a bigger
5 unit doesn't really allow you to do that well.

6 And the second is that how a practice
7 or a hospital decides how to award its money
8 internally, that its own decision, but it's not
9 really, I think, the point of pay for
10 performance. I tend to default towards sort of
11 the smallest unit of analysis that allows the
12 entity that's under study to be treated as a
13 team. So, to what extent does the practice allow
14 -- does monitoring the performance, rewarding
15 payment affect the direct delivery of care? So, I
16 do understand the value of the collaborations
17 because you can develop resources to monitor and
18 track performance. You can set some established
19 policies, but it sort of blurs things for me.

20 CO-CHAIR COURT: Tim.

21 MR. SIZE: I want to go back to Guy and
22 Greg who have been disagreeing a lot because I

1 want to strongly agree with 90 percent of what
2 they said. Where I disagree, if they're right
3 about this economic incentive doesn't matter to
4 physicians, we're overpaying an awful lot of
5 orthopedists and other doctors, so I would need
6 more conversation around that hypothesis.

7 Having said that, the rest of what
8 they said I think they understated it. I think
9 using -- solving the low volume problem by
10 requiring aggregation would be a disaster in
11 every sense of the word. I can't think of a worse
12 idea.

13 I think where we're seeing some really
14 good growth with the rural ACOs because it's a
15 voluntary coming together. But if we solved the
16 problem -- well, you guys are going to have to
17 pick somebody or we're going to force you into a
18 clump because that's the only way we can deal
19 with low volume. I mean, that would -- I wouldn't
20 want to imagine how nasty that would get. And I
21 don't think we get the best out of people when we
22 force them into unnatural relationships.

1 Having said that, one more point. I'm
2 not speaking for -- I'm not speaking against
3 mandating participation, because at my University
4 of Chicago Business School, I believe in buyers
5 and sellers. And if the buyers these days,
6 whether they be CMS, or Anthem, whatever saying
7 look, as part of this deal you're going to show
8 me you're doing X; well, the only appropriate
9 response is to exit the market, or to do a deal.
10 So, I'm not arguing against mandatory, but I'm
11 arguing it would be a disaster to the whole
12 outcome metrics process metrics movement that
13 we're all part of to use it as a way to other
14 means of consolidation. There would be a
15 rebellion.

16 CO-CHAIR COURT: Okay. Jason over here,
17 and then I think Bruce is next.

18 MR. LANDERS: I'm a payer, too. So
19 preface by saying that up front. But one of the
20 things that we deal with, and we have a PCMH
21 project, as well. Up until recently that was
22 really my main function in life.

1 CO-CHAIR COURT: Bruce, can you speak
2 more into your microphone?

3 MR. LANDERS: Yes, I'm sorry.

4 CO-CHAIR COURT: Thank you.

5 MR. LANDERS: I had a -- we -- Highmark
6 had a PCMH project that we were -- that I was
7 largely responsible for until very recently. But
8 one of the things that is curious about West
9 Virginia is that there are only a few large
10 groups, and even fewer systems, so it is a
11 collection of these I'll call them onesie-
12 twosies, momsie-popsies. So, we were kind of
13 confronted with how do we report data out?

14 We came to two conclusions, and one is
15 that it -- looking at cost and utilization
16 reporting only works if you aggregate. There is
17 no other way around it. Now, how do you
18 aggregate? Exactly what you guys have been
19 saying, you'll either come together, or we'll
20 force you together. And I can tell you that, as
21 you said, people don't like that. It never works,
22 and it doesn't work for a variety of reasons.

1 One, if you force people together, that doesn't
2 mean they collaborate. And really that's what you
3 need, is to be able to collaborate.

4 So, one way that we found that
5 actually works to help them learn to collaborate
6 is to, in that forced union of practices to
7 create a data sharing or transparency among that
8 group. And even if they are somewhat different in
9 their practice styles, and the way they do it,
10 they actually have to see it. They have to see
11 how the other guy does it, and then it
12 essentially is up to them how they allocate their
13 group's resources in terms of incentives or
14 whatever based on their outcomes of their group.
15 So, they tend to learn to collaborate almost in
16 that sense. It works only marginally better than
17 not.

18 Now, on the quality side, we tend to
19 report out at the lowest common level. I believe
20 you should always report at the lowest common
21 level, and then group those on the lowest common
22 grouping; meaning, if it's a practice of five

1 doctors, well, they can affect each other in
2 terms of their quality outcome, so you would
3 report to them, but providing them with the
4 individual data.

5 And that was kind of a question I had.
6 When you say is the lowest level in the provider
7 level, are you talking a person or an entity? I
8 think of a provider as a person, as opposed to an
9 entity, but in many cases entity reporting makes
10 a lot of sense if they're integrated.

11 I think I'm echoing what was said, is
12 that you -- what we've seen on the payer side is
13 that there is this -- some things you can't do
14 without aggregation. It makes no sense in the
15 other situation, you have to have 5,000 members
16 or 25 -- whatever the magic number is, depending
17 on who your actuary is. But in other things like
18 certain quality aspects, you can have a much
19 lower standard because really you're measuring
20 the direction of the practice, as opposed to kind
21 of that larger system entity. So, I'm not sure I
22 said anything new, but I was kind of echoing.

1 CO-CHAIR COURT: Okay. So, we'll do
2 Bruce, and then Jason.

3 DR. LANDON: So, I want to push back on
4 a couple of points, but really by making --

5 CO-CHAIR COURT: Up to your mic,
6 please.

7 DR. LANDON: I want to push back on a
8 couple of points, but really by making sort of
9 more of an overall argument. So, the first
10 question is, it's -- so, we can throw our hands
11 up and say, you know, the volumes are too small,
12 they're too disaggregated, they don't have their
13 systems. Let's just exclude them from everything.
14 I actually don't think that that's in our
15 mandate. So, if that's not in our mandate, then
16 as I said before, we have a relatively limited
17 number of options that we can choose from;
18 actually, do measurement. That's sort of
19 statistically meaningful, you know, valid and
20 rigorous. And for me, choosing the -- you know,
21 what I'm sort of starting to advocate for, which
22 is aggregating across provider groups, to me just

1 seems like a better solution than measuring over
2 three or five years, or taking very disparate
3 quality measures and just adding them all up. And
4 we can talk about some of the statistical issues
5 involved in that, and Steven can probably do a
6 better job than I can do, but I know having done
7 this in a lot of recerts that I don't think it
8 works very well. So, again, so we have to
9 remember we're not debating throwing our hands up
10 versus one of these choices. We sort of have to
11 make a reasonable choice. That's issue number
12 one.

13 Issue number two is, I think when we
14 think about sort of quality measurement,
15 reporting pay for performance, just sort of like
16 what I think of as low impact and high impact
17 uses. So, a high impact use would be pay for
18 performance where you've got money on the line,
19 would be public reporting. And I think that it's
20 paramount that we recommend that measures do have
21 statistically valid, defensible, adequate sample
22 sizes and all that, if you're going to do that

1 sort of high impact stuff.

2 Now, if you're doing internal data
3 sharing and using it for quality improvement
4 purposes, i.e., within, you know, an aggregated
5 unit, I am all for disseminating those data at
6 the smallest unit possible. And even if, you
7 know, your sample was only three, but you didn't
8 do it on two, there's some actionable information
9 there.

10 And then some made the argument, you
11 know, when you put people together all that's
12 going to happen is you're going to regress to the
13 mean because no one is going to work together.
14 And I think, you know, that's a concern but, you
15 know, if you sort of build the incentives the
16 right way, the other thing that could actually
17 happen is that, in fact, they start working
18 together. So, the aggregate data come back, and
19 people look at it, and then they actually look at
20 the individualized data. And they say, you know,
21 this practice over here -- and, also, we need to
22 start, you know, don't speak, this guy is bad.

1 They just don't have good systems, you know. This
2 practice over here isn't doing well. Let's see if
3 we can have him spend a day with our best guy
4 over here and learn what they're doing, or let's
5 see if we can have our central infrastructure
6 help them with developing their EMR better, doing
7 a better job on the registry, or developing a
8 system. And, you know, when you start putting a
9 little financial incentives in the pot, and if
10 they're groups that want to work together, you
11 could see some of that cross site sharing.

12 Now, I think I also heard a lot of
13 objections to say, you know, if we randomly just
14 throw people together, they're going to
15 completely object, and that won't work. So,
16 potentially, you know -- so, there's two
17 potential solutions to that. One is sort of, you
18 know, choose your own. The second one is, you
19 know, if you don't want to aggregate with anyone
20 and you want to be out, then you're just out. But
21 then they don't -- but that out has a penalty on
22 it, which is that if you're putting part of your

1 pay in pay for performance or part of it in some
2 sort of, you know, aggregate level thing, they
3 don't get to participate in it. And if there is
4 enough of a carrot there, then they'll work to
5 find their partners.

6 So, I think those are some of the
7 things that we need to be thinking about because,
8 again, you know, we don't have a huge menu of
9 options that we have to choose from. And if we
10 have to choose something, those are sort of the
11 three things I think that we need to sort of be
12 talking about. And, you know, we need to sort of
13 advocate for one of them at some point.

14 CO-CHAIR COURT: Jason, and then
15 Kimberly.

16 DR. KESSLER: To make what perhaps is
17 a sort of obvious statement, in looking for
18 solutions there is no one solution. And we're not
19 going to, you know, come to a consensus on one
20 brilliant idea that is going to, you know,
21 uniformly make fair, just, and accurate
22 measurement of rural health care. Wouldn't that

1 be nice? But to look at the problem, think if a
2 couple of things.

3 You know, Guy said a couple of times
4 that giving money to individuals for better
5 performance is not really a mechanism that works
6 very well. And he went on to say that it might
7 work more at a larger organizational level. And
8 don't know whether that's true or not. I haven't
9 seen any data, or have any experience on that,
10 but the first part of -- you know, that giving
11 money to individuals probably doesn't work very
12 well, I would definitely agree with.

13 I mean, I have my doubts about the
14 effectiveness of pay for performance as a
15 concept, anyway, in a health care that so
16 desperately needs to drive down the cost of
17 providing care to people. But that's not really,
18 I guess, our scope here, what we're charged with
19 trying to determine.

20 So, to address, I guess, the question
21 of the sort of levels of how we look at data to -
22 - and measure data to analyze performance, you

1 know, we've noticed that doctors, and nurses, and
2 providers tend to have some level of
3 competitiveness to them. That's the nature of the
4 profession, the types of people that take on
5 medical careers. So, to look at people at an
6 individual provider level may actually have some
7 wisdom to it, just for the sake of looking at
8 that.

9 The caveat to that is you have to have
10 -you know, if I'm going to say that you're in
11 the top 75th percentile of providers, it has to
12 be a valid comparison. You know, I have to
13 compare you to, you know, percentiles that are
14 actually relevant to you. But I guess my thought
15 then is that that would make sense than trying to
16 do a population measurement to respond to that
17 question.

18 CO-CHAIR COURT: Kimberly.

19 DR. RASK: I would really -- I just
20 want to sort of, I think, reiterate the point
21 that I think there would be a lot of value to
22 recommending mandatory reporting. I think in, you

1 know, all the years I've had working with our
2 critical access hospitals, as people have pointed
3 out, all rural areas are different. A lot of our
4 rural areas -- a lot of our critical access
5 hospitals, many of them, some of them are
6 probably going to end up being converted fairly
7 soon. And they are going from never having been
8 asked to do anything, never been required to do
9 it, and then now facing the IPPS expectations.
10 And I think there are real concerns about how
11 that transition is going to go well for them or
12 not.

13 You know, I see so much energy
14 expended by our hospital associations and by the
15 offices of rural health to get critical access
16 hospitals to voluntarily report something for the
17 activity of doing it. What if we -- I think it
18 would be a vast improvement to take that off the
19 table and say it's going to be mandatory
20 reporting. Let's figure out some core measures,
21 some optional measures, and it's pay for
22 reporting, just report. And then let the

1 competition, and then let the ongoing market
2 changes that are going on sort out. I bet, you
3 know, again, we're in a little bit different area
4 in North Carolina and Georgia. More of our
5 critical access hospitals, rural hospitals will
6 have the opportunity to become part of far flung
7 networks that will probably drive a lot of the
8 other change and integration, in which case they
9 may end up reporting under some of these other
10 entities. But simply mandatory reporting on some
11 measures for all critical access hospitals, all
12 rural providers I think could really jump the
13 whole field forward.

14 CO-CHAIR COURT: So, let's just --
15 let's segue then to -- so, we've been talking
16 about physician practices. Let's talk about level
17 of analysis for rural or critical access
18 hospitals. It seems obvious to me it's at the
19 hospital level. I mean, are there other options
20 that we should think about or suggest? Yes,
21 Marty.

22 MR. RICE: One of the things that we

1 haven't really discussed here, and as a nurse I
2 feel a little obligated to bring it up, is that
3 the true consumer of health care is a patient.
4 They purchase insurance, whether it's from
5 Medicare or whomever else, and what we're seeing
6 is -- and it's not going to happen in remote
7 areas where it's 200 miles to another health care
8 facility, but there's a tremendous amount of
9 bypass. And how do we meet -- you know, we -- I'm
10 hearing a lot about reimbursement of clinicians.
11 What do the patients need to know to make clear
12 decisions about their health care? And I think
13 that was the true reason why quality measurement
14 was put in place to begin with. So, you know,
15 what do the patients need to make a decision
16 where to go? I hate to kind of throw it in that
17 direction, but --

18 CO-CHAIR COURT: Well, I'll just have
19 some thoughts about that, because we deal with
20 this with the purchasers in our local community.
21 So, you know, some of them are moving towards
22 this pay for value, you know, high quality-low

1 cost. But two internists can't take care of the
2 entire city of Madison, so there's access issues,
3 you know. So, I think it's a great concept, but
4 being able to implement that in a way that -- and
5 those two internists already have a full
6 practice, they're not taking new patients. So, I
7 think the concept is right but fundamentally very
8 difficult to implement.

9 MR. RICE: But the patient has to be in
10 the mix. That's all I'm saying.

11 CO-CHAIR COURT: Yes. No, I agree. It
12 seems to me like -- I'm a big proponent of
13 individual physician public reporting because I
14 work with physicians a long time, and they're
15 competitive, and they will try and change a
16 result. And if the results are transparent,
17 they'll self-correct. I think once you get to
18 these penalty payment incentive, and I think we
19 should all be honest, it's going to be penalties.
20 You know, maybe that can be at the group level,
21 but physicians -- patients want physician-
22 specific results. And we've got research in

1 Wisconsin that proves that.

2 MR. RICE: But it's not just physician
3 level results, it's hospital level results.

4 CO-CHAIR COURT: Yes. No, exactly.

5 MR. RICE: It's how communities take
6 care -- because it's not just -- health care is
7 more than just medical care. It's joint care
8 between a community and the resources, and things
9 like that. So, I just throw it out there as kind
10 of -- to look at.

11 CO-CHAIR COURT: Other thoughts before
12 we move on? Bob, or Mike, sorry.

13 DR. BAER: The comment about physician
14 -- reporting data at the physician level, it's a
15 great idea, but I'm really concerned about
16 physician level attribution because one of the
17 concerns that -- one of the things that happens
18 in a claims-based reporting would be that who is
19 that patient really attributed -- all I care
20 about is I see a claim with a diagnosis code or,
21 you know, a CPT code with a patient's name on it,
22 and it meets the criteria for whatever, but it

1 doesn't mean that Dr. X took care of that
2 patient.

3 CO-CHAIR COURT: No, it has to be done
4 correctly.

5 DR. BAER: Okay.

6 CO-CHAIR COURT: Yes. And we've got a
7 system in Wisconsin that attributes patients to
8 primary care providers, and the providers do not
9 complain that those aren't my patients. So, it
10 can be done correctly, much better than how HEDIS
11 does it, where one CPT with one doc, it's your
12 patient. But there's ways to do it.

13 DR. BAER: We may need to talk because
14 I need to know how to do that.

15 CO-CHAIR COURT: Okay. I think Guy is
16 next.

17 DR. NUKI: So, I think I'm hearing that
18 there's three different levels. One of reporting,
19 the top is pay for performance where there's
20 money behind it. The next is public reporting,
21 and then the third is the individual provider.
22 And I'm talking about individuals, I think when I

1 say that, gets the data. So, if you do something
2 three times and get it wrong twice, to publicly
3 report that is stupid, but it's still information
4 that that provider can use, because it was really
5 interesting hearing what Marty said, because it
6 made me realize that we approach things from
7 different ways.

8 I wasn't thinking about the patients
9 making decisions about where to go to get their
10 care. I was thinking we do this so that the
11 system and the providers improve what they do. I
12 think both are important, but that was kind of
13 eye opening for me. So, I think, though, that
14 it's -- we can have non-statistically significant
15 data that goes to providers, and then we need
16 really good statistically important data that is
17 publicly reported, and then the pay for
18 performance. I still don't think individuals are
19 going to respond to the money, but I --

20 CO-CHAIR COURT: Okay. I think, I don't
21 know, Tonya. I'm not sure where we're at.

22 MS. BARTHOLOMEW: Thank you. Two quick

1 points. When we're talking about attribution of
2 patients, I'm going to say patient-centered
3 medical home one more time. There's a factor in
4 there that says that you attest to letting
5 patients choose their primary care provider, and
6 that you have agreements with specialists in
7 outlying hospitals and other facilities to
8 collaborate and provide that care coordination.
9 The model is already built. I think we're
10 reinventing the wheel here.

11 The second thing is, if we're going to
12 do away with pay for performance, I still have to
13 pay someone in my clinic to collect and report
14 data. How am I going to do that? My patient -- I
15 just said earlier on today my cost to take care
16 of a patient is \$132, and for Medicare under our
17 rural health clinic I was reimbursed \$78. I
18 cannot pay someone to collect and report data if
19 I don't have some sort of financial incentive to
20 do so. That's, you know -- I think what we're
21 going to come to is that, you know, small
22 individual independent practices are going to

1 have to be absorbed into some sort of an ACO
2 model.

3 CO-CHAIR COURT: Okay, Brock.

4 MR. SLABACH: Where to start? This --
5 first of all, when we talk about critical access
6 hospitals, I'll start on that first. I think we
7 need to broaden the discussion to make sure that
8 we include and make our report specific to small
9 PPS hospitals, as well, because a small volume
10 issue affects PPS hospitals just as much as it
11 does the critical access hospitals. So, I guess I
12 just want to have -- okay, Karen is shaking her
13 head, so that's good.

14 And I think a facility, whether CAH or
15 PPS should be able to select for -- if we come up
16 with an option, a menu option for small volume
17 measurement, that they should be able to select
18 that, at least the PPS hospitals.

19 Secondly, I do agree. I think the -- I
20 find myself agreeing with a number of points, and
21 some of them might be quite contradictory. And
22 that may, again, noting the complexity, but I

1 think that -- I know that there was a lot of
2 information I had on my clinics, and in my
3 hospital that I would never dream of putting out
4 public because, first of all, you have to have an
5 understanding of the information that you're
6 looking at. And, clearly, the issue is now how do
7 you use this internally for performance
8 improvement?

9 I think if there is some kind of them
10 rolling up, if you will, of the data into
11 something that could be meaningfully reported to
12 the public, I think that's incredibly powerful
13 because I think patients do need to know, to
14 Marty's point, what their providers -- how they
15 compare, how they're performing.

16 And then I'm less enamored with the
17 pay for performance because I think that there's
18 a lot of problems that could be held there. And
19 everybody -- all of my colleagues will find every
20 single flaw that will be problematic for their
21 reimbursement. And we'd be spending more time
22 talking about why they didn't get that extra bump

1 in this reimbursement than actually looking at
2 the reasons for why they should improve their
3 performance. I mean, it's -- so it becomes more
4 of an excuse making exercise than it is actually
5 a performance improvement exercise, just
6 possible.

7 And, thirdly, I will -- or fourthly,
8 I will point out that every state, all rural
9 states, 45 of them, have State Offices of Rural
10 Health. They have associated with them flex
11 programs, their Medicare Flexibility Program.
12 Those programs are set up to provide assistance
13 to critical access hospitals, and their related
14 clinics, and communities to be able to improve
15 performance. That's one of the important
16 characteristics of that.

17 I do know that the flex coordinators
18 get a certain set of data from the Federal Office
19 of Rural Health Policy through these MBQIP, as
20 we've used that before. And they actually target
21 resources, and they can use that data to target
22 resources to these facilities to help them

1 improve and initiate activities to make
2 improvement in certain areas.

3 And I think that if we did mandatory
4 reporting and we recommended coupling with that
5 targeting of assistance to those that need. In
6 other words, we're making this a robust set of
7 mandatory -- we have the mandatory, but they're
8 also recommending process issues, i.e., a MAP
9 process, or small volume providers, and technical
10 assistance for those that -- in terms of this
11 transition and adaptation to this new reporting
12 environment.

13 CO-CHAIR COURT: Ann, and then Tim.

14 MS. ABDELLA: I'm not sure where this
15 all fits into the conversation, but the idea that
16 we're going to have to make sure that people are
17 getting what they need, and managing them to
18 process an outcome. And if we're going to be so
19 data driven with all of this, I'm thinking to
20 myself what are the data sources that these
21 hospitals and these doctors are using? And it's
22 only the information that they have in front of

1 them from their electronic medical record, or
2 their paper charts, or whatever.

3 And I think in the new world order,
4 and the thing that is so helpful from a rural
5 perspective is having access to claims
6 information, because we deal with people here,
7 and we send them out into the world. And we don't
8 know what happens to them. So, if we're really
9 supposed to be managing them in a patient-
10 centered medical home environment, I think we
11 need to include something, if we're going to make
12 data so doggoned important and process and
13 outcome, then we have to be equipped with all of
14 the data to be able to do the job.

15 CO-CHAIR COURT: Okay. Tim, and then
16 Ira, but let's start thinking about appropriate
17 peer groups, too, as we suggest solutions. So,
18 Tim.

19 MR. SIZE: Yes. This is actually a
20 comment on context of our conversation, and I
21 apologize, I think it probably makes it more
22 complicated, but I wanted people to have the idea

1 in their head. And it started with Guy talking
2 about this hierarchy thing with pay for
3 performance on the top. There's actually a fourth
4 level above pay for performance. In that horizon
5 you understand what we're doing. Well, we are
6 concretely literally making recommendations into
7 CMS. Those recommendations have an impact far
8 beyond that, i.e., the commercial marketplace.
9 And we're already seeing in the commercial
10 marketplace in Wisconsin, I think we're far --
11 harbinger of a lot to come, that metrics being
12 used for purposes of steerage are simply not
13 contracting with a provider, which is more than a
14 percent or two that doesn't incentivize anybody.
15 It's either you're in the health plan or you're
16 out of the health plan. So, the metrics we're
17 talking about -- because I think we have to
18 anticipate whatever we recommend to Medicare, and
19 particularly if they actually read the report we
20 give them, will be eventually picked up by the
21 wider marketplace. So, the issues of the metrics
22 we're talking about being used for steerage

1 and/or simply not contracting is extremely
2 powerful, and I think will get people's
3 attention. It gives our work, I think, even more
4 responsibility.

5 CO-CHAIR MOSCOVICE: So, believe it or
6 not, I think we agree on most everything, but
7 there's one large issue we don't agree on. Call
8 it what you want, external use, generalizability,
9 external validity, but everything else in terms
10 of the value of the data for internal use, I
11 think a lot of people are saying the importance
12 of mandatory reporting, transparency, and so
13 forth. I think there's a lot of agreement here.

14 The one thing I don't think we're
15 agreeing on is sort of okay -- and let me add one
16 other comment before I move on, which is our
17 charge is what do we do about rural in the
18 context of pay for performance? So, that's not
19 going to go away. And I don't think -- I guess
20 one option to say well, rural shouldn't be in pay
21 for performance, but I think we'd have to think
22 real carefully about that before we went down

1 that path.

2 So, you know, maybe the best we're
3 going to be able to do in the generalizability
4 issue, or the external use, is to say there's a
5 couple of options here. And here are the pros and
6 cons. And in some ways Bruce is right, it's not
7 great but it's better than other options. In
8 other ways, though, what you're getting push back
9 from is saying it doesn't really fit in small
10 rural practices to start grouping them in any old
11 way.

12 And I think maybe that's the best we
13 could do, or maybe we can get some consensus as
14 we move through to tomorrow about how do we
15 grapple with the external use when you have a low
16 volume? But I think that's the main issue we're
17 not agreeing on. Most everything else I think we
18 really -- there's a lot of overlap in terms of
19 what people are saying, so I'd say stay positive
20 and just keep -- we'll be thinking about the
21 generalizability issue, or the external use issue
22 some more, but I think it's probably time to move

1 forward to one of the other areas in terms of
2 discussion.

3 CO-CHAIR COURT: Yes. So, let's talk
4 about peer groups. That was something that was a
5 theme in kind of our homework, and it's kind of
6 bubbled around without real explicit discussion
7 about it this morning. So, how would we suggest
8 peer groups get defined? Bob?

9 DR. RAUNER: I think I might be able to
10 segue into this one. Starting with the fact, I
11 agree 100 percent that we need public reporting
12 provided it's valid and agreed upon. So, I think
13 Brock could come up with good measures for his
14 folks, and if CMS would agree with him and pick
15 measures that Brock agrees with, because the
16 problem is, frankly, is that CMS picks what it
17 wants and they don't listen to us a lot of times.
18 And they judge us on the stuff that I think are
19 frankly stupid. So, like these 33 measures, it's
20 publicly out there. It shows how we did it, it
21 shows how Ann did it. I think it's great that
22 it's out there, except that some of these are

1 stupid measures. So, they should pick measures we
2 all agree on that are good measures, like blood
3 pressure control or med rec, for example. We
4 agree on that, that should be out there, and I
5 think it should be public, and down to the level
6 that's statistically valid. So, on the ACO level
7 it might be good, great, put it out there. If
8 it's on the clinic level and it's valid, great,
9 put it out. If it's on the physician level and
10 it's statistically valid, put it out there. I
11 think it will drive a lot of great change
12 provided the measure is appropriate and
13 statistically valid.

14 And the peers should be somewhat self-
15 defined. Like, Tim, I'm more of a free market
16 guy. Let them freely associate and the ones who
17 don't want to associate, if they can't provide
18 good results, they should get paid less over time
19 so that the market will weed them out, and the
20 money should flow to people who do a good job.
21 That's the way it should work, so I really am
22 against, like Guy has been saying -- I think read

1 Dan Pink's book about motivation. It's like a
2 mindset changing book.

3 That granular level of pay for
4 performance I think does provide bad things, but
5 in a group, larger level it's good, frankly, just
6 so it weeds out the people that aren't any good.

7 CO-CHAIR COURT: So, Bob, how should we
8 counsel CMS that -- how would we get to a set of
9 measures that we agree to? I mean, what process
10 should be used?

11 DR. RAUNER: I think it's going to --

12 CO-CHAIR COURT: It, obviously, can't
13 be --

14 DR. RAUNER: -- be a collaborative
15 approach where -- what often happens is it gets
16 defined for the most common group, which tends to
17 be urban large systems and everything is designed
18 around urban large systems. And it then doesn't
19 apply to Brock's group or my group because they
20 defined it to what works where they are in D.C.,
21 which doesn't fit in Montana, or Idaho, or
22 Nebraska. So, again, it has to be collaborative.

1 Just like actually go back to Tonya,
2 the attribution is a huge problem. Well, why
3 don't we develop a system where patients self-
4 attribute? Then all the problems get solved,
5 actually. We actually have a problem in Nebraska
6 where none of our plans can capture that, so what
7 they're using is claims-based attributions which
8 are all fundamentally flawed for the most -- many
9 reasons. If they would just let Tonya Bartholomew
10 say that Dr. Jim Miller is my doctor, and that's
11 how attribution works, it fixes a lot of these
12 attributions. But, literally, the plans, many of
13 them can't do that right now, so we get stuck
14 with these either prospective or retroactive
15 attribution models which are really screwy. So,
16 what you lead to is what I consider the poster
17 child of bad public reporting, that's United
18 Health Care's Physician Designation right now.
19 It's invalid because sometimes a sample size is
20 10, sometimes the attribution is who knows what,
21 because we would get these reports, and I
22 actually talked to a doctor who was really upset.

1 She's a new OB/GYN who got "bad doctor" award.
2 She's the new doc in town, so none of these
3 people -- they're all brand new to her so, of
4 course, they look bad. The attribution is based
5 on like 10 patients, some of which she's never
6 seen. It's horrible, and she's getting stuck and
7 told she's a bad doctor out of this really crappy
8 designation. So, there's a lot of push back to
9 public reporting because it's been so -- done so
10 badly in certain cases. But I think we have the
11 way to go.

12 I think Brock can tell you what -- he
13 could probably write on the back of an envelope
14 10 measures that are good, and if CMS would use
15 them and he'd okay it with his buddy, Tim, and
16 everybody else, there we go. We don't need --

17 sorry, I don't know. Maybe I'm going too far off
18 on this, but --

19 (Off microphone comment)

20 DR. RAUNER: I haven't had any beer
21 yet.

22 CO-CHAIR COURT: I don't think we can

1 remedy that here, but maybe later. What about
2 peer groups for hospitals? So, there was some
3 discussion about there's critical access, but
4 there's low volume PPS hospitals that have the
5 exact same challenge, the exact same environment,
6 but they've got more than 25 beds. So, should we
7 encourage CMS to look at a peer group of small
8 hospitals? We've got to define what that would
9 be, and what would that be? Tim, I knew you'd
10 have a comment here.

11 MR. SIZE: I mean, yes. I mean, in the
12 co-op, and we have a bunch of both. I mean, I
13 just don't think -- we're going to work on
14 quality issues together as we do then with the
15 hospital association. I mean, the tweeners and
16 the CAHs, I mean, they both have low volume.

17 I just wanted to introduce actually a
18 second concept I hadn't heard yet. It's peer
19 groups for what purpose? I mean, I think people
20 really like to benchmark off people who are in
21 similar situations, so I think certainly in the
22 quality improvement world that you really need

1 that. But if you're talking about from the
2 patient's perspective, if people don't go to a
3 critical access hospital in Sauk County, or Iowa
4 County, or whatever, they don't go to the next
5 critical access. They go into Madison, and the
6 same for LaCrosse. So, in fact, I think we are
7 talking about multiple care groups for different
8 purposes.

9 CO-CHAIR COURT: Ira.

10 CO-CHAIR MOSCOVICE: Yes, just in
11 response to what you were just saying. I assume
12 we're talking about peer grouping for quality
13 improvement. That's been our main focus. We can
14 go in that other area if we want to.

15 MR. SIZE: But let me just -- I'm going
16 to -- I thought we're making recommendations --

17 CO-CHAIR MOSCOVICE: No, we are.

18 MR. SIZE: -- to Medicare that go well
19 beyond quality improvement.

20 CO-CHAIR MOSCOVICE: Absolutely. But I
21 think the way at least it's been laid out up to
22 now, thinking about it in that context. If we

1 want to move to others, that's fine. But now you
2 can think about your friends, the DRGs, I mean,
3 the way they came up with peer groupings was
4 statistically to look at what kinds of conditions
5 are coming in, and what are the other factors,
6 whether it's comorbidities or other things that
7 we can say we can clump patients together and say
8 that's a grouping.

9 You know, what we've done on something
10 called the Flex Monitoring Team, my counterparts
11 on the financial side have basically, they work
12 with an expert group, but what they found were
13 CAHs with attached nursing homes and above or
14 below a certain revenue level, i.e., scale, guess
15 what? Those were more similar peer groups to be
16 looking at.

17 And I think on the quality side, we're
18 about -- it's not a trivial thing just for us to
19 come up and say what other peer groupings. We
20 could probably talk about what factors we think
21 influence them, but we're about to start a
22 project which is going to try to do that on the

1 quality side. But I think it's really important
2 because not all -- when we get down to critical
3 access hospitals at a small level, not all
4 critical access hospitals are the same. So, it
5 would be good discussions, so what do we think
6 are the key factors that distinguish one subgroup
7 from another subgroup, or on the clinic side,
8 same kind of thing.

9 CO-CHAIR COURT: Okay, and that creates
10 some good framework. The way I'd like to see peer
11 groups used is -- because, I mean, P4P is going
12 to come, so when you're compared to a group to
13 decide if you're statistically the same, better,
14 or worse, it's a group that's similar to you. So,
15 you could think about do you do surgery, do you
16 do births? And case mix I'm not a big fan of, but
17 what other attributes of what would make one
18 critical access hospital different from another
19 one or small volume? I mean, what are the things
20 they do that make them different? Yeah?

21 MR. SLABACH: Well, I think you hit the
22 nail on the head. I mean, it's basically by

1 service lines is how I would define it. And I
2 think it's already been said, so I'll just repeat
3 it, that you have core services, and then you
4 have menu of options based on your service
5 offerings beyond that. And I think that would be
6 easily achieved. I mean, to Bob's point, I mean,
7 it wouldn't take a long time, but I think that
8 over time I think we have several issues. One, if
9 we had a MAP process say for small volume
10 providers of all types, then you would have a
11 system for retiring measures because that's
12 another huge issue, is making sure that we're
13 making them relevant so that we're not topping
14 out, and everybody is measuring things that
15 everybody has done well on.

16 Secondly, introducing new measures
17 that are going to keep us current. And then
18 thirdly, importantly, looking forward to what are
19 the things that we should be projecting? And I
20 think population health sorts of considerations
21 are where I put in that, as well. So, those three
22 areas is what I would emphasize through a

1 process.

2 CO-CHAIR COURT: Other thoughts on peer
3 groups? Yes, John.

4 MR. GALE: One of the issues I think is
5 important to look at, and I agree with all that's
6 been said about the characteristics of the
7 service lines. But in the absence of mandatory
8 reporting comparisons, we do have to be somewhat
9 sensitive to bringing people along, I think,
10 somewhat more gradually. So, for rural health
11 clinics I really don't believe there's any
12 difference in primary care if you're an FQHC, an
13 RAC, private practice. To say otherwise, it just
14 ain't so.

15 But if you're going to get the clinics
16 to participate, and there are roughly 4,000 of
17 them, they're nervous enough about it. They don't
18 have to do it, so to the extent that you maybe
19 phase that reporting initially doing peer
20 grouping among real health stratified by size,
21 service line, number of providers, and then maybe
22 move toward a more transparent reporting across

1 provider types so that people can actually make
2 that decision about where to go.

3 CO-CHAIR COURT: So, is that an
4 important principle that we want to put forward,
5 that mandatory reporting and all of this isn't
6 one step. It's got to be a phased approach. I
7 mean, the hospitals went through that. Yes? I
8 think, Jason, you're next.

9 MR. LANDERS: I have a question.
10 Service line is important, but what about like a
11 catchment, a filtering up group, because service
12 line is important, but that tertiary or
13 quaternary facility is also part of that maybe
14 non-formal, but a real system. And it -- I would
15 think that in some ways a real catchment feeder
16 system is probably a good peer group to report on
17 because they're funneling in the same direction
18 maybe. And I'm asking that as a question, is
19 catchment worthwhile to think about?

20 MR. SLABACH: Let me translate that so
21 I can maybe understand in my vernacular what
22 you're saying. Are you talking about transitions

1 of care?

2 MR. LANDERS: Yes.

3 MR. SLABACH: Yes, okay. So, I agree,
4 I think hand-offs are hugely important in this,
5 and the measurements of how well those were done
6 are very important. And not just on the
7 transferring side, but also on the receiving
8 side. So, yes, I'd like to see that included in
9 our discussion here as far as measurement.

10 CO-CHAIR COURT: So, how would that
11 play out -- so, I think about we've got the
12 University of Wisconsin Tertiary Medical,
13 Academic Medical Center, and 30 miles away I've
14 got a critical access hospital, so that -- how
15 would you see that play out, Jason?

16 MR. LANDERS: Well, I'm assuming that
17 your University Tertiary is really the -- they're
18 receiving the non-critical access type of care
19 from that critical access. And I don't know that
20 there -- there's probably an industry term for
21 that; it escapes me. So, I'm making that
22 assumption that that's what you're talking about,

1 but what I'm talking about is all of the patients
2 in that -- catchment is probably an outdated
3 term.

4 CO-CHAIR COURT: Do you mean like a
5 geographic region, sort of?

6 MR. LANDERS: I mean, sort of. It's
7 more of a handoff referral transition of care. It
8 goes from me or that FQHC into a critical access
9 hospital, and then up to some parent facility.
10 That natural patient flow that kind of catches
11 all of the patient care in a region. It may not
12 necessarily be geographical in the traditional
13 sense, but I would think that they're all peers
14 and would have influence on the type of care that
15 each delivers at the next level below and the
16 next level up. So, that peer grouping of those
17 feeder systems, both up and down, is important,
18 and in my mind just as important as service line.
19 And I get service line. If you don't have a CT,
20 and that's not a good example, but --

21 (Off microphone comment)

22 MR. LANDERS: Right.

1 MR. SLABACH: So they have to then deal
2 with the contingencies of what would happen. And
3 I think that an evaluation of how effectively
4 they are transitioning care and making sure that
5 safety is paramount through the hand-offs and
6 measuring that is a very critical part of the
7 process.

8 MR. LANDERS: Right. And in terms of
9 quality, that's a big piece of that, that
10 transition of care both up and down, because it
11 flows back into the clinics.

12 MR. SLABACH: Right.

13 MR. LANDERS: And some systems are
14 really good at that.

15 CO-CHAIR COURT: Okay. Guy, and then
16 Bruce.

17 DR. NUKI: So, first off, if a critical
18 access hospital doesn't have a CT scanner, they
19 should get one. They're not that expensive. They
20 should go buy one. It's not okay in 2015 --

21 (Simultaneous speaking)

22 DR. NUKI: -- to not have one. So, as

1 I was thinking about it, I think service line is
2 very good, but there's also -- there's a very big
3 difference between a critical access hospital
4 that's located on the -- right next to the
5 entrance to a national park that's 35.1 miles
6 from a big tertiary care facility, and one that
7 is two hours away from a tertiary care facility
8 with no resources, and half the population lives
9 on the Passamaquoddy Indian Reservation. So,
10 those become very different, and so I'm wondering
11 -- and I don't know how to do this. Steven, help.
12 How do you look at the socioeconomic or
13 demographic to create peer groups, because I do
14 think that there's a difference there. I mean,
15 that's going to change the resources, and the
16 abilities, and the capability. You can't -- it's
17 easy to recruit to that hospital that's next to a
18 national park. It's not so easy to be in the
19 middle of nowhere.

20 CO-CHAIR COURT: So, that's a good
21 point, Guy. What -- when it comes to qualify
22 measures, what kinds of quality measures would

1 differ between those two critical access
2 situations?

3 DR. NUKI: I wouldn't change the
4 measures.

5 CO-CHAIR COURT: Okay.

6 DR. NUKI: But I think that the peer
7 group is what you're comparing yourself with.
8 Right? And I think that you should be able to say
9 look, against my peer group this is how I
10 compare, but you could also -- I mean, I don't
11 think it's wrong to compare against the larger
12 group, but I think you should have access to
13 that, you know, more specific peer group.

14 CO-CHAIR COURT: Okay.

15 DR. NUKI: Maybe. But once again, we
16 then start to water things down, so we have to be
17 careful. I mean, do we say OB, we have an
18 obstetrician, OB being delivered by family
19 practice? I mean, once -- if you make it too
20 micro, I think it will fall apart, but I don't
21 know exactly where you draw the line.

22 CO-CHAIR COURT: Bruce.

1 DR. LANDON: So, initially, one -- I'm
2 going to make two comments. The first one relates
3 to something that I heard like an hour ago, but
4 I'm not even sure there's -- so, it's very clear
5 that, you know, we need to have reporting at the
6 hospital level. And I think several people said,
7 you know, every hospital has to report.

8 I strongly believe that we cannot have
9 consequence -- when I say reporting, you know,
10 giving the data. I strongly believe that we
11 cannot have pay for performance or public
12 reporting at the individual hospital level across
13 the board because I think the statistical
14 properties just fall apart. I mean, if you've got
15 a 10-bed hospital that's seeing, you know, I
16 don't know, five patients with pneumonia over a
17 year, you just can't -- you know, you can't
18 report at the level of a hospital for that. I
19 mean, we -- that's just the reality.

20 And then a second issue related to
21 peer groups; so, the service line issue, that's
22 sort of -- I don't want to call it a cop-out, but

1 that's sort of like easy, like, you know, if
2 you're doing OB measures and a hospital doesn't
3 do any OB, then they get excluded from that. You
4 know, that doesn't seem like it's really rocket
5 science to me.

6 I think what is harder, though, is
7 this issue of capabilities within sort of a
8 service area or a service line. So, you know, so
9 maybe speaking to what Guy was just talking
10 about; so, not only are those two hospitals very
11 different in terms of their proximity to sort of
12 more tertiary medical care and the ability of
13 their patients to get there but, you know, some
14 are going to have MRIs, and some aren't. Maybe
15 all of them have CTs now, I don't know, but maybe
16 some have CTs and some don't. If you have an OR
17 versus if you don't, that's a big deal. If you
18 have an ICU versus not, so we might want to be
19 considering some of these sort of capabilities,
20 because certainly, you know, if you have someone
21 with a serious MI presenting to a hospital that
22 has no ICU, and no ORs, and no cardiologist,

1 that's very different than if you have somebody
2 presenting to a hospital that might be also
3 similarly kind of small, but much closer to a
4 tertiary center, or has some capabilities to do
5 some things. So, I think -- I just want to put
6 that on the table, and I don't know the answers
7 to any of that, but I think it's important.

8 CO-CHAIR COURT: I think, is it Susan?

9 MS. SAUNDERS: I think I just want to
10 kind of echo what Guy said. You know, when you
11 look at peer groups, and I think you have to
12 consider the service lines, but you also have to
13 consider some regionalization.

14 Jonathan mentioned earlier one of the,
15 you know, major health determinates is going to
16 be an individual zip code. And, you know, if you
17 -- as a clinician, I'm in Central Mississippi. If
18 you are comparing my outcomes to, you know, the
19 individual provider that's in, you know, the
20 northwest, and everyone -- you know, in my
21 perception, everyone out there is healthier than
22 what my population is, but you have to have some

1 generalizations, you know, towards the region in
2 order to keep these valid to where providers are
3 actually looking at them, and acting on them, and
4 they become meaningful.

5 The other thing kind of goes back to
6 a discussion we had earlier, but when we were
7 talking about pay for performance, you know,
8 providers, the clinicians, are the ones that are
9 driving the improvement, whether they're doing it
10 or not. There was a lot of discussion about, you
11 know, the fact that more money is not going to
12 change their behavior.

13 The other thing that I think we have
14 to consider is that more and more clinicians are
15 hospital-employed, so we're actually paying money
16 back into the hospital system, you know, and then
17 asking the provider to make changes in their
18 practice. I mean, the two are not meeting in the
19 middle at all.

20 CO-CHAIR COURT: Aaron.

21 DR. GARMAN: I guess this is somewhat
22 of a point of confusion, but my critical access

1 hospital doesn't have a surgical program, but we
2 have surgeons that come and provide that service.
3 So, what's our peer group, because we have two
4 hospitals, two tertiary care centers that bring
5 up surgeons to provide that service on different
6 days, with different staff. So, how are -- we've
7 got a surgical program kind of, but it's not our
8 program, so how do we report that? What peer
9 group are we in? Are we lumped in with the
10 tertiary centers because it's their program, or
11 are we lumped in with who?

12 UNIDENTIFIED: I think it's you and
13 other hospitals with surgery.

14 CO-CHAIR COURT: Yes, I was thinking
15 other small volume hospitals that do surgery.

16 DR. GARMAN: That have their own
17 surgeons, even though we don't control the
18 program?

19 CO-CHAIR COURT: Well, I'd say if you
20 let them do surgery there, you do somewhat
21 control the program, or you have influence over
22 it, or the outcomes of those patients.

1 DR. GARMAN: But I don't have any of
2 the surgical staff. They bring up their staff.

3 CO-CHAIR COURT: Oh, and are the
4 patients being covered there?

5 DR. GARMAN: We have a room they
6 provide to them.

7 (Off microphone comment)

8 DR. GARMAN: Yes, that's what we do.

9 MR. SLABACH: Well, to clarify, these
10 are all outpatient procedures, I'm sure. Correct?

11 DR. GARMAN: No, because we will follow
12 those surgical cases. As a primary care doc,
13 we'll follow their -- like a gall bladder, those
14 kind of things, as an inpatient. I don't do the
15 surgery, but the surgeon will do that, and then
16 we'll follow them the next day.

17 DR. NUKI: He does the re-operation
18 when they have a complication --

19 CO-CHAIR COURT: And he gets dinged for
20 the readmission, too. Mike?

21 DR. BAER: I really don't know much
22 about critical access hospitals, but I was

1 wondering as a part of, you know, the peer group,
2 is there anything in the critical access or small
3 hospitals like a case mix? And could that be put
4 into the equation for peer group? I just don't
5 know that answer.

6 MR. SLABACH: The short answer is yes,
7 but as I think I mentioned this morning, because
8 of the poor coding in the critical access
9 hospitals, often it's understated, and so I guess
10 if it's all understated then it would be
11 equivalent, but you could get some potential
12 problems there. And as I think Kelly said, case
13 mix isn't really a good indicator for complexity.

14 CO-CHAIR COURT: Well, case mix might
15 be very different than the capabilities or
16 services. You know, I think we were closer -- at
17 least I liked, you know, talking about do you
18 have an OR, do you have an ICU, do you have a CT?
19 What's your access to specialists? So, perhaps it
20 would be some kind of survey that, you know, they
21 catalogued your capabilities, and then you are --
22 for the purposes of deciding are you, you know,

1 bad or good, are compared to other hospitals that
2 have similar capabilities. Steve?

3 DR. SCHMALTZ: One approach to looking
4 at this is, I'm hearing there's a lot of
5 characteristics you can use to define a critical
6 access hospital, is to use all those
7 characteristics and maybe some characteristics of
8 the population like percent Medicare, or percent
9 Medicaid. And you kind of come up with a group of
10 hospitals that are closest to the hospital that
11 you're comparing with. So, we might define maybe
12 the 20-25 CAHs that are closest to the one, and
13 that would be the peer group based on all those
14 characteristics you're interested in looking at.

15 CO-CHAIR COURT: Ann?

16 MS. ABDELLA: One thing that occurs to
17 me as we're sitting here is the dynamic nature in
18 many respects of our communities and the level of
19 service, and the affiliations that people have.
20 So, how would it work if I've got a hospital that
21 is maybe distressed right now, is on the brink of
22 closure or affiliation, and it's reinventing

1 itself, you know, adding services, deleting
2 services, or a year from now it may affiliate
3 with someone and have a completely different book
4 of business. How are we handling that currently
5 in the system, and how will we look to be able to
6 do honest measurement going forward?

7 CO-CHAIR COURT: Well, I think if we
8 had some kind of -- create a peer group based on
9 your attributes, that can't be a one-time where,
10 you know, what are my attributes? That would have
11 to be refreshed on a regular basis, because
12 you're right, it changes regularly, which is
13 good. I mean, because then they're meeting the
14 needs of the community. Tim?

15 MR. SIZE: Yes. I mean, I'll be honest,
16 and I don't really understand the conversation.
17 Now, maybe that -- you all have known that I
18 haven't understood the conversation, but I just
19 figured out that I don't understand.

20 CO-CHAIR COURT: Well, it wasn't by
21 design.

22 MR. SIZE: I just -- if we're supposed

1 to include a patient-centered approach, I'm
2 having real trouble having a very long list of
3 metrics that I would say that it would be
4 legitimate to look at the results by peer group.

5 The one actual exception is the one
6 which, I'm assuming is from our earlier
7 discussion this morning, has to do with peer
8 groups related to those serving a similar
9 population socio-demographically. Because I think
10 other than some of the pure procedures, I think
11 the ability of the patient population to comply
12 and participate in the treatment does affect
13 outcomes. And while not adjusting, it's a good
14 way to understand where there may be more need
15 for more intervention. If we're actually
16 comparing provider to provider, I think we need
17 to control for that. And I think that's at the
18 heart of the new National Quality Forum
19 direction.

20 So, I guess other than the socio-
21 demographic thing which is obvious to me that we
22 need to create peer groups around that, it's not

1 obvious to me why we're talking about peer
2 groups.

3 CO-CHAIR COURT: Well, I'll jump in
4 there because I'm also on a technical expert
5 panel with CMS that's looking at developing a
6 Five-Star rating for hospitals. So, all the
7 measures are going to be boiled up into one Five-
8 Star composite rating. And I have real concern
9 about that, and I think if you take all of the
10 measures for a UW tertiary medical center and
11 compare them to all the measures for Ashland
12 Medical Center, which is on a -- you know, a
13 Native American tribe in northern Wisconsin on
14 Lake Superior, it's not apples to apples.

15 MR. SIZE: Okay. So, then you're -- if
16 I understand what you just said, you say in the
17 context of having a conversation about aggregate
18 measures and you get into mix issue, then we have
19 peer groups. But for lots of other measures where
20 we're not talking about aggregation, I'm not so -
21 - you're not saying we need peer groups.

22 CO-CHAIR COURT: I don't know.

1 MR. SIZE: Okay. So, I mean, I think --
2 I mean, we start off this conversation saying
3 what do we want our peer groups to be? And I
4 think well, it depends in good measure on what
5 metric you're talking about. And in some metrics
6 I don't think there should be a peer group.

7 CO-CHAIR MOSCOVICE: But there are
8 other factors. We've heard throughout the day,
9 for instance, the scale of an organization
10 affects the ability --

11 MR. SIZE: For what?

12 CO-CHAIR MOSCOVICE: -- of that
13 organization to do certain things, and to perform
14 in certain ways. And so I think --

15 MR. SIZE: But if they --

16 CO-CHAIR MOSCOVICE: -- considering
17 taking scale into account, something we should
18 do.

19 MR. SIZE: So, it's okay people get bad
20 care and --

21 CO-CHAIR MOSCOVICE: I didn't say that.
22 We're talking about peer -- it's -- you may be

1 better off and it might make more sense to
2 compare smaller CAHs with smaller CAHs, and
3 larger CAHs with larger CAHs, because the smaller
4 ones are saying they don't have the same
5 capacity.

6 CO-CHAIR COURT: And I think it's more
7 true, Tim, of the outcome measures than the
8 process measures, because they tend to be --
9 well, they're just different. But should a
10 patient get an aspirin in the ED, that should be
11 the same regardless of your size.

12 MR. SIZE: But it's okay that smaller
13 facilities have worse outcomes than larger
14 facilities?

15 CO-CHAIR COURT: No, didn't say that.

16 MR. SIZE: Then how do we justify
17 having peer groups that --

18 CO-CHAIR COURT: Well, actually, CDC --
19 the infection measures are created by peer
20 groups, and so they're adjusted. Greg?

21 DR. IRVINE: I have patients tell me on
22 a regular basis they'd rather die than go to

1 Boise. That's the ultimate bad outcome. And
2 that's the honest to God truth. I'm told that
3 almost weekly.

4 (Off microphone comment)

5 DR. IRVINE: Well, that's other people,
6 yes. There's a song about that, actually, rather
7 die than go to Boise. But these are folks when -
8 I think, you know, rural hospitals near Madison,
9 Wisconsin, 30 miles down the road are very
10 different than rural hospitals in the mountains
11 of Central Idaho, where we can't even fly people
12 out half the time because the weather has got us
13 socked in, or the roads are closed, or whatever.
14 We have to give care, and sometimes it's not the
15 same care they would get at the University of
16 Wisconsin. It's what we can give, and we do the
17 best with what we have and what we can do until
18 we can get them to a higher level of care
19 sometimes.

20 So, the answer is, we need to be
21 compared to our peers, because if you take raw
22 data and compare us with the University of

1 Wisconsin, we're going to flunk every time, I
2 guarantee it.

3 MR. SIZE: And there are hospitals all
4 over the state. And (b), I think we said earlier,
5 and I think it's important to remember, some of
6 this conversation we just haven't had time to
7 break it down, differs significantly if we're
8 talking a frontier application where -- versus
9 Wisconsin, which is pretty typically average in
10 terms of adjacent urbaness where people do have
11 choices, and it is a decision about can I get
12 care locally, or is worth my time to drive the
13 hour to get it somewhere else?

14 CO-CHAIR MOSCOVICE: Maybe that's one
15 of the characteristics of the peer group,
16 geographic isolation versus -- however we want to
17 characterize it. That's --

18 DR. IRVINE: Yes, and some of the
19 things that are being foisted on the small
20 hospitals in Wyoming and whatnot are creating
21 tremendous hardship for -- financially for the
22 hospital to survive. And if the hospital, which

1 was on the verge of shutting down four years ago
2 when I came there simply because they could not
3 generate the resources to keep it afloat. If they
4 shut down, I assure you that's not going -- you
5 know, somebody comes in with chest pain, they may
6 stop at the Rite-Aid and get aspirin but they're
7 not going to get an aspirin in the emergency room
8 because it's not there.

9 CO-CHAIR COURT: Okay. I'm going to
10 segue us into a slightly different -- make sure
11 we cover all the big areas. So, we talked about
12 alignment, and so FQHCs have their measures and
13 their program, and rural health clinics have
14 theirs, and the ACOs have theirs, and critical
15 access doesn't really have anything. PPS
16 hospitals have theirs, so if we were going to
17 advise CMS about alignment, what do we want to
18 tell them? I mean, how can -- what do we want to
19 see? Brock?

20 MR. SLABACH: If I understand the
21 concept correctly in terms of what we're wanting
22 to achieve, the biggest frustration that I have,

1 and I heard it throughout the conversation of our
2 members, is 30 or 40 different places that data
3 is reported for different things and for
4 different purposes. If there's any chance that
5 CMS would have influence on standardizing the
6 reporting process for a small facility, I think
7 they would have no trouble reporting if it was
8 one time in terms of the data collection is once,
9 and it's for multiple purposes.

10 CO-CHAIR COURT: Okay, that's a good
11 one. Ann? I think we're done.

12 MS. ABDELLA: To the point that I made
13 earlier, I think if there's the opportunity to
14 make them somehow complementary from the primary
15 care surgical and hospital measure, I think that
16 to the point of the -- you know, there's a core
17 measure, if there's a way to do some alignment
18 there. And then if there are optional measures
19 within a geography that seem to make sense, then
20 primary care should be complementary to what the
21 hospital is doing.

22 CO-CHAIR COURT: Yes, I would add what

1 we see is the hospitals are -- so you've got the
2 readmission focus, but there's nothing in the
3 ambulatory side to -- you know, so if you don't
4 employ the physicians, there's nothing on the
5 ambulatory side to get the physicians to be
6 paying attention to the readmissions. In fact,
7 sometimes it's easier for them if the patient
8 gets readmitted, so I think alignment across the
9 sectors. I think, also, there have been a lot of
10 projects, so there's been the Partnership for
11 Patients Project CMS, the big CMMI project,
12 there's the TCPI project, there's the QIOs have
13 their thing, the Office of Rural Health has their
14 thing, and they're not aligned. And they're not
15 necessarily aligned to improving the measures.
16 The PPS hospitals have gotten better, so
17 infections, readmissions are part of value-based
18 purchasing. Now, that was, you know, a big focus
19 in the Partnership for Patients, so the
20 improvement resources have to align to the
21 measures or you just start sending people in
22 multiple directions. Guy?

1 DR. NUKI: You said about 70 percent of
2 what I was going to say just then, but it's about
3 simplification. With all of these different
4 organizations, and abbreviations, and choices it
5 becomes almost impossible to figure out how --

6 what you really need to do. I spend half my time
7 arguing with the Quality Nurse Director about,
8 you know, whether the case is a fallout or not. I
9 mean, and these are supposed to be relatively
10 simple things, and sometimes things on the
11 surface appear simple, but when you put them into
12 practice they don't. So, we -- I think that
13 creating -- it's a little bit like what I think
14 the CIOs have been doing in trying to help some
15 of these rural hospitals, because there's not
16 someone who full time really understands this.
17 So, it's got to be -- that alignment needs to
18 also be easy to understand, and easy to process
19 through.

20 CO-CHAIR COURT: So, the support
21 resources have to align to the measurement
22 requirements. Is that how we would say that?

1 DR. NUKI: Yes. I think that there
2 needs to be support from CMS, or from all of
3 these different organizations that want data.
4 They all need to get together, agree, and be able
5 to put a -- you know, put it -- limit it to 10
6 pages. All of the recommendations need to be
7 written in 10 pages and given to the hospital,
8 something. I mean, it's a little ridiculous, but
9 I think you get my point about just needs to be
10 manageable by people who don't just do quality
11 measures.

12 CO-CHAIR COURT: I think -- and I'll --
13 you can tell I've got an opinion about this. It
14 doesn't seem to me like the different places this
15 is coming from within CMS talk to each other, you
16 know, so CMMI is over here giving money to do
17 things, and then there's the group that's
18 mandating measures, and not always even sure how
19 that all fits with the MAP and everything. So, it
20 doesn't feel like everybody is talking to each
21 other and knows what they're doing, so I think
22 there's got to be better coordination in

1 Washington of what all of this is, and
2 understanding the burden, the collective burden
3 that it creates, and it could be simplified.

4 DR. IRVINE: Where does HIPAA come in
5 with all of this? Because we've had some issues
6 at our facility with HIPAA investigations related
7 to transfers. CMS regulates HIPAA. Correct?

8 CO-CHAIR COURT: Are you talking about
9 EMTALA?

10 DR. IRVINE: Or, excuse me, EMTALA.

11 CO-CHAIR COURT: Yes, that's a totally
12 separate thing.

13 DR. IRVINE: That's totally separate.

14 CO-CHAIR COURT: And we're not talking
15 about conditions of participation. That's -- I'm
16 talking about measurement and improvement.

17 DR. IRVINE: That's it.

18 CO-CHAIR COURT: That's a different
19 thing.

20 DR. IRVINE: Okay, got it.

21 DR. NUKI: Did you just say
22 coordination in Washington?

1 CO-CHAIR COURT: I'll probably be
2 struck down at the airport tomorrow. Bruce?

3 DR. LANDON: So, I think there's no one
4 in this room that's not going to agree that
5 alignment isn't desirable. And this is something
6 we've been saying for, you know, 20 years of
7 quality data collection. From the hospital side,
8 you know, we can certainly -- and the other thing
9 about that is, you know, we can -- the government
10 -- at least we can suggest that they cooperate
11 together but, you know, the government actually -
12 - and we can't tell private plans what to do. We
13 can maybe make suggestions, and unfortunately a
14 lot of private plans, they distinguish themselves
15 by their quality problems, and they don't want to
16 align among themselves because that takes away
17 one of the reasons for them to be in existence.
18 But certainly, at the hospital side, you know, we
19 can ask all of the government agencies to get
20 together and actually have a core set because,
21 you know, I don't want it to differ from IHS, and
22 for HRSA, and certainly I would imagine that

1 Stephen's organization works pretty closely with
2 the CMS, so there's a good amount of overlap
3 there. And I think it might be easier to attain
4 more alignment on the hospital side.

5 I'm concerned about the physician side
6 because of this issue with sort of the competing
7 health plans on the market who end up not wanting
8 to collaborate sometimes.

9 CO-CHAIR COURT: So, we probably don't
10 have much influence over the commercial side, but
11 at least the things that CMS is funding,
12 regulating, could those be aligned? I think
13 that's what we have influence over. Stephen, and
14 then Sheila.

15 DR. SCHMALTZ: Bruce talked about
16 alignment efforts with CMS, and there's really
17 different types of alignment. If we're talking
18 about alignment of how the measure is defined, we
19 work closely with CMS. And I can tell you the
20 weekly meetings, the hours, and hours, and hours,
21 it's a very painful process, but when it comes
22 down to it, it's probably about one of the most

1 popular things we did with hospitals, being able
2 to align.

3 CO-CHAIR COURT: And we thank you.
4 Sheila?

5 DR. ROMAN: I was actually going to
6 make a similar comment that Steve just made,
7 having been involved in alignment. And I don't --
8 I think the committee may want to go so far as
9 to say, and I'll be curious if others agree with
10 me, that I don't think you can progress further
11 from pay for reporting to pay for performance if
12 your measures are not aligned.

13 CO-CHAIR COURT: Yes, well said.
14 Brock, and then Tonya. Oh, Tonya, then a break.

15 MS. BARTHOLOMEW: Just real quick, I
16 really want to reiterate what Guy said about the
17 support resources available. When I asked my
18 husband, who is a family physician, you know,
19 what from a clinician point of view do I need to
20 represent here at this meeting, and he said one
21 of the challenges that clinicians have, and I
22 think this would be from clinics clear to

1 hospitals, are the evidence-based guidelines. And
2 when those change, it changes your clinical
3 metrics. So, we need to take that into
4 consideration, I think, when -- for example, you
5 know, hypertension, that's a --

6 (Off microphone comment)

7 MS. BARTHOLOMEW: Yes, so how do we
8 keep up with the evidence-based guidelines, and
9 how do we use that in a longitudinal way to
10 measure improvement? Because what I was measuring
11 for hypertension is really kind of null and void
12 now because the guidelines have changed. So, I'm
13 not sure where that fits into the conversation,
14 but I think it's important.

15 CO-CHAIR COURT: So, maybe a principle
16 is that the measures have to keep up with the
17 clinical evidence. And then I think they have to
18 be cautious about trending over time when the
19 measure changes significantly, because then when
20 you've got the baseline from two years ago, and
21 it was a different measure, that doesn't work.
22 Okay, Bob?

1 DR. RAUNER: Kind of dovetailing off of
2 that, because the good thing at least in the
3 Medicare Shared Savings Program, they actually
4 did retire a couple of measures because of
5 recommendations around cholesterol, for example.
6 So, they did a good job there, but I don't think
7 they did it for all the other programs, too. So,
8 part of the challenge is Medicare's approval
9 cycle doesn't fit -- doesn't keep up with the
10 practice of medicine, which I think is what
11 drives some of the physicians, and nurses, and
12 everybody else crazy, is that it may take three
13 years to dump that thing off of there that's not
14 relevant any more.

15 And the other thing which I alluded to
16 earlier is that sometimes they take a measure and
17 totally apply it out of context, which is when I
18 said -- maybe I shouldn't have said stupid,
19 maybe, but there are some of these that are not
20 fit in the clinical context. They make sense from
21 a cubicle, but they don't make sense in real
22 life. So, partly evidence-based, but also that it

1 actually is clinically appropriate to use that
2 measure in that context.

3 CO-CHAIR COURT: So, how would we
4 advise them to improve?

5 DR. RAUNER: So, like when the lipid
6 panel one comes up, for example, if it changes,
7 everything gets changed, Meaningful Use, Medicare
8 Shared Savings, patients, they update them all
9 because once it's not valid it just has to be
10 dropped, and it can't take two to three years to
11 drop that one off of there. Or the blood pressure
12 where we now have two different levels based on
13 age, you've either got to adjust it pretty
14 quickly, or make it null for a year or two until
15 you can adapt it. And, of course, with the BMI,
16 they actually jumped from a very loose screening
17 tool, assuming it was diagnosis, then telling you
18 to counsel when you actually missed the middle
19 step, which is that literally you can have a BMI
20 of 31 and not be obese, so why should you be
21 counseling that person? So, I think -- I don't
22 know. Sheila, maybe you know in that regulatory

1 environment, it is hard to update things fast
2 enough to meet with the practice of medicine. And
3 then some it's just the eternal problem of policy
4 being too separated from practice, and that's I
5 think what happened with the BMI measure, for
6 example.

7 DR. ROMAN: I mean, I think it is
8 difficult because schedules are set so far in
9 advance. But I think that one can -- particularly
10 for pay for performance hold measures back. And,
11 you know, I think as you go from public
12 reporting, to pay for reporting, to pay for
13 performance, you know, you up the ante. And as
14 you up the ante, your measures have to be more
15 solid. And I think that's why you've seen
16 requirements for the value-based programs that
17 the measures be in use for a number of years, and
18 that doesn't address the issue of guideline
19 changes, which I think is a real issue that we
20 should make some comment on, and ask them to be
21 held back from pay for performance.

22 CO-CHAIR COURT: So, Karen, can you

1 help us understand how the measures get updated
2 when the guidelines change?

3 MS. JOHNSON: I can give you the NQF
4 perspective of it, and we might be able to get
5 Helen back a little bit later to talk a little
6 bit more about the CMS side, perhaps. But what we
7 do at NQF, at least for NQF-endorsed measures, so
8 part of it is schedule. Right?

9 The problem with developing measures
10 and changing measures is it takes a long time to
11 do. It's not something that people can do on a
12 dime. So, when the lipid guidelines changed and
13 the high blood pressure guidelines changed, we
14 knew that we would need to re-look at those
15 measures. Right? But we also knew that there's
16 controversy on the -- which ones? On the lipid
17 ones, so we wanted that to kind of settle out a
18 little bit before we asked the developers to come
19 in and bring in new measures. So, we purposely,
20 actually at NQF, pushed back consideration of the
21 lipid and high blood pressure measures about a
22 year to give the developers time to do what they

1 needed to do.

2 We just got through a couple of new
3 diabetes measures with different statin
4 guidelines, so those are working their way
5 through, but the CV ones are still a little bit
6 out. So, that doesn't talk about things going off
7 the P4P list. That's something else, and I
8 imagine it has to do with rules and stuff. But
9 that's at least from the NQF endorsement side of
10 things, it just -- it can't be done on a dime.

11 CO-CHAIR COURT: Okay. Ira, and then
12 let's do a break.

13 CO-CHAIR MOSCOVICE: I'll try to talk
14 real quick so we can get to the break. I would
15 just say the other side of the retirement issue
16 is CMS just with Hospital Compare continues to
17 retire measures, but quite frankly, in urban
18 areas there may not be, for instance, for some
19 measures that much room for improvement, but in
20 rural there still is. So, that takes -- and then
21 they introduce new measures that are not relevant
22 to rural, and you get a more modest set. So,

1 that's something we need to take care of.

2 I would just say, I hope the report
3 can say something like the quid pro quo for
4 mandatory reporting is that we get one set of
5 measures from the federal government. And just as
6 with the DRGs, if the feds really push in that
7 direction, guess what? The commercial side will,
8 also. So, I think that, hopefully, can be one
9 important bullet point, that really all -- the
10 feds -- CMS can only control federal programs,
11 but it is just not acceptable to have more than
12 one set of measures period.

13 And, quite frankly, what would be good
14 about that, if they actually moved in that
15 direction, is that maybe the urbans could be
16 learning from the rurals, because we'd be
17 starting this. And it's -- I think it would be a
18 terrific accomplishment if we can get them to
19 move in that direction, even if they go from --
20 we won't say this out in public, but if they go
21 from 20 measures to two measures, that's still a
22 terrific accomplishment. I say we go for one

1 measure, but you can't have multiple -- you can't
2 really have multiple sets. It's just -- it's not
3 going to work.

4 DR. BAER: Can I make one comment? I
5 know you want -- really fast. When we say the
6 feds and CMS, CMS governs directly Medicare,
7 Medicaid State plan, you know, it's a partnership
8 between states and the feds, so I would
9 strongly, as Bruce was mentioning, that it's not
10 just Medicare, but it needs to be Medicaid, too.
11 Okay.

12 CO-CHAIR COURT: Okay, 10-minute break?
13 Yes. Okay. So, back at 3:30.

14 (Whereupon, the above-entitled matter
15 went off the record at 3:16 p.m. and resumed at
16 3:33 p.m.)

17 CO-CHAIR MOSCOVICE: So, we're going to
18 get going, and we're going to spend the next
19 hour, instead of having breakout groups, we think
20 it might be better if we had the conversation
21 together, and particularly if we're looking at
22 crosscutting overtures, or opportunities between

1 the hospital and physician, and other context. It
2 would be good to have everybody hearing
3 discussion.

4 So, we've done a bit on potential
5 solutions. And one area that NQF is really
6 interested in is measurement gaps -- what are the
7 areas that we really don't have included up to
8 now, we don't know much about, that we've had
9 some suggestions, people have complained about
10 the existing ones. We can talk about ideas we
11 have for existing areas that haven't been used up
12 to now, but specifically where are the holes?
13 What are the areas that in the quality sphere
14 that we haven't really -- we're at least not
15 aware that there's much more work in. That would
16 really help.

17 There's going to be a section in the
18 report on that, and that would really help NQF in
19 terms of posturing for additional resources if we
20 feel these areas are important. So, why don't we
21 start with the hospital side, and we'll take
22 notes. And what's being passed around is about to

1 be passed around are -- not that you need to
2 memorize these -- but it's just lists of some of
3 the areas that are currently being used or looked
4 at in measurements, et cetera. So, it gives a
5 little bit of context.

6 But we're open for business on the
7 hospital side for measurement gaps, areas that
8 aren't currently being considered that we really
9 think NQF and others should be taking a look at.
10 Maybe you want a minute or two to look at the
11 sheet that went around so you can --

12 MS. JOHNSON: And just to orient you to
13 these papers that I sent out, these are just to
14 give you examples of some measures that we have
15 in different domains, if you like that term. So,
16 don't get caught in the weeds here. This is just
17 to give you an idea that -- and at least some
18 conditions. And in some cross-setting kinds of
19 ways, and some topics areas we do have measures.
20 Possibly one of the things to pay attention to
21 more is the domains, that first column there, and
22 what's missing there. And then maybe is there

1 things missing within? But, again, this is not
2 everything, this is just -- I just pulled a few
3 to give you the flavor of what's out there.

4 CO-CHAIR MOSCOVICE: Bob?

5 DR. RAUNER: Actually, I like this
6 hospital one because it's personally relevant to
7 us, and it's something that's really all over the
8 map right now, and that's timely transition of
9 transition record, that we have such a huge
10 problem, because some -- and, frankly, this is
11 actually you have more problem with the urban
12 folks. The urban folks don't send us anything
13 when our patients are there, and so we -- it's
14 hard to intervene and prevent a readmission if
15 they never tell us that the patient was ever
16 admitted, or even discharged or anything. So,
17 this is one of those integration crosscutting
18 things that it's really a big problem right now.
19 And there's places that are great about it, and
20 there's places that are horrible about it. It
21 affects a lot of problems, actually.

22 CO-CHAIR MOSCOVICE: Other comments?

1 Yes, Tonya.

2 MS. BARTHOLOMEW: Just piggybacking off
3 of Bob with that care coordination issue. Maybe a
4 solution we want to look at, which we use in our
5 clinic to find out, number one, if our patients
6 are at the hospital instead of on Facebook or at
7 the grocery store. And then also to get that
8 information back to us to use for follow-up, is
9 that we have made just a little simple one-page
10 contract with the facilities that we send to the
11 facility. It's more of an agreement, I guess. You
12 know, if my patient comes and declares me --

13 going back to attribution, as their primary care
14 provider, will you please forward these records.
15 You know, first of all, call me and have your
16 care coordinator call the clinic, and then also
17 to send those records once the patient is going
18 to be discharged.

19 It's been pretty useful. I'm a little
20 bit surprised. I was a little bit doubtful at
21 first. Actually, the hospitals in our area were
22 really responsive to it, and it's worked out

1 really well for us. Something like that a PCMH.

2 Yes, it's in the patient's new medical home

3 model.

4 DR. NUKI: This is more of just a
5 concept that we haven't brought up, but like the
6 thrombolytic therapy for stroke. I'm sorry, it's
7 controversial. I hate to tell the American Heart
8 Association, but there's still more studies that
9 show that it kills. It got stopped because it was
10 so negative than there are positive studies. But
11 one organization, the American Heart Association,
12 has managed to convince people that it's actually
13 the standard of care, when it really shouldn't
14 be. So, it's very difficult to see something like
15 this on a -- as a measure when it's really
16 controversial -- thrombolytic therapy in strokes.

17 (Off microphone comment)

18 DR. NUKI: So, the neurologist thinks
19 it's a great idea, and the emergency physicians
20 aren't convinced.

21 CO-CHAIR MOSCOVICE: Other comments?

22 Oh, Kelly has a comment.

1 CO-CHAIR COURT: And maybe this is too
2 broad, but I don't think we have enough -- there
3 are not enough measures on the hand-offs, so I
4 think someone said earlier, maybe Ann, triage. I
5 know there was like three things, and then
6 transfer was --

7 (Off microphone comment)

8 CO-CHAIR COURT: Yes. But I don't -- I
9 think we need measures of those hand-offs. So,
10 medication reconciliation is one. You know, I
11 think the -- Ira, your work on the ED transfers,
12 those measures are a lot of them and hard to
13 collect. But if the critical access hospitals
14 are, you know, doing the good work locally and
15 then transferring the patient to the
16 tertiary/secondary center, when appropriate, how
17 do we know that that goes smoothly, and that
18 everybody's got the information they need?

19 CO-CHAIR MOSCOVICE: There's a three-
20 item catch transition measure that Eric Coleman
21 developed from Colorado. Are people aware or
22 using any of that, which is a lot easier version

1 of --

2 (Off microphone comment)

3 CO-CHAIR MOSCOVICE: So, there's three
4 items that I -- Helen said they were incorporated
5 into HCAHPS, and I don't have the specific --

6 CO-CHAIR COURT: Yes, so that's the
7 CTM3. So, that's -- there's three questions on
8 the HCAHPS survey, was I involved in creating my
9 care plan? Did I understand what I need to do
10 when I went home? And then I can't remember the
11 third one. And then those get rolled up into one
12 composite measure. But I think that's from the
13 patient perspective, which is really --

14 CO-CHAIR MOSCOVICE: Exactly.

15 CO-CHAIR COURT: -- important.

16 (Off microphone comment)

17 CO-CHAIR MOSCOVICE: Are there other
18 areas related to care coordination hand-offs, et
19 cetera, et cetera, that we want to think about?
20 Guy, are you back up, or did you not take your -

21 (Off microphone comment)

22 CO-CHAIR MOSCOVICE: Okay. Bob, and

1 then I have Ann.

2 DR. RAUNER: This is just more of an
3 additional comment. I actually think of -- this
4 is one of the areas where there could be the most
5 good with the least number of measures, frankly,
6 because a lot of things that go wrong in medicine
7 happen during a hand-off, so whether it's med
8 rec, transfer note. And it applies to everybody,
9 clinic, rural, tertiary, nursing home SNF that I
10 think this could be one of the big things that
11 could come out of this group, is -- because it
12 does apply to all of us really, and that's where
13 a lot of the bad things happen in health care.

14 CO-CHAIR COURT: In the care
15 transitions work that's happened in the
16 Partnership for Patients, a common measure is did
17 the patient leave the hospital with a scheduled
18 appointment? That would apply to every single
19 patient. Nobody should leave the hospital without
20 a scheduled follow-up appointment. And ideally
21 within -- you know, not three weeks from now, but
22 -- because then you know that there's a follow-up

1 plan, and the follow-up plan at least is
2 initially, you know, hopefully in play. It
3 doesn't mean everybody is going to follow
4 through, but the first step has been taken.

5 DR. RAUNER: Sorry. A lot of those
6 readmissions happen, the follow-up appointment is
7 often made far beyond when all those bad things
8 happen, and so there's some timeliness factor
9 that probably needs to be added in there, because
10 our goal, we try to contact them within 48 hours
11 of discharge, but again we may not hear for three
12 weeks that they even were there. But there need -
13 - I think one of the things our clinics learn
14 most of all that our docs didn't even know at
15 first, is sometimes they themselves were making
16 follow-up appointments a month later when they
17 really needed to be one week or in four days. So,
18 we've learned over time to make that follow-up a
19 lot sooner than we used to just because of having
20 learned. So, I think part of that might be not
21 only that it's made but, of course, it's not
22 appropriate for everybody. Some people maybe a

1 month is good, but some people maybe it should
2 have been two days.

3 CO-CHAIR MOSCOVICE: Okay. I have Greg,
4 then Ann, then Tim.

5 DR. IRVINE: Yes, I think that
6 mandating time of a follow-up appointment is,
7 quite frankly, overly burdensome. And if I
8 discharge a hip fracture patient and they have
9 home health services, they have a nurse coming to
10 the house, they're getting physical therapy, I
11 may set that follow-up visit for a month later.
12 It depends on whether they're on anticoagulants.
13 There are a million things that go into my
14 decision as to when to see them back, and there's
15 no set, you know, time that they should
16 necessarily come back. So, mandating that is --
17 you know, interferes with my judgment as a
18 physician.

19 CO-CHAIR MOSCOVICE: Ann.

20 DR. IRVINE: You haven't heard that
21 before. Right?

22 CO-CHAIR COURT: No.

1 CO-CHAIR MOSCOVICE: The issue is
2 timing, obviously. I mean, saying you need one is
3 one thing, but what's the right time? Ann.

4 MS. ABDELLA: Well, so kind of counter
5 to that, our Clinical Integration Committee,
6 which is made up of specialists, MDs, SNF Medical
7 Directors, primary care physicians all came to
8 the conclusion that, from a claims-based
9 perspective, the measure to use was the seven to
10 fourteen day follow-up post-discharge. So, that's
11 a performance measure that we've chosen for
12 ourselves, and it can be pulled from the claims
13 when that's activated.

14 (Off microphone comment)

15 MS. ABDELLA: At this point in time. I
16 mean, we're just starting to operationalize it.
17 We'll shake it out later, but yes. Trying to push
18 the point of we need to know where these people
19 are and complete a loop of care.

20 CO-CHAIR MOSCOVICE: Tim.

21 MR. SIZE: Two issues. One is, I guess,
22 I need some clarification what the cost resource

1 use metric is, how does that work?

2 CO-CHAIR MOSCOVICE: Karen?

3 MS. JOHNSON: This is where I wish my
4 colleague, Tareem, was in the room.

5 MR. SIZE: And my concern is,
6 obviously, all things being equal, a rural
7 clinic, or a hospital is going to have higher
8 standby cost. And if this is supposed to be
9 comparing urban to rural, it wouldn't work for
10 me.

11 MS. JOHNSON: Right. So --

12 (Off microphone comment)

13 MR. SIZE: Standby cost. Like --

14 CO-CHAIR MOSCOVICE: Fixed cost.

15 MR. SIZE: Fixed cost. If you're an
16 emergency room in a typical rural hospital, it's
17 going to have less throughput, and it's probably
18 going to cost more on average because --

19 CO-CHAIR COURT: Yes, I think this
20 measure -- and jump in. So, this is totally from
21 memory, is a certain number of days before
22 admission up to I think 30 days after admission,

1 which the hospitals have some heartburn with
2 because they can't really control the cost once
3 the patient's left. So, whatever claims, you
4 know, accrue, I think it's Part A and B.

5 UNIDENTIFIED: Yes, it is. So, if
6 somebody has taken --

7 MR. SIZE: Not to contradict my
8 previous discussion on peer groups -- this is
9 certainly an area where peer groups makes sense
10 to me.

11 MS. JOHNSON: So, this one is risk-
12 adjusted, so just some of the controversy with
13 this measure, not everybody loves it, of course,
14 is questions about the risk-adjustment
15 methodology. And I cannot remember if SDS is
16 actually included in the models or not. And then
17 also there is, of course, problems with
18 attribution.

19 MR. SIZE: I may have missed -- I mean,
20 specifically saying if we're comparing an
21 isolated community of 2,000 versus one of 5,000
22 and just the scale, the size, okay. And then,

1 yes, you anticipated my other concern was we're
2 not being very explicit. And I hate to be a
3 broken record, but the whole SDS adjustment, when
4 we're having this conversation like for the 3-day
5 readmission, as presented it's not indicating SDS
6 adjustment, and we're not doing that yet. So, I
7 vote yes or no, depending on whether we're
8 assuming it's going to be with or without that
9 adjustment.

10 And maybe, it might be helpful just 10
11 minutes tomorrow morning you all could give us
12 where NQF is on that issue.

13 MS. JOHNSON: Yes, I'd be happy to.

14 MR. SIZE: Thank you.

15 CO-CHAIR MOSCOVICE: Do people think
16 that cost resource use is a quality measure?
17 Okay.

18 DR. NUKI: You really think it's not a
19 quality -- I mean, if I'm doing CT scans on every
20 headache that shows up in the emergency
21 department, that's cost resourcing, that's also
22 quality.

1 (Off microphone comment)

2 DR. LANDON: The issue with that, you
3 know -- so, for most quality measures we really
4 try to pristinely define an appropriate
5 denominator population and enumerator population.
6 And while most CTs and MRIs for headaches and
7 back pain are low value and inappropriate, that
8 might not be the case if we suspect someone is
9 having, you know, a subarachnoid, or if someone
10 has fever and back pain, or if someone has a
11 history of breast cancer and whatnot so, you
12 know, you can look at rates over time which we've
13 done in our work and be pretty comfortable that,
14 you know, changes are probably changes in levels
15 of appropriateness as opposed to clinical
16 indications. But in any one particular thing, as
17 we do with most quality measures, it's hard to
18 say definitively this is actually high or low
19 quality.

20 CO-CHAIR MOSCOVICE: Other comments,
21 Steve?

22 DR. SCHMALTZ: They had a tobacco use

1 screening measure, I think they should have a
2 substance abuse and an alcohol screening measure,
3 as well.

4 CO-CHAIR MOSCOVICE: I have Michael,
5 then Bob.

6 DR. BAER: I just wanted to support
7 what Greg said in terms of, you know, the post-
8 discharge appointment. I think it just needs to
9 be created in an appropriate way because there
10 may be risk groups, you know, that do require the
11 seven to fourteen day visit versus other groups,
12 so it just needs to be looked at.

13 CO-CHAIR MOSCOVICE: Bob?

14 DR. RAUNER: And actually I'm going to
15 throw more into that, that I think as Greg --

16 Greg is right, maybe that's overly broad.
17 However, most of what we see as bad outcomes that
18 were avoidable, the frequent scenario is they had
19 a surgical procedure in a hospital and the
20 follow-up for the hip may not be necessary for
21 four to six weeks, but the other things that
22 happened were necessary, and it was never

1 scheduled. So, one of our first anecdotes we used
2 forever was the urologic procedure where they
3 held the diabetic meds because they were
4 controlling it in the hospital, and they failed
5 to restart those diabetic meds when the patient
6 went home. And, obviously, that didn't go well.
7 So, now not all this needs a visit, though,
8 because that's actually the transitional care
9 codes, or that's part of the -- if it isn't a
10 visit face-to-face, it may be a phone call, for
11 example. So, I guess we're breaking this into
12 multiple things, but literally it is the most
13 common cause of our errors, is this transition
14 here. So, maybe they don't all need a visit, but
15 everybody at least needs a transitional -- an
16 opportunity do a transitional care code, or maybe
17 there's a threshold where, you know, if I have no
18 meds, I probably don't need to be seen. But if
19 I've got eight meds, that person does need to be
20 seen within a couple of days because a lot of
21 those fluid shifts around surgery may not show
22 up. So, I think this is more complicated, but

1 definitely does need to be fleshed out because
2 this is where we see a lot of our issues
3 happening.

4 DR. IRVINE: Yes, and the point is not
5 that some patients don't need to be seen very
6 soon afterwards by their internist, by their
7 family doc, or by me. That's not the issue. The
8 issue is, if I've got an ASA 1 patient on no meds
9 and has got everything all lined up and so on,
10 it's a waste of resources for them to come back
11 and see me, or many times they're coming back,
12 you know, 80 miles to see me. I'm not going to
13 drag them back to say hey, you're looking great.
14 We actually think about when we're going to have
15 them come back, and that's what we put in the
16 discharge order. So, I just think penning us in
17 with prescribed times, then suddenly we're out of
18 compliance because we didn't see the patient back
19 two weeks after surgery. There are certainly many
20 patients -- I mean, a hip fracture patient is a
21 medical patient with a hip fracture, and they've
22 got lots of comorbidities, lots of problems. And,

1 you know, it's an opportunity to actually get on
2 top of a lot of the problems that they have that
3 might have even led to the fracture. And that's a
4 very different animal than other cases. And
5 that's -- you know, we need to be allowed to use
6 our discretion when we're admitting and
7 discharging patients.

8 CO-CHAIR MOSCOVICE: Michael.

9 DR. BAER: One thing that's not on
10 here, and I don't know if there are any measures
11 related to telehealth, but that is something that
12 might be considered. I don't know what a good
13 telehealth measure might be to measure quality
14 but, you know, as we're thinking forward with
15 critical access hospitals and folks out in
16 nowhere where there's transportation issues,
17 maybe telehealth -- maybe a measure related to
18 telehealth would be good to think about.

19 CO-CHAIR MOSCOVICE: Any telehealth
20 experts out there who might have some areas we
21 might hone in on vis a vis developing a quality
22 measure for telehealth? Bruce.

1 DR. LANDON: I'm not an expert but I'm
2 not aware of any. And we're doing a paper on
3 this, the use in the Medicare population. We have
4 data through 2012. The graph looks like this, but
5 starting out at like 10, so it's -- even though
6 it's going like that, even at the end of the
7 period in 2012, I want to say the total number of
8 visits is like 100,000 in a 20 percent sample,
9 something along those lines. And, obviously,
10 getting higher and higher, and Medicare keeps
11 relaxing the rules and expanding indications.

12 CO-CHAIR MOSCOVICE: So maybe not ready
13 for prime time?

14 DR. LANDON: Probably.

15 CO-CHAIR MOSCOVICE: John.

16 MR. GALE: Actually, I spent some time
17 looking at this issue recently in response to a
18 question. The only measures I could find were
19 utilization measures that folks were reporting.
20 But as I think about telehealth and the area that
21 I work most closely with is behavioral health,
22 it's really only -- I don't think I know, or I

1 can clearly understand what would be different
2 about doing it through the telehealth technology.
3 You'd still have a face-to-face psychotherapy
4 interaction designed to change behavior, so I
5 don't know in my mind that the use of the
6 technology at least in behavioral health changes
7 a measure that you would use for normal
8 behavioral health encounter.

9 MR. GALE: Well, it's the most common
10 because it's the easiest, again, because it
11 translates well to that --

12 CO-CHAIR MOSCOVICE: Okay. I assume,
13 though, that the timeliness issue would come into
14 play with telehealth. Presumably, we're using
15 telehealth because there aren't providers
16 available, and that somehow this would facilitate
17 access to providers. So, I would think there
18 would be some timeliness aspects.

19 DR. BAER: And I'm really talking
20 about, there's two different -- I mean, there's a
21 couple of different things. If you're using
22 telehealth in a hospital versus using in a clinic

1 setting. So like in the ER is you're using
2 telehealth, and I'll give an example sort of like
3 Greg was talking about, he's socked in behind
4 mountains and can't even drive over the mountain
5 to get to the airport to get the patient to
6 another tertiary hospital. We had a case like
7 that in Pennsylvania where in northern
8 Pennsylvania, you know, up in Coudersport, they
9 have to go over a mountain just to get to an
10 airport, but they were able to use telehealth in
11 the ER for that pediatric patient to have a visit
12 with a cardiac specialist from Pittsburgh to
13 obviate the requirement to drive the patient in
14 an ambulance over the mountain to get on a fixed
15 wing to get to Pittsburgh. So, I see it kind of
16 differently, and so as we're thinking about it,
17 maybe it's not ready for prime time, but maybe at
18 some time in the future it might be something
19 that we could use.

20 CO-CHAIR MOSCOVICE: So, Tonya, you
21 were shaking your head.

22 MS. BARTHOLOMEW: Sorry, I have a lot

1 to say about telehealth. Being in a rural area in
2 a rural state, it all comes back to what you
3 said, Ira, is access and quality of care for our
4 patients.

5 We do not have access in most of our
6 state. I think Cheyenne might be the only --

7 let's say it's one of the biggest communities in
8 our state with 55,000 people in it, small state,
9 that has access to behavioral health. And that is
10 our most utilized telehealth service, because we
11 have so many kiddos, we have so many elderly
12 people who need those services, and they can't
13 get them unless they drive at least 150 miles.
14 So, it becomes an access issue, it becomes a
15 quality of care issue, because if we are not
16 providing those services for our patients, then
17 they are going to the ER. It also trickles down
18 into a utilization issue.

19 We had a very small clinic that had no
20 providers that was several hundred miles away
21 from us who only had a nurse, and they called us
22 up on telehealth and they said we have this

1 patient here who has a UTI. Can you please see
2 them over telehealth and we can get the
3 medications? It's huge in rural areas, and I
4 think it's vital. That's my two cents.

5 CO-CHAIR MOSCOVICE: I had Kimberly,
6 and then Guy.

7 DR. RASK: The two -- when I look at
8 some of this list of measures here, I think two
9 areas that are particularly pertinent to our
10 rural sort of essential community providers that
11 I don't see here are the accessibility/timeliness
12 measures, something to say the reason that we
13 support these institutions and are willing to pay
14 a little higher cost for them is for
15 accessibility to the community that otherwise
16 would not have a provider to go to.

17 I don't know whether there might be
18 some measures that are being used by FQHCs, or
19 maybe some of the accessibility measures that are
20 used by NCQA for managed care plans. If there's
21 something that could be kind of adapted for
22 measuring are you serving your community and are

1 people being able to access care in a timely
2 manner?

3 And then the second area would be that
4 notion of trying to capture the sense that
5 sometimes what these rural providers have to do
6 is to provide services that may be beyond --
7 either beyond their general scope or beyond a
8 typical scope because they're in an area where
9 there is not an appropriate next level of care
10 that can be given in a timely manner. So, are
11 there some measures around the scope of practice
12 that's being provided, and timely transfer to the
13 next appropriate level of care, and how that
14 communication process goes so that a -- assuming
15 a high quality provider is able to manage the
16 triage and stabilization in their setting, and
17 appropriately transmit the information to a next
18 site of care, if that's what's required, or
19 manage it entirely in their scope if that is, in
20 fact, accessible. But those kinds of things I
21 don't think it captured very well by a lot of the
22 measures that have been developed currently that

1 really talk about what happens within this
2 specific scope -- I'm sorry, this specific
3 physical planned.

4 CO-CHAIR MOSCOVICE: Okay, I have Guy,
5 then I have Jason.

6 DR. NUKI: I never get my name up fast
7 enough. I was going to say basically what Kim
8 said, but let me just reiterate, I think, how
9 important it is. If I had to judge a CEO's
10 performance at a hospital in a rural area, one of
11 the major things that I would want to judge them
12 by is how able they are to provide the services
13 that their community needs. So, access to care is
14 huge. It's very easy for a -- it's very easy to
15 just say you know what, we're only going to do
16 orthopedics and invasive radiology, and
17 everything else gets sent out. You'll make lots
18 of money that way, but you're not really
19 servicing the community's needs. So, there's not
20 a category here about access to care.

21 I almost think that that's probably
22 one of the most important categories we could

1 have, but once again like the telehealth, it's
2 probably nothing that I know that's necessarily
3 already developed. And developing that and making
4 it ready for prime time would be difficult, but I
5 think it would probably be worth it.

6 CO-CHAIR MOSCOVICE: Jason.

7 DR. KESSLER: I'm just going to make a
8 comment on that before I say what I actually
9 wanted to say here. There are some measures out
10 there for accessibility. I've never been totally
11 happy with them, because they basically take a
12 population and say what percentage of this
13 population had a service, which I don't know if
14 that's a useful measure or not, but just to add
15 on to that, that there's a few measures like that
16 that exist. I believe they're in the pediatric
17 for specific age ranges.

18 So, what I was actually going to say
19 was at the risk of kind of taking a few steps
20 back in the conversation, I wanted to add on a
21 couple of things in defense of measures around
22 cost of care. You know, it's arguable whether you

1 really apply the term quality measures to those
2 things, but I think they're, nonetheless,
3 important. To use a health care cliché, you know,
4 the triple aim of reducing cost, improving health
5 care, and improving the health of the population,
6 and all three of those things really do need to
7 go together.

8 One of my colleagues described them as
9 three different legs of a stool, and if they
10 don't balance out, you can't sit on that stool.
11 You can't rest the weight of our health care
12 system on that uneven stool. So, I do really like
13 the idea of having measures that do look at the
14 cost of care.

15 I personally don't think that one that
16 bases it strictly on Medicare spending is such a
17 good measure, unless you are a Medicare program
18 and looking at -- specifically at that
19 population, particularly in a rural setting where
20 Medicare is one population, and it's an older
21 population, plus a few really sick people. But
22 you'd be better off looking at the cost of care

1 over an entire population, which is something
2 that at least in some data that I have seen,
3 rural systems do fairly well on in comparison to
4 their urban peers.

5 CO-CHAIR MOSCOVICE: I got Brock, and
6 then Tim. John, is yours still up? Okay, so Brock
7 and Tim.

8 MR. SIZE: I wasn't prepared. I was
9 going to use you for my prep time. Jason reminded
10 me of something I've been meaning to say, but I'm
11 hesitant to because, again, we have enough work,
12 but it would probably be inappropriate if it's
13 not at least in as a placeholder for a little
14 further down the lane.

15 Going back to triple aim, and it
16 references one of the legs of the stool as
17 population health. That very rapidly has been, I
18 think, almost misinterpreted or overly narrowly
19 interpreted to something I would call the
20 medicalization of population health. And it's
21 come to be a narrower interpretation than I think
22 was in the original thinking around the triple

1 aim. It's come to mean my population of patients
2 who are diabetics, versus those metrics that we
3 are increasing looking at in terms of the health
4 of the community. And I'm not sure we're ready to
5 make a recommendation that we should be doing the
6 pay for performance on hospitals to the degree
7 that they're making their community more
8 healthier than it would otherwise be. But,
9 clearly, the responsibility, and our ability to
10 measure the responsibility of clinics and
11 hospitals to helping their community improve is
12 certainly -- for us to be silent on that is
13 probably a mistake, so just kind of putting that
14 into the hopper. And the minutes should show that
15 Brock said that, and not me, because I'm not sure
16 my hospitals are ready for that.

17 MR. SLABACH: Thank you.

18 MR. SIZE: You're welcome.

19 CO-CHAIR MOSCOVICE: Kelly.

20 CO-CHAIR COURT: So what I hear from
21 our members is they do lots of outpatient stuff,
22 but there's really no measures of the outpatient

1 stuff they do. So, you know, if they're doing
2 procedures there's no measures really of the
3 therapies that they do. So oftentimes they're the
4 only PT/OT, whatever diagnostic imaging center,
5 and that's a lot of what they do. So, that's a
6 gap, I think.

7 The other thing, and it's maybe not a
8 rural issue, but I think it's a huge issue, is we
9 don't have enough appropriateness measures. So,
10 for orthopedic surgery, to pick on Greg and the
11 surgeons, there's good measures about, did the
12 wound heal? Did we do the procedure right? But we
13 don't have measures about did we even need to do
14 the procedure? So, you know, once the patient got
15 to the hospital, did we do the right things, but
16 did they even need to be here to begin with? And
17 I think that's a big part of the cost issue is
18 not using the right setting at the right time, or
19 didn't even need the service, or could be done
20 later. And that's -- I'm not sure what the answer
21 to that is, but I think it's a big measurement
22 gap.

1 DR. IRVINE: Trying to deal with that
2 through looking at appropriateness, and looking
3 at procedures, and when they actually make sense
4 and when they don't, things like laminectomy for
5 low back pain, and the viscosupplements for
6 chronic knee osteoarthritis, and so on. So, I
7 think a lot of that is going to be driven at the
8 specialty level, and should be since we're the
9 ones that are doing those things. But I agree
10 that that's where the cost savings are going to
11 occur a lot, is by not doing procedures that have
12 no benefit.

13 CO-CHAIR MOSCOVICE: Other comments?

14 Bob.

15 DR. RAUNER: Dovetailing on Greg's, I
16 think that's one of the biggest missing gaps,
17 actually, is that we've got great primary care
18 measures, we've got great hospital measures, but
19 what we're really lacking across the board is in
20 specialty measures. I have a colleague who's an
21 orthopedic spine surgeon, we've been talking a
22 lot about this, is that some specialties have

1 great measures, like cardiology and oncology, but
2 a lot of other specialties don't really have good
3 appropriateness, other measures like the other
4 fields, and those really need to be developed. I
5 think it's way out of the scope of this for the
6 most part, although Greg's situation, even rural
7 ortho is an issue. What are those appropriate
8 measures? I don't know.

9 CO-CHAIR MOSCOVICE: Can you give an
10 example of -- just an idea of what might be a way
11 to measure appropriateness for something that you
12 do, Greg?

13 DR. IRVINE: Well, I think looking at
14 Academy guidelines, looking at the specialty
15 societies in terms of -- I mean, one small tiny
16 thing that's kind of come to the fore is the
17 whole issue of the appropriateness of
18 viscosupplements, which are used heavily in the
19 outpatient setting both by primary care
20 physicians, internists, and orthopedists, and
21 others. They're extremely expensive, and have
22 never been shown to significantly alter the

1 outcome of treatment for osteoarthritis of the
2 knee. But the industry is fighting back tooth and
3 nail to keep those from being implemented. There
4 could be huge cost savings just from that,
5 looking at that guideline alone. The Academy
6 recently came out with a position that they could
7 not recommend the use of viscosupplements in
8 osteoarthritis of the knee, and those Academy
9 guidelines are, I think, helpful both for that
10 and surgical procedures of various sorts.

11 CO-CHAIR MOSCOVICE: Bob. Ann.

12 MS. ABDELLA: Have you looked at the
13 Choosing Wisely work that's been done, because
14 there have been huge debates within the colleges
15 and academies in specialty to identify those very
16 debates.

17 DR. RAUNER: Actually, that's what I
18 was going to say, is Choosing Wisely is like the
19 right place to start because they're already
20 aligned with the specialty societies, so always
21 leave -- I have a wife and three daughters, I
22 know I'm supposed to yield.

1 CO-CHAIR MOSCOVICE: Bruce.

2 DR. LANDON: Just related to Choosing
3 Wisely, we've actually done a lot of work in
4 trying to actually translate Choosing Wisely
5 recommendations into quality -- or measures, you
6 could call them quality measures, use measures,
7 whatever you want to call them. And, you know,
8 they've been submitted by like 51 societies. Each
9 one of them has like five. We've been able to
10 code up a total of 31 using administrative
11 claims, and many of them are sort of low value,
12 but also low cost. And others are really hard to
13 get your hands around, like a really good
14 example, hopefully you're not a spine surgeon
15 mostly. So, I'm one of those people that's not a
16 big believer in spine surgery. Let's say if you
17 counted spine surgery procedures done in the
18 United States, many of them are inappropriate,
19 but just like I was saying before, you really
20 can't tell the few that might be appropriate from
21 claims in any way.

22 CO-CHAIR MOSCOVICE: That issue of

1 being able to use claims data is a big issue, and
2 when we had some technical panels together in the
3 past, when we looked at the appropriateness of
4 imaging services, and the committee basically
5 came to the conclusion you just can't do it using
6 claims data. It's just impossible to do.

7 DR. LANDON: Yes, we call this issue
8 sort of -- it turns out that there is practically
9 no things on the Choosing Wisely list that either
10 don't have some caveat like after trying
11 appropriate physical therapy and this and that,
12 or whatever, that are things that you can
13 actually identify in claims, or more importantly
14 have what we sort of refer to as clinical
15 heterogeneity. So, yes, it turns out that for
16 most applications this is a low value service,
17 but for this little group over here, very high
18 value service. And when you can't distinguish
19 those, it's really hard to get them in one fell
20 swoop.

21 Now, when you look at things sort of
22 like trends over time and whatnot, and papers

1 like that looking at back pain imaging, for
2 instance, you know, those trends over time, that
3 all probably nets out. But, again, when you're
4 looking at sort of an individual case or
5 comparing people, it's hard to do that netting
6 out.

7 DR. IRVINE: But another thing is
8 relevant on your list here, is all the issue --
9 or all the guidelines referable to osteoporosis
10 screening, the Academy of Orthopedic Surgery has
11 actually begun to question the advisability of
12 Fosamax in most therapies for osteoporosis, and
13 it's changing the way we're thinking about
14 osteoporosis screening in terms of what we advise
15 and so on. There are definite complications,
16 problems. Today's dogma is tomorrow's dog poop,
17 as is often the case in medicine. And that may be
18 going away, so that's one of those things that
19 you may want to watch closely. There may be
20 different recommendations. Not that we shouldn't
21 be counseling our patients about osteoporosis and
22 proper conservative management, but we may lose

1 one bullet in our holster on that treatment
2 that's been used fairly heavily. And, quite
3 frankly, I think was largely industry-driven,
4 also.

5 CO-CHAIR MOSCOVICE: Bob.

6 DR. RAUNER: Just comment on that,
7 because I'm really happy to hear you say that,
8 because I always wish there would have been a
9 randomized controlled trial of Fosamax versus
10 going for a walk.

11 CO-CHAIR MOSCOVICE: Any other issues
12 with respect to measurement gaps? We distinguish
13 it between hospital and physician, clinic side,
14 but we've had some discussion of both. But any --
15 on the physician, clinic side, other stuff you'd
16 like to talk about? Ann.

17 MS. ABDELLA: Just a question. Are we
18 suggesting that we're endorsing these measures?

19 CO-CHAIR MOSCOVICE: No, we're
20 identifying areas that are gaps that we really
21 are recommending that NQF and CMS take serious --
22 a serious look at are these areas we want to try

1 to develop measures in.

2 MS. ABDELLA: Okay.

3 CO-CHAIR MOSCOVICE: So, these are the
4 areas where we don't have appropriate measures at
5 this point.

6 MS. ABDELLA: Can I tell you how much
7 my doctors hate the diabetic eye exam? Unless
8 you're going to give us the claims, we can't do
9 it, because the patient doesn't know the
10 difference between a refracted exam and a
11 clinical eye exam. And if you don't get the
12 report back which Walmart just isn't willing to
13 do, we won't be able to report on that.

14 CO-CHAIR COURT: So, maybe a gap would
15 be being held accountable to a measure that you
16 don't have the data for. So, another example in
17 the hospital setting, but it got suspended, maybe
18 permanently, I hope, was the patient that's had
19 cataract surgery, did they have an improvement in
20 their vision? You know, how does the hospital
21 know that? So, that's an example of the data
22 lives in a different setting, and you don't have

1 access to it. So, I think maybe a principle we
2 would want to endorse is if you're held
3 accountable to the measure, you have access to
4 the data to show how you're performing, because
5 then you can improve it.

6 CO-CHAIR MOSCOVICE: Any other final
7 comments on measurement gaps?

8 DR. KESSLER: I just had kind of a
9 follow-up, I guess question about that. Because
10 those two situations I think would be the same in
11 a rural hospital that they would be in an urban
12 hospital, or anywhere else. Are there some areas
13 where rural hospitals are more likely to have
14 specific gaps in their ability to collect data
15 than would another hospital in a larger setting?
16 And I don't know the answer to that. I just throw
17 it out as a question.

18 CO-CHAIR COURT: Well, I think -- I
19 mean, the cost measures get to that, you know, so
20 if you've initiated the care and end up
21 transferring the patient, and you're held
22 accountable for the cost that happens outside

1 your walls, you know, that doesn't make sense.
2 And maybe we're kind of jumping to principles,
3 but it seems like if you're going to -- if it's
4 going to be reported on publicly and used in some
5 kind of incentive or penalty program, you have to
6 be able to control, you know, the result. I mean,
7 wholly control the result. You can't be dependent
8 on someone else further down the line, or
9 shouldn't be held accountable for someone else's
10 performance that's not part of your system.

11 CO-CHAIR MOSCOVICE: I think Jason has
12 raised an important issue, though, which is this
13 is supposed to be about rural environment and
14 these issues. And I think as we write the report
15 and look through this, and if you have
16 observations now about other issues we've talked
17 about that really are sort of rural-centric or at
18 least much more important to a rural environment
19 as compared to an urban environment, or most of
20 the stuff we talked about, do you feel that the
21 same issue exists out in urban environments? Just
22 interested if you have any thoughts on the rural

1 centrality of these kinds of issues. Guy.

2 DR. NUKI: So, I'm going to go
3 completely against what you just said, and I
4 apologize, but -- so one of the things you're
5 hearing, and it's not just rural, is that, you
6 know, kind of the data behind some of these
7 measures just isn't really there. And the one I
8 brought up was TPA, the osteoporosis screening. I
9 don't know if this is something that we can use
10 this forum for, but to say, you know, to really
11 use data to drive the measures, but to leave
12 industry out of the room. The process that we
13 went through where we disclosed was fine, and I'm
14 going to bet you that when you sit there and do
15 the thrombolytic therapy measure there's somebody
16 from the makers of TPA in the room and they just
17 disclosed, but they're allowed to be there.
18 Europe doesn't let them show up at the table, and
19 they end up with much better measures. So, my
20 vote would be that if we can we use this to say
21 in reviewing measures there's some that clearly
22 don't match the data that's out there. They're

1 controversial, and they seem to be driven by
2 various industries that have -- for-profit
3 industries. And that our recommendation is that
4 these are made with -- by excluding all those
5 people who have for-profit industry connections.

6 CO-CHAIR MOSCOVICE: Michael.

7 DR. BAER: Two things related to
8 diabetes. One on here is missing, the nephropathy
9 screening. I don't know, this is just a list here
10 but, were we going to look at other ones that
11 maybe include -- if we're not, I would consider
12 including nephropathy screening for diabetics.

13 CO-CHAIR MOSCOVICE: I believe it's
14 just -- these are examples.

15 DR. BAER: Okay.

16 MS. JOHNSON: Yes, these are just
17 examples. Yes, so just to give you a --

18 DR. BAER: And coming back to the
19 retinal screening for diabetics, and I'm a family
20 doctor, but my exam doesn't meet the HEDIS
21 criteria for retinopathy screening in diabetics.
22 When I look in eyes and I can see cotton wool

1 spots and hemorrhages, I think I -- not that --
2 I'm not saying the optometrists and
3 ophthalmologists shouldn't be doing it, but the
4 question is, you know, the family doc wants to do
5 his due diligence and has to get the patient to
6 Walmart to get the optometry exam, but then he
7 never finds out, or she never finds out that it
8 was done. So, this is maybe just a comment on
9 further future work on the actual measures
10 themselves for the retinal screening.

11 CO-CHAIR MOSCOVICE: Okay. Any other
12 final comments on measurement gaps before we turn
13 it back to Kelly? You want to talk about a few
14 other overarching issues? Tim.

15 MR. SIZE: I'm not sure what measures
16 -- what the screen was to get measures on or off
17 this sheet. I just had a question. I know in our
18 state there's a huge, huge push around advance
19 directives. Should there be a metric in here
20 somehow about that? And I'm not sure if that's
21 hospital, or clinical, or both.

22 CO-CHAIR COURT: Maybe we can expand

1 that to end of life, I mean, as a broader
2 category.

3 MR. SIZE: Yes. Well, except actually,
4 you know, I mean, honoring choices in our state
5 is a lot more than end of life. It gets closer to
6 a measure for the patient being brought into the
7 decision making process, and giving that patient
8 the support to be able to in advance at various
9 stages in the person's life and disease,
10 whatever, to speak up.

11 CO-CHAIR MOSCOVICE: Jason.

12 DR. KESSLER: Well, my bias is that,
13 you know, I work for a program Medicaid that is,
14 you know, if you look at the numbers, 25 percent
15 of the population is in the 50 or older age
16 range. The majority of the population are healthy
17 kids, so if we start looking at metrics in rural
18 settings where volume is a limiting factor to
19 measuring, I just -- I have some wondering if
20 things like advance directives that, you know,
21 are only going to apply to the older population,
22 is that you're going to have more problems with

1 numbers, things like diabetics. Diabetes is 10
2 percent of the population which is huge, but if
3 you already have issues of low volume, does it
4 make sense to be throwing in lots of measures
5 around any one specific condition at all? And
6 that's just kind of rhetorical question, I'm not
7 trying to pooh-pooh the idea.

8 MR. SIZE: Well, no, this is an open
9 discussion. No, advance directives a) aren't just
10 for old folks. B) Since we're going to Medicare
11 that by definition is kind of about older or late
12 middle, I prefer the term late middle, actually,
13 that's all.

14 (Off microphone comments)

15 MR. SIZE: No, we're not, but it's (a)
16 we sort of said advance directives is well -- at
17 least in our state we're promoting it well below
18 Medicare age. And there's -- you know, most rural
19 is serving Medicare so I don't think that's
20 actually a small number issue.

21 CO-CHAIR MOSCOVICE: Bob.

22 DR. RAUNER: Yes, kind of jumping onto

1 that. Although it may not be relevant for
2 Medicaid, it's relevant for everybody else in the
3 room, family medicine, rural, CAH, everybody.
4 Almost every state now has a state-recognized
5 version of the POLST form that started in Oregon.
6 Nebraska, as usual, is probably going to be one
7 of the last, but we're working on it right now.
8 Using something like the state-recognized POLST
9 form, it's equivalent I think actually will be
10 hugely beneficial for lots of reasons. And I'll
11 put a plug in for a book, read Atul Gawande's
12 Being Mortal. It's a great book, but a lot of it
13 goes along with some of this stuff, so I really
14 would be a huge fan of having a POLST-like
15 measure, probably the state-designated, because
16 there's variation from state to state what's
17 actually in that POLST form, or even what the
18 acronym is. But most states now do have a state-
19 recognized form like this. In Wisconsin, I know
20 they've got some great programs. I think La
21 Crosse has a really nice one, for example.

22 CO-CHAIR MOSCOVICE: Ann.

1 MS. ABDELLA: And just to hitchhike on
2 that, if we think that these measures can change
3 behavior that would be huge, because we have most
4 in New York State and doctors and hospitals are
5 just reticent to put those forms into place. And
6 we've been working on it for five years, and
7 until something more -- with more oomph comes
8 behind that in a pay for performance type of
9 environment, I don't think it's going to happen.

10 CO-CHAIR MOSCOVICE: I have Jason back
11 there, and then Bob.

12 MR. LANDERS: A question, is -- and I'm
13 cautious to ask this with so many primary care
14 physicians in the room. There's an obvious lack
15 of appropriate use of antibiotics on this list.
16 is that -- is there a reason for that, or was
17 that just in the sense of not including every
18 important measure?

19 CO-CHAIR MOSCOVICE: This was almost a
20 random list put together by NQF staff. And really
21 as Karen said earlier, it's the topics that in
22 many sense -- in no way, shape, or form is this -

1 - should this be viewed as a measurement list and
2 that works for them.

3 MR. LANDERS: That's an important
4 measure that I want to talk about --

5 MS. JOHNSON: I will -- Helen remembers
6 things much better than I do. My memory is not so
7 good, but the antibiotic measures that I can
8 think of are really surgery measures, so are
9 there other ones, as well, Helen?

10 MR. LANDERS: Yes, appropriate --

11 DR. BURSTIN: Yes, there was a whole
12 series of --

13 (Simultaneous speaking)

14 DR. BURSTIN: -- bronchitis, et cetera,
15 overuse measures.

16 (Off microphone comment)

17 DR. BURSTIN: No, there's actually --
18 we actually have a couple of dozen overuse
19 measures now, including imaging, cardiac imaging,
20 things like that.

21 MR. LANDERS: Pharyngitis testing,
22 which is essentially --

1 DR. BURSTIN: Yes, we've got all those.
2 Yes, and the question would be, you know,
3 particularly in areas where under-use may be more
4 of an issue than overuse, is that the right
5 logical approach for rural when access may be a
6 bigger issue? So, those are questions I would
7 pose to you.

8 CO-CHAIR MOSCOVICE: So, Helen has
9 raised the issue of under-use as compared -- you
10 know, often we worry about over-utilization of
11 resources, so in an environment where we don't
12 have a large -- as many resources as other
13 environments, any concern about under-use?

14 DR. BURSTIN: I'll just follow-up and
15 say, I mean, many of the measures could still be
16 about appropriateness, but it may not always be
17 appropriateness towards the eye of saying it
18 shouldn't have been done. My guess is Greg
19 probably has a whole lot more patients in his
20 area who need total knees and hips who don't come
21 forward, who probably are appropriate. So, you
22 know, who don't have access.

1 CO-CHAIR COURT: I think the challenge
2 with that is where -- so, it's easy to measure
3 what happened that wasn't supposed to happen, but
4 how do you measure something that didn't happen
5 that was supposed to?

6 DR. BURSTIN: That was a contorted
7 sentence, that was good. You know, there are
8 measures of appropriateness.

9 (Off microphone comment)

10 DR. BURSTIN: Yes, and there also are
11 measures of patient reported outcomes of
12 symptoms. I mean, that's the other piece of this,
13 is do you begin assessing sort of physical
14 function and mental function as a starting point,
15 and being able to see those difference might be
16 profound, as well.

17 CO-CHAIR MOSCOVICE: Brock.

18 MR. SLABACH: Yes, going back to the
19 advance directives. My memory is not as good as
20 it used to be, so Helen or someone at the MAP
21 work -- the hospital work group back in December,
22 did we -- we did not approve the advance

1 directives to be recommended to CMS for hospital
2 inclusion, did we?

3 DR. BURSTIN: I think there was -- I
4 think you're right. I think it was a whole issue
5 of where should it be done. I think everybody
6 agreed it was an important topical area, but it's
7 a question of is it an outpatient issue, an
8 inpatient issue, should it be done repeatedly?
9 There are already HEDIS measures that look at
10 advance directives for older folks in the
11 outpatient arena.

12 MR. SLABACH: Yes, I just wanted to
13 clarify because, again, that goes back to where
14 you do the -- where does accountability rest for
15 that particular function. And I think that's an
16 important question as we move through this.

17 CO-CHAIR MOSCOVICE: Hearing the sirens
18 and no further cards, I think we'll move to the,
19 I believe, last session. And we're not going to
20 have reports out from the breakout groups because
21 we didn't have breakout groups, but we have a few
22 other issues we want to get some conversation on.

1 And Kelly is going to lead that discussion.

2 CO-CHAIR COURT: So, we have a little
3 more time today, and we've kind of circled around
4 many issues, but let's kind of nail them down
5 related to program design, for lack of a better
6 term.

7 So, assuming that P4P is coming, what
8 kind of things do we not want the design of that
9 program to have, or things we want it to have?
10 So, for example, right now in the HAC penalty
11 program that applies to the PPS hospitals,
12 there's two domains.

13 And if you don't have measures in the
14 one domain, all your weight goes into the second
15 domain. I think that's flawed, so if there's
16 going to be domains around this, the weighting of
17 those domains has to be done in such a way that
18 it guarantees there's measures, or enough
19 measures in each of the domains, or the way the
20 domains get re-weighted based on absence of
21 measures in one or more, doesn't put all the
22 weight in the other ones. And I don't know what

1 the answer to that is, but it seems -- you know,
2 you could have your whole program based on two
3 measures, because the domains tend to not have a
4 lot of measures in them, so if you don't perform
5 well on one or two measures, that could be your
6 whole incentive or penalty.

7 So, what other things as measures
8 would get applied in an incentive or penalty
9 program, do we think need to be considered? Ann.

10 MS. ABDELLA: Straight from the lips of
11 four small PPS hospitals, the return on
12 investment of their time and energy just isn't
13 there. They do it because it's the right thing to
14 do, but that's -- the money is not sufficient.
15 So, if they're putting all their money in a
16 bucket to do this, and they generally perform
17 pretty well, it's just -- it is what it is.

18 CO-CHAIR COURT: So, would we want more
19 money to be at risk? I mean, what's the solution
20 to that?

21 MS. ABDELLA: I don't have the answer

22 --

1 CO-CHAIR COURT: I don't want to go on
2 the record saying that as a hospital association.
3 I'm sorry. Guy.

4 DR. NUKI: That's where it's going
5 anyway. Right?

6 CO-CHAIR COURT: Yes.

7 DR. NUKI: I mean, the whole way we get
8 paid is going to completely change.

9 CO-CHAIR COURT: Tim.

10 MR. SIZE: Yes. I think what's unique
11 about this conversation then is what's the
12 ethical and effective approach, pay for
13 performance for cost-based providers who are
14 cost-based for a particular reason. So you take
15 those who are struggling, maybe not all that
16 successfully to do the right thing, and so if
17 they don't achieve it, you take more resources
18 away from them. I think that's kind of
19 counterintuitive. And I think that's a position
20 for some of us who were at the ACO meeting Monday
21 that Lynn Barr certainly spoke about, that her
22 experience was telling her it's about providing

1 opportunities for a little bit additional on top
2 of the cost.

3 And again, you know, going back, cost
4 doesn't mean 100 percent of cost, or 101, or 98
5 doesn't mean a full cost, it means you really get
6 around 93. So, if all they have is what they're
7 getting from Medicare on their costs, they're not
8 going to survive. So, it's not like we're giving
9 them money to go to Vegas or something.

10 I think -- I had one more thought. I
11 think I forgot it. I'll come back to it.

12 CO-CHAIR COURT: We'll turn to Brock,
13 and then maybe you'll remember.

14 MR. SLABACH: Well, Tim said what I was
15 going to say, so I'll probably finish the thought
16 that he lost.

17 (Off microphone comment)

18 MR. SLABACH: No, I may do that here.
19 I think, again, we go back to this balance
20 between our obligation in terms of a safety net
21 and access, and a lot of the facilities -- I
22 mean, if you look at the statistics of the

1 financial status of critical access hospitals as
2 a group, you're looking at about 70 percent that
3 are now losing money on an annual basis on
4 operations. So, I think I would agree with Tim,
5 if it was an additional amount of money that you
6 could stand to gain if your performance is good,
7 would be a much better direction than to do a
8 discount based on not performing. And I -- so, I
9 would agree with that, and I'll stop there.

10 MR. SIZE: Back to what I forgot?

11 CO-CHAIR COURT: No way. Okay, go.

12 MR. SIZE: Yes. I just was going to
13 make the point is, you know, the most recent
14 iVantage data that was just released Monday, I
15 mean, they're basically making the point that
16 Medicare's expenditure per beneficiary in rural
17 areas is on average 2.5 percent less than urban.
18 So, it's not like there's not a little bit of
19 money that's in the trust fund that they could
20 spend for incentives and still have the
21 investment to rural beneficiaries being below the
22 national average. I think the money is there, and

1 the case could be made for it.

2 CO-CHAIR COURT: Greg.

3 DR. IRVINE: I would concur with that
4 completely, what was said, that we don't want to
5 take away because there's nothing to be taken
6 away, and you're going to kill hospitals if you
7 do that. Critical access hospitals are going to
8 go down, especially in the west, I think. Places
9 that are truly critical access, and that there's
10 just nothing else. There's no other option.

11 I would also plead for -- when it
12 comes to pay for performance, looking at the
13 measures that you are going to be using as your
14 marker, that hospitals be given at least some
15 flexibility, if not allowed to design their own
16 program, at least be given a menu of quality
17 measures to look at and say this one doesn't make
18 sense for us, but this one does. Kind of like a
19 Chinese menu, one from Column A, one from Column
20 B.

21 Don't force them to necessarily live
22 with everything, and if you give them enough

1 choices, they'll find things that make sense for
2 their environment.

3 CO-CHAIR COURT: I'd like to see the
4 dates of the measures closer to -- a faster cycle
5 time, because in the hospitals there's a -- I
6 mean, you've got to get your measures in fairly
7 quickly, but it seems like the time that then
8 those measures are applied to the program is so
9 far after the fact that it's really hard to get
10 too excited about something that happened two
11 years ago. So, if there would be a way to speed
12 up the cycle time between the performance and
13 whatever they're used for. Tonya.

14 MS. BARTHOLOMEW: If I could choose one
15 thing that this program would have it would be
16 going back to the alignment, and reporting the
17 same data to the same place for multiple
18 entities. I think that you'll do a better job of
19 recruiting people to do that to participate in
20 the quality measures, and I think it would really
21 ease the burden of the cost of creating the data
22 used in the reporting mechanisms.

1 CO-CHAIR COURT: Brock.

2 MR. SLABACH: I think an additional
3 item that would help make, if we're assuming
4 mandatory reporting, is to ensure that for --
5 well, for all facilities not currently
6 reporting, that there's technical assistance
7 that's provided in terms of the ability to get
8 this underway within these particular groups of
9 people, facilities.

10 CO-CHAIR COURT: Steve, I'm sorry. You
11 have to like wave your hands, too, I guess. The
12 closer you are, the harder it is to see.

13 DR. SCHMALTZ: Things like the VBP
14 program, you also need a component for
15 improvement and for what their current level is.

16 CO-CHAIR COURT: Yes, so include credit
17 for improvement, not just achievement.

18 CO-CHAIR MOSCOVICE: How would you
19 design that, Steve?

20 (Off microphone comment)

21 CO-CHAIR COURT: Yes, I agree.

22 DR. SCHMALTZ: You'd have to follow

1 them a couple of years, but -- so there's the
2 currency, I guess, that would cut into that, but
3 --

4 CO-CHAIR MOSCOVICE: Would there be a
5 base that they have to reach at least even in
6 terms of improvement to --

7 DR. SCHMALTZ: Yes, yes. You'd design,
8 I'd say pretty much parallel the VBP program.

9 CO-CHAIR COURT: Bob.

10 DR. RAUNER: We just had this
11 discussion actually with Michael's counterpart in
12 Harvard Health Plans, like we picked a new
13 measure, depression screening in adolescents, and
14 because they -- how they define their
15 denominator, they wanted the whole population
16 whether we see them or not. We said well, how do
17 we even start the baseline then? So, we actually
18 decided to mix this by first six months that we
19 establish a baseline that would be at least 10
20 percent.

21 Second six months it'll be either an
22 improvement upon that baseline by a certain

1 percentage or a threshold, because most
2 improvements will have kind of an S-shaped curve,
3 so you can't always say 10 percent every year
4 because eventually that doesn't get -- and you
5 can't always get 100 percent, so we actually I
6 think came up with, I think, kind of a unique
7 solution where it's the baseline, then percentage
8 on, then up to a cap because you'll never get
9 everybody, for example. And I think that was kind
10 of a way to blend both improvement and
11 achievement, and we'll see how it works. I don't
12 know, we just started.

13 CO-CHAIR COURT: Mike.

14 DR. BAER: Yes. I wasn't so sure I was
15 thinking of having a blended program where you're
16 saying, you know, if you have improvement there's
17 a payment, and then if you meet a target there's
18 a payment. But I'm -- what I was going to say
19 before Steve said that, was that one way to look
20 at it, and in Pennsylvania we do this in our pay
21 for performance from the Department, as well as
22 in some other areas where we have a goal, and if

1 they don't meet that goal, but year over year or
2 measurement period over measurement period
3 there's a percentage increase, then they would
4 get a payment for that improvement, even if they
5 didn't meet the goal, but they've made a
6 significant, like a 10 percent increase in their
7 performance over the measurement period prior.

8 CO-CHAIR COURT: I think the hospital
9 VBP, that you have to meet at least a minimum
10 threshold, don't you, to get any payment?

11 DR. SCHMALTZ: Well, there's two
12 criteria, so the first is what their achievement
13 is. If their achievement is below a certain
14 level, then they look at improvement. If they
15 meet the improvement goal, then they can get the
16 payment.

17 CO-CHAIR COURT: Yes. Kimberly.

18 DR. RASK: And one of the things I
19 would add to it, and this is slightly self-
20 serving since I do work for QIO, but as we think
21 about, we've talked about rolling out these
22 measurement programs to small volume providers

1 who don't have a lot of infrastructure, don't
2 have a lot of resources. As this was rolled out
3 through all the different steps for hospitals
4 over the last many years there was a lot of
5 technical support, technical assistance that was
6 available to them through QIOs and similar type
7 programs to really help people learn how to
8 report, what field you put in, what does it mean
9 if this is blank, or how do you include this,
10 that, or the other.

11 And I think it would be important to
12 recommend that whatever measures get put out, and
13 if this becomes mandatory reporting, and so for
14 these providers that have -- are so low on
15 infrastructure, and on other resources, having
16 mechanisms for some kind of technical support to
17 help them report accurately, effectively, and
18 consistently will go far to making it a useful
19 program, as opposed to a gigantic headache.

20 CO-CHAIR COURT: Ann.

21 MS. ABDELLA: Relative to the idea of
22 the measures with quality improvement or

1 baseline, would they -- are you suggesting they
2 would reach a certain threshold and that's okay,
3 or are we seeking constant steps up in
4 improvement? And one of the challenges that we've
5 had on a -- working with -- on the commercial
6 side is the idea behind statistically significant
7 improvement. I don't know if that's how you all
8 operate with your quality improvement measures
9 for the hospitals. But, you know, they're always
10 arguing with us statistically significant every
11 year, it has to be in order to qualify. And when
12 you're dealing with small numbers, that can be a
13 real challenge, so --

14 CO-CHAIR COURT: Sheila.

15 DR. ROMAN: Just to follow-up on what
16 Kimberly said. I think, you know, we're dealing
17 with a population of providers that has not had a
18 lot of experience with reporting quality
19 improvement. And perhaps jumping to pay for
20 performance is really too big a jump at this
21 point, and that we should really be recommending
22 pay for reporting at this point, rather than pay

1 for performance, which has higher stakes. And we
2 really don't have the measures and measure
3 experience with this population to know how it
4 will play.

5 CO-CHAIR COURT: And then, Sheila,
6 earlier you put public reporting in between
7 there, so -- I guess that's implied in the pay
8 for reporting.

9 DR. ROMAN: I think at this point it's
10 implied in pay for reporting.

11 CO-CHAIR COURT: Yes, okay.

12 DR. ROMAN: It wasn't initially.

13 CO-CHAIR COURT: Okay. So, a phased
14 approach is -- this isn't a one-step process.

15 DR. ROMAN: Right. Walk before you run.

16 CO-CHAIR COURT: Yes. Bob. Other
17 things?

18 MS. JOHNSON: So, I think we covered
19 our agenda. We got through what we wanted to go
20 through today. Yes, we still have to get our
21 public comment, which I'm not going to forget.
22 Thank you, at this time. But I don't -- does

1 anybody have any objection to leaving a little
2 early today?

3 Okay. So, we're going to open for
4 public comment. Is there anything else we need to
5 do, any housekeeping for the rest of the day?

6 Okay, we had -- we didn't set up an official
7 dinner for you guys. We didn't set up like
8 reservations, but we can recommend some
9 restaurants around if you guys are interested.
10 I'm not sure if you guys already had plans or
11 what have you, but there's several that are good
12 that are very close, so we can talk about that
13 after. But let's just open it for public comment,
14 and then we'll adjourn for the day.

15 MS. GHAZINOUR: Operator, would you
16 please open the lines for public comment?

17 OPERATOR: At this time if you would
18 like to make a public comment, please press *1 on
19 your telephone keypad.

20 And there are no public comments at
21 this time.

22 MS. GHAZINOUR: Thank you.

1 MS. JOHNSON: So, just so you know
2 what's on our agenda for tomorrow. One of the
3 things that we're going to do is we're going to
4 huddle here and make sure that we got what we --
5 we'll make sure that what we wrote down and what
6 we think you said is what you said. And we're
7 going to present that to you tomorrow morning,
8 and we'll just go through and see if we missed
9 things, did we misunderstand anything, that sort
10 of thing. We want to go through that. And then we
11 will just continue the conversation. I think what
12 we got through today was some of the bigger
13 measurement issues, so there are other ones I
14 think that you may want to talk about, and we
15 could talk about solutions for those.

16 And we've purposely not talked much
17 yet about those bigger rural issues that are a
18 little tangential to measurement, but apply. And
19 there may be recommendations that you want to put
20 forward on those kind of things, so we want to
21 give you that opportunity to do that tomorrow.

22 Also, Helen, I'm not going to put you

1 on the spot now, but they did want to know a
2 little bit more, and I didn't have the context to
3 be able to say, when guidelines change, the P4P
4 for programs don't change. They're still out
5 there, those measures are still on the list of
6 being -- people are still being held accountable
7 to measures that maybe aren't quite with the
8 guidelines. So, do you have any context on that?

9 DR. BURSTIN: Yes. So, I mean, it's
10 pretty dependent, but usually what happens if
11 it's a guideline that's had a significant change
12 like lipids, the measures are pulled from the
13 program. So, for example, currently the measures
14 of lipid control are no longer in most of the
15 federal programs. There's even still ongoing work
16 to revise the blood pressure measures based on
17 the new guidelines, so it isn't quite that they
18 stay out there. I think sometimes the problem is
19 that you've seen one guideline and then two days
20 later there's another one saying the opposite, so
21 I think it's often hard to figure out when the
22 ground has stopped moving enough to figure out

1 what the new measure should be.

2 But, you know, as NQF looks at
3 measures, and we'll do an update -- we'll do an
4 ad hoc review on any measure any time where
5 there's a change in evidence, so we'll do that
6 immediately. We just did that for the sepsis
7 guidelines, for example, when the process trial
8 came out in the New England Journal. But it's --
9 we require the quality, quantity, and
10 consistency of evidence, and consistency is most
11 important, as certainly the clinicians in the
12 room know. And we won't put forward a sort of
13 evidence-based guideline unless there's
14 consistency of evidence.

15 MS. JOHNSON: And then another thing,
16 Tim had asked tomorrow morning, so maybe you and
17 I can huddle, Helen, and just give a real brief
18 synopsis of where we are with our SDS work, so
19 I'm not sure if it'll be Helen, or me, or some
20 combination. Ann.

21 MS. ABDELLA: You've referred a couple
22 of times, some of you, to this MAP process, and

1 I'm wondering if you could add that to the mix to
2 give everybody just an overview? Might be really
3 helpful.

4 DR. BURSTIN: In terms of the SDS
5 discussions we could talk about because there's
6 really sociodemographics. I think part of what
7 didn't happen when we did our initial work around
8 thinking about what variables were there, is
9 there really wasn't a focused discussion of what
10 would those variables be from a real context. I
11 think earlier, I forgot, it was Brock or Tim
12 mentioned, you know, distance to the local
13 facility. That didn't come up, but in a context
14 of thinking about adjusting rural measures that
15 might be a very useful discussion tomorrow that's
16 directly relevant now that we've opened --

17 measures can now come in with that kind of
18 adjustment. They could really use advice on what
19 kind of variables they should be adjusting for.
20 So, I think that would be a useful exercise, too.

21 MS. JOHNSON: Okay. Anything else?

22 All right. Thank you guys so much for

1 a great conversation today. I will see you
2 tomorrow. We're starting at breakfast at 7:30 and
3 discussion at 8:00.

4 (Whereupon, the above-entitled matter
5 went off the record at 4:48 p.m.)
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This is to certify that the foregoing transcript

In the matter of: Performance Measurement for Rural
Small-Practice Health Providers

Before: NQF

Date: 02-05-15

Place: Washington, DC

was duly recorded and accurately transcribed under
my direction; further, that said transcript is a
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