FEDERAL TRADE COMMISSION

ROUNDTABLE ON THE COMPETITIVE SIGNIFICANCE OF HEALTHCARE PROVIDER QUALITY INFORMATION

Thursday, October 30, 2008

9:00 a.m.

Federal Trade Commission

600 Pennsylvania Avenue, N.W.

Washington, D.C.

Room HQ 432

1 FEDERAL TRADE COMMISSION

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

2 **(9:00 a.m.)**

3 MR. WROBLEWSKI: Thank you all for joining us
4 this morning. My name is Michael Wroblewski and I'm an
5 attorney in the Bureau of Competition, the Office of
6 Policy and Coordination. My co-moderator today, and the
7 person who has been my partner in crime, is Pat
8 Schultheiss, also in the Bureau of Competition, Office of
9 Policy and Coordination.

10 Before we start, I need to go over a couple of
11 housekeeping security matters. Please if you'll turn off
12 your cell phones or put them in silent mode, any
13 BlackBerries, electronic devices.

14 The restrooms are right outside the double
15 doors to the left-hand side.

16 In the unlikely event that the building alarms
17 go off, we'll proceed calmly down the stairs, which are
18 down to the right-hand side, out across the street to the
19 sculpture garden. But please follow directions and
20 remain calm.

21 If you spot any suspicious activity, please
22 alert Pat or me or the security staff downstairs.

23 CHAIRMAN KOVACIC: That doesn't include
24 unorthodox thinking.

25 **(Laughter.)**

1 MR. WROBLEWSKI: As we're assembling this
2 morning, these microphones actually are on the entire
3 time. So, if you're not speaking, if you can turn the
4 microphone away, that will reduce some of the chatter
5 going on in the background.
6 I'd like to introduce everyone here before we
7 get started as well. I'm going to start on my right-hand
8 side. I'm just going to give names and titles. More
9 biographical information is included on the FTC Web site
10 and also in the packets that are outside.
11 First, we have Dr. Michael Barr, Vice
12 President, Practice Advocacy and Improvement, at the
13 American College of Physicians.
14 Next to him we have Elysa Ferrara, Director,
15 National Provider, Quality Performance Programs for
16 Aetna.
17 Next to her we have Nancy Foster. She's Vice
18 President for Quality and Patient Safety at the American
19 Hospital Association.
20 Jack Fowler is to her left. He's the President
21 of the Foundation for Informed Medical Decision Making.
22 Dr. Ardis Dee Hoven, she's a member of the
23 Board of Trustees of the American Medical Association.
24 Kristin Madison, Professor of Law at the
25 University of Pennsylvania Law School.

1 Andy Webber, President and CEO of the National
2 Business Coalition on Health.
3 I'm going to skip over the Chairman for just a
4 second.
5 **(Laughter.)**
6 MR. WROBLEWSKI: Markus Meier, who will be
7 joining us shortly, is the Assistant Director for the
8 Bureau of Competition for the Health Care Management
9 Services and Products Division.
10 Dr. Beth Nash, Manager, Partner and Product
11 Development for Consumers Union.
12 Then Dr. Clyde Chumbley, he's the President and
13 CEO of ProHealthcare Medical Associates and he is
14 representing the Wisconsin Collaborative for Healthcare
15 Quality this morning.
16 Dr. Vincent Kerr, President, Care Solutions and
17 Chief Medical Officer, National Accounts for United
18 Healthcare.
19 Peter Lee, Executive Director for National
20 Health Policy at the Pacific Business Group on Health.
21 And, finally, we have Barbara Rabson, Executive
22 Director, Massachusetts Health Quality Partners.
23 Thank you all for joining us today.
24 To kick off the roundtable it's my pleasure to
25 introduce FTC Chairman Bill Kovacic. Bill was

1 instrumental in me coming back and I really appreciate
2 the opportunity to put into play what we actually started
3 -- what we talked about in April, May time frame. It's
4 actually nice to see that it's coming to fruition this
5 morning. So, thank you.
6 Bill?
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1 **INTRODUCTORY REMARKS BY CHAIRMAN WILLIAM KOVACIC**

2 CHAIRMAN KOVACIC: Thank you, Michael, and my
3 thanks also to Pat for your extraordinary and
4 characteristically skillful efforts to assemble this
5 program.
6 I think, as many of you who are students of the
7 Commission know, this format for policy development has
8 become an increasingly important part of what the
9 Commission has done over the past certainly 15 years.
10 And I thought to begin today I'd put today's proceedings
11 in a little bit of context to give you a fuller sense of
12 why Michael and Pat asked you to come today and what
13 purpose this type of discussion serves for us.
14 For many years, many observers realized that
15 the FTC had capabilities that went beyond simply being a
16 law enforcement agency. We do enforce competition and
17 consumer protection law in this area, but a major, I
18 think, renaissance for the agency took place just about
19 15 years ago, when Bob Pitofsky began the process of
20 coming back to the agency as Chair.
21 And Bob's particular insight for the agency was
22 that it had a distinctive role and mission to be a forum
23 for discussion and to use a variety of different tools to
24 assemble a base of knowledge to make judgments about key
25 areas of policy concern.

1 We deal with a number of subjects that could be
2 called complex and difficult. I'm actually not
3 accustomed to seeing any industry or sector that we deal
4 with call itself simpleminded and routine. All are able
5 to identify complexities associated with what they do and
6 what they provide.
7 But I don't think anyone would contest the
8 notion that the preparation and delivery of health care
9 services is certainly as complex, as difficult, as
10 complicated as any, not simply because of difficult
11 issues of science associated with the formulation of
12 treatment programs, the unique and difficult regulatory
13 context in which health care services are provided in
14 this country, a mix of competitive processes, a mix of
15 particularly elaborate and complex public regulation at
16 the national and local level, but also a host of
17 extremely difficult substantive issues associated with
18 choosing a business model and organizational approach
19 that delivers the best possible results for American
20 citizens.
21 For all of those reasons, this body of endeavor
22 is especially difficult. And I think the agency,
23 beginning with Bob's tenure, recognized the importance of
24 investing in knowledge, that if we were to do good policy
25 work by way of making recommendations to our legislature,

1 making a wise choice of enforcement programs, designing
2 public education programs, that we had to make a
3 conscious effort on a regular basis to invest in
4 accumulating knowledge, and that the holding of
5 workshops, conferences and related programs ought to be
6 an indispensable part of that.
7 That the Commission could play a distinctive
8 role by being a convener where individuals in a setting
9 such as this, all committed to a search for the best
10 solutions, could discuss in a constructive and
11 informative way what the way ahead ought to be for the
12 FTC.
13 The role of competition in generating
14 information about quality to consumers has been something
15 in this decade that has been highlighted again and again
16 as an important possibility. As you know in watching
17 what we do, it’s not the first time that this topic has
18 come up.
19 Indeed, because of the past work of people like
20 Pat and Michael, the agency has had an eye for this topic
21 over time and this can be considered to be the latest of
22 what will be a continuing set of explorations about this
23 issue.
24 As you are more keenly aware than I am,
25 particularly where one is dealing with complex goods and

1 services, the question always arises what role is there
2 for information about quality to guide the choices of
3 consumers or intermediaries who act on their behalf? Are
4 consumers able to absorb the relevant information? Can
5 they make sensible judgments based upon information
6 that's provided?
7 Whether one is a scholar and teacher in the
8 field of contract law, a physician working with a health
9 care provider, whether one is working for an NGO that
10 acts on consumers' behalf, I think all of us are quite
11 aware that basic questions about how consumers absorb
12 information, how they form judgments on the basis of that
13 information, whether selected types of information can
14 properly be assessed by individual consumers or those who
15 act on their behalf is a continuing and important
16 question in this field, as well as others.
17 My hope for today is that through the very
18 skillful and thoughtful assembly of the panel, that by
19 the close of the discussion today and in the proceedings
20 to come, that we will have a better understanding of
21 these topics.
22 For those of you who have not engaged in this
23 process with us before, I can assure you that your
24 comments today become the stimulus for significant and
25 ongoing consideration of what we ought to do. In many

1 ways today, we are your students and we look forward to
2 learning from what you have to say.
3 Two further thoughts. One, I want to give you
4 my profound thanks for being here to do this. As Michael
5 and Pat have seen -- and you will see their real artistry
6 in assembling panels and formulating issues because
7 they've done this so well in the past -- the essential
8 ingredient of successful programs is to have the most
9 thoughtful observers come and spend their time with us.
10 And we are deeply grateful for your taking a day to come
11 back and forth, even more of your time, to make this
12 possible and to give us your thoughtful reflections on
13 the many topics that are here in short.
14 If you're not willing to do this on our behalf,
15 the undertaking is not successful. So thank you, thank
16 you greatly, in advance for doing this.
17 And the second is I think to see this as part
18 of a process of policy development that's going to
19 endure. There are always questions associated with a
20 change in regime, a political electoral cycle in which
21 management changes, in which new leadership comes to the
22 agency, about what the future of the agency will be. If
23 we were to see ourselves as a firm, this is a product
24 that's going to be in our inventory for a long time.
25 This issue will be a perennial.

1 If we were to see ourselves as being the
2 Kellogg's Company, I can imagine that a new chair at some
3 point will come in and say maybe we ought to have
4 granola, maybe we ought to put frosted sugar on this
5 product, but we're certainly going to keep making
6 cornflakes. That is, we have a number of well-respected
7 brand items in our product line. And this format for
8 discourse, this set of policy issues I think will be
9 enduring ones.
10 So I want to add the further assurance that by
11 contributing your thoughts and your energy to this
12 program today, you're making a contribution to the
13 capital account of the agency that we will be drawing on,
14 I think, as long as this agency exists, not simply to its
15 centennial in a few years, but I hope for the many happy
16 centuries beyond that.
17 So, thank you again. My deep thanks again to
18 Michael. I can't tell you how much our stock went up
19 when the market saw that Michael was coming back to us.
20 But I'm enormously grateful to Michael and to Pat for
21 doing this on our behalf. And, once again, to you for
22 making this what I'm sure will be a most informative and
23 successful event. Thank you, Michael.
24 MR. WROBLEWSKI: Thank you, Mr. Chairman.
25 CHAIRMAN KOVACIC: I'm going to go next-door to

1 mission control.

2 **(Laughter.)**

3 MR. WROBLEWSKI: Thank you.

4 CHAIRMAN KOVACIC: Thank you all.

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1 **CONSUMER, PHYSICIAN, EMPLOYER AND INSURER QUALITY**
2 **INFORMATION NEEDS**
3 MR. WROBLEWSKI: The objective of today's
4 discussion is really to look at what's the competitive
5 significance of health quality information. This
6 morning, we thought we'd do it a little bit differently
7 and try to go through each four groups -- we'll call them
8 the demand-side groups -- consumers, physicians,
9 employers and insurers -- users of health quality
10 information, and find out what really makes consumers
11 move from one provider to another provider. What is it
12 about that information?
13 So, the first session that we're going to have
14 this morning is really going to focus on the needs of
15 consumers and of physicians, primary care physicians in
16 particular. And to help lay the groundwork for this
17 discussion focusing on consumer and physician needs, Dr.
18 Chumbley of the Wisconsin Collaborative and Barbara
19 Rabson from MHQP will present what they've been doing in
20 their states to advance these issues.
21 Dr. Chumbley, you can stay there if you'd like.
22 DR. CHUMBLEY: I think if that's okay, I'll
23 just stay here. That's good. It's always good to go
24 first so you can get it out of the way here.
25 MR. WROBLEWSKI: You may want to move the

1 microphone a little closer. There you go.
2 DR. CHUMBLEY: This is just a copy of who we
3 are and what we do. That's in your packets. I'm not
4 going to read through that for you. But we are a
5 voluntary consortium of organizations that are listed on
6 this. I think the important point here is that we
7 represent 40 percent of all Wisconsin physicians and 50
8 percent of the primary care physicians.
9 Wisconsin is lucky when it comes to this sort
10 of thing by being organized into medium-size and very
11 large multi-specialty groups. I think that's because we
12 were so close to the Mayos and the Mayo Clinic and a lot
13 of our clinics were actually developed by Mayo graduates
14 anywhere from 50 to 75 years ago.
15 We have a number of business partners. When we
16 established the collaborative, we looked for business and
17 purchaser partners and this is a list of some of the
18 partners that we have from the business community. It
19 doesn't show up too well.
20 But in your packet it basically gives you a
21 chronology of the history of the Wisconsin Collaborative
22 Healthcare Quality and it was really the brainchild of a
23 number of these large group CEOs back in 2002, about
24 seven years ago. They published their first report in
25 2003. That was about five years ago. Since that time,

1 we've increased the number of measures that we've
2 reported on and we've increased our membership.
3 When they first started this, I think there was
4 only about 12 organizations and I do recall writing them
5 and asking to be one of the founding organizations, but
6 they were already well on their way at that point. So,
7 we came in the next year, at least my organization did.
8 The key characteristic of the Collaborative is
9 it's a voluntary data collection by provider
10 organization. So when my organization joined, it was
11 voluntary. We went in and said that we will report on
12 these measures. We have administrative data to identify
13 the denominator, the patients, combined with the clinical
14 information, again, whether they had clinical -- had an
15 A1C or some type of laboratory test.
16 We report performance at the group level, which
17 includes all patients, regardless of payer. So, this
18 data actually comes from the medical groups directly into
19 the Collaborative and it was -- an important part was it
20 was outside verified initially by Medistar, and since
21 that time we've developed an outside auditing function
22 where the data is audited as well.
23 So, what is the value of this? It gives us an
24 option to view the performance of our individual groups
25 compared to other groups in Wisconsin, drill down to the

1 provider level if we choose to. We do include all the
2 patients within a system, within the clinic. All payers
3 are represented. It delivers a road map for the
4 improvement. And it has stimulated a number of
5 collaborative efforts by large multi-specialty groups in
6 the state to improve cardiac performance or orthopedic
7 performance by looking at what others are doing.
8 I know in my own organization, we were not
9 doing well on cancer screening measures that we were
10 reporting, and so I initiated an effort to improve the
11 number of screenings we did in the area of colonoscopy,
12 mammograms, et cetera.
13 This is just what one of our Web pages looks
14 like. You can access it. It's a fairly, I think,
15 user-friendly Web site. You can look at the Institute of
16 Medicine categories, you can look at a particular
17 clinical topic. It is listed by the clinical topics or
18 you could look at all ProHealthcare Medical Associates'
19 parameters. It is divided up by region as well. So, if
20 you ever have time to go on, you can play with it a
21 little bit and see what we report on.
22 This is just a list of the current measures,
23 A1C screenings all the way down to cholesterol
24 management. We also have preventive care screenings,
25 which is the one I was mentioning for my organization.

1 And we have some new measures coming up, adult screening
2 for tobacco and screening for osteoporosis.
3 We have tried to engage the consumers over
4 time, but frankly we've not been too successful. When
5 you look at the hits to our Web site, the vast majority
6 are the organizations that are looking at their
7 competitors to see how they're doing and to see where we
8 need to improve.
9 I believe it has increased the quality of
10 medical care provided in Wisconsin on that basis alone,
11 but we have not seen a great deal of consumer or patient
12 use of the Web site. We've encouraged businesses to use
13 it in their open enrollment, but I've not seen a great
14 deal of that as well.
15 Our philosophy has been to report the
16 information unaltered and allow the reader to drive the
17 conclusions. So, we don't have three-star, two-star,
18 one-star ratings for the individual organizations.
19 Again, the primary users are the providers. We
20 have an RWJ research project to try to increase the
21 awareness of patients in Wisconsin, consumers in
22 Wisconsin, and we're also in the middle of a
23 complementary strategy called "Ask Me 3," which is what
24 do I have, what do I do about what I have, medical
25 condition I have, and why is it important. And, so,

1 we’re trying to get that drilled down to the patient
2 level as a way to improve the use of the site.
3 And I think -- maybe not last, but the near-
4 term evolution is that we are thinking about increasing
5 or expanding to ambulatory quadrants, the cost versus
6 quality measures. We have some of those for some of the
7 hospital measures. We are considering some specialty
8 measures in cardiology, orthopedics and nephrology.
9 We would like to start reporting at the
10 practice site granularity like Minnesota does, so that
11 you could go on the site and you could go to one of my 28
12 clinics and click on that and tell what our diabetic
13 screening rate is or what this rate is or that rate is.
14 We don’t currently do that. We just report totally by
15 the organization, all sites.
16 There’s a lot of talk about physician-level
17 reporting. It is still our policy that we do not report
18 at the physician level. We believe that there are
19 significant problems remaining in this data. I think I
20 recently heard Beth McGlynn report on some of the
21 Massachusetts data which highlighted some of the -- at
22 least on the cost side. It’s cleaner on the quality
23 side, but not as clean on the cost side. But we are
24 working more in teams than individuals and we wonder
25 about the fairness. So, we still report just at the

1 practice level.

2 So, last few thoughts, we were lucky enough to
3 have a lot of people involved, a lot of multi-specialty
4 groups, a really shared vision. The groups themselves
5 did the work, which made it credible to the physicians,
6 and I think if you ask any of the physicians in Wisconsin
7 -- and I hope the business partners we have -- that we
8 have credible, reliable data at this point, although it's
9 certainly not doing everything we had hoped it would do
10 for consumer engagement.

11 MR. WROBLEWSKI: Thank you very much. If
12 you'll hand the clicker to Barbara at the end of the row
13 there, we'll start with a look at Massachusetts. Thank
14 you.

15 MS. RABSON: So, I appreciate the opportunity
16 to speak with you all today and look forward to the
17 discussion. I'm going to talk about the experience we've
18 had in Massachusetts on performance reporting, both on
19 the physician and consumer side. We've been reporting
20 for over a decade publicly about performance measures in
21 Massachusetts.

22 Our first public release was in 1998 and this
23 was the first-in-the-nation statewide hospital-wide
24 survey of patient experiences with acute care hospitals.
25 It was a voluntary survey, but we had the majority of the

1 hospitals in the state participate and it was really very
2 -- it stimulated tremendous improvements on the side of
3 the hospital.
4 This was actually before the IOM had recognized
5 patient experiences as one of the important measures,
6 that care should be patient-centered. So, we were a
7 little bit ahead of our time.
8 We switched over to the physician measurement,
9 and since 2005, we've been having annual reports of
10 physician performance on clinical HEDIS measures. We
11 report for 150 medical groups across the state. We've
12 also been reporting on patient experience with patients'
13 visits with their primary care doc at the practice site
14 level. We've had two public releases in 2006 and 2008.
15 Just this year we added specialties, although we did not
16 publicly report on the specialists that we added. It was
17 a first-time round and it wasn't quite ready for prime
18 time.
19 MHQP, similar to Wisconsin, is a broad-based
20 quality collaborative. We have different players at the
21 table for Massachusetts. I'd say that what's really
22 important about these collaboratives that are springing
23 up all over the country, which is terrific, is that the
24 concept of fairness really shifts when you have all these
25 people in the room.

1 So, if you have a group of physicians, what's
2 fair is that nobody gets hurt. If you have a group of
3 consumers in the room, and employers and health plans,
4 they'll begin to say, but wait a minute, I've been making
5 decisions with no information for years and people have
6 gotten hurt.
7 So, it's a really important concept and I think
8 that's why there's so much new highlight or spotlight on
9 these coalitions, because they add a lot of value.
10 Our goal is to provide health care information
11 that you can trust, and we have -- provide this
12 information both to physicians so they can improve the
13 care they provide, and to patients so they can take a
14 more active role in their health care decision-making.
15 And it really, at times, creates great tensions that we
16 are trying to do both, that we really have these two
17 goals of meeting the consumers' needs and meeting the
18 providers' needs.
19 But what we found is that we feel it's very
20 important for people to get the same information and be
21 working off the same data set. We also know from
22 numerous focus groups that patients turn to their
23 physicians as a first point of getting health care
24 information and they really trust their physicians.
25 So, if you provide information to consumers,

1 they bring it into their doc and the physician discredits
2 it, well, you haven't gained anything because then you've
3 just, you know, sort of lost what you have. So, I will
4 say this is a harder route to go, but I feel it has great
5 value in the long term.
6 Certainly, engaging physicians in performance
7 measurements has been a very -- it's been a very -- it's
8 a journey that started hard and has been getting easier.
9 I'll say it that way. But the way we do it is that when
10 we started focusing on physician measurement, we felt it
11 was really important to have physicians at the table
12 whose job it was to implement improvements within their
13 organization. And having a medical society at the table
14 was great, but we needed these on-the-ground docs.
15 So, we set up what we call our physician
16 council, and these physicians are leaders from 16 of the
17 largest groups across the state. They are advisors.
18 They've become ambassadors from MHQP. I think of them
19 sometimes as the jewel in our crown.
20 Here's a quote from one of our physician
21 council members, who's no longer there, but continues to
22 be an ambassador. She says, "A voice at the table is
23 huge. Physicians know all their concerns are not going
24 to be met, but to be able to raise what is really
25 important and have it taken seriously and used to modify

1 the process is worth everything."
2 So, I think the importance of this is that some
3 people say if we get the physicians to the table,
4 everything will grind to a halt. Well, that's not the
5 case. It does create some challenges, though.
6 Here is a list of some contrasts in what
7 consumers and physicians -- physician preferences for
8 comparative information. And I think sort of the top
9 level here is that consumers want easy to understand and
10 physicians want fairness. And, so, if you look at
11 symbols, consumers want symbols they can easily recognize
12 and interpret. Physicians don't want anything
13 judgmental. They want it purely statistical.
14 Consumers want simple messages. No caveats. I
15 heard from a study, the more caveats you put, people just
16 sort of doze away and say, wait a minute, what you're
17 telling me is that there's nothing I can believe here,
18 and so, they walk away. On the other hand, physicians
19 want full disclosure of all the limitations, caveats and
20 methodology.
21 Consumers want a synthesis of all the
22 information. So, clearly, you can just tell me who's
23 good and who's bad. Physicians are saying, well, wait a
24 minute, if you have a specific measure, that measures
25 that specific thing. It doesn't mean that that physician

1 is good at everything just because they're good at one
2 thing. Like all people, physicians are good at some
3 things and not so good at others. And, so, they feel
4 that it shouldn't be rolled up into a yes/no.
5 And, so, we've tried to navigate between these
6 two. I think it's been a very challenging but rewarding
7 experience. It's something you have to continually
8 address because these things also shift in terms of
9 preferences.
10 So, as far as the impact of MHQP's public
11 reporting, I'm going to talk about the clinical HEDIS
12 reporting we've done. We are currently involved in a
13 study with the Commonwealth Fund to look at the impact of
14 our patient experience reporting. But that hasn't been
15 completed yet.
16 So, in terms of the impact, there's a much
17 greater impact on physician behavior than consumer
18 behavior. We know that. Physicians have improved -- of
19 all the measures that actually can be trended over the
20 period of time we've been doing it, physicians have
21 improved on eight over nine.
22 Clearly, there is lots going on in the
23 Massachusetts marketplace, so we can't claim that this
24 improvement is due solely to MHQP's reporting to
25 physicians and the public. However, it has some impact.

1 The fact that we can track it is a key issue because most
2 communities can't track this because they don't have this
3 kind of reporting.
4 I think the greatest impact on our public
5 release is to influence physicians on sort of
6 understanding that they need to improve how they practice
7 and changes they've made. And I've got two great
8 stories. One is from Tom Lee at the Partners System.
9 The first time we had a public release it was
10 actually in 2004 on the physician side. It was at the
11 network level, so the very large physician organizations.
12 All of Partners, all of Harvard Vanguard, all of Lahey
13 Clinic, Fallon Clinic, UMASS, Caritas, so on, and Harvard
14 Vanguard was at the top and Partners was not.
15 So, Tom Lee called over to Vanguard and said,
16 well, can we come over and see what you're doing, how we
17 provide care, because we consider ourselves number one
18 and we want to get there. And what they focused on was
19 the idea that there was a centralized electronic health
20 system, electronic health record capture was centralized.
21 And Partners was beginning to embark on a
22 requirement that all the physicians in their network
23 implement electronic health records, but they had no
24 rules around sort of what they'd pay for. There was sort
25 of a list of eight different approved vendors.

1 After seeing the results of MHQP'a data
2 publicly, after talking to Vanguard, they realized they
3 needed a much more centralized system. So, they changed
4 what they were going to pay for in terms of implementing
5 electronic health records. So, they could either get
6 onto the Partners homegrown system or one other vendor,
7 which was huge really.
8 The other example is a very small group that
9 wasn't in the first public release, but they saw the
10 writing on the wall and they had been planning to
11 implement electronic health records, but not for quite a
12 while. They saw what their quality scores currently
13 were.
14 They saw what the benchmark scores were, those
15 that we'd already publicly released. They said the only
16 way they were going to get from where they were to where
17 they wanted to be to be competitive was to implement
18 electronic health records earlier. So, they fast-
19 tracked two years earlier than planned and implemented
20 their electronic health records.
21 The other use of this reporting is that
22 physician organizations use the information internally to
23 -- for pay-for-performance to reward individual
24 physicians with the group. We currently only have the
25 primary care data. They've asked for specialty

1 information, both for distributing within their
2 specialists, but also the primary care docs have said
3 they'd like to have that information when they make
4 referrals.
5 But it's hard to get -- so, this is on the
6 physician side. It's hard to get consumers engaged.
7 This is what we know about consumers from some focus
8 groups when we showed them our publicly-reported data.
9 It was really very eye-opening. We're very proud of our
10 Web site.
11 So, we showed them a slide of our data showing
12 how different groups performed on screening for breast
13 cancer. And, so, one woman looked at it and she said,
14 okay, so what you're telling me is that 92 percent of the
15 women that go to Fallon Clinic get their mammograms on
16 time. We said, yeah. She said, well, why should I care?
17 I go. I get mine on time. So, why are you telling me
18 this? This is not helpful to me. What I want to know is
19 if I go, I'm going to be cured, or I go, I'm going to be
20 treated with respect.
21 So, consumers want outcome data, physicians
22 want outcome data. We clearly need to move to outcome
23 data if we're going to get all parties more engaged. So.
24 that's on the clinical side.
25 On the patient experience side, consumers are

1 engaged with this data. They love having information
2 about how their physicians communicate and listen to
3 their patients, whether they know their patients well,
4 whether they coordinate their patients' care.
5 And, so, on the patient experience side,
6 consumers really felt this was the kind of information
7 that would let them pick the type of doctor that they
8 wanted. And, so, strategically, if we had started I
9 think as a rule to engage consumers, starting on the
10 patient experience side is really the way to go. We've
11 all started on the clinical side because that's been more
12 developed and that's more helpful to clinicians, at least
13 that's how it evolved. But I think that there's an issue
14 there.
15 Finally, just having any information, consumers
16 have said in our focus groups, having options, the
17 ability to make a choice in finding a doctor is really
18 empowering. They felt like they could take charge of
19 their health more because they had information that
20 helped them do that.
21 Interestingly enough, they said I really hope
22 the doctors use this information for quality improvement,
23 which was surprising to us a little bit, but it really
24 reinforced the idea that you should have the physicians
25 using the same data and embracing the data that you have

1 because, you know, it basically goes full circle. The
2 purpose is to improve quality. And if physicians use
3 this information for improvements, that makes the
4 patients happy because they'll get better care.
5 I think that this is just a summary slide. We
6 have not done efficiency yet. I just make a note of
7 that. As Dr. Chumbley mentioned, Beth McGlynn has been
8 working in Massachusetts on efficiency metrics. We're
9 still on the research side of that, sort of kicking the
10 tires on the efficiency metrics that are out there and
11 looking at the validity.
12 We did ask consumers about efficiency and they
13 said they didn't really get it at all. It's a challenge
14 to understand. They associate it with businesses, not
15 doctors. To them it means somebody is going to shortcut
16 their care.
17 I just wanted to take a quick tour of our Web
18 site and make a few points. Consumers really need
19 context to engage and embrace and understand quality
20 information and lots of different levels. And what we
21 found on the way we report, we report at the medical
22 group level, the practice side and not yet at the
23 physician level, but we hope to do patient experience
24 down at the physician level. Consumers didn't get those
25 different sort of concepts. So, we drew pictures, which

1 people felt really helped them ground sort of what the
2 relationships were.
3 Our site is interactive in that you can put in
4 your Web site -- excuse me, your zip code and you can
5 enter a name either of the medical group if you know it,
6 practice site if you know it or the doctor and then it
7 will map to the appropriate group.
8 I just went to a conference of IT folks in
9 Boston and they basically said if you have a Web site
10 that pushes information at people and doesn't let them
11 interact with it, just forget it. People will stop using
12 it. So, I think that's a challenge for us all as we move
13 ahead.
14 Understanding sort of all these concepts again,
15 we worked with a health literacy specialist and we ran
16 focus groups to understand what categories or labels to
17 use in the public reporting that we do. So, we came up
18 with these different categories of how we could group the
19 patient experience survey.
20 We put summary results up, as you can see, and
21 do use stars. But we also put the item detail here for
22 those patients who want to drill down and also physicians
23 felt it was important to have these specifics. So, it's
24 a phenomenal amount of data actually to put on the Web
25 site. So, for every practice we go down to every

1 question asked and how every patient answered it.
2 And I want to put this up because we also put
3 up data on our Web site that we know is not consumer-
4 friendly, but for a policy perspective. We really feel
5 that the policymakers in the state were looking to say,
6 okay, where should we focus our improvements in
7 Massachusetts.
8 And, clearly, what jumps out at you is while
9 we're really good at giving the tests, controlling HbA1C
10 and controlling cholesterol is another story altogether.
11 So, we really need to move into that area. And that
12 requires -- while we have the test data at the statewide
13 level, we don't have it down to the individual physician
14 level because we don't have the data sources coming in.
15 On our Web site, we also put explanations of
16 the ratings that we use and, finally, we really want to
17 put some information for consumers about what they can do
18 and other useful resources. So, we really try to
19 identify ways -- what they could expect of their doctor
20 and we've had -- just as an example, what your doctor
21 should do. And that was totally pushed back. So, ways
22 your doctor can help. It was -- you know, these things
23 are -- you know, you have to understand all parties when
24 you put the wording down. So, it's very carefully
25 worded.

1 And, also, when we go public with information,
2 there's two public releases, the press releases in your
3 Web site. We always put a checklist on -- one is working
4 with your doc to improve your care. On the other, we
5 talk about things they can do to improve their diabetes
6 or their cholesterol. So, that's...
7 MR. WROBLEWSKI: No, that's perfect. You're
8 going right to my next slide. Thank you very much.
9 Thank you, both of you.
10 What I'd like to do in this part of the
11 discussion is really focus on consumer information needs.
12 And I think what we heard this morning really that can be
13 broken down into three -- we heard about two main areas
14 and then a third area that I'd like to add at the end of
15 our discussion when we focus on consumers.
16 The first one really is what are the types of
17 performance measures and scope of differences that allow
18 consumers to differentiate or select among providers?
19 That would be the first topic I'd like to go through this
20 morning.
21 The second one is the presentation and format
22 issues that both of you talked about this morning.
23 And then the third is what comparative
24 effectiveness information would assist consumers to
25 evaluate and select treatment options?

1 So, I'd like to start with Beth Nash. Barbara
2 indicated in her presentation that patients were looking
3 for outcomes that show differences. So, I'd like to get
4 your reaction to that. And then as we work the panel, if
5 you'd like to add a comment, if you can just turn your
6 name card on its side, that would be great so we won't
7 have to raise hands. Thanks.
8 Beth?
9 DR. NASH: Thank you. So, yeah, I'm going to
10 hit upon some of the things that have already been
11 mentioned. I will get to the outcomes question. But I'm
12 going to try to focus on, you know, do patients really
13 care about this stuff? If so, what do they care about?
14 What do they perceive their needs to be? How do they
15 want the information presented?
16 Just by way of background, you may think it's a
17 little strange that somebody is here from Consumer
18 Reports talking about this stuff and a doctor to boot.
19 And I just wanted to say that, you know, at Consumer
20 Reports, we have over seven million subscribers to our
21 various publications, and we really have been providing
22 health information from the very first issue of the
23 magazine in 1936.
24 And over the years, what we've found is that
25 consumers are increasingly interested in health care.

1 They’re really demanding information about comparing
2 different things in health care, just like we compare
3 different refrigerators or automobiles. And, so, we do
4 think it’s an area that’s very necessary to the American
5 public and also in which Consumer Reports is
6 well-positioned to provide that kind of information.
7 So, we clearly know that consumers are
8 interested in health care information. They want to be
9 part of the dialogue. And they’re particularly
10 interested, as Barbara alluded to, in issues around
11 communication, how well their doctor communicates. And
12 in terms of clinical measures, they really are
13 interested, they want to -- they know they should be
14 interested, but they really don’t quite get it.
15 So, as an example, we just recently did focus
16 groups as well where we showed consumers different
17 information about different hospitals and, you know,
18 said, well, this one’s infection rate is this, this one’s
19 hospital mortality is that and that kind of thing, and
20 they just sort of looked at us like why would I be
21 interested in that because even if that’s what the
22 hospital does, my doctor’s really good, so it won’t
23 happen to me.
24 So, there’s this really big education piece.
25 And I think the really good news is that consumers can be

1 educated. So, for instance, on our own site, we recently
2 presented some very complex information about comparing
3 hospitals which came from the Dartmouth Atlas.
4 This is information that's all about the
5 intensity of services. The point of this work is that
6 more intensive services, so getting more care, if you
7 have a chronic condition may be worse for you. And I
8 think it's a non-intuitive concept. And the bottom line
9 is that we were able to present this in a way that
10 consumers really understood.
11 And, so, I think the issue is that you just
12 really need to go slow, be very transparent, be very
13 clear about why a consumer should be interested in this
14 information and they really will get it.
15 In my former life, which was working in
16 evidence-based medicine at the British Medical Journal,
17 we had a similar experience where we were able to
18 communicate really complex issues to consumers and they
19 really got it, sometimes better than the doctors get it,
20 because in some ways the consumer is much more invested
21 in getting that information.
22 Now, there are also some challenges. So, for
23 instance, in the issue of hospitals and selecting a
24 hospital, again in our focus groups, patients said to us,
25 I don't pick my hospital, I go where my doctor is. And,

1 so, you know, I think that there's some education there
2 as well.
3 Now, they are interested in knowing if that
4 hospital is good or not, but not entirely clear on the
5 fact that they really have some choice in the matter and
6 how they might go about exerting that choice.
7 MR. WROBLEWSKI: Beth, can I interrupt for just
8 a quick second? How did Consumer Reports present its
9 hospital information in terms of the format? Was it a
10 score? Was it a symbol? Was it a -- in terms of trying
11 to get that information across to find out kind of what
12 was usable for the consumer.
13 DR. NASH: Well, first of all, and this is
14 another piece that I think Barbara touched on as well, it
15 needs to be interactive. And, so, the way that, again,
16 this Dartmouth Atlas information that we presented, you
17 needed to be able to search, to be able to find hospitals
18 nearby, that kind of thing, you know.
19 And I think the other piece of that, which I'll
20 come back to if I have time, is it really is all about
21 me, you know. So, consumers really need to not only get
22 the information that they need, but understand how it's
23 relevant to them.
24 Now, in the Dartmouth Atlas example, again,
25 what we did was to present things sort of on a scale. So

1 where an organization is on a particular scale. Now, as
2 you all know, Consumer Reports is all what we call blobs,
3 so little red circles about what's the most effective and
4 what's the least effective. And we don't have time to go
5 into that here, but where we can, we are using that very
6 same blob system and applying it to health care because
7 it's something simple that consumers understand.
8 So, whatever the scale is, however you present
9 it, it needs to be visual and it needs to be clearly
10 understandable to the consumer and, again, Barbara
11 mentioned this a moment ago as well, it can't really have
12 too many caveats and disclaimers and asterisks and
13 special cases. It's really got to be very simple and
14 very clear.
15 Another challenge I just want to mention is
16 that, again, when it comes to clinical information,
17 outcomes information, it's got to show some differences.
18 So, if everyone's kind of the same, you know, why do I
19 care? Or if most things are the same, why do I care?
20 So, there's got to be something that distinguishes one
21 place from another.
22 And a further challenge is that -- and, you
23 know, this was a little discouraging to us when we
24 recently did some focus groups on hospital ratings, is
25 that patients really care a lot about parking and

1 cleanliness and, you know, those sorts of factors, which
2 I'm not saying they're not important, but those are the
3 things that they know. And, again, I think there's a big
4 education piece, and I think an organization like
5 Consumer Reports can play a big role in educating the
6 consumer.
7 One last thing that I'll say that, again, some
8 of the others have mentioned, is this whole notion of
9 experience. What has been the experience of others?
10 Really, really important. Patients really, really care
11 about that. They're particularly interested in the
12 experiences of their own family and their friends, but I
13 think any kind of rating system or any kind of comparison
14 really has to bring in that piece.
15 And if I have one more second, I just want to
16 close --
17 MR. WROBLEWSKI: Just one.
18 **(Laughter.)**
19 DR. NASH: Thank you. With just a brief
20 mention of comparative effectiveness, because, once
21 again, I've had some experience in this area and patients
22 really, really do understand the notion of comparative
23 effectiveness. Some drugs work better than others. Some
24 treatments work better than others.
25 And I think in this whole health care arena,

1 what we're trying to do is to level the playing ground.
2 So to get the same kind of information in the hands of
3 the doctor and the patient so that they can engage in a
4 meaningful dialogue to figure out what's best for that
5 individual patient.
6 MR. WROBLEWSKI: Thanks, Beth.
7 Peter, did you have comments in terms of what
8 consumers were looking for to make a difference?
9 MR. LEE: Just to maybe build and reinforce a
10 couple of things that Beth said, and I thought that the
11 last two presentations were great in sort of queuing
12 things up. Though many ways they were framed, to my
13 mind, largely from a QI, quality improvement, provider
14 perspective, not from a consumer perspective. And I
15 think Beth sort of reflected some of that.
16 I thought Barbara notes what consumers look for
17 versus physicians was, in many ways, a telling piece to
18 start some of this discussion because I just -- consumers
19 want outcomes. They want the results. Am I more likely
20 to get cured or not? They're less interested in process
21 measures which are more useful for quality improvements.
22 There's tensions we have here. So, that's one.
23 The other that I'd reinforce is patients like
24 me. Consumer experience resonates very strongly, is a
25 very compelling thing for consumers.

1 Third is the more specific the better. I know
2 we're going to get to treatments in a minute. But we
3 heard from the focus groups and others, the groups are
4 kind of interesting. But I want to know about the
5 doctor. Or I want to know that -- I just got diagnosed
6 with breast cancer. I want to know about treatment.
7 And, so, the more specific, the more relevant and it
8 needs to be interactive.
9 And the last two other points I'd note, and I
10 know this is a scary one, but this is where -- validity
11 is not -- consumers don't start looking at statistical
12 significance. They will get on the Web and they'll look
13 at an N of one because someone logged on and said I had
14 this experience with this doctor.
15 If that's better than nothing, they'll take
16 that. That may be totally wrong on a statistical basis,
17 but validity is not where they start. They start with
18 does it speak to me and is it relevant to me?
19 Finally, in terms of types of information, I
20 know you've got it in your slides, I'm jumping ahead, I
21 shouldn't do this, but the thing that we really haven't
22 heard about yet is cost. Efficiency doesn't play at all
23 as a concept.
24 But, increasingly, consumers are very concerned
25 about what is this going to cost me? And what is my

1 financial exposure going to be, given I'm in this PPO and
2 I've got a $5,000 out-of-pocket maximum and a deductible.
3 From our experience at looking at this, they are very
4 interested in cost. So, this idea about efficiency is
5 like a huh?
6 But it's not to say what are these two
7 different treatments going to cost you. What's this
8 choice going to mean? That's a piece that really didn't
9 come up in the last two presentations. It's really not
10 what they're looking at so much. They're looking at
11 system issues. But from a consumer perspective, I'll
12 tell you that is an increasingly important piece of what
13 I think they're looking at. I don't know if Beth would
14 agree with that.
15 DR. NASH: Yes, I do.
16 MR. WROBLEWSKI: Thank you.
17 Nancy, you wanted to add something to that?
18 MS. FOSTER: Sure. Thank you very much. And I
19 appreciated both presentations, very helpful to me in
20 thinking further about the discussion today.
21 I just wanted to highlight a couple of things.
22 One, Peter, I think you actually touched on this a little
23 bit, but we talk about consumers as if they are monolith,
24 which we know they are not, and we talk about consumers
25 wanting information for choice, as if that is their only

1 relationship to hospitals, doctors or others. And we
2 know that's not true as well.
3 Consumers may want to know things that may not
4 affect whether they vote with their feet and go
5 elsewhere, but may affect their interaction with the
6 health care system in a very productive way.
7 So, to the extent, Michael, that you want us to
8 tease out some of that as well in this discussion, maybe
9 we need to expand our thinking around what consumers use
10 information for, because it may be as simple as having a
11 more informed discussion with their clinician or in how
12 they approach their upcoming hospitalization, whether
13 they take someone with them, whether they ask particular
14 questions when they're there in the hospital.
15 And the only analogy I can think of to just
16 sort of make it a little more concrete is to say I'm an
17 active member of the PTA at my son's school. There's
18 very little about the national or even regional test
19 scores that are going to make me pull him out of that
20 school and take him to another school. But I'm keenly
21 interested in that data, and it does affect my
22 interaction with the school and with his teachers. So
23 just a different frame on that.
24 MR. WROBLEWSKI: Sure.
25 DR. HOVEN: Thank you. I've been very

1 interested in the presentations thus far. I'm going to
2 speak to some physician issues obviously a bit later, but
3 I want to go back to Beth's comment on hospital selection
4 and I go where my doctor sends me. And in one of the
5 slide sets for today, there is -- you know, you don't
6 have a laptop in the ambulance when you're going to the
7 hospital and you've had an accident.
8 And I think that sort of has -- all these
9 issues are going to have to come into play as we talk
10 about these things. I may have to send a patient to a
11 particular hospital because the cardiologist I want to
12 see that patient is there and not at some other
13 particular facility and I think that cardiologist is the
14 best one for my patient.
15 And, so, I think hospital selection has got to
16 be done very cautiously. Yes, we need to know what their
17 infection rates are and, yes, we need to understand what
18 happens in those facilities and are they adhering to the
19 Joint Commission and all the improvement guidelines and
20 that sort of thing.
21 But, you know, I really do think that this is
22 going to be something that, again, has to be
23 personalized. Back to what you talked about is, in fact,
24 I need to be able to talk to that patient and make them
25 understand why they're being sent to a particular

1 facility. But they still have choice, if there's a
2 choice. I practice in a community with one hospital.
3 There ain't no choice.
4 So, having said that, I think we'll be coming
5 back to this again in different ways going forward.
6 MR. WROBLEWSKI: If there were a way to
7 prioritize what consumers wanted, whether it was outcome
8 measures or performance measures at the hospital level,
9 at the group practice level, at the physician level, at
10 the medical condition level, where should we be putting
11 -- where would it make the biggest difference in terms of
12 consumers selecting one over the other?
13 If there are barriers to hospital selection,
14 should we be putting our resources into selecting primary
15 care physicians because they don't have -- or the
16 specialists because they don't have a choice of
17 hospitals? Anyone can -- Vince, you had your card up,
18 you can answer that question.
19 DR. KERR: I thought I misunderstood. I got
20 this up. Maybe it was this one.
21 **(Laughter.)**
22 DR. KERR: I'll take that just because it's on
23 the table. I think it depends. This is back to the
24 comment that consumers are not monolithic. We developed
25 a construct inside our company that looks at

1 decision-making. It’s really three-dimensional.
2 So, when you think of consumers, they are
3 different and it’s not just by education levels, et
4 cetera. You can measure something called activation,
5 which is their sense of empowerment, their sense that
6 they can interact or control whatever the outcome is.
7 That’s very different. And you can divide them into four
8 distinct groups. That will influence how they process
9 information and what they do with that information.
10 It is also influenced by perception of the risk
11 or benefit. So, we map sort of various sort of decisions
12 that consumers have to make. A one-time instance is a
13 lot easier than persistence, like taking a medication
14 five times a day for the rest of your life, even though
15 that sounds like a simple task. So, there are various
16 factors that influence risk versus benefit and the effort
17 that’s required to achieve that.
18 It may be very difficult to maintain a woman
19 who’s pregnant, expecting, may be able to stop smoking
20 for that nine months because highly motivated, but find
21 it very hard to quit lifetime, those sorts of things.
22 So, when you ask a question like that, you have
23 to remember it isn’t -- the answer is it depends. For
24 someone with an acute condition that is perceived as
25 high-risk, they will be very interested in the treatment

1 information, in the things that might make a difference
2 to them and their outcome or the side effects that
3 they're going to feel or something else that affects a
4 part of life. They may not care where they get a flu
5 vaccination or, for that matter, an MRI or something
6 else. That's not perceived as high-risk or with much
7 differentiation.
8 So, if I were to, given those comments, try to
9 answer your question, it would proceed from treatment to
10 physician to facility.
11 MR. WROBLEWSKI: Thank you. I'm going to turn
12 to Elysa. I think yours was up next.
13 MS. FERRARA: Actually, I think his was up
14 next.
15 MR. WROBLEWSKI: Okay. Dr. Chumbley, I'm
16 sorry.
17 **(Laughter.)**
18 DR. CHUMBLEY: Oh, I'll pass. We were just
19 testing you.
20 **(Laughter.)**
21 MS. FERRARA: Well, I had wanted to speak to a
22 couple of things. One was the comment on personalization
23 and one was a comment on variations and populations and
24 the fact that we are not monolithic. There is not a
25 question that there's a body of literature that shows

1 that half of adults in the U.S. cannot locate, match and
2 integrate information.
3 So, health literacy, you had mentioned it, and
4 it’s something we really need to be mindful of. That’s
5 why we go to symbols that are self-explanatory to some
6 degree. That’s why the Consumer Union and Consumer
7 Reports is so successful, because it’s understandable to
8 consumers.
9 We cannot forget as we’re talking about a non-
10 monolithic population racial and ethic disparities, an
11 obligation that we all work toward around this table to
12 eliminate those disparities in health care and health
13 outcomes and services. So, there are special things we
14 need to focus on in order to address that.
15 Then in terms of personalization, I think this
16 is where competition on the health plan level emerges
17 because health plans -- you’ve done it, we’ve done it,
18 we’ve built personal health records, we’ve built the
19 ability for consumers to have a personalized space within
20 their own health E-records.
21 So, it’s not just their personal health
22 records, but I can go into my Web site with my insurer
23 who, of course, is Aetna, and I can say I have a
24 16-year-old son who I’m worried about accidents and I’m
25 worried about drugs. And, gee, I’m in that menopausal

1 age. Gee, my mother had breast cancer. And I will get
2 alerts, I will get information that are very much
3 tailored to me.
4 Over time, we've certainly seen, combined with
5 employers creating incentives for use of that
6 information, that consumers will come and they will use
7 the information. But definitely personalized, definitely
8 not making me wade through things. We find that our
9 members over time will stop going to the Web site and
10 type in breast cancer cure, you know, in a Google world,
11 and will start going to more informed choices. I think
12 that's the other thing we have to remember.
13 Consumers aren't out there not getting
14 information. They're Googling. And I can tell you you
15 can Google any physician's name in this country, any
16 physician's name, and you're going to get one member
17 experience somewhere off one of those public Web sites.
18 So, to the point that people will act on one experience.
19 When you said that it reminded me of an
20 experience I just had. We went on vacation to the wine
21 country of Upstate New York. I bet you didn't know that
22 even existed, but it does.
23 **(Laughter.)**
24 MR. WROBLEWSKI: They have to import the
25 grapes.

1 **(Laughter.)**

2 MS. FERRARA: No, they grow them. But they
3 have no hotels. So, I did my Google search for a hotel
4 and I read this review, one review. It said the rooms
5 were dirty and a two-year-old was murdered in the hotel
6 five years ago. I didn't go to that hotel. It was only
7 one review.

8 **(Laughter.)**

9 MS. FERRARA: But sometimes one review can be
10 extremely -- well, it actually turned out to be true,
11 once I got there and found out. I figured that's good
12 enough for me. The rooms are dirty and it's probably not
13 too safe.

14 So, I think consumers act on the N of one and a
15 lot of what we need to do is really get credible
16 information out there and credible information means all
17 of the partnerships we just talked about at this table.
18 You know, it's physicians and health plans and consumer
19 groups working together to make this information
20 credible. So, the symbols really mean something.

21 MR. WROBLEWSKI: Thank you.

22 Kristin, can I also ask you to address -- we
23 had talked earlier about efficiency and what -- first of
24 all, if you can at some point explain what efficiency is
25 so that we're all kind of talking about the same thing

1 and then your comments as well.
2 MS. MADISON: Yes. That's a really interesting
3 question about what efficiency is. When I think about
4 efficiency, I think about productive efficiency. So,
5 minimizing the input that you need to produce any
6 particular output. So, quality, for example, would be a
7 measure of output.
8 So, when I think about what an efficiency
9 measure within health care should be, I would think about
10 it as the cost of producing a certain level of quality.
11 I think the way that a lot of people end up defining it
12 is the cost of producing a particular type of care,
13 right, a typical episode of care, for example. And I
14 think it's a really confusing measure for consumers. I
15 don't think it has a lot of meaning. You need really to
16 couple it with quality for it to have any meaning.
17 If you think about, say, the most efficient
18 restaurant, it's probably McDonald's, right? It's very,
19 very good at what they do, producing things at very low
20 cost. But if your choice is between a McDonald's
21 hamburger and another hamburger at a fine French
22 restaurant, if they have hamburgers, you would probably
23 choose the fine French restaurant because what you care
24 about is quality and not the efficiency of production.
25 And, so, at the very least you need to couple

1 efficiency with quality, so choose the most efficient
2 producer at the quality level that you want. Or you
3 could just make it more straightforward and talk about
4 cost and quality, so the cost next to the quality
5 measure.
6 What I wanted to actually talk a little bit
7 about was consumer satisfaction or patient experience or
8 patients that are going to switch. A couple people have
9 brought it up already. And I have to admit I'm a little
10 conflicted on this kind of information.
11 In one sense, I think it makes total sense to
12 produce these measures and to disseminate them widely
13 because patients, as people have been saying, really do
14 care about them and in a competitive marketplace you try
15 to meet the needs of your consumers.
16 On the other hand, I have a couple of problems
17 with them. One is just a question of comparative
18 advantage. As someone mentioned, you can get quality
19 information from your friends. You can get quality
20 information, patient experience quality information from
21 yourself, right?
22 You see a doctor once. You can decide whether
23 they like that doctor, whether they like that office,
24 whether they want to go back there. So, there's a lot of
25 places where you can get that kind of information or the

1 cleanliness of rooms.
2 You can't get information about past mortality
3 rates from your friends or from your past experience.
4 And, so, in terms of where we want to put our resources
5 in measuring quality, I think that's something that you
6 have to take into consideration.
7 The other thing goes back to this comment about
8 how people don't understand clinical quality information,
9 and that's something that troubles me as well, because
10 the question is if you go to a Web site and you've got
11 six measures of patient experience and you've got two
12 clinical quality measures, which you don't get, what are
13 you going to decide based on?
14 You're going to decide based on that patient
15 experience measure, which may be perfectly fine. Maybe
16 that's what you care about. Maybe it's correlated with
17 clinical quality. That may be a good thing. But I worry
18 that people will overweight those patient customer
19 satisfaction or patient experience measures.
20 There was a sort of an experiment that was run,
21 a study was published where doctors had -- the question
22 was basically do people choose higher technical quality
23 or do they choose better patient experience doctors when
24 you're forced to make a choice?
25 The answer was that when it was sort of a clear

1 choice between those two, people were more likely, in
2 fact, to choose the technical quality. But there was a
3 substantial majority of people who preferred the higher
4 patient experience doctors over the clinical quality
5 doctors.
6 There are other studies, Kaiser ran a survey
7 saying, you know, would you rather go to a doctor that
8 your friends have gone to, not even that your friend said
9 was good, but your friends have gone to, or would you
10 rather choose a doctor that has good quality as shown by
11 independent reviewers? Again, a significant number of
12 people chose the doctor that other people had gone to.
13 And, so, maybe this is just a question of
14 presentation. How can you educate consumers, as Beth was
15 saying earlier, to understand what that clinical quality
16 is? How can you present that information so that they
17 take both into account? But I'm feeling a little bit
18 paternalistic and a little bit worried about the use of
19 patient experience in these settings.
20 MR. WROBLEWSKI: Thank you.
21 MR. WEBBER: Thank you, Michael. It's great to
22 be here and hear this conversation. And, of course, this
23 conversation sort of reminds me, having been in health
24 care for 30 years, that there is an active debate about
25 whether competition in health care is even possible.

1 And I think already we’ve had comments from
2 people suggesting that really the end goal of
3 information, whether it’s for providers, information for
4 consumers to better interact with the system really
5 challenges the notion of competition.
6 I, for one, because we’re at the FTC, would
7 like us to at least have the premise that we are talking
8 about, the vision and possibility of value-based
9 competition. And it’s not a discussion of no because of
10 all these things that we know. We don’t have good
11 measures. Consumers don’t know how to use the
12 information. Physicians don’t like to compete.
13 I think our discussion today, again, because
14 we’re here, Michael, at the FTC, is we should be saying,
15 yes, if we do certain things. So, I hope we could get
16 away from the debate, even if we feel it passionately,
17 that competition as a vision in health care has too many
18 obstacles that we can’t get there and try to focus our
19 attention as experts on building the infrastructure and
20 those basic market dynamics that would get us to a
21 value-driven health care delivery system.
22 And, yes, it includes things like having good
23 measures of value, which we’re not there yet. Yes, it
24 means full transparency and ways that consumers can
25 really understand the information. Yes, it means health

1 care plans, how to organize provider networks and
2 differentiate reimbursement to providers based on
3 performance and value.
4 And, yes, it means consumers and employers need
5 to be making better choices at all levels for consumers
6 not only choosing doctors and hospitals, but, as we've
7 talked about, choosing high-value medical services. For
8 purchasers, it's about perhaps choosing the right health
9 care plan that's providing the health care services to
10 our employees.
11 So, anyway, I'm just feeling a sense that we're
12 back to the debate of, you know, the last 30 years about
13 whether competition in health care is even possible.
14 MR. WROBLEWSKI: You know, I appreciate those
15 comments, because the reason why we've started this, why
16 we started the way we did was to look to see, well, what
17 has worked so far and what are consumers looking for,
18 and we'll go through each of the other groups as well,
19 in terms of what would make a difference, kinds of needs
20 -- an ideal world. What would you need in order to
21 select based on value? And, so, I think these
22 perspectives are important.
23 I want to go to Dr. Hoven and then Barbara and
24 then Nancy and then I want to turn to Jack -- and Dr.
25 Chumbley, and then I'm going to turn to Jack to start on

1 the last bullet point.
2 Dr. Hoven.
3 DR. HOVEN: Thank you. I will be brief. I
4 want to go back to Barbara and the slide comparison of
5 what consumers want reported and what physicians want
6 reported because this gets to the guts of what we're
7 really trying to talk about today.
8 I'm intrigued by some of the comments which
9 have been made around the table because if you think
10 about it for a minute, this is all language and it's the
11 interpretation of language. And what I need and what I'm
12 telling you I need is based on the way I think. I want
13 validated, sound data that's relative and timely and that
14 sort of thing.
15 What my patients want, though, is an entirely
16 different mix of information. They're rating me in a
17 process, maybe because they couldn't find a parking place
18 in the parking garage. They get to the front desk and
19 they're mad as hell when they get there. So, the whole
20 experience wasn't very good for them that day. They were
21 late for their appointment and they had to wait.
22 So, I think you've got issues here which -- and
23 back to your point, Kristin. I think you've got to weigh
24 out some of this personal stuff that gets mixed in in
25 interpreting information. But I think we really have to

1 be very challenged on this.
2 This is a language issue that what I need and
3 what my patients need are going to be two different
4 things. How we make those come to the middle and be
5 interpreted are going to be very, very difficult.
6 MR. WROBLEWSKI: Thank you. We'll go to
7 Barbara and then Nancy.
8 MS. RABSON: Okay, thanks. I'm going to come
9 back to the point of definitions around patient
10 experience because, you know, some of your comments
11 worried me, both of yours, and so I want to be clear that
12 patient experience -- you know, there's patient
13 satisfaction I see as different than patient experience.
14 And, in fact, we are vigilant about people who
15 talk about our survey to say this is patient experience;
16 it's not patient satisfaction. Because it's not about
17 the food, it's not about the parking, it's not about
18 cleanliness. This is not part of our survey.
19 What we're really doing and MHQP is using a
20 survey that was developed by Dana Gelb Safran, so it's
21 very methodologically sound. There are plenty of surveys
22 out there that don't follow this, and that falls into the
23 patient satisfaction bucket.
24 But in the patient experience bucket what it
25 really gets at is issues that are key to improving the

1 relationship and improving the care of patients and
2 improving patients' willingness to actually do what the
3 physician tells them to do or the care provider. And,
4 so, it talks about communication. It talks about
5 respect. It talks about understanding. It talks about
6 coordinating care. And these are really key to a good,
7 solid experience in health care.
8 And, so, it is part of quality. It gets to the
9 IOM, as I said, the patient centeredness of this.
10 So, we have to be careful not to throw out the
11 baby with the bath water because this is something that,
12 as a rule, physicians are not very good at all the time
13 because we're learning that as we've issued our results,
14 physicians are coming back to us and saying, help me with
15 this, and there's not a whole lot of programs out there
16 or not as much understanding as we have on the clinical
17 side, what do we do next in improving some of these
18 things.
19 So, I think it's a really, really important
20 area. So, we do have to differentiate.
21 MR. WROBLEWSKI: Thank you. Nancy?
22 MS. Foster: I, too, will be brief. I just
23 wanted to address Andy's point. I've been in many of
24 those conversations myself. I don't really want to
25 rehash them. But I think maybe to the point of today's

1 conversation, it's really about getting smarter about how
2 we use competition and to use it as part of a panoply of
3 activities that are both encouraging quality and
4 encouraging consumer engagement in a whole array of
5 aspects of health care.
6 But as I think about it, there are at least
7 some deep concerns about whether competition, in itself,
8 will lead to some things that we wouldn't want in the
9 health care system, like is it really acceptable if some
10 places give aspirin and beta blockers to heart attack
11 patients and others don't and we'll just let the
12 consumers choose on that, or is that a basic element of
13 care that really has to be there? Where do we want
14 competition and where don't we want competition is a
15 question I think we need to ask ourselves repeatedly.
16 And my delight has been to watch some of the
17 consumer engagement and use of the, unfortunately, too
18 small number of decision support tools that exist right
19 now around choosing treatments. They really resonate
20 with those, at least at the data I'm looking at.
21 And despite the efforts that a number of us
22 around the table have been involved in in getting quality
23 data out there for the last five, six, seven years, they
24 normally don't resonate with it. At least the latest
25 data suggests fewer of them are looking at it than were a

1 year ago.
2 So, they're telling us we're not doing it
3 right, at least.
4 MR. WROBLEWSKI: Dr. Chumbley?
5 DR. CHUMBLEY: I think there is another level
6 of competition and that is between the medical groups to
7 improve the quality of the care that they deliver, which
8 is external to the patient or the consumer. I mean, we
9 haven't seen shifts in Wisconsin of patients between one
10 organization and another based on this, but we have seen
11 improvement because the organizations and the physician
12 leadership in those organizations want to improve. We're
13 not proud of our international record of providing health
14 care. And, so, we have seen a great deal of improvement
15 just based on that level of competition.
16 So, I think the reporting of this information,
17 even if the consumers are not involved, is raising the
18 bar and raising the quality of the medical care in
19 Wisconsin.
20 MR. WROBLEWSKI: Thank you. Michael, did you
21 want to add something on that point and then we'll turn
22 to comparative effectiveness of treatment?
23 DR. BARR: Just I was holding my time a little
24 bit earlier because I was going to say something. But I
25 think what Nancy and Clyde just said is sort of -- for

1 some things, we may want to remove choice or remove the
2 need for choice, for example. That raising the bar.
3 Why should people have to be able to choose
4 between a hospital that does not give aspirin and beta
5 blockers? That level of competition should go away. We
6 shouldn’t have to compete. Everybody should be doing
7 that.
8 I think that’s sort of what Clyde is saying and
9 I think that’s important, we recognize that. Not
10 everything needs to be judged in the form of competition.
11 We need to simplify things so that patients or consumers
12 choose on the things that are relevant, that are
13 important.
14 But the goal should be there should be no need
15 for competition on these kinds of things. They should
16 all be delivering that kind of care.
17 MR. WROBLEWSKI: Go ahead, Jack.
18 MR. FOWLER: Okay.
19 DR. CHUMBLEY: That is the goal.
20 MR. FOWLER: I think one of the things I wanted
21 to address, getting down to point three there, is whether
22 we have the right measures for how well-served consumers
23 actually are by the health care they’re getting. And I
24 think this also resonates for some of the things Nancy
25 and Michael were talking about.

1 Al Mulley makes a distinction between doing
2 things right and doing the right thing. Most of the
3 measures that we're talking about for quality have to do
4 with doing things right, and that's everything from
5 giving proven treatments to people where we really know
6 it's right to not infecting folks and having clean
7 restrooms or whatever that is, and whether you get out of
8 the hospital alive when you have bypass surgery.
9 None of that addresses the question of whether
10 you should have bypass surgery in the first place. It's
11 hard to get into that, you know, clinically when your
12 measures are records and claims, as your sort of measures
13 of quality. That's one of the reasons we don't have
14 that.
15 But I think the notion of whether the process
16 of care involved communicating to patients the
17 information that's available about the options and about
18 the comparative effectiveness information that we have,
19 prior to getting people on an operating table, not as
20 part of the informed consent process, but as part of the
21 informed choice process before you get there, is really
22 an important part of getting -- is measuring the value of
23 the care that people are getting.
24 One of the things that bothers me about all the
25 measures that are prevalent in our society about quality

1 performance is it's all about doing more stuff to people
2 and there are hardly any measures of doing less stuff and
3 of overtreating and of giving people meds that aren't
4 doing them any good and of giving people tests at a time
5 when it probably won't do them any good and if they
6 understood them, they wouldn't want them in the first
7 place.
8 There are some challenges in getting good
9 measures of how the decision process went. We have
10 pretty good data from a Michigan study that shows that
11 the decision process, at the moment, is pretty terrible.
12 It's hard to get from just a patient experience survey if
13 you're kind of generalizing across all, but when you look
14 at individual decisions, it's pretty cursory and doctors
15 pretty much sort of tell people what they think they
16 ought to do and they pretty much do it. That's not
17 astounding, but kind of a model built in.
18 But we can do better than that. I think that
19 when you're talking about measuring quality of what the
20 medical care is that's being delivered to people, and if
21 you're going to move that, I think you've got to work a
22 little bit on the process of getting the other aspect of
23 how involved patients really were in the choices that
24 were made about them.
25 And the value of that is both, one, that you

1 can get them more to buy in and be committed to the stuff
2 that will actually do them some good, rather than just
3 walking out with a prescription and not understanding
4 why.
5 And, on the other hand, that they can protect
6 themselves from -- some of my friends would call it
7 overtreatment, from things that if they were really
8 informed and understood and knew the pros and cons, they
9 really wouldn't want to do them.
10 So, I'd like to expand the discussion about the
11 measures of what's good and what's bad and how you tell
12 good care when you see it to include that sort of
13 patient-centered approach.
14 MR. WROBLEWSKI: Beth, did you want to add
15 anything when we had talked earlier in terms of
16 comparative effectiveness?
17 DR. NASH: Yes. Actually, I want to add
18 something that's not about comparative effectiveness, but
19 which is something related and was spurred by what you
20 were saying, which is it seems to me there's this balance
21 that we have to try to find between coming up with a
22 composite measure, an overall measure really, taking into
23 account all the important things.
24 So, everyone here is commenting on, for
25 instance, when we're looking at hospital quality or

1 doctor quality, you know, that not everything is equal.
2 We don't want to over weigh the patient testimonial
3 piece, for instance.
4 So, I think there is value in coming up with
5 composite measures that take into account and weigh
6 different things that will really be helpful to the
7 consumer. On the other hand, we don't want to lose this
8 other piece, which is really important, which is that
9 what's important to me may not be what's important to
10 somebody else. So, there's this whole value-based
11 decision-making that needs to happen as well. And, so, I
12 actually think we need both.
13 But, you know, how do you provide a composite
14 but then sort of say to the patient, but you really need
15 to make the best decision for you, weighing this, that
16 and the other thing. So, I just think it's an
17 interesting challenge.
18 MR. WROBLEWSKI: Peter, I'm sorry. Go ahead.
19 MR. LEE: I want to sort of do a hooyah to
20 Jack's point. But, also, you asked a question earlier
21 about in this sort of dashboard, where should we put in
22 our chips. I think the answer is clearly across the
23 board.
24 **(Laughter.)**
25 MR. LEE: With that said, I want to note that

1 in the framing, both agreeing with Andy and disagreeing a
2 little bit. It's not a matter of which boxes are
3 competitively significant. Which boxes are significant
4 to consumers for which purposes? Sometimes it's going to
5 be for choice, which would call for competition. And
6 others it's going to be to better partner with their
7 provider they've already selected. And others it's going
8 to be for a whole range.
9 I think Nancy's point is really well-stated
10 there. But when we look at that, I would note that the
11 area that is most salient to consumers and future
12 patients is on the treatment side of the choices. And
13 it's least on the insurance, except for once a year, the
14 plan choice. And that is a very discrete choice where
15 for a large employer, at least, they've got a real choice
16 and they engage in that and they do that. Those that
17 have a choice. Many don't.
18 But really we aren't seeing so much this
19 treatment issue. I just want to highlight two pieces in
20 that. One, what aspects are in the shared
21 decision-making about where we know something about where
22 preference plays a role?
23 But the other is -- Dr. Hoven or another of the
24 physicians could flesh this out better than I can -- but
25 a huge amount of treatment isn't well-developed on the

1 evidence. So, we talked about what really is the right
2 treatment. In a lot of areas there's huge uncertainty.
3 I think it really comes to noting that we have
4 major gaps both on the physician side and then on the
5 patient side to say, boy, which of these drugs are
6 better? We aren't really that sure. Should we be doing
7 anything? We aren't really that sure.
8 I actually think -- if I had my 100 chips that
9 I'd be putting here, one of the areas that I'm not really
10 seeing on here is not just treatment choice where we know
11 here's the implications of risks and benefits, which is
12 incredibly important.
13 But it's on the level of absence of information
14 of should it be that X device versus X medical therapy
15 versus nothing and what are the benefits and what we
16 don't know. And that's an area that there's a lot of
17 discussion across the park, so to speak, compared to
18 effectiveness research for good reason, because right now
19 we're driving blind in that area.
20 Again, I think it's what patients care about.
21 They start with, boy, I just got a diagnosis. That's
22 what I want information and help about and I'm going to
23 do that with my doctor. And the doctors are driving
24 blind, too.
25 DR. HOVEN: If I could just make a quick

1 comment. I couldn't agree more. This is the one thing
2 that I think every physician in this country will support
3 and embrace because we don't have that information.
4 I would like to be able to say to my patient
5 who comes in just having watched a direct-consumer ad on
6 the television that requires a very expensive drug, this
7 isn't going to make any difference and it's going to cost
8 a lot more money and it's not going to do any better than
9 this generic medication which you can buy over the
10 counter very inexpensively at your local drugstore. It's
11 that kind of information that needs to be out there that
12 we can all use and feel comfortable with and know that we
13 have done the right thing.
14 Now, having said that, this is going to be
15 expensive to do. It's going to be hard work. It's going
16 to take a lot of time. But I don't think -- I think at
17 this day and age, we have got to go there now and get
18 this done. And it's something we've all been waiting
19 for.
20 We know all the new information on new cures
21 and new medicines. And I'm an HIV specialist, so, by
22 golly, I'm cranking this stuff out every day. But, on
23 the other hand, it's imperative that we get this
24 information. And absent that, we're not going to get
25 where we need to be.

1 MR. WROBLEWSKI: Dr. Chumbley?

2 DR. CHUMBLEY: I just wanted to comment a
3 little bit about -- I think all this data that's in the
4 marketplace right now is very hard to sort through. One
5 of the hospitals I'm affiliated with was designated to be
6 one of the top 100 heart hospitals by some organization.
7 We have an internal joke that says we are now one of the
8 top 100 500 hospitals.

9 **(Laughter.)**

10 DR. CHUMBLEY: Nationwide. Unfortunately, it
11 doesn't stop the system from using that in its marketing
12 or the other system from picking out what it wants from
13 this survey or that survey or that and then delivering
14 that. So, there's just so much noise in the system. I
15 don't see how consumers can sort through that on a direct
16 marketing basis.

17 MR. WROBLEWSKI: Thank you. Andy?

18 MR. WEBBER: I also wanted to say an amen to
19 Jack Fowler's comments on informed decision-making and
20 state the obvious, that those consumer choices, whether
21 you do surgery or medications or lifestyle, that is a
22 competitive choice. There are suppliers on the other
23 side of that choice who are going to be winners and
24 losers, big time, when consumers are making those
25 decisions.

1 And I do agree, too, that in terms of looking
2 at value-based competition, this might be the arena where
3 we can generate, at the consumer level, competition,
4 perhaps a lot faster because we have information that can
5 be arrayed in ways that consumers understand than we can
6 do it on the provider choice side of competition. So,
7 Jack, thank you for those comments.
8 MR. WROBLEWSKI: You know, one of the things
9 that we've talked about this morning is kind of the
10 difficulty in using a communications direct to consumer
11 kind of information strategy to try to get either
12 provider differences or comparative effective differences
13 to the decision-maker, to the consumer.
14 And, so, in the panel that we have later this
15 morning, I'd really like to come back to this idea on
16 what are the strategies that employers and insurers can
17 take to kind of incentivize that people will have -- that
18 they'll be incentivized to go to the higher quality
19 provider or to the more effective treatment.
20 Because if we've talked about the difficulty in
21 a communication strategy, whether it's stars or relevance
22 or interactivity or all the things that we've talked
23 about, what are other ways to get that information so
24 it's actually acted upon?
25 We have about a half-hour left and I wanted to

1 turn to -- turn the focus slightly to physician
2 information needs. And these are really -- this is the
3 idea of, as primary care physicians, what do primary care
4 physicians need in terms of specialists and hospitals in
5 terms of making decisions on behalf of their patients?
6 And are they aligned with what consumers are looking
7 for?
8 And I'll turn to our two primary care
9 physicians, Dr. Hoven and Dr. Barr, to start us off on
10 that.
11 DR. BARR: Thanks very much. Just the last
12 reaction to the former, I think the information in terms
13 of informed medical decision-making has to take place at
14 someplace. One of the places folks often turn to, of
15 course, is their primary care physician. I think whereas
16 the information and the tools and resources are there,
17 Jack does a great job.
18 The timing and the opportunity to actually
19 interact with the patient in that way doesn't exist
20 currently in the current system. So, I think we need to
21 think about that for the afternoon discussion. I think
22 I'll bring that back up.
23 But in answer to the direct questions about
24 primary care, I think the conversation really -- I jotted
25 down in my notes, I had to go back -- is so much aligned

1 with what the consumers need. In terms of being a
2 primary care physician, what we want to do on behalf of
3 our patients in terms of advocate, we need some of the
4 same information that Barbara is collecting and others
5 are looking for in a useable way because that's our role,
6 at least it should be our role when we have the time and
7 the space to do it, is to advocate for our patients
8 appropriately.
9 It's important that the information needs to
10 include hard and soft indicators because there are things
11 we can measure and things that we can't quite measure
12 just yet. I'll give you some examples later. We
13 shouldn't discount the credibility of that latter part.
14 So, we also need to not forget, and I sort of
15 alluded to it, that there are significant challenges
16 faced by physicians in practice even if we develop a
17 credible, reliable, transparent and accessible source of
18 information, the workload challenges and the demands on
19 the office to actually use that would be significantly
20 challenging in the current environment.
21 Finally, this is what Barbara is doing so well
22 in Massachusetts, the measures need to be credible,
23 reliable. The differences need to be apparent and they
24 need to be meaningful. I think there are a lot of
25 principles that a lot of organizations, such as the AQA

1 and others, have developed that guide some of that.
2 But when I think about the actuality, I think
3 there are sort of three categories of information as a
4 physician that we would be interested in. There's sort
5 of this basic information we need. Then there's
6 condition or need specific data for that specific
7 patient.
8 What does this patient need and how am I going
9 to get it for that patient or help them get it and
10 navigate the system? And then there's this past
11 experience, what happened before. So, let me break that
12 down in terms of real specifics, though.
13 As I look across, generically, the practices
14 that I might relate to as a primary care physician in the
15 community, I want to know -- and I can't know a lot of
16 this right now -- is what's the access like to these
17 specialists? What is my patient going to experience when
18 they get -- can they get in, number one? What are the
19 scheduling options? What's the scope of that practice?
20 I had a personal example. I was referred to
21 one physician who said, oh, I can't take care of that.
22 So, I was referred to another physician. I'm sure that
23 happens over and over again. So, knowing fully well what
24 that practice can take care of so I make the appropriate
25 referral the first time and don't get this endless cycle

1 for folks who go through the system and more
2 opportunities for errors and safety concerns.
3 How does this practice I might refer to, or
4 hospital, for that matter, communicate? Do they do
5 email? Do they do some of the advanced modalities? Do
6 they have other kinds of access for the patients? What's
7 their turn-around time on the requests for information?
8 What kind of technology are they using? If
9 they have an electronic health record, is it going to
10 work with mine? Am I going to be able to share
11 information, participate in health information exchange?
12 To the extent they are available or in there, has this
13 practice adopted sort of the community standards for
14 transitions in care?
15 Some of the things we were talking about in
16 terms of let's agree that our communication about
17 patients when we make a referral is going to be in this
18 way. The turn-around time is this. We're going to use
19 these modalities. This is the acceptable standard in the
20 community.
21 Now, some of these things don't exist. I'm
22 sort of projecting the ideal. That's all sort of
23 challenging the current.
24 So, that's still the generic. If I want to
25 look at the population that I'm going to potentially --

1 I'm sorry, the groups of physicians I may want to refer
2 to, that's sort of generic stuff. Then you've got to
3 drill it down into I have a patient with a specific need.
4 Who's doing it best in the community?
5 That's where you start looking at special
6 qualifications, procedures that they do. What is exactly
7 -- if it's a procedure-oriented consultation, what is it
8 that that particular physician does? If you go, for
9 example, in orthopedics, one orthopedic surgeon is
10 different than another orthopedic surgeon in terms of
11 what part of the body they're going to operate on.
12 I remember I was at one practice, a large group
13 practice, an academic medical center, the department of
14 orthopedics sent around a picture of the human body with
15 their names attached to the different parts of it so we
16 would know who to refer that.
17 **(Laughter.)**
18 DR. BARR: I mean, that's sort of a comical
19 example, but it really gets down to, you know, within the
20 specialty, there are subspecialties and sub-
21 subspecialties and I want to make sure I can get my
22 patient to the right person as quickly as possible. That
23 information is difficult to come by often, even where I
24 work now.
25 Quality metrics and cost metrics. We've talked

1 about that quite a bit. I think it's important, though,
2 that we separate them. Even if it's blended into a star
3 or a rating system, we need to know the difference. We
4 need to be able to look and I think -- I want to be able
5 to find the best cardiac surgeon for my patient. Yes,
6 cost is a consideration. But if it's complicated, I want
7 to see who's the best in that and who's done the most
8 around the country. I want to be able to do that for my
9 patient. So, those are sort of the harder ones.
10 Then you get into the softer ones. This gets
11 to the experience. When the patient has gone somewhere
12 and then they come back to me, I get a lot of information
13 about what happened when they went and that's really
14 important. It's not codified anywhere. You can't look
15 up the stars on an -- you can't look at a measure. But I
16 want to know what that patient experienced.
17 There's also my perception about how reliable,
18 how relevant, what the communication was between that
19 specialist and referring back to me or the hospital. How
20 that patient was able to navigate the system if it was a
21 complicated care.
22 What happened when the patient was out of my
23 vision and now is back and what was their perception of
24 that? And, yes, some folks are going to look at was the
25 office clean and stuff. But it's more important, did

1 they relate to the patient? Was there a connection?
2 Did that physician understand what the patient
3 was trying to tell them? Did they take into account
4 their needs and their preferences and work with them?
5 Those are really important, and I don't know how we
6 measure them, but that would be useful if I was going to
7 make the appropriate referral and consultation with the
8 patients.
9 We get into other things with hospitals. What
10 I've just said is very important. But then the other key
11 is what's the relationship with the hospital in terms of
12 am I able to get -- many doctors don't often go to the
13 hospital anymore. The hospital has inpatient services.
14 So, their relationships have changed over time.
15 I think there are opportunities now in terms of
16 transition support for the patient. How did that work?
17 Are there services in the hospital that will support my
18 patient coming back and forth, that white space between
19 inpatient and outpatient? Let's make sure the patient
20 doesn't drop through.
21 The technology support and technical
22 assistance. Can we build those bridges so the
23 information about the patient flows with the patient for
24 the patient wherever the patient goes? That's real
25 critical.

1 Communities -- that's challenging if you start
2 referring outside your community for the other
3 subspecialties that may be a couple of states over. That
4 becomes more challenging.
5 So, that's sort of it. And I think the one
6 quote that always comes to mind when we talk about these
7 is from Einstein, which is "Everything that can be
8 counted does not necessarily count and everything that
9 counts cannot necessarily be counted." I messed that one
10 up. So, that's pretty important. Thanks.
11 MR. WROBLEWSKI: Sure. Thank you.
12 DR. HOVEN: Thank you. And before I get to the
13 questions, I wanted to make a couple of background
14 comments, but, first, just thank you all for having the
15 AMA here at the table. This is a great opportunity and
16 we're very much engaged in this process. So, I do want
17 to thank you.
18 I think it's important for us to talk real-
19 time, real-world information right now, and then, as I
20 said, I will get back into the questions. A physician's
21 performance is dependent upon three big items. The first
22 is the patients they treat. Secondly, the practice and
23 community resources that are available to them and our
24 health insurance coverage and payment systems as they
25 stand right now.

1 Physicians practice in teams of care and across
2 a continuum of care that often will dictate the outcomes
3 for the patients. I think we cannot lose sight of that.
4 This is a critical point for patients in particular with
5 chronic medical conditions and it dictates how we're
6 going to handle referrals and how we're going to handle
7 their actual care coordination.
8 Systems have got to be in place to allow
9 physicians to develop and utilize quality information.
10 Right now, there's an inadequate investment and
11 development of that infrastructure, and this is something
12 that clearly is going to have to be addressed.
13 Having said that, let me go on to what doctors
14 need or could use in delivering their care. And in the
15 ideal world, we need to look at three categories:
16 Physician performance itself, the clinical information to
17 inform treatment decisions and information that can guide
18 physician referrals to other providers.
19 This information that I need for me to deliver
20 quality care must be timely and it has got to be
21 accurate. It's got to be based on quality measures
22 developed by physicians, measure both process and
23 outcomes, be adequately risk-adjusted and it's got to
24 take into account severity of illness, the multiple co-
25 morbitities that's we deal with and the important

1 economic and cultural characteristics that have already
2 been referred to today.
3 And this information has got to be well-linked
4 to actionable strategies of quality improvement. It must
5 not be just measurement or recordings simply for
6 compliance or payment purposes. And it's got to be
7 available at the point of care. It cannot be in some
8 cyberspace out there which is useless for me to deliver
9 care. It's got to be relative to my peers. It's got to
10 be timely, frequent and detailed enough to allow me to
11 make corrections when the data is there that warrants the
12 adjustments and the change.
13 The next one is the clinical issues, the
14 comparative effectiveness information, and I've already
15 made a comment about this. But, again, it's got to be
16 real-time. It's got to be available at my fingertips in
17 the office with the patient, with a computer and updated
18 and user-friendly.
19 It's got to be very interoperable because,
20 absent that, I don't have time to run out to my office
21 down the hall, look up some information and come back.
22 It's going to have to be very, very available to me in a
23 timely manner.
24 And then, thirdly, information to guide
25 referrals to other providers. And in thinking about

1 this, we've got to look at a very large picture. I want
2 to make the best decision for my patient regarding that
3 particular problem, and to achieve this, I'm going to
4 have to take into account a composite of factors, not
5 just one or two. I want to know the quality and outcome
6 information that's out there, that's valid, that's
7 substantiated. I also must consider patient
8 satisfaction, their preferences and convenience issues
9 for them.
10 And to the previous speaker, the timelessness
11 of communication. If I've had dealings with a particular
12 specialist who communicates with me readily, I have no
13 trouble getting the information and I share information
14 with he or she, it makes the care for that patient so
15 much better, and that is so important.
16 The access and the availability of that
17 physician or hospital or outpatient facility. It's got
18 to be there. If it's not there, it's going to be very
19 difficult.
20 What are the physicians' hospital privileges
21 and contractual issues? You cannot imagine how many
22 hours we spend navigating this to see whether such --
23 this patient can be seen by that psychiatrist or they
24 have to go someplace else. It is a huge issue. And the
25 health plan is what dictates that.

1 So, there’s got to be feedback on how the
2 patient is doing so that I can work in partnership with
3 that physician to whom I’m making the referral or to that
4 facility, and those communication systems have got to be
5 absolutely in place.
6 The other audience, though, that is of
7 significance, of great significance, and the reason I’m
8 where I am today as a physician is my patient. I want my
9 patients to be engaged. I want them to be informed.
10 They must be uniquely motivated to receive quality care.
11 And how we do that is going to be very, very important.
12 But we also need as we partner -- and we’ll be talking
13 more about this this afternoon, as we partner with the
14 insurers themselves, all this information out there has
15 got to be transparent to us.
16 Payment, physician contracting, data
17 collection, reporting, tiering, all those issues have got
18 to be very transparent. Our patients don’t understand
19 this and they don’t care about it until it starts really
20 messing with their care. Until it makes their ability to
21 get the care that they and I think is the best for them
22 becomes an issue. So, these have got to be very
23 transparent in order for us to move ahead.
24 MR. WROBLEWSKI: Thank you. Kristin, you
25 wanted to add something?

1 MS. MADISON: I actually had a question. So
2 when I think about the kinds of measures we've been
3 talking about and where consumers need more measures, I
4 would say the biggest thing they need more measures on is
5 outcomes and they need broader measures of outcome. So,
6 when I look at the list of measures available, almost all
7 of them are mortality probably because a lot of them are
8 cardiac measures and that's sort of an obvious and easy
9 kind of quality measure.
10 But I would think that as a consumer, I'd want
11 to see more kinds of outcomes. Do you feel better? Do
12 you function better? Things like that. I was just
13 curious about your perceptions, you as physicians, what
14 kind of outcomes do you want to hear more about?
15 DR. HOVEN: I want to know when my patient
16 comes back to me from a specialist, let's say I've sent
17 them to an orthopedist and they had knee pain to start
18 with. I want to know, you know, from the outcome what
19 was actually done for the patient, what diagnostic
20 testing was used and did they, in fact, get the result
21 they need in order that they can go back and be
22 functional? Now, that outcome may not be a knee
23 replacement. That outcome, in fact, may be they're able
24 to function and work and exercise and that sort of thing.
25 So, from the patient's perspective, I'm looking

1 not only at the quality of care they receive from the
2 provider, the experience they had with that provider, but
3 when they come back to my office I can say, how are you,
4 and they say, I'm doing great, this was wonderful, my
5 knee is fine. So, that outcome can be somewhat
6 intangible. That's the problem in measuring these
7 things.
8 DR. BARR: I have not much more to add. I
9 think that's what I was trying to emphasize, too. There
10 are some intangibles or things you can't measure. That's
11 sort of what the patient experienced. Then there's the
12 hard ones, like you said, the mortality, morbidity,
13 length of stay, those kinds of things. But I think when
14 it comes down to what's going to benefit the patient the
15 most is me being able to direct the patient to the best
16 person I know that can handle that condition without
17 having to go to two or three other folks because I sent
18 them to the wrong person.
19 Then the consideration of the patient's
20 interests and unique needs, family, support, all those
21 things, if it's a procedure, in other words. Do you want
22 to really replace the knee in somebody who's not mobile
23 to start with and never is going to be mobile for other
24 conditions?
25 Did you put a pacemaker in somebody who really

1 probably only has a limited life span? I mean, those are
2 the kinds of questions that currently there's no measure
3 currently of overuse that we're getting in the way that
4 we've just been describing or appropriate use that we can
5 see. I think that would be important.
6 That's what you get to know in terms of the
7 relationships. You know that this cardiologist will do a
8 stent, but will not do a stent when it's not necessary,
9 in other words. And that's really important and I don't
10 know how we get at that right now. That would be
11 important for me as a referring physician.
12 DR. HOVEN: One of the things I frequently do
13 is when I'm talking to a patient about something that
14 needs to be done in a referral, let's say they need to go
15 to a surgeon for something, I will frequently tell them,
16 based on my experience with this particular surgeon, you
17 know, this guy's a big teddy bear, but he's technically
18 the best guy I know, and you're going to be very pleased
19 with how he manages your particular situation. But that
20 is accumulated knowledge that comes over time in how to
21 manage my patients.
22 And I will say to them, I can send you to
23 another one. This is my preference. It's based on this.
24 And you're going to be very pleased with the way you do.
25 So, it's very difficult to put numbers and measurements

1 on a lot of these things.
2 DR. BARR: The opposite is this guy’s got a
3 terrible bedside manner, but he’s the best technical
4 person, has the best technical outcomes. Just tolerate
5 it and have your family member with you.
6 **(Laughter.)**
7 DR. BARR: You know, that actually can happen.
8 MR. WROBLEWSKI: Dr. Chumbley?
9 DR. CHUMBLEY: I just wanted to add to what
10 Ardis was saying. There are dynamics in referring from a
11 primary care to a specialist. She mentioned one of them.
12 That’s the insurance network. Some of the insurance
13 plans are now ranking and, so, the co-pay may be
14 different if you go to a different specialist. So,
15 that’s a dynamic.
16 Which hospital staff -- if you want to follow
17 that patient in the hospital, you have to use specialists
18 that are on that hospital staff. There’s large groups
19 that typically refer internally and there’s employment of
20 primary care physicians by systems and with or without
21 the expectation that they utilize specialists and are
22 aligned with the system. So, it isn’t a clean decision.
23 There are dynamics there.
24 MR. WROBLEWSKI: Peter, you wanted to add
25 something?

1 MR. LEE: Like many of us, I have relied upon
2 accumulated knowledge of going to family members and
3 friends to get referred from my family member physicians
4 to other physicians. I guess I'm a little troubled.
5 Instead of saying shouldn't we be going beyond
6 accumulated knowledge that's personalized to -- and I
7 thought there was a leading question, if I may, which is
8 rather than to say here's the body chart and three
9 doctors point at the knee, which of those three doctors
10 have, in a standardized way, better functional status six
11 months after a procedure is done or whatever that mix is.
12 I would hope -- and to my mind when I look at
13 that dashboard -- again, I'm going to pull it up there --
14 primary care is measured up the whazoo. And the ability
15 to actually have data that is based on 60 primary care
16 doctors' referrals, accumulated knowledge and the
17 experience of specialty care on functional status so you
18 can make better referrals, I mean, quite honestly, I
19 heard a lot of information about what I would call
20 service issues, insurance relationships. Those are a big
21 pain in the butt. You've got to know those.
22 But I'm struck by not hearing quite as much as
23 I would have, on some levels, don't you really want to
24 know where there is differences, what the differences
25 are. So, I'd actually just sort of challenge my

1 physician colleagues to -- you know, outcomes are
2 important to patients, but they should be important on
3 the referral side, at least as much from the referring
4 primary care doctor and for the patients making choices.
5 DR. BARR: Peter, maybe you misheard, but
6 clearly the ACP has been out there supporting performance
7 measures. We were one of the first professional sites to
8 say, it's okay to link payments to health care quality.
9 I think what we haven't heard enough of is what
10 we try to describe here, that there are hard indicators,
11 as I started off with, and the soft ones. We shouldn't
12 discount some of the soft ones because they're very
13 relevant.
14 So, I chose to emphasize that a little bit,
15 with the idea that I think it's pretty open that -- I
16 mean, at least the ACP is supportive of the professional
17 measurement, performance measure, as long as it takes
18 into account the very things that Ardis was talking about
19 in her comments, in terms of it's got to be credible, the
20 AQA principles have all worked and been hammered out.
21 So, I took that perhaps a little bit for
22 granted and I wanted to make sure it was balanced in
23 terms of how we're considering this, because I think a
24 lot of the other stuff gets lost. I think there is value
25 to a primary care physician knowing the needs, wants,

1 desires of his or her patient and their family and then
2 making sure that we can direct appropriately. Some of
3 those things aren't measured. So, I don't think that
4 there's the chasm that you sort of just described.
5 DR. HOVEN: I was going to say the same thing.
6 We believe in this process of the performance measures.
7 I wouldn't use that doctor if I didn't know for a fact or
8 had data to tell me that the outcomes were where they
9 needed to be and they were doing what I wanted them to
10 do. The other piece of this --
11 MR. LEE: But what if we don't know that
12 today?
13 DR. HOVEN: But we've got to get that
14 information. I mean, there's nothing wrong with that.
15 The other piece of this, though, that is the
16 big elephant in the room is the risk adjustment and not
17 every patient looks alike. And you've got to have the
18 ability to say Dr. A will be fabulous with a diabetic,
19 morbidly obese, cardiac patient who just fell and broke
20 their leg, and being able to risk adjust this. So,
21 you've got to be careful how you put that data out there
22 because it all isn't going to be clean like we would --
23 it isn't black and white all the time.
24 DR. BARR: The other key is just, as I said
25 earlier, making the time and the space for that physician

1 to make those sort of evaluations and look at the data
2 that are out there. It doesn't exist right now. We
3 can't layer on this responsibility in terms of, at least,
4 primary care on top of it without giving them the
5 opportunity.
6 We mentioned about consumer incentives. I
7 mean, the incentives for physicians to actually look at
8 the data was part of the original NCQA tool that came out
9 because we didn't think it was achievable in the short
10 term. We maybe ought to relook at it, hopefully.
11 MR. WROBLEWSKI: Beth, did you want to add into
12 this?
13 DR. NASH: Yes. I want to say something
14 actually in support of accumulated knowledge. You
15 know --
16 **(Laughter.)**
17 DR. NASH: -- there is something --
18 DR. CHUMBLEY: But we lose the opportunity to
19 keep relearning the things we already --
20 DR. NASH: I would argue that those of us on
21 the panel who are doctors, and there are a lot of us, who
22 probably evaluate some of the doctors, if we saw them in
23 practice, we would have a similar evaluation of them. But
24 we don't really have very -- they're kind of squishy
25 measures. If we can find a way to measure that a little

1 better, I think it would be great.
2 Now, I was a managed care director many years
3 ago and tried and I think it's incredibly, incredibly
4 difficult. I also think that a doctor who I think is
5 fantastic and I love everything about them, I could send
6 a patient to and that patient might not like that person.
7 And, so, that's something else we need to think about,
8 which gets back to Jack's point. I mean, there is this
9 whole piece about choice that's really important.
10 And I also wanted to say one other thing about
11 research, getting back to something that Ardis was
12 saying, which is we do need more research to make the
13 right decisions, but the research we have is flawed as
14 well. So, you know, the selection criteria to get into a
15 clinical trial, you know, may not apply to your
16 particular patient.
17 You mentioned comorbitities. We need to figure
18 out what to do with a patient who's got more than one
19 medical condition. And the research today doesn't
20 necessarily deal with the outcomes that are important to
21 patients. They may be the outcomes that are easiest to
22 measure.
23 So, I would argue that we actually need a
24 different kind of research, and this is going to sound a
25 little out there, but I think that when authors submit

1 their articles for publication, they should submit their
2 data sets and those data sets should be searchable so
3 that you can ask clinical questions around data and find
4 out something specific about your individual patient. I
5 think that's something that is certainly worth exploring.
6 MR. WROBLEWSKI: Jack, did you want to follow
7 up on that?
8 MR. FOWLER: I think one of the realities
9 that's here is that everyone's saying it would really be
10 good to know what the outcomes were for particular
11 doctors. We don't have that information, which means
12 that we're making rankings basically without the
13 information that's relevant. Hardly any medical care is
14 life and death, so that mortality is not the right
15 measure. You would really not want it for your knee
16 surgeon, to have mortality be the measure.
17 **(Laughter.)**
18 MR. FOWLER: If you can measure that, you've
19 got a real problem.
20 But that's true for almost all the specialist
21 interventions that you're thinking about. Mortality is
22 just the teeniest tip of the iceberg.
23 So, the fact of the matter is that we don't
24 have good information about outcomes for almost any
25 doctors. I think that's the important stuff that they do

1 and, so, the bases on which they're selected. They could
2 be the interpersonal things and those you can measure, I
3 mean, some parts of it. You can find out if they talk
4 and listen and if they're accessible. And those are good
5 things to know. I don't want to down that.
6 And you could find out whether or not they are
7 patient-centered when they make decisions in some ways.
8 And that would be really good things to know, too.
9 But the outcomes part are really tough. I
10 think we just need to acknowledge that the bases on which
11 they're being evaluated are probably irrational or, at
12 least, not science-based.
13 MR. WROBLEWSKI: Andy, did you want to --
14 MR. WEBBER: Yes. So, Michael, I want to get
15 to the role of the primary care physician in informed
16 decision-making, where there are sort of different
17 treatment options. And of course the worry is, you know,
18 you diagnose someone with an illness, it's off to the
19 specialist.
20 That specialist is biased towards certain
21 intervention strategies that they are comfortable with,
22 and the individual never gets a trusted source and an
23 unbiased view of all the different options. And isn't
24 the primary care physician best equipped to provide that
25 information? And how do we make that happen?

1 DR. BARR: Thanks, Andy. I mean, that's what
2 the goal of the patient-centered medical home is. In
3 other words, to create a system in which the needs of the
4 patient are known, the relationship is reinvigorated and
5 that when a decision is made, that the tools and
6 resources are there and the medical home takes the
7 responsibility for actually having that discussion and
8 not just generate the automatic referral, which right now
9 in a volume-based, episodic fee-for-service system;
10 volume in is what the doctors have to do.
11 So, what we're looking at, and that's what
12 we've been advocating so strongly for, is a different way
13 of thinking about primary care to actually get exactly
14 what you -- doctors would like to do that. I firmly
15 believe that physicians would like to have that
16 conversation. Some of them still do. It happens
17 erratically.
18 I think there are tools and resources out there
19 that if we make the time and space and we give the
20 responsibility and accountability, as well as the support
21 financially for them to do that, some of this will
22 happen. I think it will pay dividends so you won't have
23 those unnecessary procedures.
24 One other point. I know we're looking at
25 outcomes, but sometimes a proxy for whether things happen

1 is looking at process and structure measures. I don't
2 think we should throw those out necessarily. That's part
3 of the medical home right now. It's a model to be
4 tested. We heavily emphasize the process and structure
5 within the practice as a proxy. Then you can have the
6 measures to see how things happen down the road. We
7 don't have to be upfront.
8 So, this is a pilot to test and I think we
9 should emphasize that and build it in the system. I
10 think that's very important and I think it would be
11 well-accepted among the physician community.
12 MR. WROBLEWSKI: Thank you. Vince?
13 DR. KERR: I wanted to react to something Jack
14 said. It's clear that the outcome metrics we have are
15 rudimentary. I don't think anyone would dispute that.
16 But they're not useless. Those two things are not the
17 same.
18 And while mortality may be the crudest judge --
19 and I would argue there are people who might want to know
20 at some level, five times the mortality rate versus
21 another, that that is an important indicator for
22 selection, their complication rates, their redo rates.
23 There are structure or process measures that
24 have to do with functionality, time to recovery, length
25 of stay in the hospital, that could all be useful,

1 particularly when added to a set of other determinants
2 that help you select the physician. I wouldn't discount
3 those. I think we have those on the table and don't use
4 them to the extent we could.
5 MR. WROBLEWSKI: Thank you. I'll give -- Nancy
6 and then Dr. Hoven and then we'll take our break.
7 MS. Foster: I'm reluctant to do this, but I
8 want to just throw this idea out on the table which is
9 that we've been talking about this as if it's a measure
10 of a clinician and his or her practice. But as I look at
11 most knee patients, there's sort of a set of providers
12 across the continuum and that's a fairly short episode of
13 care relative to diabetes treatment. And, so, I just
14 wanted to raise this notion that maybe measurement at the
15 clinician level isn't really going to get us where we
16 want to go.
17 MR. WROBLEWSKI: So, in our chart up here, you
18 would put all your chips in the column, the second from
19 the right-hand side, in terms of outcomes?
20 MS. Foster: I would love to put all of my
21 chips there, but I don't think we're ready to do that
22 yet.
23 MR. WROBLEWSKI: Okay.
24 MS. Foster: But in terms of an end goal, that
25 would be my desire.

1 MR. WROBLEWSKI: Okay.
2 DR. HOVEN: I'll be brief. To Nancy's comment,
3 I couldn't agree more. I mean, I really believe that
4 this continuum of care, as I said in my comments, is an
5 absolute. I don't practice in a silo. I am surrounded
6 by people who help me deliver the care.
7 The point I wanted to make with Andy -- pardon?
8 MR. WEBBER: Oh, no, no. I was just saying
9 something to myself.
10 DR. HOVEN: Oh.
11 **(Laughter.)**
12 DR. HOVEN: I don't think so, but anyhow.
13 MR. WEBBER: For transparency, I'll tell you
14 what I said. The comment was, yeah, we all want to get
15 to continuum of care in integrated systems and we have to
16 have payment systems that reinforce that.
17 DR. HOVEN: To follow us. Exactly.
18 MR. WEBBER: That was what I was saying to
19 myself.
20 **(Laughter.)**
21 DR. HOVEN: Here, here, I agree with you.
22 I wanted to come back, though, to your
23 question, Andy, about the primary care physician being in
24 the seat to coordinate the discussion with the patient
25 about the treatment options and choices. And I will tell

1 you in the perfect world, that would be ideal.
2 There are going to be a lot of clinical
3 conditions that I think -- and, Michael, correct me --
4 that I may not have all the tools to provide them that
5 information, so that we're going to have to have systems
6 in place to make sure I can do the collaboration to get
7 the information that my patient is going to need or get
8 them to somebody else who can provide that information.
9 So, the medical home concept does meet the bulk
10 of those needs, but I think we're going to see some on
11 both ends of the spectrum where that isn't going to be
12 appropriate.
13 MR. WROBLEWSKI: Okay. Thank you. Why don't
14 we take a break now. We'll resume at 11:15 starting with
15 the employer and the insurer discussion.
16 **(Brief break taken.)**
17 MR. WROBLEWSKI: Why don't we get started with
18 our second session this morning, really looking at the
19 quality information needs from the employer and insurer
20 perspectives. Peter Lee has volunteered to provide some
21 opening remarks from the employer side. Then we're going
22 to turn to Vince Kerr for the insurer side before we
23 start our discussion.
24 MR. LEE: Thanks very much. It's interesting,
25 from an employer perspective, obviously the primary

1 choice an employer is making is of their health plan.
2 I'm going to talk about this in two ways.
3 First, the choice of plan and what goes into
4 that, but then follow that with some of the discussion of
5 what our expectations are of the plans once they've been
6 selected. So, it's sort of a two-part framing and it
7 will tie back to a lot of our discussion earlier this
8 morning.
9 The first thing that I would note, though, is
10 this is -- you know, I'm on record, but employers don't
11 look at quality. They look at performance that includes
12 quality. I think that's an issue when we talk about
13 competition, there's different performance domains. It
14 actually resonates strongly with what we heard earlier
15 this morning.
16 In many ways, the physician perspective could
17 say, well, the first thing employers will look at, which
18 is absolutely the case, is cost. So, when they're
19 looking at a plan, they're looking at what for their
20 population is the total cost going to be for a certain
21 set of coverage compared to other plan options. That's
22 number one.
23 Number two, this really does track to some of
24 the notes that we heard from Michael and Ardis earlier,
25 it's not first about -- second about quality. It's

1 second about what I'd call service elements, which is
2 similar to issues about accreditation, is someone
3 trained, et cetera.
4 Employers will look at which plans handle them
5 well, will process claims, will deal just on the
6 day-to-day brass tacks issues with their employees, deal
7 with them well, efficient in their management.
8 And third is quality. Quality domains fit into
9 a range of factors that include HEDIS scores, some roll-
10 ups and include some of the dimensions I'll talk about,
11 what our expectations are of health plans.
12 Andy is here and he can speak to this later,
13 but one of the better tools used for employers to get a
14 handle on what plans do is an RFI called EValue8 which
15 collects in eight or nine domains what does a plan do in
16 terms of delivering effective care for the chronically
17 ill, wellness promotion, engaging patients, et cetera.
18 Those are elements that I call the quality performance
19 elements that employers look at. So, that's sort of the
20 framing when you think about what employers do.
21 I want to note a couple things about what's
22 happened in the last ten years, though, to frame this and
23 thinking about what employers go through in their
24 choices. This is very recent data on the migration over
25 the last 20 years from fee-for-service to HMOs and now,

1 largely, to PPOs.

2 What is misleading here, though, to my mind, is
3 what we're seeing in what employers are choosing in their
4 plans isn't a movement to no management. It is a
5 movement towards, in many ways, a blurring of what you
6 see in an HMO or PPO.

7 You see now what was a PPO in the mid '90s was
8 very, very similar to fee-for-service. It was an
9 unmanaged network with better discounts. As opposed to
10 today what you're seeing -- and we'll come to this in a
11 moment -- is the selection process of looking at we don't
12 care what the label is, we have expectations of you as a
13 health plan and we're going to buy based on these
14 expectations, based on what you deliver on two primary
15 tracks.

16 And one of those tracks is a provider-directed
17 track of how you select your providers, what you --
18 strategy to engage them, in terms of chronic illness, et
19 cetera. The other track is how you engage the enrollees,
20 the consumers.

21 So, the other data point that I'm going to note
22 on plan selection, and this is again very recent data,
23 it's on the footnotes, et cetera, what do employers think
24 is effective? And it really does come into what I call
25 two tracks for employers, selection of the plan, which is

1 anchored, one, in a provider-centric view. We're looking
2 at those that manage our networks well, have the right
3 folks in the game and do good disease management on the
4 provider side.
5 And the others would say it's really about
6 engaging the consumers. It's about having, you know,
7 consume-driven plans with high deductibles, it's more
8 cost sharing. And I'm framing those not as mutually
9 exclusive. Obviously, they are overlapping parts of a
10 Venn diagram. But they are both sort of two distinct
11 approaches.
12 When an employer says which plan am I going to
13 buy and hence how plans are competing, they're both
14 competing again, number one, on cost and then competing
15 on how they do these things better. These things say,
16 we're selecting and steering to better doctors and
17 hospitals, or we're doing a better job giving consumers
18 tools to make their own choices and then cutting across
19 the disease management.
20 Now, the main thing I would note on this is we
21 often talk about silver bullets. If you look at the data
22 here, no one thinks anything is very effective, okay? I
23 mean, one of the big lessons is -- this goes back to the
24 uncertainty -- employers are not jumping to particular
25 solutions saying, and, boy, we really have the answer.

1 What you see is, with one exception, which is
2 the only thing that gets over 25 percent of employers
3 finding it to be very effective is disease management and
4 that's for large firms. These are large firms that have
5 spent a lot of time and investment. And many of them are
6 carving that out, but they get it, that chronically ill
7 patients cost a lot, need big intervention.
8 Besides that, there's less than 20 percent that
9 think any of these things are very effective. So, they
10 are definitely using shotguns. If you think it's
11 somewhat effective, you get 50 percent either somewhat or
12 very effective. But you see, you know, a huge percent of
13 employers are saying we don't know which of these really
14 work. That's the bad news on this.
15 What does that mean when they come to what they
16 look at for choice of plan, back to what performance
17 domain? The number one performance domain they come back
18 to is what's the cost. Now, I wish it weren't the case,
19 but that's what it ends up coming to.
20 Within that mix, the other performance elements
21 they look at are, again, HEDIS scores, EValue8 results,
22 and, not dissimilar to consumers, it's a minority of
23 large employers, even small employers in particular, that
24 use those scores, but those that do, I think, drive the
25 market.

1 So, let me then talk from what -- that's how
2 employers choose plans. So, now, what do employers do
3 with that information? This is, I think, an important
4 framing. We were noting the fill-in-the-grid. One of
5 our members, Wells Fargo, uses a chooser tool. Large
6 employers still offer choice of plan. Small employers
7 rarely do. There's been a decrease even of large
8 employers offering choice of plans.
9 So, here you have a tool that actually PBGH
10 designed that helps an employee choose which plan is
11 right for them. Now, it starts with about you, including
12 how much health care do you use, do you have a chronic
13 condition, et cetera. So, it doesn't start -- I think
14 the note about interactivity that we heard earlier, 15
15 years ago report cards were put out there saying here's
16 your health plan's HEDIS score and here's four, you know,
17 big, huge, think reports. Choose the right plan, as if
18 people could use that. People weren't using it. People
19 said, well, why is that?
20 I say the same thing when I now look at, you
21 know, some of the great reports out there, for instance,
22 from Pennsylvania on hospitals. Really great reports on
23 hospitals, but totally unusable and unengaging.
24 So, this starts a patient -- excuse me, an
25 enrollee, in that once a year time when they've got the

1 reason to make a choice. Start with about you, how much
2 do you use the health care system, your circumstances.
3 Then it says here's costs. For your plan option, not
4 just what the cost of premium is, but your total cost
5 over the year is likely to be, given how much you say
6 you're going to use the health care system. So, it loads
7 in out-of-pocket costs, et cetera.
8 Then it says -- and this is based on testing,
9 what consumers care about -- is your doctor in the
10 network? That's because they care more about that than
11 they do about abstract quality. Then it takes in the
12 quality ratings. These quality ratings use NCQA, HEDIS
13 scores, use patient experience in standardized ways.
14 In this case, you'll note that Wells Fargo says
15 team members because they evaluate Wells Fargo's members
16 cap scores on plans, not the global scores that NCQA has
17 because they speak to them in that language. And then it
18 takes you through features of service.
19 The interesting thing here, back to our earlier
20 discussion on how do you engage consumers, is it doesn't
21 throw out there at the starting point here's a HEDIS
22 score. It starts with where people are, walks them
23 through a process, and through this, there is huge
24 migration or there has been at different points.
25 Then once people get settled on a plan, they

1 don’t change. But they move a lot. And 50 percent of
2 the consumers that go through the tool use every element
3 and appreciate every element. Some go through cost and
4 doctors and then they can jump to the end. You can stop
5 at any point. You don’t have to use every point. But it
6 engages them actively in some of these performance
7 elements.
8 Next, I do want to note about what we, as
9 employers, look to our plans to do. This is some of my
10 chasm crossing attempts earlier, noting that there is a
11 distribution of where physicians or groups or hospitals
12 fall in terms of how they use resources and how effective
13 their quality is.
14 And this is actually -- and I know I always
15 alienate physicians because each of these little dits is
16 a doctor. So, that’s probably one way to alienate
17 doctors right out of the gate. So, they’re distributed
18 across the board in terms of use of resources by episodes
19 and then scores on outcome and process measures.
20 Employers look to our plans using -- to do two
21 things. To either help consumers make better choices
22 towards the up and right, so identify folks in a better
23 way that are higher quality, more cost effective, and to
24 do payment designs that encourage providers to move up
25 and right.

1 And we look to providers to use quality
2 improvement and tools to move up and right. It’s not
3 ever about let’s get rid of the bottom quarter because,
4 oh, there aren’t enough doctors there, there aren’t
5 enough hospitals there. It’s all about moving up and
6 right.
7 But the tools we look to our plans to use is
8 consumer tools for selection, payment tools for wards,
9 all to sort of move up and right. So, that’s one of our
10 expectations of plans.
11 The next expectation of plan -- and we actually
12 score and evaluate again the RFI. Ask specific questions
13 about what are you doing as a plan to steer patients to
14 make better choices, what are you doing as a plan to pay
15 differently, et cetera. So, we assess how plans are
16 doing this.
17 We spend a lot of effort at our selection of
18 plans on what are they doing relative to the chronically
19 ill, the 5 percent of the population that, from an
20 employment perspective, costs over 50 percent of the
21 dollars.
22 That’s where you saw large employers that spend
23 a lot of analysis, almost a third of them believe in DM.
24 I think there’s huge questions about should DM live in
25 the medical group or live in the plan? How is that

1 shared? Great discussion we could have, probably not for
2 today.
3 But employers look to the plans and say, what
4 are you doing to make sure that those that are sick
5 people, that are expensive, are being served well? And
6 what are you doing to keep those 50 percent of the people
7 that cost nothing down there?
8 So, there's a lot of focus on what plans are
9 doing to promote wellness and keep well people well. So,
10 we will assess the plans in terms of their wellness
11 strategy, their consumer engagement. That's another
12 expectation.
13 The third big expectation, and it relates very
14 much to the whole framing of the day, is very much seeing
15 health plans as infomediaries, as information sources for
16 enrollees. And this is a question of consumers of saying
17 what is your health plan doing now, not doing now but
18 want, not doing now but don't want? If you look at the
19 biggest expectation that is desired but not being done,
20 it's providing information on best doctors and hospitals.
21 This is what -- and people often say, oh,
22 people don't trust your health plan. You know, if
23 consumers think they're evil, they won't go to them.
24 When consumers are asked what do you want your health
25 plan to do that they aren't doing, over 52 percent said

1 they want that. The other 35 said they're doing it now.
2 So, you have almost 90 percent of their consumers want
3 their health plans to be doing this, see this as
4 something they want them to do, whether they're doing it
5 or not. So, that's part of the expectation side.
6 A couple other data points, and then I'll wrap
7 up. I think Nancy actually alluded to some of this data.
8 This is data from '06, which was updated three weeks ago.
9 I do have a new slide. I forgot to load it in here, but
10 I'll do the foreshadowing, which is the really
11 interesting thing here is two things.
12 Because I know we're supposed to be talking not
13 just about physicians, we're talking choice across the
14 board. The health insurance plan, the left-hand side of
15 this is who saw the information; the right-hand is who
16 saw information and said they used it.
17 I want to do one huge caveat here. This survey
18 did not then drill down and say to a consumer, what did
19 you mean by quality information? It said quality
20 information. And, so, for some this means that doctor
21 quality, N of one, I had a bad experience. For others,
22 it may be a full-on report that shows scores on X, Y and
23 Z, and rolled up patient experience, et cetera. But
24 consumers believed it was quality.
25 And the two big things that I'd note here is,

1 if you look at health plans, there's been some increase
2 and some increase in hospitals in '08, the health plan
3 and the hospital numbers actually went down a little bit.
4 So, that's what Nancy was alluding to. The rate of those
5 that actually used it went down a tiny bit on the
6 hospital and insurance plan.
7 Now, I'll tell you, the hospital point
8 surprised me a little bit. The insurance plan didn't
9 surprise me at all. One of the things we've seen over
10 the last five, ten years is more and more employers not
11 offering choice of plan.
12 So, the fact that large employers continue to,
13 but even large employers instead of offering 12 plans are
14 offering three plans. So, you're seeing quality
15 information about plans and open enrollment, but fewer
16 employers are offering choice. So, that's not that
17 surprising.
18 The other thing is if an employee has been in a
19 plan for a long time, they might skip right over it and
20 they stay in the same plan. What you are seeing here,
21 though, is continued growth of the number of Americans
22 seeing quality information on doctors, whatever that
23 means. And the thing that I find most striking -- and
24 the last slide is taking the information and translating
25 it into numbers -- is what's this mean. And this number

1 is about exactly the same for 2008, even though it's
2 2006.
3 Twelve percent of Americans said they saw
4 physician quality information. Fifty percent of them, so
5 about 7 percent of Americans, said they used that
6 information in making a decision. Now, I think that is
7 not a 93 percent glass empty. I think that's a huge
8 number.
9 I think one of the questions, that's enough of
10 a number, back to Dr. Chumbley's point, to make sure that
11 you don't need a lot of folks to make sure doctors
12 themselves or medical groups are going to use that
13 information, too, because they will.
14 There will be a lot of use for quality
15 improvement, whether it's public or not. But there are a
16 huge number of Americans that are using quality
17 information today either to confirm a choice, to engage
18 with their provider or to change their choice.
19 And these are choices that unlike the health
20 plan, which is you know when to reach out to them,
21 employers spend a huge amount during open enrollment to
22 say, hey, you guys, you got your plan choices, we're
23 giving you financial incentives, et cetera, et cetera.
24 On the physician side, increasingly, plans are
25 where folks go. But this is -- you've got to diagnose

1 us. You have a new treatment. That's when you're sort
2 of searching around in the ethernet or with your plan and
3 other sources.
4 And we're seeing, you know, again, more than
5 one out of 20 Americans finding stuff that they're using.
6 And, often, they're using very inconsistent information
7 and I think that's some of our charge, to try to get
8 better standardized, et cetera. So, that's my quick
9 review.
10 MR. WROBLEWSKI: Thank you. Vince?
11 DR. KERR: As usual, Peter is always thoughtful
12 and I think very thorough. He's teed up a number of
13 things that perhaps I can expand on a bit. I'm really
14 going to make only four points, not because only four
15 points are important, but, at this age, four points is
16 probably all I can remember.
17 Health plans occupy a unique space if you think
18 about it and Peter alluded to this. We have, as
19 customers, employers who come to us seeking
20 administration of services or depending on what they buy,
21 product they buy, indemnification against the risk of
22 health expenditures for their employees. So, we interact
23 with them, we hear very loudly what they're seeking and
24 we see how they make purchase decisions based on those
25 parameters.

1 We also have business relationships with
2 physicians, contractual relationships, and a very
3 different arrangement with physicians, and with the end
4 consumer, people who are sometimes patients. We call
5 them members. They don't always see doctors, believe it
6 or not. And, so, we're at the nexus really of this and
7 getting inputs from all three sides. And that sort of
8 shapes a little bit about what we do.
9 Clearly, imperative for doing this, Peter
10 alluded to, it really is about cost. A lot will say
11 value. They don't want lower cost at any cost. They're
12 really looking for improvement in the care or in the
13 services that their employee populations receive.
14 And, often, plans are held to pretty strict
15 standards around those things. Parameters are created,
16 penalties are created when you're unable to meet those in
17 order to ensure that.
18 But it is impossible to avoid this. The
19 largest opportunity in health care, if you think about
20 reducing the drain on resources, the CDC would say is
21 prevention. Something like 60 to 70 percent of current
22 expenditures are tied to modifiable risk factors. If you
23 could magically remove all of those, somehow you would
24 remove at least those costs, maybe not reduce the entire
25 pie.

1 The second largest opportunity is really around
2 this: 30 percent of the incremental value of health care
3 is locked in consumer decisions, decisions about which
4 treatment to pursue for a given condition, the setting
5 for that treatment or facility and which physician is
6 going to provide that.
7 And I say 30 percent because that's, on
8 average, the variation we see inter-hospital, between
9 treatments or between doctors in rendering a service of
10 treating an episode or a condition, achieving a similar
11 outcome with very different total cost.
12 So, let me just set up what I think might be
13 the way you could think about quality measures. And it's
14 important to remember -- I think this was my number one
15 point, that the spectrum is broader than simply quality
16 the way we think about it or talk about it typically. If
17 you look at it as a consumer and the way we have to look
18 at it, it really spans a much broader spectrum.
19 So, regulation you could put in quotes. That
20 could be things that are driven by contract as easily as
21 by regulation or law. You see the things that are
22 probably not as strongly driven, that are evidence or
23 consensus-based or a community standard of practice.
24 And then, finally, over into preference, which is very
25 individualized.

1 The things on the left are typically system
2 driven. Things on the right are driven by individuals.
3 And the outcomes for doing these things are at the
4 bottom.
5 Part of the problem we have, and one of the
6 things that I want to avoid if you talk about the ask, is
7 picking something that is so narrow that you cannot
8 really meet the needs of this entire spectrum. So, if I
9 looked at it from a consumer point of view, they might
10 care about the 50 percent moving from the right to the
11 left. They may assume that things are safe. After all,
12 hospitals and doctors are licensed. That isn't even an
13 open question. We probably care about the 50 percent or
14 60 percent moving from the left.
15 The problem with focusing on a narrow band,
16 unless you're trying to drive -- and I listened carefully
17 to your comments -- a public health goal, it would be
18 great to get all hemoglobin A1Cs down and you would have
19 a massive impact on the system.
20 What you miss there are the 90 percent of
21 consumers whose concerns have nothing to do with that
22 particular parameter. So, we're forced to have a broader
23 view even though driving system change or public health
24 change may mean using a very narrow band of quality
25 measures.

1 The other thought here is that health plans do
2 this in sort of a tiered fashion. All health plans do
3 some sort of initial screening or quality measures for
4 physicians. And I have to be careful. I would make
5 light of this, but I'll get grief from the network people
6 if I make jokes about it. But, you know, you have to be
7 breathing, walking.
8 **(Laughter.)**
9 DR. KERR: You have to meet certain criteria
10 that are really important, license, privileges, lack of
11 sanctions, et cetera. Those are kind of barriers to
12 entry, if you will. And the vast majority of physicians
13 meet those. Those will not help anyone, you, me or any
14 consumer, or a health plan differentiate between the
15 levels of quality delivered. And, so, it becomes
16 necessary to do something more than that.
17 And, in fact, it isn't hard to do something
18 more than that. What you're looking at here are two
19 charts which I think are my second and third points. And
20 one is the -- the top chart is a bubble chart similar to
21 the scattergram Peter showed. The size of the bubbles
22 are volumes. Those are actual providers in a market. It
23 happens to be interventional cardiologists in Atlanta.
24 They're splayed on a scale that looks at efficiency
25 compared to a market average, which is one, so less or

1 more, and on a vertical scale, which looks at a composite
2 quality score.
3 But I could take out a single measure like
4 complications, I could take out a measure like redo
5 rates, you would see a very similar graph to this. So,
6 the marketplace presents an opportunity to do
7 differentiation without changing anything. In fact, it
8 almost feels, and it's to your consumer survey, that
9 we're obligated to begin to do this at some point. I
10 mean, consumers will want to know what we know and they
11 will want to pull that into their decision-making.
12 The second graph does something totally
13 different and it's a separate point that is important to
14 make. So, efficiency was defined earlier this morning.
15 It can be confusing. We think of it as the product
16 between resource consumption and pricing.
17 The second chart is that it is important to
18 look at cost or efficiency in that way and not as unit
19 price. What you see here is a scattergram of all ETGs.
20 This happens to be one market's claims. We used
21 diamonds, too. That way you can get around calling them
22 dots. Diamonds for the physicians.
23 And you're looking at the correlation between
24 the price of an office visit, so that's a unit price, and
25 a set of ETGs, which you would think of as driving office

1 visits, so a rash, a routine visit for follow-up for
2 diabetes. What you see is that, in fact, unit price --
3 and when you look at the total cost folded in around that
4 single visit or episode -- varies markedly. In fact, the
5 correlation is below .01. There is no correlation.
6 So, unit price can be very misleading if we're
7 putting that there to drive consumers in a way,
8 particularly if we're sensitive to cost. We think there
9 are some attributes to measures, which I won't go through
10 here. We have some standards for putting these in.
11 They're very similar to AQA, in fact, probably overlap,
12 and many other agencies that have interacted to begin to
13 regulate or express what a good measure should be. We've
14 talked about all of this this morning.
15 Meaningful, meaning meaningful to consumers.
16 The difference means something. And I would argue that
17 those differences in quality for the cardiologists
18 clearly mean something that would be explainable to a
19 consumer.
20 The cost clearly means something that would be
21 explainable to a plan sponsor when it's literally several
22 thousand dollars per episode difference that you're
23 talking about, sometimes for a worse outcome.
24 Comprehensive in a way that -- by that I mean not a
25 single measure that you need to have, measures that are

1 relevant to the specialty accurate.
2 We think national standards for quality make
3 sense. So, instead of a relative standard, well, you’re
4 the best in Peoria. But I don’t know what that means.
5 Maybe you want to drive up to Chicago for this procedure.
6
7 **(Laughter.)**
8 DR. KERR: That a national standard and
9 measuring everyone regardless of region against that
10 standard if it can be agreed on is more useful to
11 consumers, having the process externally validated. It
12 always has to be paired with efficiency. Or you could
13 say it the other way. Efficiency always has to be paired
14 with quality to satisfy, once again, our customers. It
15 needs to be fair in this process to physicians.
16 I took out the chart because of our discussion
17 on what happens with this information because that should
18 have fit under consumer. But we have three and a half
19 years of data, of putting this information out in front
20 of consumers, and some very interesting statistics. That
21 if you compare behavior in a marketplace pre and
22 post-introduction of this information, you get somewhere
23 between 11 percent and 23 percent of consumers shifting
24 behavior.
25 So, the fact that they say they want this, they

1 actually do incorporate it. That could be with or
2 without benefit design incentives. Some would say
3 penalty. Most employers choose to do relief, meaning
4 there's a copay, but you don't have to pay it if you pay
5 attention to this information, or some other sort of
6 reduction.
7 The fact is, though, that when we look at what
8 the difference is between using incentives and using
9 information, information contributes an equal amount of
10 consumer behavior shift if done in the right way to a
11 financial incentive. Financial incentives, in our view,
12 probably serve only as a cue that there's something in
13 this information you want me to pay attention to. In
14 some instances, it's trivial, the forgiveness of a $10,
15 $15 copay are relatively trivial for most people.
16 So, consumers are shifting. There's some other
17 information about how consumers use this behavior, and
18 setting and context is critical. Setting and context is
19 critical.
20 You need to present this information in a
21 variety of ways because consumers access and process the
22 information in a variety of ways and that includes
23 putting in the hands of physicians the same information
24 you're putting in the hands of the consumers who might
25 use it. Having that conversation with them so they know

1 what their patients are talking about when they come in,
2 and you can either validate or dispute that, depending.
3 We find that when that happens, referral rates
4 change. That when objective information is given,
5 particularly about procedural or surgical specialties,
6 many physicians are not aware of complication rates,
7 mortality rates, length of healing, redo rates. They
8 don't know those things.
9 They have a sense of how someone performs, but
10 the vast majority of physicians have not done the
11 homework, if you will, to understand what's beneath that
12 sense that they have. They're folding in multiple
13 factors.
14 So, the third point I make about consumers is
15 that when this information is presented to them at the
16 point of making a decision, there's certain things that
17 don't work. You won't get change of a primary care
18 physician or what we would call relationship physicians.
19 Those exist over time and across family members and you
20 need to be respectful of those. But you have huge
21 opportunities to influence subspecialty and specialty
22 usage.
23 The other thing that often happens is when this
24 is presented at the point of decision-making around a
25 treatment decision, when you give quality information so

1 they can then couple that with where should I have this
2 done? I've just decided, you know, to have that lobotomy
3 because it seems like a cool thing, what's the best place
4 for doing that?
5 **(Laughter.)**
6 DR. KERR: Well, it's important to you now.
7 Trust me, after the lobotomy, it won't matter.
8 **(Laughter.)**
9 DR. KERR: They will make a decision. The
10 survey that's done immediately after that structured
11 conversation where you're trying to present all of the
12 treatment options, that often, by the way, does not yet
13 happen in practice. I know from calls and discussions.
14 I didn't even know that could be done that way. It
15 depends on who you see, as was made earlier -- a point
16 made earlier.
17 That when you do this in the context of that
18 sort of decision-making, the immediate survey rate, about
19 well, you were planning on having this done here, do you
20 think you will change, is about 7 percent. If you look
21 at claims data, it's about 33 percent that shift.
22 So, something happens. They leave that
23 conversation. They have time to think about it. They
24 cross-check it with their physician. They validate it on
25 the Web. Something goes on. But their ultimate decision

1 seems to be influenced by providing objective information
2 in a fashion that helps answer the questions and lead a
3 consumer to decision around choice.
4 And, so, I'm going to end there because I've
5 used up my ten minutes. But the point at the bottom is
6 the one that's important. I think you need to pair
7 performance information with treatment decision exercises
8 so that the two can be made together.
9 If I could ask for anything -- and we do get an
10 ask here, right -- I think at the top of my list would be
11 the ability to get CMS data under a set of controlled
12 circumstances, that CMS data for hospital and physician
13 and drug, that could be folded into a database, provided
14 the user of that meets certain sets of conditions that
15 ensure safety of the data, security of the data, fairness
16 to the parties that might be impacted by the data. You
17 could craft a list of things. But that would greatly
18 enhance the ability to make this information relevant.
19 The wish, not the ask, would be to have more
20 clinical data folded into comparative performance
21 evaluation. We get some today. We can get lab results.
22 We can get drugs. But it's not universal. It's not as
23 complete as some of the other pieces of administrative
24 data. Those would probably be the two asks that I would
25 have.

1 And, finally, comparative effectiveness. There
2 isn't enough of it.
3 **(Laughter.)**
4 DR. KERR: I don't know how to solve that. I
5 think that's a problem we all share.
6 MR. WROBLEWSKI: Okay, thank you very much.
7 I'm going to turn to Andy to kind of kick off our
8 employer information needs. Peter broke it off nicely in
9 terms of two ways to look at quality information. One in
10 terms of the selection of the plan, and then once the
11 plan is selected, within the providers and treatment
12 options within it. And I'll ask Andy to start off.
13 MR. WEBBER: Sure. Peter had a, I think,
14 follow-up comment for Vincent's remarks.
15 MR. WROBLEWSKI: Oh, I'm sorry, go ahead.
16 MR. LEE: Very briefly. I just want to connect
17 two dots. One is to the earlier discussion around
18 expectation of plans relative to performance information
19 is unlike consumers, which will take an N of one and
20 delegate validity, employers do.
21 I mean, Andy may speak to this. But, for
22 instance, in evaluating, we actually ask the plan to what
23 extent are you using NQF approved, nationally
24 standardized measures, to what extent are you complying
25 with national patient charter for physician performance

1 reporting, et cetera.

2 So, that's one thing I want to sort of connect
3 a dot to. So, this is the place where purchasers see
4 things very similarly, in many ways, to physicians and
5 providers.

6 MR. WEBBER: But then beyond that, how do you
7 use that information to generate value-based benefit
8 designs or high performance networks or to differentiate
9 reimbursement based on performance? All of those issues
10 start with the foundation of provider level measurement
11 and making sure that we have confidence that plans are
12 doing that the right way. But, again, that's just the
13 foundation for lots of other things that we want plans to
14 do.

15 DR. KERR: Could I add another ask?

16 **(Laughter.)**

17 DR. KERR: With that comment. And that is that
18 we work to create a system that is less prescriptive
19 around performance measurement. We could be prescriptive
20 about a core, but we should be able to evaluate a process
21 to measure generation which will allow much more rapid
22 expansion than we can get through sort of the current
23 means for approving and stamping measures. It's too far
24 short of what consumers ask for.

25 I get about four calls a month and that's only

1 because most people don’t have my number. But those
2 calls will be things like, I’m a senior executive at this
3 large Fortune 500 firm that you do business with, and my
4 13-year-old son, who’s a star athlete in three sports and
5 a straight A student, is just going to be stellar and a
6 CEO himself one day, has sustained an injury to his
7 shoulder and needs repair. I’ve done the research and
8 found that there are three places that can do this
9 pediatric shoulder surgery, and here are the surgeons.
10 Who should I go to?
11 That’s the level of -- it’s those kinds of
12 requests. If we’re held to 40 measures, there’s just no
13 way of answering that for an individual in my capacity
14 or, I would even think, in practice.
15 So, if we had a process that could validate how
16 measures are vetted, generated and the validity of them,
17 sign off on that and let the folks who are using them
18 adhere to that, that would be an advancement over the
19 prescriptive.
20 If you look at OSHA, as an example, safety in
21 the workplace -- that used to be a past role of mine, as
22 part of my job -- I would say that over almost 30 years
23 of existence, maybe a little bit less, OSHA promulgated
24 something like 22 rules for chemical safety in the
25 workplace. At the companies I worked at, we were

1 introducing somewhere close to 1,000 new compounds into
2 the work site.
3 If we were simply calling it safe because we
4 adhered to the 20 -- it takes them three years to
5 promulgate a rule. They've got to investigate it, public
6 comment. We wouldn't create safe workplaces. We
7 wouldn't be able to.
8 But they had a general duty clause, which
9 there's stuff that we can't possibly anticipate, but if
10 it is harmful and you haven't taken actions as a
11 corporation to understand what that is and protect your
12 employees from exposure or screen them, then you are
13 liable. It allowed a process outside of the sort of
14 fixed process. In a similar way, I think we need
15 something for quality measures.
16 MR. LEE: The other thing, if I could note --
17 and I'm saving my ask list for this afternoon, because I
18 do have one.
19 **(Laughter.)**
20 MR. LEE: This is a hand back to Andy. It's
21 related to this morning and an expectation on health
22 plans, is a lot of the framing so far has been quality
23 information as if it's on the Web or in paper as opposed
24 to human intermediated. I think the issue of coaching,
25 who is that coach, sometimes it can be your primary care

1 doctor. Other times it’s going to be an “advocate” or
2 navigator or nurse or whatever.
3 Large employers look to plans to say we want
4 coaching because you’re going to call. And some get
5 through to Vince. But there’s two million that get
6 through to trained nurses that have this information.
7 So, these bubble charts aren’t what you
8 necessarily send out, but there’s millions of
9 conversations that United enrollees or Aetna enrollees
10 are having with nurses saying, I have an X, what do I do?
11 And that is an expectation that people won’t -- the
12 literacy issue, we don’t expect people to be able to
13 digest charts or even a full dot or a half dot
14 necessarily. But then you’ll have conversations.
15 So, that issue about quality information
16 translation is, I think, often going to be the human role
17 in the middle of it.
18 MR. WEBBER: And just sort of one comment on
19 that is sort of what is the trend in the health plan
20 role? We’ve counted on plans, historically, perhaps
21 because of the fragmentation of the health care delivery
22 system and the fact that there have been gaps in care,
23 particularly around chronic care management and coaching
24 and counseling. Employers have relied heavily on plans.
25 But I don’t think that’s static.

1 I think there is this evolution as we build out
2 more integrated delivery systems, as we build out,
3 Michael, the medical home model, where perhaps the more
4 -- and I would argue for this, the more trusted source
5 for coaching and counseling at the individual level is
6 more the primary care physician than the big, bad, you
7 know -- I respectfully say this, Vincent, but we all see
8 the public opinion polls -- the trusted source or not
9 very trusted source of the insurance company.
10 DR. KERR: You know, you have to be careful
11 with that, Andy, because, A, if you look at polls that
12 have been done sequentially, that has actually changed.
13 If you look at the data Peter showed, that would be
14 directly in opposition, an expectation that you get this
15 information. Our focus groups that we've done tell us
16 that. That's perhaps a limited view when you speak with
17 consumers and their view of plans.
18 If you talk about it from the perspective of,
19 will I get paid for what I want to do and can I see who I
20 want to, that's absolutely true. When you talk about in
21 other domains, you see very different ratings.
22 MR. WEBBER: Well, that's good. The issue is
23 still on the table in terms of sort of the division of
24 responsibility and maybe, Vince, you're arguing for it
25 takes a village and we should reinforce at every level,

1 whether it's coming from a health plan, whether it's
2 coming from an individual physician, the support that
3 individual consumers need to make better decisions.
4 DR. KERR: Yes. I think that's the ideal
5 world, where you've tied all three points.
6 MR. WEBBER: Right. But that is -- I just want
7 to sort of identify that as a very active debate that's
8 going on in terms of how do we divide or share those
9 responsibilities moving forward?
10 Barb, you had a comment?
11 MS. RABSON: I just wanted to comment on the
12 role of the health plan because I think the regional
13 coalitions, like MHQP, like Wisconsin and California
14 have, also get into the area of the role of the health
15 plan. Because we come together, shared stakeholders, and
16 put this information out, our plans don't have to do that
17 anymore because we're doing it.
18 We don't want them to do it themselves because
19 then physicians get lots of conflicting reports and they
20 spend a lot of money doing something they don't need to
21 do because they're paying the coalitions to do,
22 hopefully.
23 MR. WEBBER: And, more importantly, you've been
24 able, at a community level, to aggregate plan information
25 so you have more robust information than Vince at United

1 could provide in any one market where he’s working, even
2 where he’s got, you know, very large customers and lots
3 of business.
4 MS. RABSON: Right.
5 MR. WEBBER: Right? So, that’s the other
6 virtue of moving in that direction.
7 MS. RABSON: Right. And I just want to say one
8 thing, if I can, to Vincent’s point about CMS data.
9 Because there were BQI or better quality information
10 pilots that Minnesota, Massachusetts, California, also
11 Indiana, Minnesota, yeah, and Arizona got. So, there’s a
12 precedent for that. I mean, it’s a little discouraging
13 what’s happened with those pilots after. But I think
14 that we have something to build on in terms of to say,
15 you know, let’s keep pushing on that.
16 MR. WEBBER: Well, Michael, I don’t have much
17 to add after Peter and Vincent’s comments, but let me
18 just say a few things.
19 First, to state sort of the obvious, how
20 important this employer plan relationship is. I mean, as
21 both of them said, employers are the paying customer and
22 employers count on health care plans to be their agent in
23 the marketplace, to do a lot for them.
24 Peter teed it up well in terms of measuring
25 performance, the transparency issue, rewarding providers,

1 and then this big role in influencing decision-making at
2 the individual consumer level.
3 Let me just say sort of, historically,
4 employers I don't think have done a very good job, as the
5 paying customer, in evaluating the performance of health
6 care plans over time. And I think a lot of employers
7 have been making decisions about selection of health care
8 plans not based on the robust information that we think
9 they need in terms of all the different roles that plans
10 have. And we hear this from health care plans in
11 response to our evaluating tool.
12 You know, MBCH and your 20 coalitions and some
13 employers who are asking good questions and you have a
14 very robust tool. But when I go out and talk to a lot of
15 employers about decisions, you know, that sort of
16 information base is not being used when a decision is
17 being made by an employer to choose an individual plan.
18 So, I just want to note for the record that, you know,
19 we have to be, as employers, more discerning customers
20 and consumers when we make selections about health care
21 plans.
22 And that is the tee up to the other comment.
23 NBCH developed the eValue8 tool with some large
24 companies, particularly General Motors, 10 years ago to
25 really create a voice from the employer community and a

1 set of expectations about what we think health plans
2 should be doing in the marketplace and as a way to
3 differentiate performance among different health care
4 plans.
5 And, so, that tool, together with other tools,
6 NCQA, obviously, accreditation and HEDIS performance
7 measures and other factors that employers put into the
8 equation, particularly on the cost side, provider network
9 side, can be used as a tool to make better decisions
10 about plan selection. This is a critical choice that
11 individual employers have, that basic decision. Even as
12 Peter said, the trend has been moving toward fewer plans
13 or selecting a single plan. This is particularly true
14 with small employers, a single plan that then perhaps
15 offers different choices to a plan. But it will be
16 United Healthcare that has the entire book of business
17 for a large employer, but you've created different sort
18 of plan choices or coverage choices for individuals. And
19 I do think that is a trend.
20 So, there are still employers that are able to
21 select multiple plans and then provide for their
22 employees a choice of plan. There, the individual
23 employer has a big role in making information known on
24 those different plans. Again, Peter identified the
25 health plan chooser tool that Pacific Business Group on

1 Health has used and I think there are other models like
2 that around the country.
3 And, importantly, too, there are a few large
4 employers that actually provide economic incentives for
5 individuals to choose the higher-performing health plan.
6 And we would like to see more employers do this, based
7 on, again, more robust, objective information. Those
8 employers say to individuals, if you choose the
9 high-performance plan, your premium share will be
10 reduced. We're going to create an explicit incentive for
11 you to shift your selection and to move the market. So,
12 certainly, we would like to see more of that happen.
13 The last comment that I make is information
14 that employers can generate on health care plans, much
15 like information that can be generated at the provider
16 level, can be used as a quality improvement tool. A lot
17 of what coalitions do in using EValue8 with individual
18 employers is simply to feed back the information on
19 EValue8, to identify opportunities for improvement, to
20 set performance expectations for a health care plan, to
21 have that ongoing dialogue between the customer and the
22 provider of the service, and that can generate, again, a
23 very positive endpoint in terms of overall plan
24 performance and setting priorities, again, from your
25 customer, Vince, about what is the most critically

1 important things that you want us to focus on in the
2 coming year.
3 So, there is this sort of quality improvement
4 aspect of the generation of plan-specific information
5 that, again, employers and coalitions can use in driving
6 better performance at the health plan level.
7 MR. WROBLEWSKI: Let me ask a couple questions
8 about the first bullet up there and then we'll go to the
9 second one.
10 Peter, you indicated that cost was very
11 important, number one concern. Andy, obviously, you can
12 answer, too. Do employers have sufficient information to
13 compare to actuarial benefit of plans -- of competing
14 insurers' plans?
15 MR. LEE: That's a great question. And it's --
16 I think Ardis rightly raised when you look at outcome at
17 the physician level, risk adjustment, sine qua non,
18 you've got to have it done well. When you really look at
19 employers' selection of which plan costs the right
20 amount, it's very hard to actually do -- which on the
21 employer side is the actuarial adjustment to understand
22 what am I really paying and what's being gained versus
23 not gained, I think the answer in the end is large
24 employers, absolutely. But that's because they spend a
25 bucketload of money with large consultants to look at

1 what am I spending, what is the risk mix of my population
2 and we'll then be able to have actuarial equivalency.
3 When you get to where the majority of Americans
4 are actually covered, I think it's relatively opaque. It
5 is not as clear because they aren't benefitting from
6 actuaries that they're bringing in and they're looking at
7 the rack rate, so to speak, of what they're being
8 charged. It becomes very hard because the actuarial
9 equivalents, adjusting for benefit design, often you'll
10 have two benefit designs being compared that aren't just
11 the same. And we'll have different implications. So,
12 what the costs are, you aren't really dealing apples to
13 apples.
14 So, my sad note is that it's a mixed bag.
15 There are larger employers which, I think, often large
16 plans have to be responsive to, so drive the market in
17 many ways, get it. Smaller employers, I think, are all
18 across the board.
19 MR. WROBLEWSKI: Okay, thank you. Did you want
20 to add a --
21 MS. FERRARA: A comment to that.
22 MR. WROBLEWSKI: Yes, please do then.
23 MS. FERRARA: The comment that I wanted to add
24 was this is an area where health plans compete for
25 employers, right? So, we want to be able to demonstrate

1 that we have the strongest risk assessment methodology
2 and we can stratify their population in a meaningful way
3 and we can tie that to cost and we can tie that to
4 benchmark index. Then we can tie that to what we're
5 offering for solutions for those different populations,
6 whether it's the wellness or the chronic disease. And we
7 want to talk about ROI. Because that's really what you
8 want to know.
9 You know, if I'm investing in your disease
10 management program or your wellness coaching program, how
11 do I know you're capturing the right people? How many of
12 my people is this helpful for? Is cardiac disease a big
13 issue for me in the relative scheme of issues? How do I
14 compare to other employers for cardiac disease? And what
15 can you do about it and what's your ROI? Are people
16 healthier? Do they return to work faster? That's how we
17 compete.
18 We used to compete potentially more on price,
19 you know, what's their fee versus our fee? But these are
20 the things that matter. So, if you talk about
21 competition, you have to talk about how we're competing
22 as well.
23 MR. WROBLEWSKI: Nancy, you wanted to add?
24 MS. Foster: I just wondered if I could ask
25 Peter a question.

1 MR. WROBLEWSKI: Sure.
2 MS. Foster: Or anybody.
3 MR. LEE: No, not Nancy.
4 **(Laughter.)**
5 MS. Foster: That's one, Peter.
6 MR. WROBLEWSKI: And, Nancy, I have a question
7 for you afterwards.
8 MR. LEE: I didn't mean to say that.
9 **(Laughter.)**
10 MS. Foster: The question I wanted to ask
11 was does the picture change a little bit for the
12 self-insured large employer because they're using some
13 plan to manage --
14 MR. LEE: I'm saying virtually all the large
15 employers, if you're big, they all have significant
16 self-insured and some insured because of where they are,
17 et cetera, and will do just as -- will look at the data
18 with real discretion and will expect the plans will come
19 in and say, here's what we can tell you about your
20 population and where they are. So, for that large
21 population, self-insured, absolutely, they look at it
22 really closely. It's just when you get into mid and
23 small employers, it becomes very much about price.
24 And then major tactical choices that employers
25 make. Am I going to do a consumer pay through a

1 consumer-directed plan and some features of a plan and
2 price that are more sort of philosophical.
3 MR. WROBLEWSKI: The question I ask for you,
4 Nancy, based on your comment, and actually it was
5 Michael's comment from earlier this morning, and I
6 thought one of Vincent's slides maybe teed up maybe how
7 we could discuss this for just a real brief point because
8 you both have brought this point up. So, I wanted to
9 address it.
10 You said, where is competition appropriate?
11 So, I was looking at if you were to move that red line
12 from left to right, are you saying that in terms of when
13 we were talking about consumers this morning, that
14 competition on moving -- if the red line were, say, more
15 in the middle of the screen rather than where it is right
16 now, that competition would probably be better when it's
17 to the right? Is that what you're saying? And that
18 there's a certain baseline that you expect that would be
19 on the other side of the red line and that's where it
20 would not? I saw this graphic and was just thinking
21 about it.
22 MS. Foster: I think competition on safety is
23 not appropriate. I mean, just personal opinion.
24 MR. WROBLEWSKI: Right.
25 MS. Foster: Competition on compliance -- the

1 terms here are befuddling me a little bit because you
2 used them in a slightly different way than I would have
3 used them. I mean, in some degree you'd expect everyone
4 to be able to deliver patient-centered care. Would you
5 have competition on I can be more patient-centered than
6 you? Yeah, that might be appropriate.
7 MR. WROBLEWSKI: Or dimensions of cases.
8 MS. Foster: Dimensions of cases. Compliant
9 care -- again, I would hope that people were compliant
10 with well-founded, evidence-based guidelines. But as
11 we've talked about here, there's a lot of territory out
12 there for which evidence is insufficient. And, so, some
13 of that might be appropriate.
14 DR. KERR: If it's clarifying at all, I would
15 say that given the bubble charts that we've seen, you're
16 stuck here. I mean, you are going to compete on being
17 able to be in that upper right-hand quadrant as a first
18 order of competition.
19 It would be great if everyone were there
20 already. It would change the domains.
21 MALE SPEAKER: I won't speak for Nancy, but I
22 don't think we're saying anything different except we're
23 saying there should be, across the board, an assumption
24 that there's a certain level of performance that we
25 shouldn't have to bother our consumers about worrying

1 about who's doing what. And I agree with you, we're not
2 there yet.
3 But, at some point, that level of competition
4 should be moot and we should be competing on other
5 elements that really are truly differentiating providers
6 and systems, et cetera. So, I don't know how to
7 interpret the diagram any better than just describing
8 what I was relating.
9 DR. KERR: I think, if I can, safety is
10 foundational. And the reason that's sort of a sliding
11 chart is that when you get to the other end of that, it's
12 an assumption. You don't even ask.
13 Right now, when you leave town, for those of
14 you who are flying, you're not going to look on a Web
15 site to see whether Delta or Northwest has a better crash
16 record. You're not going to do that. You're going to
17 look at other parameters. If, in fact, there were vast
18 differences --
19 MALE SPEAKER: Cost.
20 DR. KERR: Yeah, cost.
21 MALE SPEAKER: How much does a pillow cost?
22 DR. KERR: And time. Can it get me there?
23 All sorts of things.
24 MALE SPEAKER: Sure.
25 DR. KERR: If, in fact, there were vast

1 differences in the crash rates, you would be paying
2 attention to that.
3 MALE SPEAKER: Well, yeah, I mean, back to
4 Beth's point earlier and some others. I mean, the way we
5 judge airlines right now, after you've been a few -- you
6 know, you look at whether the cabin is kept up, whether
7 the tray table is clean. Is that a proxy for how well
8 the pilot's doing? I don't know. But it's what you can
9 see. And I think that's where some of the measurement is
10 right now. I think that's what we're all trying to move
11 away from, so it's meaningful. Although I would like a
12 clean cabin.
13 MR. WROBLEWSKI: Barbara.
14 MS. RABSON: It's interesting because this
15 whole competing on safety issue is playing out a bit in
16 the Boston market. Peter Levy from Beth Israel Deaconess
17 Hospital has begun posting infection rates, never events,
18 all kinds of complications on the Web and they've run
19 into turbulence as they found a wrong site surgery in the
20 last few months. Unfortunately, a young woman died
21 delivering a child. So, there's these issues that are --
22 they're very transparent about it.
23 And, so, there's one worry that because these
24 have been in the Globe, people say, well, I don't want to
25 go to the BI. But there was a great quote from one of

1 the surgeons that the BI is safer than it's ever been.
2 This is not an anomaly that these things are happening at
3 Beth Israel. These are happening everywhere. Beth
4 Israel happens to be very transparent about it.
5 And Peter was joking that some of the other
6 CEOs are pressuring him and saying he's doing this for
7 competitive purposes. And he's laughing and saying, wait
8 a minute, you know, like what are you saying? So, the
9 idea is, you know, he's one of these innovators that's
10 out there saying this needs to be done and we're doing
11 it. But this whole issue of drawing the issue about what
12 we take for granted is not -- it's hitting the press.
13 MR. WROBLEWSKI: Andy, you wanted to --
14 MR. WEBBER: Well, sort of to bring this to a
15 sort of practical level in terms of some examples out
16 there, you know, what if Vince created a high-performance
17 network that was based on good information that
18 demonstrated that the hospitals and physicians in his
19 network are providing higher quality, more efficiently,
20 driving costs down. He's able to create that product and
21 go to employers and go to employees of those employers
22 and say, if you're willing to join a plan with just as
23 high-performance network, this is sort of back to the
24 future. We all remember these days. But your choice of
25 provider will be restricted.

1 But particularly in this economic environment,
2 remember, all the cost shifting that's moving on to
3 employers. Look at the economic meltdown. You're able
4 to say to an individual consumer in choosing this more
5 restricted network -- and, by the way, I'm going to
6 demonstrate to you, because I've got the data, that
7 you're going to get higher quality at lower cost. Your
8 quality is going to go up. It's not going to be
9 compromised. And you're going to have a lot fewer
10 dollars in your premium share. It's going to cost less
11 for you, individual consumer.
12 I think that is competitive. I think that is a
13 winning product in the future. And I think even
14 individual consumers, at least some of them, not all of
15 them, are willing, if, again, they had trust in the
16 information, to go in that direction.
17 MR. WROBLEWSKI: How does that square with --
18 you raise such a good point. I was fascinated by Peter's
19 slides. When you look at the ability, at least from what
20 employers think, in terms of the ability to use a tighter
21 managed care network to actually reduce costs would be
22 that when I added the numbers, it looked -- even though
23 none of them were a silver bullet, it was really, you
24 know, pewter. I mean, it was really very low in terms of
25 that number. So, how does that square in terms of what

1 employers are saying?
2 MR. WEBBER: Can I --
3 MR. WROBLEWSKI: Sure.
4 MR. WEBBER: Well, again, we all went through
5 the wars, the managed care wars, and we all heard from
6 the public that choice is everything and employers and
7 plans got beat up. That was not a sort of pleasant time.
8 And yet there were elements of that period -- and,
9 Michael, back to -- remember how we used to call it the
10 primary care gatekeeper?
11 MR. LEE: Yeah.
12 MR. WEBBER: Does that sound an awful lot like
13 the medical home concept?
14 DR. BARR: No, no.
15 **(Laughter.)**
16 DR. BARR: Can that be struck from the record,
17 please?
18 MR. WEBBER: No, but in terms of the vision.
19 But in reality --
20 DR. BARR: Not to be flip, you take away the
21 gatekeeper, but you think about as a facilitating system,
22 where there’s an organized principle around how you
23 deliver care, but not the barriers that were put in force
24 before.
25 MR. WEBBER: Right. The vision of managed care

1 was never created. But if you take the elements of where
2 we wanted to go with some of those concepts, having a
3 medical home, having a provider network that's
4 high-performance that's been identified, again, having
5 individuals be part of a more integrated, closed panel,
6 high-performance network, that was -- that was what, at
7 least, the theorists were talking about when they talked
8 about managed competition.
9 The marketplace didn't realize it. There was
10 tremendous political pushback. But I think those issues
11 and that vision is still very relevant in terms of
12 competitive marketplace.
13 MR. LEE: What I was going to say, if I could,
14 the tighter managed care networks -- and I'm not
15 surprised why it's pewter -- is that it does bring up for
16 employers 15 years ago a managed care backlash. What's
17 changed, though, and this is what I think we see in the
18 major plans, is that -- and that migration from an HMO
19 model to more PPO, is it's variable. There's money on
20 the table and you can make a choice. It's a choice-based
21 model where it's not anchored in tighter management; it's
22 anchored in more information that links quality and cost
23 and incentives to make a different choice, as opposed to,
24 sorry, you picked X and that means one-third of the
25 doctors are in.

1 I think that's a conceptual change in terms of
2 a -- which, to my mind, is both pro value, encourages
3 quality improvement better and is more competitive. But
4 it's not a tighter managed care network. It's a very
5 different model. So, the pewter side of this doesn't
6 surprise me.
7 MR. WROBLEWSKI: Okay. Dr. Hoven, you wanted
8 to raise another issue.
9 DR. HOVEN: Correct.
10 DR. WROBLEWSKI: Go ahead.
11 DR. HOVEN: Thank you. And this is directed to
12 Vince, a comment and a question. And I would be
13 extremely remiss if I did not put on the table the
14 discussion of physician tiering and bring that out in the
15 open and what those discussions are centered around and
16 what the financial incentives are for the patients and
17 what the implications are for that. Because as most
18 everybody in this room knows is that the data that has
19 gone into this tiering has not been good data in most
20 situations. And I think that that has created, if you
21 will, a real barrier -- and we'll discuss it more this
22 afternoon, but a real issue in terms of where plans are
23 going to go with this.
24 And, again, I understand the mentality behind
25 it, but I think as you're going forward with this, you're

1 going to have to look very critically at what you're
2 doing with that information and that data and, more
3 importantly, how valid and good is that data. So, any
4 comments you would make, I would be appreciative.
5 MR. WROBLEWSKI: Go ahead. She jumped ahead to
6 my next questions, but, please, go ahead.
7 DR. KERR: There are many ways of structuring
8 tiered networks. The most extreme would be sort of what
9 Andy's talking about, which is a completely closed
10 network. You don't have access to physicians other than
11 those who are named.
12 I don't think many are going that route and I
13 think there are a variety of reasons for that. It's hard
14 to go back. And large employers particularly --
15 actually, this is where the small employer market leads.
16 So, there are products out there that make
17 differentiation around benefit design based on those
18 metrics. And individual members, people who are buying
19 their own insurance, and small employers are rapidly
20 electing that product.
21 What they're saying is I can handle the
22 difference. I have choice, but that choice is going to
23 cost me something. And the rationale behind that is
24 while there are a host of issues around trying to depict
25 quality performance, there are not as many issues around

1 depicting efficiency. There’s some, but not as many.
2 And you can do those depictions at a level that would
3 satisfy the scientific community, meaning at a .95
4 percent confidence interval. If you hold yourself to
5 that standard, why wouldn’t you use that as a way of
6 differentiating?
7 In saying to a consumer, you’re perfectly free
8 to make the choice, but just know that this costs me
9 more, so it’s going to cost you more. You’re going to
10 share in that additional cost. When the availability of
11 service at equal or better quality is available, that
12 would be less costly. I don’t think that’s an unfair
13 conversation to have.
14 Your point is absolutely well-taken. The
15 structure around that in terms of not doing it strictly
16 as an internal, you know, this isn’t Vince’s mad, you
17 know, scientist lab cooking up, but exposing that to
18 external scrutiny and validation, receiving input from
19 the stakeholders who might be impacted by that are all
20 requirements for, I think, developing that sort of
21 system. It’s not a no-go in my mind.
22 MR. WROBLEWSKI: Elysa, you wanted to add
23 something to that?
24 MS. FERRARA: Yes. I would say, in addition to
25 those comments, that we can’t forget that there’s a

1 consumer purchaser disclosure project in the patient
2 charter. We can't forget that there was a New York AG's
3 settlement agreement and, in fact, the plans fared well.
4 Ours was one, but we weren't the only one.
5 So, there is a rigor to the work that is being
6 done. There's a commitment to exchange and development
7 with physicians and with other providers for any of these
8 tiered networks. Quite frankly, the employers are
9 demanding it. And many of these innovations for
10 measurement are coming directly from what we're hearing
11 at the table from the employers.
12 They started Leapfrog, they started Bridges to
13 Excellence, they started HEDIS, and they were the
14 innovators for the consumer purchaser disclosure project.
15 So, the demand is real, and we talk about tiering, which
16 would say, as you said, we pay more, you need to pay
17 more. There's evidence of quality here.
18 We have employers who are demanding domestic
19 tourism programs and international health tourism
20 programs. So, for them, differentiation is important and
21 they'll invest. They'll pay $10,000 for travel to
22 invest, to get high-quality, value-based purchasing.
23 And, so, that's the world that we all live in.
24 I spend a lot of time internally with that with
25 our medical directors and with our network people,

1 sharing with them this information from EValue8,
2 information from the Leapfrog users group surveys and
3 information from RFIs. We also do that when we're out
4 with the physicians. There's an IPA we have a contract
5 with that's 2,200 docs. That's a lot of docs.
6 When we sit with them and we show them the
7 questions -- I had one yesterday that I responded to.
8 How specifically do you profile your physicians for
9 quality and efficiency? How do you give that information
10 to your physicians? How often do you give it and what do
11 you use it for? That is nearly a quote. And it's not
12 uncommon, I'm sure you know. This is what we get asked
13 every day.
14 So, these are the payers who are asking for
15 this kind of information from us. But they're also
16 asking us to be credible, respectful and collaboratively
17 engaged when we do it. And I think that's the challenge
18 for us. How do we do this together? Because it will
19 happen. It's already out there on the internet. It's
20 our obligation to work together to do it in a way that is
21 prudent and disciplined.
22 MR. WROBLEWSKI: Dr. Chumbley, did you want to
23 add something? Then I'll turn to Nancy and to Michael.
24 DR. CHUMBLEY: Sure. I think you said it very
25 correctly. In Wisconsin, when the collaborative looked

1 at episode of care and efficiency a numbers of years ago,
2 we realized there just wasn't enough data out there to
3 come up with it. So, we spearheaded creating the
4 Wisconsin Health Information Organization, which we
5 haven't spoken of yet this morning. But that
6 organization brings together the medical society, the
7 collaborative, as well as Anthem, BlueCross-BlueShield,
8 Humana, United Healthcare, Wisconsin EA Trust, Wisconsin
9 Physicians Service, which is another insurance company,
10 and probably two private plans, and we'll have about 1.2
11 million members and associated data that we will come out
12 with our first pilot period early this next year.
13 The most important part, we're trying to do
14 exactly what you did. We brought the medical society,
15 the physicians, the major payers. We have a clinical
16 advisory group that looked at how the measures were going
17 to be developed. I sit on that. So, we're trying very
18 hard to do it collaboratively.
19 The biggest question that came up early was the
20 tiering question. The physicians on both sides, the
21 medical society and the collaborative almost backed away
22 from this project because we really couldn't get the
23 plans to say we won't tier.
24 Well, we've got an advisory group, we've got
25 this. And, so, I think it's in that test period now and

1 we’ll see whether we actually can collaborate and
2 cooperate and come up with something that serves the
3 needs of the people in Wisconsin. I’m pretty hopeful and
4 supportive. But it’s going to be tough.
5 MR. WROBLEWSKI: Nancy, you wanted to add
6 something?
7 MS. Foster: Yes, and thank you. Sort of
8 picking up on that notion, because you spoke to the
9 collaborative, I just wanted to, a while ago, just sort
10 of put on the table one of my underlying fears about
11 over-reliance on competition or over-exuberant
12 competition I guess would be the right way to put it.
13 The ways in which providers have most
14 successfully, in my opinion, made improvements in the
15 quality of care that they are delivering around this
16 country has been to work together, to share strategies
17 about how to get done that which we know needs to be
18 done, that which there’s evidence to show us needs to be
19 done.
20 Those collaboratives are very open. The
21 information, the tools, the strategies they share would
22 not normally be shared among competitors who are seeking
23 to differentiate themselves. And I don’t want to lose
24 that, because that’s what’s driving safety. That’s
25 what’s driving down the infection rate.

1 Folks point to Michigan. There are a lot of
2 states now engaged in similar projects. It's really that
3 sharing. If we stifle that by being over-exuberant with
4 our competition, I think we will do real damage to our
5 patients.
6 MR. WROBLEWSKI: Michael?
7 DR. BARR: Just a quick follow-up to Nancy and
8 then a question for Vince, which hopefully will be pretty
9 simple. We're starting to see, interestingly, the plans
10 compete on the medical home demonstration plans. So, you
11 have these several plans in a community and one wants to
12 go real fast, real forward and not play with the others
13 in the sandbox, so to speak. That becomes a problem at
14 the level of the practice. You duplicate sort of the
15 fracture and different things.
16 Vince, in your comments earlier you said
17 something about efficiency and quality. If I heard you
18 correctly, you said it was easier to measure efficiency
19 than it was to measure quality. I wasn't quite sure I
20 understood because I've always thought of efficiency as a
21 measure of cost versus quality and if you're having
22 difficulty measuring quality. Can you help me understand
23 what you meant by that? Because it doesn't jive with at
24 least my understanding.
25 DR. KERR: I was speaking from partly a

1 technical aspect of both and definitional. Quality is a
2 broad canvas when you try to define it. And when you
3 hold to a handful of measures, you cannot be complete
4 enough. Primary care you can cover, oh, maybe 15
5 conditions with an average of about five measures for
6 each condition, something like that, or four measures for
7 each condition, and paint a pretty robust picture. For
8 surgical procedures, you have some information that's
9 probably important, meaningful, indicative and relates to
10 outcome.
11 Efficiency is easier in some ways because the
12 definitions around what you're looking at are more
13 discreet. That's what I meant. So, you note cost as a
14 number and it's not -- it doesn't need a qualitative
15 explanation.
16 Quality, that's a redundant term, but you will
17 translate into numerical, but describing what it is and
18 deciding what's in that box or out of that box requires
19 some decision-making or judgment. That's what I meant.
20 DR. LEE: I think, Vince, if I may, that you
21 used the term "efficiency" as we often use global cost of
22 care.
23 DR. KERR: Yes, right.
24 DR. LEE: As opposed to one of the other
25 technical definitions of efficiency is always the

1 combination of cost and quality. So, this is back to the
2 -- we often speak past each other because efficiency is
3 used in different ways.
4 DR. BARR: And there may have been others at
5 the meeting with the AQA where we talked about efficiency
6 for a whole day. I don't want to duplicate that. But I
7 think it points out that when we talk about these things,
8 we have to understand talking the same lexicons. So, I
9 appreciate the clarification, Peter.
10 DR. KERR: And they are related in some way.
11 DR. BARR: Oh, absolutely. I mean, I just
12 brought the AQA principles just for reference because I
13 knew it might come up. And I won't read all of it, but
14 efficiency is a measure of cost of care associated with a
15 specified level of quality of care. It talks about value
16 as a measure of specified stakeholders; preference-
17 weighted assessment of a particular combination of
18 quality and cost secure performance. That was hammered
19 out over a long time, for those of you who are familiar
20 with it.
21 DR. KERR: I actually would disagree with one
22 point. Why isn't efficiency an absolute? Why can't you
23 look at it -- why is it attached to? Why aren't those
24 two independent variables?
25 DR. BARR: I think you get to the different --

1 I think Peter's point earlier is that you're talking
2 about a total cost.
3 DR. KERR: Yeah, okay.
4 DR. BARR: And we're saying that if you're
5 looking at the efficiency of, I'm a doctor --
6 DR. KERR: I got you, I got you.
7 DR. BARR: -- how do you measure my efficiency
8 because it includes quality?
9 MR. LEE: And that's what I think Vince was
10 very articulate about, not about defining efficiency, but
11 was that you must look at total cost of care with quality
12 to get to efficiency. Those two have to be together.
13 That's in the spirit of what's the AQA definition without
14 getting into the -- yeah.
15 DR. BARR: Exactly, right. That's why I
16 hesitated to read it, but I had to.
17 DR. KERR: We probably should use the word
18 "cost."
19 DR. BARR: Total cost. Global cost, right. I
20 mean, it points out your other -- I don't mean to take --
21 but your nice graph about the initial cost of a visit
22 versus the total cost. We start getting into
23 transparency and the movement to doctors to post their
24 prices. It has no reflection in reality when you think
25 about the rest of it, and you just proved the point right

1 there.

2 MR. WROBLEWSKI: Go ahead. Go ahead.

3 MR. LEE: Just one anecdote on consumer

4 transparency. I see Andy's flag is up. So, I'll be

5 really, really brief.

6 MR. WEBBER: And yours wasn't.

7 **(Laughter.)**

8 MR. LEE: This goes back to consumers and cost

9 versus price. One of the plans, which isn't at the table

10 here, in California, wanted to educate consumers about

11 how much it would cost, and they put dollar signs next to

12 hospitals thinking that would indicate be careful, this

13 is an expensive hospital. Consumers said, hot damn, I'm

14 going to the more expensive one because I don't pay much,

15 and, clearly, more expensive is better.

16 This comes back to the issues around how do you

17 communicate some of these issues. Multiple dollar signs,

18 if that means -- well, generally, we Americans think if

19 it costs more, it's a better it. We know in health care

20 that's not the case. So, we have a lot of communication

21 challenge. But I want to note that the confusion we have

22 on efficiency versus global cost of care translates, in a

23 big way, out to consumers as well.

24 MS. Foster: Couldn't you solve that by paying

25 all hospitals all the same, high rates?

1 **(Laughter.)**
2 DR. LEE: I thought we did.
3 MR. WROBLEWSKI: But, Nancy, you raise a good
4 question. Actually, it was a great segue to my question.
5 To the extent that if higher quality is paid more and
6 you're trying to incentivize consumers to go there by
7 giving them a lower share, copay, how does that work?
8 DR. KERR: Well, you lower the -- when you say
9 how does it work, you mean how is that --
10 MR. WEBBER: The total cost has come down, so
11 there's some sharing to --
12 DR. KERR: Do you mean from a total cost
13 perspective?
14 MR. WEBBER: Yeah.
15 DR. KERR: Yeah. It's very easy to do the
16 models to -- yes. Exactly. You're sharing the savings.
17 You're paying for that --
18 MR. WROBLEWSKI: So, that's always assuming
19 that higher quality is of lower cost?
20 DR. KERR: No. No, in fact, you can't do that.
21 If you go to that bubble chart, you will see very high-
22 quality cardiologists who cost a hell of a lot, and there
23 are very few people who would want to put an incentive to
24 drive folks to those docs. It's because you're using
25 that right quadrant I think on everyone's chart. They

1 shift around. It gets very confusing.
2 But it’s the most cost-efficient --
3 DR. BARR: I see a standard in the future.
4 **(Laughter.)**
5 DR. KERR: It’s the most cost-efficient who are
6 also in the top tier from a quality performance to the
7 extent you’re using quality measures.
8 MR. WROBLEWSKI: And do you pay differentially
9 now for higher quality, for hospitals and/or providers in
10 that upper right quadrant?
11 DR. KERR: For physicians.
12 MR. WROBLEWSKI: For physicians.
13 DR. KERR: For physicians, we do. And all of
14 those things have to align. You’re really sending mixed
15 signals if you don’t do that. So, information that
16 physicians get around this quality measurement will be
17 more detailed and robust than what the consumer will see
18 or that you could even let the consumer see. You will
19 have patient-level detail around measures with patients
20 identified. So, you can validate or correct the
21 derivation of that quality metric.
22 That’s important, that there’s symmetry in the
23 information that’s shared. And it’s also important if
24 you’re going to align any kind of reward or incentive,
25 that you give credence to that in your compensation.

1 MR. WROBLEWSKI: Elysa, did you want to add
2 anything to that?
3 MS. FERRARA: Just a couple of quick comments.
4 If you use an example, we all want our quality providers
5 to be identified in that top quality tier, and then we do
6 look at the differences in total global cost, looking at
7 readmissions, looking at total costs, and sort of taking
8 an interest that's not at the table. The surgeon may
9 learn that the reason they're at the highest cost is
10 because of the choice of implantables they're using from
11 across multiple types of implants, which are equally
12 efficacious. It may well be that the hospital has been
13 looking to partner with the physicians and potentially do
14 some gain sharing around this.
15 So, you know, one of the opportunities is to be
16 able to open the doors to those kind of initiatives. You
17 know, you certainly want your members to have access to
18 that very high-quality cardiologist. We'd like to see
19 them reevaluate, work with the hospital, make some other
20 choices and have that greater option, because they are
21 more of a value for the consumer. And I think that's
22 what folks are driving at.
23 Get meaningful information out there. Get it
24 to the consumers. But, please, get it in the hands of
25 the providers and the health systems together so that

1 they can act on that information. And that's an area
2 where you've maintained quality. You haven't imperiled
3 quality in any way. And, yet, you've resulted in lower
4 cost, which puts more money in the health care system.
5 It's not money that disappears.
6 DR. KERR: And to that extent, your point about
7 higher quality being related to better efficiency, there
8 is a component of that that is true, and that is if we
9 simply look at, in our system, the docs who have met
10 quality criteria, and compare them to the universe, all
11 the other docs, docs who we don't have enough information
12 on to gauge a quality ranking, docs who we do have enough
13 information on to gauge a quality ranking and they don't
14 meet the set of standards that are agreed upon, you will
15 see a 200 percent increase in the complication rate for
16 that other group. You will see a 70 percent increase in
17 the redo rate for surgical procedures. All of that gets
18 folded into the cost.
19 So, there's something about the process or the
20 ability, risk-adjusted, to obtain results that partly
21 influences the cost. There are other things that do that
22 that are elective or can be choice-based, particularly in
23 orthopedics.
24 MR. WROBLEWSKI: Thanks. Jack?
25 MR. FOWLER: I was just going to talk about the

1 measure of quality again. Complication rates and all
2 those things are really great, but I remember that Rudy
3 Giuliani said he was so happy that he was operated on in
4 the United States where 80 percent of the prostate cancer
5 patients live five years as compared to Great Britain
6 where only 40 percent did. And, of course, the problem
7 is we operate on twice as many people.
8 **(Laughter.)**
9 DR. KERR: Some of them didn't have prostrates.
10 **(Laughter.)**
11 MR. FOWLER: But, in particular, complication
12 rate is only one measure of quality. And the cost thing,
13 it's really hard to get population-based rates for a
14 provider, because figuring out what the population is is
15 really tricky. Doing a lot of stuff in a vacuum.
16 MR. WROBLEWSKI: The one last point that I have
17 -- and I wanted to ask both Kristin and Beth and Jack and
18 anyone who really wants to participate -- is does the
19 information that was listed that Peter put up in terms of
20 what consumers were looking for and what Vince talked
21 about square with what your -- what are your reactions to
22 that?
23 DR. NASH: I'm not sure if this is the question
24 that you are asking, but one of the things that certainly
25 came to mind for me is that, in our experience with

1 consumers and also in focus groups, consumers don't
2 really care at all about the cost of care. And they kind
3 of look at you quizzically like, I have insurance. Why
4 would I care about that?
5 And, you know, so I think it's a really
6 fascinating dynamic. I think it's going to change and I
7 think it's an educatable moment. I think there are some
8 very illustrative examples of -- and there are some
9 people doing a lot of really good work that we're working
10 with in this area, that a person with breast cancer, you
11 can go through an example and show to a consumer that
12 their out-of-pocket costs could be extremely different
13 with one plan versus another. But I think, generally,
14 they don't get the cost issue.
15 MR. WROBLEWSKI: Okay, thanks. Kristin?
16 MS. MADISON: I guess I would agree with that.
17 As a consumer, I'm most interested in the cost to me.
18 DR. NASH: Right.
19 MS. MADISON: Whatever form those costs take.
20 And I should say we've mostly been talking about insured
21 patients. For uninsured patients, they really do care
22 about the bottom line cost of all these things.
23 I'd also -- I mean, thinking about this
24 question of insurance design, I wasn't sure from your
25 comments, Vince, whether -- if you do tiering based on

1 efficiency, whether you tell your enrollees that that's
2 what you're doing. I mean, from my perspective, if
3 quality is really the same, I'm not sure that I care or I
4 need to know that information when what I really care
5 about is quality.
6 I think, Peter Lee, you can correct me if I'm
7 wrong, but I think you've used an example of a Las Vegas
8 union group or something, where they looked at
9 efficiency, they cut out a very few doctors from the
10 network on the basis of that kind of measure, and then
11 they communicated to their enrollees some information
12 about their quality which they could then use. That
13 seems to make a lot of sense to me, as a consumer, of how
14 you might manage something like that.
15 MR. LEE: Well, it is a real and true example.
16 But this comes back to that scattergram. This particular
17 union excludes very few of those shining diamonds, not
18 dits. But it was very few, a small handful who were
19 incredible outliers on inefficient use of global
20 resources. They still did identify, of those that were
21 still in, higher-performing and all the others and they
22 had some incentives to choose and they actually had a
23 huge impact on trend.
24 But I think the issue of -- that exclusion
25 issue, which I think for many physicians is one of the

1 more troubling areas, is what I'd call the tighter
2 managed care element. It was used very sparingly. And,
3 also, they engaged the physicians in conversations about
4 how they were measuring episodes, et cetera, et cetera.
5 But I would just strongly agree, I think I said
6 earlier, episode cost is like -- is a nonstarter for a
7 consumer. Cost to them and how that relates to episode
8 is very much an engaged element. And I think that we've
9 seen a lot of demands to help plans, of enrollees saying,
10 give me information what it's going to cost me. If I get
11 an MRI, what's it going to cost me, which I think is the
12 healthy thing. Because 15 years ago, people didn't ask
13 at all because it's insured, it costs me nothing, as if
14 it costs all of us nothing.
15 So, there is, I think, a movement towards
16 looking at exposure to the consumer to the price.
17 MR. WROBLEWSKI: Let's have Elysa and then,
18 Michael, final comments.
19 MS. FERRARA: I was actually going to answer
20 your question. Under the PHQ standards of NCQA, in order
21 for us to be compliant and hence to be compliant with the
22 patient charter as health plans, if we have tiering, if
23 we make comments about efficiency and put it into the
24 public domain or quality, we have to provide member
25 placing materials, plan sponsored placing materials and

1 physician detailed monographs on what was the basis, how
2 was it measured, what were the statistical rules that
3 were applied. So, there is tremendous transparency and
4 methodology that has to be out there.
5 MS. MADISON: So, is that if you call it an
6 efficiency-based network or is that for any -- so, you've
7 got all sorts of --
8 MS. FERRARA: If you act upon -- if a health
9 plan acts upon -- you're the expert over there. This is
10 like a test.
11 If a health plan acts upon information, so if
12 you're publishing it, if you're putting report cards out,
13 if you're tiering, if you're using it, if you're acting
14 upon that information in some manner, then you've got to
15 be transparent about it. Now, you could choose not to
16 pursue PHQ NCQA recognition. You could choose to ignore
17 the purchaser disclosure projects. But the large
18 employers -- the employers are not really going to allow
19 you to do that.
20 MR. LEE: If I could just, it's not just the
21 employers, but the patient charter was endorsed by --
22 supported, I won't say endorsed, by the AMA, ACP, the
23 physician community as a set of physician expectations.
24 I think one of the important things, back to
25 this discussion, is that one of the elements of that

1 charter was that plans wouldn't use cost alone. That's
2 because there's such concern that the only element looked
3 at would be cost and, rightly or wrongly, the concern
4 that it would be driving people to "cheap doctors."
5 But if a plan is using only quality
6 information, even that needs to meet all these standards
7 of transparency. If you're using quality with global
8 cost of care, you need to show how they're weighted,
9 their respective weights.
10 I mean, there was a very long, good legal piece
11 on the different elements of regulation. And that piece
12 -- that was yours. Excuse me, sorry. I haven't read the
13 law reviews in a long time, but it's sort of how
14 regulation works. This is an element of self-regulation.
15 The plans don't have to do this by any legal standard,
16 but that their clients, purchasers and their other
17 clients, the doctors that work with them are saying, you
18 need to do this, has, in some ways, become a regulatory
19 process in terms of how physician performance measurement
20 is happening.
21 MS. FERRARA: And I think part of the beauty of
22 it was that it brought together the physicians. So,
23 there is a major process built into there for
24 reconsideration. So, a doc can come back and say, my
25 member got her mammography at the public health bus that

1 came to her or her employer has a mammography clinic.
2 It's something unique in our community.
3 So, there is a process that is a disciplined
4 process to correct errors, to make the data valid, to
5 give a notice period for the providers where they have
6 that information first.
7 And then the other process on it is it's as
8 stringent -- and I used to be in government, and I was a
9 director of internal audit for a state health department,
10 and it is the most stringent audit process, you know,
11 that I have seen in terms of if a physician asks for a
12 reconsideration, show us the file that shows that you
13 responded, examined and charged.
14 MR. WROBLEWSKI: Okay. I'm going to give Vince
15 the last word.
16 DR. KERR: Wow. Because I never get that at
17 home.
18 **(Laughter.)**
19 DR. KERR: I'm going to savor this. I hear
20 laughter. So, apparently, you share my pain.
21 I made the statement that you always had to
22 pair -- if you're going to show efficiency, you have to
23 pair it with quality. So, I don't know anyone that's
24 doing a pure -- or there may be, but we just would not
25 believe in doing a pure efficiency network. In fact,

1 when that information -- there’s a second principle that
2 we strongly believe in.
3 If you’re rating along those domains, you show
4 them separately. That way the consumer can make his or
5 her judgment. And we don’t show docs who meet efficiency
6 but can’t meet quality. So, you wouldn’t, as a consumer,
7 have that information to be able to even make that
8 choice.
9 MR. WROBLEWSKI: Okay, thank you. We’re going
10 to break for lunch. A couple announcements. If you go
11 out for lunch, please keep your badge and then you won’t
12 have to sign in again. You’ll have to go through the
13 metal detectors, but not the screening process. For the
14 panelists, we do have lunch being brought in. That
15 should be here by now.
16 And we’re going to start back at 1:45. Thank
17 you all very much.
18 **(Morning session concluded.)**
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1 **BARRIERS TO QUALITY-BASED COMPETITION AMONG PROVIDERS**
2 **AND TREATMENTS**

3 MR. WROBLEWSKI: Good afternoon. For those of
4 you who are just joining us, my name is Michael
5 Wroblewski and I am with the FTC's Bureau of Competition.
6 My co-moderators this afternoon are going to be James
7 Cooper, who's Deputy Director of FTC's Office of Policy
8 Planning, and Pat Schultheiss, who's my colleague in the
9 Bureau of Competition.
10 I know we have some new people that we've
11 joined in to our discussion and we are grateful for your
12 participation.
13 Security has asked me to go over a couple of
14 details that everyone heard in the morning, but I do have
15 to go over them again. In the unlikely event the alarms
16 go off, please proceed outside the doors to the right.
17 There's a staircase to go downstairs, and the meeting
18 place is across the corner street over at the sculpture
19 garden. If you spot any suspicious activity, please
20 alert me or James or Pat or the security personnel and we
21 will act accordingly.
22 Restrooms are out the door to the left-hand
23 side. And if you can please turn off your BlackBerries
24 or cell phone or at least put them on silent mode, we'd
25 really appreciate that.

1 We have five people who have joined us this
2 afternoon. Let me go around and introduce them first.
3 To my far right is Richard Sorian, Vice
4 President, Public Policy and External Relations for the
5 National Committee on Quality Assurance.
6 To his left is Karen Milgate, Director of the
7 Office of Policy Centers, for Medicare and Medicaid
8 Services.
9 At the far end of the table next to Beth Nash
10 is Dr. Janet Corrigan, President and CEO of the National
11 Quality Forum.
12 And then all the way at the end of the table is
13 Dr. Irene Fraser, Director of the Center for Delivery
14 Organization and Markets at the Agency for Healthcare
15 Research and Quality.
16 Paul Ginsburg will be joining us a little bit
17 later today. He won't be here probably until about 2:30
18 and his seat is next to Michael Barr's over there on the
19 right-hand side there.
20 On our agenda, we had John Richardson, also,
21 from MEDPAC, who has taken ill and will be unable to
22 join us this afternoon.
23 To get started, this morning we went through
24 basically a needs analysis from the different
25 perspectives, from the demand side whether they were the

1 consumer, the insurer or the employer or the physician in
2 terms of what information makes a competitive difference
3 to them.
4 This afternoon we would like to switch gears a
5 little bit and turn to what are the barriers to greater
6 competition based on quality.
7 To start that discussion off, Irene Fraser from
8 AHRQ is going to give us her thoughts and then we can
9 open up the discussion and we'll go from there. Irene?
10 MS. FRASER: Well, good afternoon, everybody.
11 I'm sorry if I've got my back to some of you. I'm so
12 sorry I could not be here this morning. It looked like a
13 wonderful, wonderful program.
14 I'm going to try to just kind of set the stage
15 for this discussion. It is humbling to be in the
16 presence of all of the other panelists here who will have
17 a lot to say, I'm sure, about many of these topics. But
18 I wanted to just kind of set a framework to get us
19 started.
20 In trying to think about the use of competition
21 as a way to improve quality, of course, this ties you
22 back to the use of competition in general in our country,
23 and, of course,, we all know that that is not without its
24 hurdles and without its problems. In the case of health
25 care, it can be even more problematic in many ways.

1 So, some of the problems that you experience in
2 other industries you see two or threefold in health care.
3 That does not mean that it can't be done, but it means
4 that we have to be really mindful of the barriers. So,
5 what I'm going to try to do is set the stage by talking
6 about some of the barriers and also trying to set the
7 stage for the following discussion by looking at those
8 things that are being done now to start to surmount those
9 barriers.
10 There are three paths that you can think about
11 through which competition would improve quality in health
12 care, and each of them faces similar, but not identical
13 hurdles. It's pretty much the same hurdles, but they
14 play out in different ways depending on the path. This
15 is probably something you all got to this morning in your
16 discussions.
17 The first path would be that consumers of
18 health care would choose higher quality providers. As a
19 result of those choices, the addition of all those
20 individual choices, those providers would then get more
21 market share and potentially higher rewards. So, that
22 would be one way that the market could play out.
23 A second way is that payers would make those
24 same sorts of choices which would then cause more market
25 share to the higher quality providers.

1 And a third path would be that the providers
2 themselves are competing among themselves, and this is
3 not necessarily directly for shares of the market, but
4 for their own intrinsic reasons, because, for the most
5 part, people who go into some of these professions, just
6 like other professions, are, by nature, a competitive lot
7 and are intrinsically motivated and want to do well and
8 want to do well in the eyes of their peers. So, that
9 generates some competition.
10 There are six hurdles that occur on each path,
11 but as I mentioned, they tend to play out a little bit
12 differently depending on which path you are talking
13 about. There is, by the way, some evidence for each of
14 these paths, probably the most at this stage for the path
15 of the providers. But I think a growing amount of
16 evidence that the other two paths can, in fact, work as
17 long as they're constructed ideally.
18 The first hurdle that I wanted to talk about
19 briefly is awareness. Here the problem is that many
20 consumers and some payers don't really recognize that
21 quality differences exist. Certainly, 10 years ago that
22 was a huge issue, that was a huge hurdle. I think,
23 increasingly, with the publication of the IOM report, "To
24 Err Is Human," and a few well-publicized horror stories,
25 we're beginning to change that and there is some growing

1 recognition that quality does differ from one provider to
2 another.
3 On the other hand, most people believe that
4 their own provider is good. So, it actually takes me
5 back to my days as a political scientist studying
6 political science. We were talking about this, actually,
7 a couple of us were earlier. This has been a truth since
8 way back when. That most people would say that Congress
9 is not great and probably their opinion of Congress has
10 declined at times. But they would say their own
11 Congressman is good. I think that we have a similar
12 kind of approach to providers, many do. So, that is a
13 bit of a hurdle because if you don't know what the stakes
14 are, you are not likely to follow the other steps in the
15 path.
16 The second is measures. This probably, also, I
17 would imagine, came up this morning. But in order to
18 have really informed choice, you need valid uniform
19 measures that are relevant and credible to whoever of the
20 these three actors you're talking about, the consumer,
21 the payer or the provider. And they have to not only be
22 valid, but be perceived to be valid and relevant. And,
23 so, that's kind of a double hurdle.
24 The barriers to this is that, in some ways,
25 there are too many measures and in other ways there are

1 too few measures. In terms of measures that consumers,
2 payers and providers really consider, boy, this really
3 matters, this is valid, this resonates with me, there are
4 probably too few. On the other hand, there are so many
5 measures that it can get overwhelming. And trying to
6 figure out how to deal with this challenge is a really
7 major, major issue.
8 Most of the measures are process- or diagnosis-
9 specific and that can be a problem because you can't
10 always predict what diagnosis is going to befall you,
11 because process measures are not all that easily
12 explained to consumers and often to payers. And
13 different payers, as I'm sure you heard this morning,
14 value different measures.
15 There has been, in the last few years, an
16 amazing amount of progress on this and I would say -- and
17 you'll, I'm sure, hear more about this from Janet -- some
18 of the work that the NQF has done has really brought a
19 lot of focus to our efforts in measurement and has
20 created consensus around and agreement on a core set of
21 measures. I'm sure nobody would say these are the very
22 best measures one could come up with, given an infinite
23 amount of time, but they are good and they are
24 respectable and they are agreed upon, which gets rid of a
25 lot of the issues.

1 Some of these measures increasingly are being
2 adopted by Medicare and Medicaid and states and private
3 payers, thereby leading to some of that uniformity. A
4 lot more work to be done, but a lot of progress.
5 Just as one example, from my own home, the
6 agency has developed a set of quality indicators and many
7 of them have been accepted by NQF and are now in
8 widespread use across the country. Right now, there are
9 12 states that are using many of these measures for
10 public reporting. Many other states are in the wings.
11 They have just been waiting for the NQF endorsement
12 process to start doing this. So, this is comparative
13 reporting for hospitals. CMS is going to be using nine
14 of these under their new inpatient payment rule.
15 So, a third hurdle is data, because even though
16 most of the attention goes to measurement, measures
17 without data are really useless in the market. They're
18 interesting, they're kind of amusing, but they don't
19 actually get you to where you need to go in a market
20 system.
21 The other thing is that you need data at the
22 market level, and a lot of the databases that exist right
23 now in the United States are not at the market level.
24 They can give you national data and, in some cases, state
25 data, but they cannot give you data at the individual

1 provider level or at the market level. Or, on the other
2 hand, you may have data that can give you the market
3 level, but they don't give you the national level.
4 You really need both, because, to some extent,
5 showing that place A is better -- that provider A is
6 better than provider B within the same market is useful
7 and probably that's sort of the basis of competition.
8 But it's helpful, also, to have some external benchmarks
9 because you don't really want them competing on
10 mediocrity. That's not the ultimate goal. So, having
11 some national benchmarks and examples is a useful thing.
12 We know that measurements and data can improve
13 with use. They tend to get better once people are being
14 held accountable to certain measures. The data tend to
15 improve or at least to change; in most cases, to improve.
16 But even good measures with bad data, in the meantime,
17 can create mischief. So, that's really a complex issue.
18 Another issue is that data needs to be both
19 good and cheap. There are a lot of places where there
20 are trade-offs there. To get the really, really pristine
21 data, it's very, very costly. On the other hand, there's
22 other data that's very readily available, but it is a bit
23 too crude, at least in the eyes of some of the players,
24 and, therefore, not valid enough to be making decisions
25 within the marketplace.

1 There is no real gold standard here. Almost
2 any kind of data has its pros and cons. Even the
3 electronic health record, as much as some folks have been
4 hoping that will provide a panacea, does not necessarily,
5 because it may not include some of the very variables
6 that are most needed.
7 There has been a good bit of progress in this
8 area, and I'm going to speak now primarily about
9 hospitals because that's where much of my own work and
10 much of the work of the agency has been done. There was
11 a study that we commissioned a couple of years ago that
12 has had several very significant findings in publications
13 indicating that if you add a few fairly easily accessible
14 -- this is all relative -- variables to claims data, and
15 specifically if you add the patient's existing conditions
16 "present on admission" and laboratory values at
17 admission, you can get quite close to the adequacy of
18 chart review data.
19 Now, this is really huge because the gap in
20 expense between claims data and chart review data is
21 really immense. If there are some steps that you can
22 take to add slightly to the cost, but add tremendously to
23 the accuracy of this data, that is really huge.
24 Right now, because of changes in CMS
25 regulations, states are in the process of adding

1 “present on admission” data. We are working with several
2 states on some pilots to show proof of concept for adding
3 laboratory values. In most hospitals, that is already --
4 the laboratory values are already electronic, and so,
5 making that addition is not all that difficult.
6 So, as a result of all of this, states are
7 building much improved all payer data systems and the
8 measures that rely on these are becoming refined systems
9 to include these measures as well. So, where we’re
10 ending up, and this is something that AHRQ has been
11 working very closely with others on, is toward a hybrid
12 data strategy where down the road we won’t be thinking
13 about claims data and electronic data: we will just be
14 thinking about data because we will have merged the two.
15 And in other really good news, both for quality
16 purposes and for cost purposes, it is really important to
17 look not just provider by provider -- we do need to do
18 that, because one way to improve quality and to reduce
19 costs is to look at what an individual provider does.
20 That should not be neglected. But if you are really
21 going to improve quality, you also have to look at the
22 transitions, the gaps, the unnecessary duplication of
23 services between one provider and another. In other
24 words, you have to look at whole episodes of care, and
25 that is something that NQF and others have been

1 targeting, which is also excellent progress.
2 So, this is just kind of a summary of where I
3 would see administrative and hybrid data in the future.
4 Where we have, because of the union of clinical and
5 claims data, we have much improved timeliness, we have
6 both market level data and national data both on quality
7 and cost. You have the clinical detail that's needed.
8 You have the outpatient reach. And you basically have --
9 you know, nationwide, you have data available that can
10 help you both with measuring quality with quality
11 improvement and with public reporting for competition on
12 quality.
13 Good data are not enough, however. You really
14 need to have customer-friendly tools. This is a picture
15 of an inconvenience store. In other words, a 7-Eleven is
16 designed by a researcher, where everything stays nicely
17 aligned and clean and not messed up by the customer, but
18 does not get a whole lot of use.
19 So, what that really means is that we need to
20 make things into convenience stores for data. This is a
21 place where things often really, really do fall apart.
22 We have been seeing a tremendous growth in the use of
23 quality reports over the last several years, but,
24 frankly, most of them are not very good, if you think of
25 "very good" meaning something that is credible,

1 actionable, usable by the person for whom it is intended
2 or the organization for whom it's intended. The
3 information is not presented simply or effectively in the
4 way the reader understands and cares about it.
5 This is something about which there can be a
6 science base. One of the things that we often forget is
7 there's a potential science base around a lot of things
8 that we don't normally think of. There's a science base
9 on how to create incentives. There's a science base on
10 what kinds of payments are more effective, and there's a
11 science base potentially on what kind of public reporting
12 is going to be useful.
13 There is a growing evidence base on this. In
14 fact, for the quality indicators, Shoshanna Sofaer did a
15 good bit of research, focus groups, et cetera, to create
16 some public reports, report card kind of models that
17 would provide a template for that, similarly with our
18 CAHPS initiative. There's going to be an NQF guidance on
19 web-based comparative quality available soon. I've got a
20 couple of links and aids for that.
21 So, the fifth barrier, after you get through
22 all of those -- and these are somewhat sequential. On
23 this one I found a wall rather than a barrier, because,
24 in some instances, it can be a brick wall. These are
25 kind of more physical barriers, if you will. You can

1 have all of the other things, but if you are in a one
2 hospital town, it’s pretty hard to compete on quality. I
3 can’t remember back, but back in my days when I was at
4 the AHA, it was about at least half of the towns in the
5 country had only one hospital. So, in those areas, under
6 normal circumstances, there’s not going to be a lot of
7 competition on quality.

8 Now, to some extent, purchasers have been
9 creating centers of excellence or whatever to kind of
10 transcend that, but for the most part you can’t really
11 have competition on quality in a place where there’s a
12 one-hospital town.

13 Similarly, many people have very limited
14 options for providers. So, for them, even if they’re
15 living in a two-hospital town, it’s, in fact, a one-
16 hospital town. They may lack money or insurance. In
17 other words, there is no demand. Economists use the
18 terms “demand” and “money” kind of interchangeably. But
19 demand is not the same as need. It’s need plus money.

20 So that if you don’t have need plus money,
21 you’re not in the market basically, at least not the
22 regular market. And time, there is no Web access in the
23 ambulance. Most of the measures and reports actually are
24 on conditions that you don’t really plan in advance.
25 They’re on things like heart attacks. They are not

1 things like normal delivery. And, so, that also creates
2 a barrier.
3 And then, finally, there is a variety of other
4 market realities that play in. One is that there are
5 multiple markets in a way. As long as you are talking
6 about making choices provider by provider, it matters
7 less. Once you start trying to do it on a package basis,
8 it will be more of an issue. But the hospital market and
9 the physician market is not the same market if you were
10 to draw a perimeter around that in any given area.
11 Geographically, the physician market is a smaller space
12 than the hospital market is, and long-term care has its
13 own, et cetera.
14 There are also multiple product lines, and,
15 actually, the correlation between your score within a
16 hospital, say, on quality score on AMI and your score on
17 pneumonia may be diametrically different. So, you don't
18 really choose a hospital; you choose a product line
19 within a hospital.
20 There is also a great deal of market
21 segmentation by payer source. That is sort of a fancy
22 way to say that the people who are uninsured don't go to
23 the same hospitals that the people who have private
24 insurance go to, and, in fact, even the people on
25 Medicaid tend to go to different physicians and

1 providers. So, the market does not behave as you would
2 expect if it were a single market for all payers.
3 There is a great deal of segmentation in that
4 way. So, for example, studies that have tried to show a
5 correlation between access to availability of primary
6 care providers and quality of care or preventative care
7 for Medicaid beneficiaries don't take into account the
8 fact that most of that primary care may not be available
9 to those Medicaid beneficiaries. So, there's a great
10 deal of segmentation.
11 There are some factors that are starting to
12 facilitate tearing down some of those barriers or
13 surmounting them. Again, the use of the episode measures
14 and cost-cutting measures, so if you have a cost-cutting
15 measure of safety within a facility that says something
16 regardless of what part of the facility, you're going to,
17 and, also, a good bit of payer cooperation on the
18 measures. A good bit of cooperation between Medicare and
19 private payers, for example.
20 And, then, the final challenge is that all of
21 these barriers are existing at the same time. So,
22 figuring out the right path to go from one to the next is
23 a challenge. But, as I mentioned, I think we are coming
24 up with tools to start to overcome some of those
25 barriers. So, I look forward to hearing the discussion

1 of folks in this session and the next both about the
2 barriers and the tools.
3 MR. WROBLEWSKI: Thank you. Thank you, Irene,
4 for that comprehensive presentation.
5 What I would like to do is for the new folks
6 who have come in, if you would like to be recognized,
7 we'd just ask you to turn your name tag on its side and
8 we'll call on you to add comments. But I would like to
9 turn to Richard and to Janet and to Karen for any
10 thoughts in terms of additional barriers, other than the
11 ones that Irene has mentioned, or to put some priorities
12 around which ones are the most significant barriers, even
13 though I know we're, as Irene said, we're addressing them
14 all at the same time. But which ones are the most
15 significant going forward? So, I'll start with you.
16 MS. CORRIGAN: That was a great presentation,
17 Irene. I think one additional barrier that I would add
18 to this is the lack of evidence on effective care in many
19 cases. You've got to have evidence of what works if
20 you're going to present information to consumers to make
21 rational choices for themselves or others.
22 Let me give you an example. The U.S. spends
23 $20 billion a year managing chronic wounds, like pressure
24 ulcers and diabetic ulcers, yet the recent evidence, a
25 review of the literature, found that a common treatment

1 called negative wound therapy, there were only six trials
2 that had been done. All of them had major methodologic
3 problems. Five of those clinical trials had fewer than
4 25 patients in them. Now, that's a pretty lean evidence
5 base for a $20 billion a year expenditure. So, it's the
6 kind of thing -- these gaps in evidence occur in many
7 places in health care. We are not working from a solid
8 evidence base.
9 I think one of the solutions to this -- I mean,
10 part of it, it will always be there because health care
11 is complicated. The evidence base grows so rapidly, the
12 knowledge base and all the rest of it. But it doesn't
13 have to be nearly as bad as it is. And one of the
14 solutions, I think, is that we need a formal feedback
15 loop and communication from payers and consumers and
16 others that discover these evidence gaps to those who
17 build the NIH research agenda.
18 That research agenda, now a lot of it is
19 generated by investigator-initiated projects. It isn't
20 necessarily responsive. The Federal Government pays for
21 about half the clinical research, so there's no reason
22 that some of that couldn't be more responsive to the
23 needs of consumers and purchasers and others for this
24 information. It's also just critical needs for patient
25 care.

1 I think a second barrier that we have on
2 measure development, we now have a lot of different
3 measure developers. There are a handful that account for
4 a disproportionate share of measures. We call them the
5 major measure developers, but there's also probably over
6 about 50 measure developers out there. And there has
7 been a critical need to develop -- we've been working
8 very -- we've made progress on this -- developing
9 guidelines for how they specify their measures. So,
10 every measure developer, you don't want them to use
11 different age breaks when they construct the measure.
12 You don't want them to exclude different things from the
13 denominator.
14 Unless there are common conventions, two things
15 happen. It's hard to implement the measures and the
16 providers who are trying to act on them can't improve.
17 They don't understand the data. Everybody does things a
18 little bit differently. So, you look at a health care
19 card infection rate at the hospital and there's different
20 exclusions, different age breaks, different everything
21 from the same kind of measures and the same factors that
22 are at the physician level. Those should be common
23 conventions. We should do things the same.
24 The other problem is if you don't have common
25 conventions, the EHR vendors that are trying to build

1 electronic health records can't do it because they don't
2 know what data to capture, and it is very complicated for
3 them to capture the necessary data and develop the
4 appropriate programming skills to generate all the
5 measures.
6 So, simplification and common conventions for
7 measure specification and development are critical to
8 addressing what I think is the third barrier, which
9 really is the data platform, which right now is limited.
10 We are moving on two parallel paths. We have a lot of
11 efforts in communities to develop these health
12 information exchanges, which is just another word for
13 pulling together the electronic data that you have in
14 different sources and trying to make it more useful for
15 secondary uses.
16 There's another parallel path that's going
17 along with that, which is the one we want to be longer
18 term, which is getting electronic health records and
19 personal health records in place that have connectivity.
20 We have to move in parallel paths. We have to be dealing
21 with both at the same time, even though sometimes it
22 diverts attention from the longer-term agenda, which is
23 the EHR/PHR agenda.
24 I think it is important to note with the data
25 platform, just about all of our efforts right now are

1 focused on data that resides within the health system,
2 whether it's claims data; sometimes it's registry data on
3 a particular condition. It's laboratory results data.
4 It's pharmacy prescription data. But what's really
5 important to patients out there, I think, in making
6 decisions is outcome data. It's whether I got better.
7 If I have the back surgery versus medical interventions
8 and watchful waiting, am I any different six months
9 later?
10 We now know, after spending a fortune in this
11 country for 10 or 15 years on these two conditions that
12 you're not any different six months later. That's an
13 important choice for patients, and it shouldn't have
14 taken a decade or two to know that from a very slim set
15 of studies. We should be getting information on an
16 ongoing basis about patient outcomes, and it's hard to
17 capture. You need to get out to those patients, and
18 somebody has to be following patients.
19 Right now, in our delivery system, nobody
20 follows patients unless you happen to be in one of those
21 prepaid health plans that are only a small fraction of
22 the market. So, there's no accountability for those
23 patients over time in tracking and getting information
24 whether it made a difference six months, 12 months down
25 the road.

1 Two last things I'll mention quickly. One, I
2 think these data, also, as we begin to pull together and
3 generate these reports at the community level, another
4 area where we started to make some progress is, I think,
5 for this data really -- this information, rather, to have
6 real credibility with multiple audiences, we've got to
7 have more developed auditing mechanisms in place so
8 people know that what they're looking at has been audited
9 by a third party. They know it's good. That's important
10 to both the clinicians and the hospitals that are being
11 judged. They need to know that the data is good, that
12 they are fair comparisons. It needs to have face
13 validity to them to act on it. It's also going to be
14 important to consumers and payers and everybody else down
15 the road.
16 In addition to that, I think reporting is a
17 challenge, and one thing I would add to the other
18 comments that have been made is that all consumers are
19 not alike. We need to be segmenting the market. We know
20 from Judy Hibbard's work that people are very different
21 and have a very different readiness to act on this kind
22 of information. We need a lot more research in this area
23 about how we segment the market, where people are at and
24 how we tailor the information to them.
25 Right now, the data people get are old. It's

1 given to them at the wrong time, when it's not very
2 useful, not at the point where they're making a decision.
3 And last, but not least, we've got to get a
4 systematic feedback loop in place because we aren't going
5 to get this right the first time. We have been working
6 at it for 10, 15 years, and we haven't gotten it right,
7 and we aren't going to probably in the near future. This
8 is a learning process. We need a systematic feedback
9 loop from providers and from patients, payers and others
10 that are using this information.
11 I view clinicians as a really important
12 audience here. The person who helps me most when I'm a
13 patient is the doctor that gives me referrals to the
14 hospital, to the specialist and to others. They're my
15 agent. So, provide them with the information, at least
16 they can start to help me if I'm a consumer that doesn't
17 know how to interpret it or do it myself.
18 MR. WROBLEWSKI: Thank you. Richard or Karen?
19 MR. SORIAN: Thank you. I will try not to be
20 redundant. I think we have covered a lot of really key
21 issues. I'll touch on two or three that I think can be
22 added to the group. One is we've talked about and I'm
23 sure you've talked earlier about the fact that there is
24 this feeling that we have too many measures, conflicting
25 measures, a lot of confusion. I don't disagree, but I

1 think we have an impression that we measure much more
2 than we actually do.
3 The NCQA is the home for HEDIS, the Healthcare
4 Effectiveness and Data and Information Set, probably one
5 of the longest standing sets of quality measures and a
6 fairly comprehensive data set. In the most recent year
7 that we collected that information, we were really happy
8 that we exceeded 100 million Americans covered by HEDIS
9 reporting. But that means 200 million Americans are not
10 getting that kind of comprehensive information.
11 So, just to break it down quickly, a little
12 less than half of the people with private, commercial
13 health insurance in this country have that kind of
14 information collected, reported and available to the
15 public, a quarter of Medicaid beneficiaries and about a
16 seventh of Medicare beneficiaries. So, there are lots of
17 reasons for that, but there are huge gaps in the amount
18 of information we have about the quality and performance
19 of our health care systems. So, that's one.
20 Two is our incentives are all skewed. I like
21 to put it that way. That's better.
22 **(Laughter.)**
23 MR. SORIAN: We don't have payment systems,
24 whether they're public or private, that truly encourage
25 improvement in quality. They certainly aren't tied to

1 the performance of the health care system, whether it's a
2 hospital, a physician, a medical group, a nursing group,
3 any of the -- there are great experiments that have been
4 going around the country. Pay-for-performance is one
5 category of those that have really shown some great
6 promise. But we also have a lot of payment systems that
7 are disincentives to quality and, actually, penalize more
8 efficient and more effective health care provision. So,
9 we need payment reform. I think that's going to be a
10 major piece of health reform in the next few years.
11 And, then, finally, as one of my favorite
12 health services researchers would say, Paul Newman, we
13 have a failure to communicate.
14 **(Laughter.)**
15 MR. SORIAN: Janet mentioned how little we
16 spend on research and how to talk to consumers and
17 patients and their family members about health care
18 quality.
19 To be blunt, the AHRQ budget is a rounding
20 error in the CMS budget, and that's got to change. We
21 can name the people who do research on this topic on one
22 and maybe part of another hand. They are terrific, but
23 they can't do it alone. There is very little consistent
24 funding for that.
25 Just to give one example and then I will pass

1 it to Karen, we've done a little bit of focus group
2 research -- and we have kind of pulled the money from
3 that from little corners of the budget, so it is not
4 comprehensive. So, let me caveat that. But we have done
5 some focus groups. For example, where we say value and
6 efficiency, consumers hear cheap. We say quality, they
7 hear cheap. We talk about a medical home and they think
8 we're going to put them in a nursing home.
9 **(Laughter.)**
10 MR. SORIAN: So, when we talk about quality to
11 those who are listening -- and it's unfortunately a
12 declining percentage, according to the surveys, that are
13 listening and using the information -- we're saying one
14 thing and they're hearing another. I think we need a
15 steady and consistent and bigger investment in research
16 on how to effectively communicate.
17 Corporations that sell soap and other products
18 around this country and around the world have put a lot
19 of money into those kinds of things. Maybe we can get
20 them and harness their brilliance on those kinds of
21 things. It's not always the government that has to do
22 these things, but we have to figure out how to talk to
23 consumers before we can expect them to use the
24 information to improve the quality of their health. So,
25 those are three items that I would add.

1 MR. WROBLEWSKI: Thank you.
2 MS. MILGATE: From my perspective as a staff of
3 a purchaser, I would echo, I think, some of what Richard
4 said in terms of the need for more demand for use of the
5 measures. I guess it would be my observation that
6 measures will continue to expand and improve. Presumably
7 there would be, although I suppose this is maybe more of
8 a presumption than it is the truth of it, more research
9 when, in fact, the measures are used for more and more
10 effective reasons; if there were incentives for patients
11 to use them, if there was incentives for providers to use
12 them. And, so, to me, it is a matter of just creating
13 that demand even more.
14 I mean, sometimes I listen in meetings like
15 this and others and I was just recently at a conference
16 and there was a lot of really good discussion about how
17 to improve the measures, how to get more information, and
18 then when the question comes, but do consumers really use
19 it, and I would put the CMS Web site in that same basket
20 of, you know, well, do consumers really use it. There's
21 kind of this, well, we've done a little research, but we
22 don't really know.
23 I don't have any specific suggestions for
24 exactly how that happens, but it doesn't seem like
25 consumers are finding as much of a need for using it.

1 I'm not sure if providers are finding as much of a need
2 for using it as they should. So, I would just throw out
3 the use of what's already built as one thing to add.
4 The other observation I would make -- and,
5 Irene, you did say this, I want to echo it, though --
6 I've been thinking a little bit about what is the right
7 unit of measurement, particularly when you get to
8 physician measurement. As anyone in this room knows,
9 it's an extremely difficult place to try to attribute
10 accountability. So, is it right to attribute
11 accountability at the individual physician level, the
12 practice level, or what about the concept of some sort of
13 small region where there is some kind of joint
14 accountability among providers?
15 In thinking about that, I thought, you know, if
16 you are really looking for beneficiary, as I think about
17 it, or patient-focused measurement, what we are doing is
18 sort of slicing that patient up and we're looking at,
19 okay, well, what happens here, what happens here, what
20 happens there. And when you're looking at physicians in
21 the Medicare population, there's multiple physicians.
22 It's -- really attribution is an extremely difficult
23 concept and I've begun to wonder if, in fact, we're
24 trying to fit something that just doesn't fit.
25 So, I would throw out that I do think it's

1 important for us to begin to examine and think about and
2 I think most people at this table have thought about
3 this, to some extent, episodes of care and coordination
4 of care across settings as a kind of a direction we need
5 to start thinking about how to head in. And that that
6 would be -- I don't know if that's more actionable, I
7 don't know if that will mean that will encourage more
8 competition, but it seems to me that it would be at least
9 of more interest to the patient.
10 MR. WROBLEWSKI: That was a nice summary of
11 what we did this morning.
12 **(Laughter.)**
13 MR. WROBLEWSKI: Thank you. Nancy, you had a
14 comment probably on that last point.
15 MS. Foster: Actually, I thought all of our new
16 colleagues did a great job. Irene, I really want to
17 thank you for articulating -- I actually think I have one
18 that plays off of what Karen was just saying and maybe
19 one other to add.
20 The one that plays off of what Karen was just
21 saying is I hear from hospital leaders across the country
22 that they think we are not, in fact, measuring the right
23 things about hospitals. And I would agree with them.
24 That, in fact, they're looking to us to be able to
25 describe for them what are the key elements of the

1 organization that is driving quality, safety, high-level
2 performance, and start measuring those. We don't have
3 the evidence base to inform that discussion about how we
4 create the measure, but we need it. Back to Janet's
5 point, we need much more evidence. But that, I think,
6 would really have the capacity to drive quality forward
7 enormously.
8 And the second one -- and I want to play off of
9 something that Janet is doing or is leading through the
10 National Quality Forum is one of the barriers that I
11 think, at least that hospitals see, is that we don't have
12 enough focus. We are measuring a lot of little things
13 all over the place, and different payers and different
14 consumer groups and business coalitions and others are
15 measuring different things. It just looks like a lot of
16 noise to the providers. You can't get a lot of traction
17 behind engaging in real quality improvement if you've got
18 all of that noise that you're dealing with.
19 Janet and the National Quality Forum has
20 convened a group of folks to bring more focus to that.
21 Peter's part of the group. There are folks from the AMA
22 and CMS and other players at this table on that group. I
23 certainly hope that has the kind of success that the
24 energy involved in the National Priority Partners has
25 suggested it would. But it would put us all on that same

1 page about what we want to drive and drive in the near
2 term.
3 MR. CORRIGAN: And we'll be releasing them on
4 November 17th.
5 **(Laughter.)**
6 MR. WROBLEWSKI: Well, thanks. I had a
7 question -- actually, a very basic question kind of
8 getting back to first principles maybe here. In Irene's
9 slides, the first slide, I guess, is the hurdle of
10 consumer awareness. Consumers have to understand that
11 there is a quality variation, and I guess getting back to
12 that, the basic problem here is what are the underlying
13 causes of this quality variation both in terms of, say,
14 pure quality, Dr. X has a lower mortality rate than Dr.
15 Y. And, also, sort of relatedly, in resource use, it's
16 not correlated with quality outcomes.
17 Maybe I would throw that to Janet first, but
18 open it up to anyone else who may want to speak to that.
19 MS. CORRIGAN: I think there's actually quite a
20 few variables or factors that contribute to variability.
21 Part of it is because our measurement systems have,
22 frankly, been so crude, and because they also are or tend
23 to be at a micro level, we measure little pieces of
24 things in one setting, in one aspect of care. The
25 providers can't even see the larger picture.

1 It has really only been fairly recently --
2 well, we've had some variability -- we've had a lot of
3 variability information across communities and geographic
4 areas, but it's only been fairly recent that we brought
5 that down to show variability across hospitals and
6 different diagnostic groups and physicians and, you know,
7 where it really could be something a bit more meaningful
8 and where we tied it to actual quality and outcomes. So,
9 I think part of it is that I don't think that the
10 providers have appreciated how variable it is.
11 Another factor that influences variability, and
12 probably one of the most important ones, though, that we
13 just have to put on the table, and it's that we have a
14 payment system that drives towards volume. So, you see
15 in communities, especially where the supply of providers,
16 particularly specialists and hospital beds, is higher,
17 each provider generates more units that bring in a fee.
18 Hospitals drive towards filling up their beds and
19 competing and trying to do that, and physicians want to
20 fill up their schedule. If you have an excess supply of
21 cardiac surgeons, you are going to have a lot of cardiac
22 surgery in the community. We see dramatic variability
23 depending upon the supply of providers and beds.
24 We have known that for decades. A guy named
25 Milton Romer ages ago said, "Build a bed, fill a bed."

1 It’s as true as it is. So, we have to -- it’s the
2 payment system, I think, that drives a big piece of it.
3 Others say that variability sometimes, too, may
4 well be driven, to some extent, by consumer demand. But,
5 once again, the supply has to be there really for the
6 patients to get it. So, there’s various factors that
7 contribute to it.
8 MR. WROBLEWSKI: Peter?
9 MS. CORRIGAN: But it’s only recently -- I’m
10 sorry -- that we were able to demonstrate in the
11 literature that when you reached a certain point of sort
12 of excess supply and you see that volume of services go
13 up high and the variability in the high ones, that you
14 see a decrement in quality in those communities, and that
15 is an important step for us. We finally got to the point
16 of being able to demonstrate that because, prior to that,
17 I think we were always sort of fighting this, well, my
18 patients need it, you know, and there was pent-up demand
19 and need for the services. Truly, a lot of it driven by
20 supply.
21 MR. WROBLEWSKI: Peter?
22 MR. LEE: I will confess, I wasn’t going to
23 answer your question. So, if others want to answer the
24 question, I’ll pass and then come back. That’s my true
25 confession point.

1 DR. BARR: I actually was going to react, but
2 Janet took part of what I want to say, but if I could
3 just echo that and then Peter can jump off on a different
4 tangent. How does that sound?
5 **(Laughter.)**
6 DR. BARR: I was going to say another great
7 presentation, but I was going to add another barrier to
8 Irene and sort of Janet referred to the mixed incentives
9 in the system we have now because people live on the
10 volume. But let's say we're successful, you think with
11 the end in mind, we'd get actually good measures and you
12 drive. Well, okay, we identify the great quality
13 physicians and now we're going to drive more volume to
14 those.
15 Well, from the primary care perspective, most
16 of the primary care doctors I know don't want more
17 volume. So, they're thank you very much. So, there's
18 that mixed incentive of about, okay, if I do well, I
19 might get more. Really don't do me any favors. I don't
20 need any more. So, we need to think about that.
21 The other thing is physicians are -- in the
22 current market, are price takers. In a regular market,
23 if you do better, you get to set your prices to some
24 degree and maybe there's a little wiggle room here. But
25 in the current environment, you're sort of a price taker.

1 So, you don’t really have the win on that end, even if
2 you do take more volume without sort of pretty tough
3 negotiations. If you’re a one or two-physician practice
4 that builds a new medical home, puts infrastructure, does
5 all the things right, there’s very little ability to
6 negotiate that side of the equation.
7 MR. WROBLEWSKI: You know, we have been talking
8 about payment reform and we talked about it a little bit,
9 or at least some of the payment incentives, at the very
10 end of the second morning session. And what are the
11 barriers then to payment -- I mean, if it isn’t volume,
12 if you’re saying that -- I mean, what are the other
13 drivers that prevent payment reform from occurring at the
14 private level -- the commercial level?
15 DR. BARR: Well, look what -- I mean, we’re not
16 advocates of any -- but look what happens with boutique
17 or concierge medicine. The way they set their prices,
18 they step out of the whole system. All right? And they
19 say, I’m going to build this, but that’s the kind of care
20 -- when we talk about the medical home, that’s the kind
21 of care we want to have for everybody and actually
22 support it appropriately.
23 So, we talk about the principles and what it is
24 about. And then we say, well, you can’t exist unless you
25 do some of the changes. So, the barriers are you just

1 need to be creative and think about what's the best way
2 to fund. We also have to prove the concept, and that's
3 what all these demonstration projects kind of show,
4 whether we can reduce the variability, unwanted or
5 unnecessary care, reduce emergency department admissions,
6 those kinds of things.
7 MR. WROBLEWSKI: Vince or Elysa, do you have
8 any comments just on the last piece in terms of the
9 barriers for rewarding quality?
10 DR. KERR: I guess I have one or two comments.
11 In my household, my wife is the budget director. She has
12 finance training and it is very difficult to go back to
13 her and say, I really think I need a 20 percent increase
14 in the budget because I would look great in a red
15 Ferrari.
16 **(Laughter.)**
17 DR. KERR: We have a zero sum game. Unless
18 you're going to add new dollars to the system and find
19 the support for that from Peter's constituents or others
20 -- listen, I've got a great idea. I know we have a $2
21 trillion system, but I want to kick in an extra 400
22 billion bucks to the system to drive quality. We're at
23 bail out levels. It might not take that much. I don't
24 know what it would take. Somewhere between that, where
25 you're dealing with sort of a zero sum game, and the

1 difficulty of re-rationing allocations the way they are
2 already fixed in the system, that's a Herculean task to
3 take on. We know there are problems with that, with
4 underfunding of primary care, for example, that haven't
5 been fixed for years.
6 There are ways of getting at it. They're slow
7 and they're incremental. You can vary the rates of
8 increase of the escalation in fee schedules and make
9 those quality-sensitive.
10 We looked at our spend, along with another
11 customer, a large customer, and I think this would be
12 true almost anywhere, less than 1 percent of the spend in
13 the U.S. is quality-sensitive. One percent of the
14 dollars.
15 MR. LEE: I'll jump in.
16 MR. WROBLEWSKI: Okay.
17 MR. LEE: I'll respond to this one and then,
18 also, pick up on my other line, if I could, which is
19 commercial payers pay the vast majority on two dimensions
20 now, only two, which is the volume and the unit price.
21 Each of those are affected. Unit price, they try to
22 squeeze down on the doctors and the hospitals, and the
23 hospitals and the doctors try to consolidate and get
24 better bargaining position to charge more, and volume is
25 just gained by supply and other factors.

1 I mean, I thought Irene's position was great,
2 but it was absolutely the fact that the seventh hurdle is
3 payment. All this issue about performance measurement,
4 to have that be a factor in payment, is -- I'd be
5 surprised if it's 1 percent today. It depends on what
6 you count it as. I think that is an incredibly important
7 observation.
8 I want to jump to a couple other quick
9 observations, if I could, that build on these other
10 discussions that -- I saved my ask for the morning to the
11 afternoon.
12 MR. WROBLEWSKI: Now, if they're
13 recommendations, we want them in the later session.
14 MR. LEE: Dammit. So, I've got to hold them
15 again?
16 **(Laughter.)**
17 MR. WROBLEWSKI: We're still talking barriers
18 here.
19 MR. LEE: You know I have to leave a little bit
20 early.
21 **(Laughter.)**
22 MR. LEE: Well, given that I will probably
23 never speak again, I'll --
24 **(Laughter.)**
25 MR. LEE: Those that know me laugh. First,

1 back to -- I really want to use Irene's framing, which
2 was so good for the remarks about the three paths -- I
3 think when you keep on coming back to what a consumer
4 wants versus what a payer wants versus what a provider
5 wants is not the same thing. And it's different at
6 different points of time. We often get those confused,
7 as well as that consumers are different.
8 So, I mean, I react to that. Boy, I want
9 accountable cure organizations and people are more than
10 their silo. But if I'm a diabetic that then gets
11 diagnosed with cancer, I want to know my cancer treatment
12 options and who does better for treating my cancer, even
13 though I'm still diabetic. How do we both aggregate and
14 disaggregate is one of the things about measures we need
15 to think about.
16 But the other two on the measures issue -- and
17 I want to reinforce the issues on prioritization. The
18 priority partners will help that. I think it's
19 incredibly important. We don't have prioritization. But
20 the big piece here -- if we think about a competitive
21 system is developing performance measures is developing
22 the public good. And you think about to have a
23 competitive system, right now, this is totally under-
24 supported and almost unsupported.
25 So, the AMA chips in some money for PCPI. But,

1 you know, it's tiny amounts of money compared to what we
2 need for developing good performance measures. Everyone
3 says we need better functional status measures, better
4 outcomes measures. They don't come cheap. So, when we
5 think about the public good of developing those, I think
6 it's one of the things that it's not just going to happen
7 because we wish it were.
8 Finally, on the data element, using Irene's
9 hurdle number three, I want to do a second -- Vince's
10 earlier note around collaborative work also relies on
11 sharing data, in particular, Medicare data. We have
12 taken some micro steps in that direction, but having good
13 ways to share Medicare data is critical.
14 But the other -- and this is a sort of story
15 from the streets is that we have, in California,
16 particular hospitals, as well as medical groups, that are
17 saying your health plan cannot use our data to develop
18 performance reporting because, not totally unreasonably,
19 we don't trust that you're going to do it in just the
20 right way. But they aren't saying we're going to
21 negotiate around. They're going to say, sorry, our data
22 is only usable for X, which is for paying us. You can't
23 use it for other purposes.
24 So, we talk about the efforts to combine data
25 and then we have, not unreasonably, providers saying, I

1 want data to be perfect, but all of a sudden we're knee-
2 capping efforts to actually use data together. That's a
3 huge constraint around the data hurdle. That's another
4 one that I don't think people hear about because it
5 happens out there in the streets, so to speak, where
6 contracts are being written by those that have the power
7 to write them and, in some cases, it's a provider group,
8 or it's a hospital. In some cases, it's the plan that
9 has the power to write the contract.
10 So, people are saying whoever is in the
11 dominant place will write contracts to say, you can't
12 tell a story about me about quality performance. That's
13 one of the other pro-competitive things that I worry
14 about seeing being undercut.
15 MR. WROBLEWSKI: Jack, you had your --
16 MR. FOWLER: With all these wise payers sitting
17 around the table, no one's caught up on the point Janet
18 was making, that if you put twice as many specialists in
19 a place, you get twice as many specialist visits. If you
20 build an MRI machine, then you get MRIs --
21 MR. WROBLEWSKI: Can you pull in the
22 microphone?
23 MR. FOWLER: Oh, I'm sorry. So, the point was
24 made that when the supply of medical resources of
25 whatever sort gets used, and with all these smart people

1 around the room, I just wonder whether there are any
2 thoughts about how do you -- how do you address the fact
3 that in Miami, you know, you get many, many more test and
4 specialist visits than you do in Minnesota or San
5 Francisco or Tampa?
6 Is there no way you can intervene in that
7 process when there is pretty good evidence that there is
8 no medical benefit being generated from that extra use?
9 MS. CORRIGAN: I can quickly answer that, at
10 least tell you what efforts are underway to try to do
11 something about it. We did just receive some contracts
12 from CMS to try to identify and endorse measures of
13 overuse. We're trying to get into the report cards
14 measures of overuse.
15 Now, as Richard and others can tell you, it's a
16 lot easier to talk about constructing or building a
17 measure of overuse than it is to actually do it, because
18 you've got to be able to separate out. It's not just a
19 measure of resources. You've got to separate out
20 appropriate from inappropriate use of it. That's a bear
21 to do. It's tough to do.
22 MR. WROBLEWSKI: Vince or Elysa, do you have
23 any reaction?
24 MR. FOWLER: Could I just say one thing?
25 MR. WROBLEWSKI: Okay, go ahead.

1 MR. FOWLER: One of the things, when we
2 surveyed physicians in these different areas, you get
3 things like how often do you see your hypertension
4 patients back, and there's no evidence that it matters
5 whether you see them every three months, every six
6 months, every nine months. But in the higher areas, I
7 saw them every three months and in the low areas -- the
8 low-cost areas I'd see them every nine months. They just
9 made that up, you know. But it's part of the medical
10 culture in those areas.
11 DR. KERR: It's not made up. You look ahead at
12 your appointment log and you decide --
13 **(Laughter.)**
14 MR. WROBLEWSKI: I think we -- what are your
15 thoughts on that issue?
16 **(Laughter.)**
17 DR. HOVEN: It is definitely not made up. Here
18 we get into risk adjustment. And the thing we talk
19 about, we use the term "risk adjustment" quite loosely,
20 but I don't think we've actually delved down into risk
21 adjustment to look at the sickness of the patient. Those
22 folks that are sick, you're having trouble controlling
23 their hypertension, they have renal disease associated
24 with it, peripheral vascular disease, you have got to see
25 them more frequently. You do not arbitrarily say,

1 they'll come into the office every nine months, period.
2 So, we've got to be very careful how we look at
3 this information. This goes right smack back to the
4 quality stuff we were talking about this morning. If you
5 don't look at this and risk adjustment methodologies, you
6 are going to screw up the system.
7 DR. KERR: So, as part of what makes medicine
8 difficult to quantify in some areas because you are
9 pegging it to a set of variables that are individual
10 variables in terms of how compliant a patient is, how
11 well they understand their medication, as well as the
12 physiologic variables that you're treating. All that
13 aside, it is incredulous when you look at data, for large
14 populations, without an explanation about some difference
15 in the nascent severity of a given diagnosis, that there
16 would be that kind of variation.
17 Over and over again in medicine, when we
18 subject these kinds of things to scientific study,
19 controlled study, we often find that what we think is
20 necessary does not yield the benefit that we attribute to
21 it.
22 MR. WROBLEWSKI: What are the barriers then --
23 and this follows up one of the things that we want to --
24 in terms of what are the barriers then to get that
25 information? I mean, I'll open it up. Go ahead.

1 MS. FERRARA: I want to actually address a
2 number of the comments that were made here to your point
3 about variations. I had been speaking on the break about
4 bariatric surgery, and seeing in just one region of the
5 country, including the bariatric surgery, and I can't
6 recall if it was 60 or 90 days post-surgical date. The
7 variation in cost between 12 and $70,000 on average, per
8 hospital. That is a huge sweeping variation. And the
9 employer whose employees are primarily in the marketplace
10 that's dominated by the $70,000 procedures facility want
11 change.
12 Now, is $12,000 the right price? Probably not.
13 There's probably an issue there, too, at the other end.
14 But those are the kinds of variations when they translate
15 into practice patterns that translate into dollars that
16 have employers alarmed. These employers are seeing this
17 because they have employees in Maine and New York and
18 Virginia and California and they are demanding the
19 information, and they're saying, well, wait a minute, why
20 am I paying -- and this is a discreet procedure, so, yes,
21 there are certainly variations in risk associated with
22 this. But for a discreet procedure within an eight state
23 area, to have that kind of a variation is clearly going
24 to be an employer red flag, and we need to do something
25 differently.

1 So, then you get to the question of payment
2 reform and, you know, what are the challenges. One
3 interesting challenge that I've experienced -- we have
4 pay-for-performance systems. All payers have pay-for-
5 performance programs. We've had employers say to us
6 stop. I think I spend too much already and you're asking
7 me to pay more because this hospital is safer than the
8 average of 80 percent, or you're asking me to pay more
9 because they're within 70 percent of meeting evidence-
10 based standards of care. It's really an interesting
11 conversation that you have.
12 We believe in quality improvement. We want to
13 reward the providers who invest. But we also have payers
14 who say, I'm really -- I'm having a hard time wrapping my
15 head around the idea that I have to pay more to come
16 close to meeting the standard. So, I think these are
17 some of the challenges and the conversations we have to
18 have. One of the ways that we payers address that is we
19 say, okay, get to a point and we retire a measure. So,
20 you're continuously improving.
21 The other thing is we've talked about
22 high-performance provider networks. We also have
23 high-performance provider initiatives, which is a little
24 bit different. Those are gain-sharing initiatives where
25 you find the creative providers. And, again, it's not

1 specific to us. You do the same thing, and you innovate
2 with them. So, they do look and they bring the docs to
3 the table and a system, along with the health care --
4 with the radiology providers and along with the
5 hospitals. And they look at their own data with us.
6 They take our claims data as well. We work together and
7 they figure out, gee, maybe there is a variation that we
8 can reduce, and then you gain-share around it.
9 There are barriers to that. There are
10 regulatory and other barriers related to that. And then
11 in terms of payment reform, one of the biggest barriers
12 is the complexity of the systems changes that are
13 required in order to really launch global payment reform.
14 And there's a huge cost associated with that.
15 DR. KERR: I feel we didn't answer Jack's
16 question, his initial question about dealing with the
17 variation. We've described the problem.
18 MR. FOWLER: Yes. Are there any interventions?
19 DR. KERR: No.
20 **(Laughter.)**
21 DR. KERR: The truth is that, absent a measure
22 that can get at what is overuse or something that can
23 flag appropriateness, it is very difficult to do. What
24 we have are crude measures, which are comparative and
25 relative. So, in this market for this patient population

1 the best we can understand it, you are seeing similar
2 patients. Your rate of this is three times everyone else
3 in the community. Help us understand that. That is
4 about as scientific as it is right now.
5 MS. CORRIGAN: Could I add to that? I think
6 what we have to do -- one thing I want to point out is we
7 focused on overuse, but the evidence actually shows that
8 there's a lot of underuse. The work at Rand shows that
9 when you -- you know, a typical consumer that goes into a
10 provider, you have only a little over a 50 percent
11 chance, a 52, 53 percent chance, of receiving the
12 services, the set of services from which you would likely
13 have benefitted. So, it's really a flip of the coin when
14 you go in as to whether you're going to get the ones that
15 you really would have benefitted from as well. It is
16 this underuse/overuse. So, what we've just got is a lot
17 of variability.
18 Now, what you would do in most sectors, I
19 think, or other industries when you have a lot of
20 variability, you standardize the process. You go in and
21 you analyze every step in the process, and you attempt to
22 standardize it and say what's appropriate. And then you
23 monitor to make sure that you're doing it exactly as it
24 is supposed to be done.
25 That is really hard to do in health care for a

1 whole lot of reasons. One of them, patients do vary.
2 So, specialty societies develop practice guidelines, but,
3 you know, you quickly get them out there in the field,
4 and they apply to some patients and they don't apply to
5 other patients. But they try.
6 The second reason it's really hard, though, is
7 that the delivery system is so fragmented. Patients with
8 diabetes or COPD or a common condition, they need to see
9 multiple providers, multiple settings across time. Yet,
10 we have basically organized as a cottage industry.
11 The third reason it's hard really goes back to
12 the earlier account about we need to move to a different
13 unit of analysis here. It really should be the extended
14 episode, the patient care episode. You know, if you're
15 diabetic, you want to know if you're going to be -- how
16 much is it going to cost and are you going to be better
17 at the end of six months or 12 months or 18 months. But
18 unlike producing cars, we can't even figure out what the
19 time period of time should be. And a piece of this is
20 out of the control of the providers. It's also in the
21 control of the patients and how they behave.
22 MR. WROBLEWSKI: Barbara, did you have a
23 comment?
24 MS. RABSON: Yes. I think there are some
25 success stories on the interventions that you can have

1 for overuse. One of them I'll mention is in Rochester
2 with the Rochester IPA. Howard Beckman is the medical
3 director of this group. And they really are looking at
4 efficiency measures and why the variation within the
5 Rochester community. And what they found was they
6 drilled down to find what about those measures, like what
7 -- not just that physicians were spending more, but what
8 were they spending more on.
9 So, one of the examples is carpal tunnel
10 surgery. And they had some that were using a local
11 anesthesia and some that were using a general anesthesia.
12 Same results, seemingly, and the expense was just, you
13 know, three-fold different. Once you drill down to
14 something very specific, then you can go back to the docs
15 and say, why are you using this? And they say, I was
16 trained this way. And you ask the other docs, why are
17 you using this? And they say, I was trained this way.
18 So, then you say, well, wait a minute, you know, as long
19 as we can find that the outcomes aren't different, then
20 docs are very willing to change practice given the data
21 and given this kind of thing.
22 So, I think that it's a matter of drilling down
23 into these communities. It's labor-intensive, but you
24 can get successes and then you can actually go to
25 community guidelines.

1 Another way to address overuse is to say, okay,
2 docs are always saying that I can explain to every
3 patient why they shouldn't go for this service, why they
4 shouldn't take this drug, but it takes me 15 minutes. If
5 I'm not up for that, I'm just going to give them the
6 referral. So, if there are community guidelines that
7 say, you know, with patients with this condition, we send
8 them there and everybody's agreed to them, they say,
9 these are community guidelines. You know, that what we,
10 as a community, have decided, so that's what we're going
11 to do with this.
12 While I have the mic, just one more point on
13 payment reform and the idea of what the barriers are. I
14 think, again, there are a number of local communities or
15 regional collaboratives that have had some really
16 successful quality improvement and payment reform
17 initiatives, whether it be Pittsburgh or Minnesota or
18 Massachusetts. One of the barriers is that you can
19 get -- aggregate the commercial payers, get them all
20 around the table to agree on a particular incentive or
21 reimbursement plan, but then CMS doesn't.
22 So, then you've got, within those practices,
23 half the patients are reimbursed one way and the other
24 half the other, and some of the doctors and hospitals
25 throw up their hands and say, you know, I can't do this.

1 We all have to be together because we sort of counter
2 each other out, and it's too hard to do this.
3 MR. WROBLEWSKI: Let me go to Richard and then
4 I'll go to Dr. Hoven.
5 MR. SORIAN: Just continuing a bit on the
6 payment reform. I mean, I really think payment reform
7 has to be the horse pulling the cart. We could spend
8 hours and hours talking about the cart. That's what my
9 company does full-time.
10 **(Laughter.)**
11 MR. SORIAN: But if we don't change the way we
12 pay for care, then the incentives are never going to be
13 there for people to make the hard choices that people are
14 talking about. What do we lack in terms of the ability
15 to make payment reform? We lack the will, whether you
16 want to call it political will or personal individual
17 will. But we, basically, have to have our backs against
18 the wall and then we really make changes.
19 If you look at the last major changes in '81,
20 '82 when we went to DRGs and '89, '90 when we went to
21 RBRVS, certainly in the first case, there were some real
22 political and financial pressures going on. I think we
23 have all seen that there are some real political and
24 financial pressures going on right now.
25 **(Laughter.)**

1 MR. SORIAN: So, we have the opportunity to
2 exert the will. Frankly, I believe, because of the way
3 the system works, that Medicare does have to be sort of
4 the canary -- a very large canary, that when Medicare
5 changes the way it pays -- and Congress needs to do that,
6 and I make that very clear -- then the commercial sector
7 tends to follow. It doesn't happen immediately. So, I
8 think we do need to change the way Medicare pays for a
9 whole lot of things.
10 I think that we have to keep the providers in
11 the game because you hear very clear, whether it is
12 pay-for-performance or gain-sharing, there has to be
13 something in it for those who are delivering care in
14 order for them to make the changes they need to make.
15 Because you hear examples all the time about, yes, if I
16 deliver more high-quality, efficient care in this area of
17 care, I will get less revenue. So, my CFO is not going
18 to be really happy with me. You know, Brent James from
19 InnerMountain gives great examples of the losses that
20 they incurred by changing some of their systems and such.
21 Back pain is a great example. We have a back
22 pain recognition that basically rewards physicians for
23 doing less. But the rewards are way less than the money
24 they're giving up by not doing x-rays and MRIs and all,
25 not putting patients in the hospital, et cetera, et

1 cetera. So, there has to be some kind of system where
2 they get bigger rewards, and some of the gain-sharing
3 experiments have been promising in that area, but there
4 are a lot of concerns, antitrust concerns and others,
5 that need to be addressed. But the ideas are out there.
6 We just really need to get moving on them.
7 MR. WROBLEWSKI: Dr. Hoven?
8 DR. HOVEN: Thank you. I've got several points
9 I want to make and I wanted to do that before we ran out
10 of time, so I appreciate it.
11 This morning we did talk about physician
12 measurement reporting of our performance. I wanted to
13 make it very clear, despite the conversation we had out
14 there, there are issues going on at the ground level
15 right now with physicians in which this information is
16 not very clear. The methodologies are perceived as being
17 black boxed. We don't know what's in them. The feedback
18 issues are astronomical. We can't do anything unless we
19 get the right feedback and we know we are getting the
20 right information. I cannot make that point any more
21 forcefully.
22 Richard's point about funding and that kind of
23 thing leads me to the next one, which is the fact that we
24 have got to have sustainable funding in order to support
25 the physician's abilities to engage in data gathering,

1 one of the hurdles you mentioned. Absent an HIT system
2 that is interoperable, user-friendly, at point of care,
3 real-time, we're not going to be able to do this. There
4 are huge issues out there -- Janet referred to them
5 earlier -- about many of the guidelines and the
6 principles and the standards that are going to have to be
7 applied to this. But absent the funding, wherever it
8 comes from, private payers, public payers, it's going to
9 have to be in place for us to get the data.
10 I don't have an electronic medical record in my
11 office. Would I like one? I would love it. That is a
12 hurdle that we're going to have to overcome. The example
13 I use is if my BlackBerry is not in my pocket and I can't
14 Google something sitting in the office, I have to go out
15 of the office with the patient, out of the exam room,
16 down the hall, get online, look something up. I've
17 wasted the patient's time. I have taken time away from
18 what I could be doing explaining something to the
19 patient. So, this is a very crucial issue.
20 Thirdly, I want to talk about, since we're
21 sitting in this austere building, the emphasis of the
22 Federal Trade Commission and its role in what physicians
23 can and cannot do. Right now, the enforcement policy is
24 an active barrier to physicians' ability to participate
25 in many, many ways. I can't get together in my small

1 community where I practice with a one-doc practice or a
2 two-doc practice and us put together something that is
3 workable in terms of getting legitimate networks to look
4 at aggregation of our own data, what we're doing, how we
5 can improve things. The Federal Trade Commission
6 prohibits us from doing that.
7 So, I think we're going to have to look, going
8 forward, at a very large barrier that is going to allow
9 us to work together, to be collaborative. Right now,
10 we're all kind of compartmentalized. We have to get rid
11 of this in order to make this happen.
12 MR. WROBLEWSKI: Thanks. Let me turn to
13 Michael Barr and then, Paul, welcome, and we'll turn to
14 you to end up the session before we take a break.
15 DR. BARR: I'll be brief, actually, because
16 Ardis picked up on the health information technology
17 question. I was going to actually turn the question to
18 Janet, because one of the concerns you raised, actually,
19 is the lack of measurements that are keyed up and ready
20 for implementation with health information technology.
21 Two questions. One, and Ardis already
22 addressed it, we desperately need health information
23 technology. It's not going to solve everything by
24 itself, but it will contribute. The question is, do you
25 think it will contribute to sort of the reduced

1 variability once you start getting measures there and
2 then the actual work of the physicians is actually
3 contributing to the data collection that's done so
4 automatically and fed back?
5 So, you get that feedback loop and the response
6 and the data collection at a different level. Because
7 there's no way you're going to get to the level of detail
8 right now to kind of answer some of the questions we've
9 been asking ourselves about how to improve the system.
10 So, the question is, do you think we're getting there?
11 Will we get there?
12 MS. CORRIGAN: Yes, absolutely. I think that
13 there's good evidence coming out on EHRs. We have
14 wonderful examples where we have been able to change
15 practices through collecting the right information,
16 clinically rich information. You can calculate measures
17 that are really meaningful, that take into account the
18 risk-adjustment issues that have been brought up. And
19 you can provide decision support, clinical decision
20 support to patients.
21 The world we want to be in is when we roll out
22 at the national level, you know, a new set of measures
23 that go into Medicare can pay or whatever condition, we
24 ought to have that teed up so that every one of those
25 electronic health records, it is capturing the right

1 information and it’s also providing the clinical decision
2 support.
3 I mean, the measures and the decision support
4 come off of the practice guidelines that come off of the
5 evidence base. This is a supply chain. There’s the
6 evidence, there’s the practice guidelines it gets
7 translated into. Those turn into the measures, they turn
8 into the clinical decision support. The EHRs get built
9 to capture the right information to generate the measures
10 and provide the prompts, the reminders and the other
11 supports to the physicians and to generate the
12 information to the public on the users.
13 MR. WROBLEWSKI: I understand that supply
14 chain. But how does the -- when we were talking about
15 outcomes earlier, if you are looking at a performance
16 measure that shows that the recovery time for your hip
17 surgery was much shorter and that is the outcome, how
18 does that type of outcome fit in that chain that you just
19 described? Because that’s not a practice guideline.
20 MS. CORRIGAN: That the recovery time or --
21 MR. WROBLEWSKI: You know, if you’re comparing,
22 say, a redo rate, a readmission rate or an amount of
23 recovery time, how does that fit into that supply chain
24 that you just described in terms of the measure
25 development?

1 MS. CORRIGAN: Well, we have to know that -- I
2 mean, that's part of the knowledge base, that it isn't
3 necessarily going to be embedded in the clinical record.
4 But if we know that by doing certain things, the
5 readmission rate will be less or the patient will get
6 better outcomes, then you prompt and remind and encourage
7 them to do whatever those things are that lead to it.
8 But the problem we have is we don't capture
9 that information in many cases on patients. We're not
10 picking up the outcome information. For many patients,
11 they leave the hospital and we don't know what happens to
12 them. They may or may not have any follow-up. It never
13 gets back. We don't know what happens to them. So,
14 there isn't that.
15 So, I also want to emphasize it's not only
16 EHRs. We have to get to the personal health records.
17 That is really important, especially as we move into
18 health behavioral changes and all these chronic
19 conditions. That's all in the hands of the patient and
20 the family care-giver. They deliver more care than
21 professional health care providers do, patient and family
22 care-giver.
23 MR. WROBLEWSKI: Dr. Chumbley?
24 DR. CHUMBLEY: Just a quick comment. We had
25 talked earlier about payment reform, and if we want to

1 start with payment reform, I really encourage us to start
2 with the primary care physicians, you know. Twenty years
3 of leading physician groups, the neuro pathways are
4 different in primary care physicians from specialists.
5 **(Laughter.)**
6 DR. CHUMBLEY: And I really do believe it would
7 be a great deal easier if you started with just primary
8 care.
9 **(Laughter.)**
10 MR. WROBLEWSKI: Thank you for prioritizing the
11 significant barriers.
12 **(Laughter.)**
13 MS. CORRIGAN: If you don't do it fast, there
14 won't be any primary care physicians left
15 **(Laughter.)**
16 MS. CORRIGAN: It's a dying breed.
17 MR. GINSBURG: Well, I'm going to live
18 dangerously by coming into the discussion toward the end
19 and take the chance that some of the things I say may,
20 you've already taken care of it before.
21 But two thoughts from what I've listened to
22 before. One is, I've just been doing a lot of site
23 visits, and when it comes to the quality improvement
24 area, when asking about how organizations motivate their
25 physicians to improve their quality, it is almost all

1 facilitated and driven by what they can measure. So, in
2 a sense the measurement is really important not so much
3 for the consumers or the public, but just to be used
4 within organizations so they can identify which
5 physicians can do better and learn from others.
6 The other comment I wanted to make is just
7 after I came in, Richard Sorian was talking about the
8 payment reform is the horse, and I agree with that. He
9 was talking about the political will. My sense is that
10 what needs to be done in payment reform may not be that
11 difficult politically, but we need some development work
12 to be there so that it can be pushed across.
13 Now, when I think of payment, you know, the
14 first thing -- and this is mostly in physician payment,
15 we did it in hospital payment, even if the problem wasn't
16 as severe, is just getting our current payment system,
17 the relative values, the structure correct, more accurate
18 and more accurately reflecting costs. Because there are
19 many examples of attempts to re-engineer delivery, like
20 what Virginia Mason Medical Center did where, you know,
21 fee-for-service wasn't great. But what really killed
22 them was their distortions in fee-for-service payment,
23 the fact that rationalizing re-engineering care for those
24 conditions meant cutting back on the very profitable
25 procedures, and it just made it not viable.

1 I think that that's stuff we are really ready
2 to do. I don't think we need a lot of development. But
3 to start paying on the basis of multi-provider, acute
4 episodes and capitation-like payments for a chronic
5 disease -- in fact, I worry about all the focus on the
6 medical home. That's such a baby step toward the broader
7 thing of using capitation, that I think the bottleneck is
8 developments, that we need more technical tools as how to
9 do it.
10 I don't know that it will be that difficult
11 politically if it can be pulled off. And I agree with
12 Richard that Medicare has to be the leader because,
13 otherwise, payers are too fragmented to really have an
14 impact.
15 MR. WROBLEWSKI: Okay, thank you. With that,
16 we'll take maybe a 10-minute break. We'll start at 20
17 after 3:00 for the last session of the day. Thank you.
18 **(Session concluded.)**
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1 **POLICIES TO FACILITATE QUALITY INFORMATION MEASURING,**
2 **COLLECTION AND REPORTING**
3 MR. WROBLEWSKI: Why don't we get started on
4 our last session for this afternoon. We are very
5 grateful that Karen Milgate from CMS will be able to give
6 a brief presentation on some of the initiatives that CMS
7 is undertaking in terms of quality improvement. Thank
8 you. Karen?
9 MS. MILGATE: Sure. Let me start off by just
10 giving a brief non-political statement. I don't know if
11 you all focus on it as much as we do because our bosses
12 are about to change next week, but the current
13 administration has been a very strong proponent of
14 transparency and has really pushed all parts of the
15 agency, particularly at HHS, to use its information as
16 much as possible, to try to make it available. I think
17 AHRQ has felt this. Certainly, we at CMS have felt this.
18
19 Having said that, sometimes they, I think, like
20 to take credit for more of the progress than maybe that's
21 due to them because it was really possible to push
22 forward in part because there was a very strong
23 foundation built in previous administrations. As those
24 that have been around a while know, there was a lot that
25 happened, also, in previous Democratic administrations.

1 All that is to say that I think this work will
2 continue, and so, pressing forward, at least, I'm not
3 nervous that this kind of push will end. So, I would
4 hope that others would have the same feeling that I do,
5 and I don't think it is a partisan issue. So, we'll
6 continue forward with trying to get as many and as good
7 quality measures as we can.
8 I wanted to just make a comment off of what
9 Richard said, because at least in the Medicare realm --
10 and I know it's true for private payers as well -- we
11 really do have our backs up against the wall situation in
12 terms of funding. I give a whole presentation on this,
13 and I won't do that at all. But the reality is the
14 Medicare cost growth is really higher than can be
15 sustained, and the problem is even greater because we are
16 going to have a large number of retirees in the next few
17 years. So, we have more people. We have cost growth so
18 that it's higher than we can afford. And at the same
19 time, we will have fewer workers to support the
20 beneficiaries that come onto our program. So, we have a
21 real cost problem in the Medicare program.
22 I throw that out here in, you know, a group of
23 folks that are looking primarily at quality information
24 in part because I think there are really two very
25 significant needs for quality information in this kind of

1 scenario. One is it can help us actually design rational
2 policies for identifying care and trying to put
3 incentives in the system to actually encourage the
4 greater use of efficient care, and that could be
5 incentives by providers. It would also be incentives for
6 patients.
7 Two, though, I think is an area that we have to
8 just keep in mind that if there is a decision by Congress
9 to actually try to push for greater cost containment, it
10 could be done less or more rationally. And if it's not
11 done rationally, it could actually harm the quality of
12 care. Therefore, it means that it's really critical that
13 we have good measures so that we have a good measure of
14 if a certain type of policy has gone too far or cut too
15 deep or that kind of thing.
16 So, I just want to suggest that, at least, as
17 I've evolved over my time in Washington working on policy
18 issues, I used to think of myself as sort of a -- more of
19 a pure quality person. But as time has gone on and the
20 cost issues have become more and more paramount, I guess
21 I've seen that quality information is even more and more
22 important and it's not just necessarily in and of itself.
23 So, having said that, I'm going to now talk
24 about what I'll characterize -- and Richard and I can
25 argue about it later -- is, in part, the 93 percent of

1 Medicare beneficiaries that don't have comprehensive
2 health information. I would suggest that, in fact,
3 there's pretty good information for fee-for-service
4 beneficiaries, whether it is perfect or not.
5 So, the three things I'm going to talk about,
6 the first is just kind of a framework for how to think
7 about using Medicare information, and it's very similar
8 to what others have talked about. Second, just go over
9 CMS initiatives to make Medicare information available.
10 Here, I'd like you to think about, because we try to --
11 are beginning to think more about how the information we
12 have on Medicare beneficiaries is actually helpful not
13 only to Medicare beneficiaries, but could also be used by
14 others. So, private sector payers, for example, for
15 states. Others can use the information that is on our
16 Web site beyond beneficiaries.
17 And then also talk a bit about something that I
18 think will probably generate some conversation, which is
19 some of the challenges to using Medicare claims data. I
20 want to make a distinction between Medicare data
21 generally, which I'm not sure what anyone would define as
22 that. There's a lot of Medicare data. But a lot of what
23 we get asked for is Medicare claims data and talk a
24 little bit about the legal challenges that we have.
25 So, I think this has been talked about before

1 by several speakers and really that there's three
2 different audiences for quality and price information to
3 foster more informed decision-making. There's providers
4 to support quality assessment and improve efforts;
5 consumers to support decision-making about plans,
6 providers and treatments; and then purchasers to support
7 the alignment of incentives for high-value health care.
8 For consumers -- and I want to just drill just
9 a little bit here because our Web sites really focus
10 particularly on the top two. First of all, there are
11 choices where consumers have to make about which health
12 plan to choose. So, from a Medicare perspective, there's
13 several different choices that are made that we provide
14 information on. One is whether you want to be in a
15 prepaid health plan or a Medicare Advantage plan or
16 whether you want to be in the fee-for-service part of the
17 Medicare program.
18 In addition, the Medicare Part D, prescription
19 drug benefit, was designed so that beneficiaries have to,
20 again, make another choice about a health plan and
21 there's two options there. One is you can be a part of a
22 comprehensive plan that is a Medicare Advantage plan with
23 drug coverage or you can choose one of many other private
24 plans and still stay in the fee-for-service program. So,
25 there is a lot of choice there, there's a lot of

1 different aspects of choice, and we try to provide
2 information to help beneficiaries make those choices.
3 Providers are clearly -- it's been said before,
4 there's many different providers that beneficiaries need
5 to make choices about, and, of course, it depends upon
6 what their needs are as to what they -- you know, when
7 they would look at a Web site on a provider.
8 Treatments, I think that's kind of a next
9 frontier so to speak, certainly for Medicare. We've had
10 a lot of internal debates about how we even want to move
11 into the space or if it's something that is appropriate
12 for a public payer. There is a Web site called
13 MyMedicare.gov, where beneficiaries are signed up
14 automatically when they enter the program. And we have
15 actually been considering giving prevention alerts so
16 that we can track claims to see if a particular
17 beneficiary is eligible or due for a particular
18 preventive service. There have been other suggestions
19 for how we might be able to use Medicare claims, and so
20 some of the pushing out of messages that other health
21 plans do.
22 We also have some research underway on personal
23 health records and what the role might be in the Medicare
24 population for personal health records, whether that
25 would be something where we would just kind of be a

1 portal to commercial offerings, not thinking that
2 necessarily the government would be the best developer
3 and maintainer of a personal health record or would we
4 have one vendor. So, there's a lot of questions how that
5 might work in the Medicare program. But discussion is
6 under way.
7 The next slide is just a list of our various
8 compare Web sites. So, this is the homepage of
9 www.medicare.gov. This gives you kind of a sense of the
10 kinds of Web sites that are on the -- these are the types
11 of Web sites that are on the CMS overall Web site. I
12 will go in more detail so you don't have to look through
13 each of those arrows. But you can pull up one page and
14 then just choose one that you want to go to.
15 This is to give you a sense of the types of Web
16 sites that are up there, but also these are the number of
17 hits or page views that occurred in one month, in
18 September 2008. So, at least when we're looking at these
19 in the agency, it gives us some interesting information
20 on how many people seem to be going to those Web sites.
21 They're probably not all beneficiaries. I certainly go
22 to those Web sites sometimes and others in this room
23 probably have, too. Some are better than others.
24 But the two that I find, I guess, most
25 interesting are, one, the physician directory because

1 people say, oh, you don't have any information on
2 physicians, and we don't have really performance
3 information on physicians. But there is a Web site
4 called the physician and other non-physician provider
5 directory that has information for people who are looking
6 for a physician by zip code. It has kind of the health
7 plan information on address and zip code and phone number
8 and I think where they went to school, that kind of
9 thing. People certainly seem to be using it.
10 The other one and the one that's used the most
11 is the health and drug plan finder. In part, that's
12 because that's such a critical choice for beneficiaries,
13 but I also think, in part, because it's one of our better
14 Web sites.
15 The bottom line best feature on that Web site
16 is you can actually plug in your drugs and your zip code
17 and you can plug in a couple of other factors as well,
18 but it will calculate from a cost-sharing perspective
19 what the best plan for you would be, taking into
20 consideration premiums, deductibles, their copay
21 policies, making sure that the drugs that you have are on
22 the formulary.
23 So, that's, I think, a really good example of a
24 tool that combines both access to necessary drugs, which
25 I guess I would call at least some type of a quality

1 indicator with the dollars at a very personal level.
2 Now, of course, it has its problems. You can't always
3 anticipate what drugs you'll need or what conditions
4 you'll have. But it gets about as specific as you can in
5 that kind of Web site.
6 So, this is -- I think I probably shouldn't
7 characterize our Web sites as some better than others,
8 but our Hospital Compare is certainly one of the older
9 ones that have been up there and these are the kind of
10 measures. As Nancy characterized, perhaps it's too many
11 different types of measures, but these are the variety
12 that there is. So, beneficiaries can go on it and look
13 in a variety of different ways. You can plug in your
14 condition and get scores, for example, if you -- I said
15 -- well, I don't suppose you would know. An AMI is --
16 Irene said ahead of time -- but there is CHF, for
17 example, you can plug in and get whatever measures apply
18 to that.
19 It has patient experience of care. So, that's
20 the results from CAHPS surveys. There is also -- we have
21 just put together the information on quality with also
22 some of the volume of services so you can look at which
23 hospitals have a higher number of procedures that are
24 performed at that hospital. And you can see down at the
25 bottom bullet that it's searchable by a variety of ways.

1 You can look at hospital name, zip code, city, county or
2 state.
3 We also have some -- and I would call this
4 definitely a baby step -- provider reimbursement
5 information. So, this does not tell the beneficiary what
6 he or she will have to pay. This just looks at what the
7 Medicare program pays. So, there is a Web site for
8 looking at common and elective hospital inpatient
9 procedures, outpatient procedures, the same things that
10 are done in physician offices and ambulatory surgery
11 centers. So, these are not the same procedures across
12 all these settings. We look for, basically, the top in
13 each of those settings and then you can look at in your
14 area generally what the Medicare reimbursement is for
15 those services in your area.
16 The second large bullet there is just where you
17 go to look at that. And then the third is just to kind
18 of transition into the next slide a bit. We are
19 beginning to focus a lot more energy on episodes of care
20 and how you might look at episodes of care across
21 settings of care and actually measure the resources for
22 that. We haven't even really begun the discussion of
23 whether you would somehow post that information publicly.
24 We are really just trying to figure out how to measure it
25 at this point in time, which I think is where a lot of

1 other initiatives are as well.
2 I talked about this a little earlier, but the
3 plan finder Web sites are very well used and, in part,
4 because there's a pretty serious cost differential for
5 beneficiaries. So, this helps beneficiaries choose
6 Medicare Advantage plans or prescription drug plans and
7 there's quality information, cost information and
8 coverage-specific information so that beneficiaries can
9 actually compare and decide which plan best meets their
10 needs.
11 This is just a shot of the plan finder tool.
12 So, you can see here, for example, that in this
13 particular beneficiaries area, Aetna is a possibility.
14 You can see whether there's any coverage in the gap. I
15 won't go into gory details of what the gap is. But
16 there's a certain gap in coverage in the Medicare
17 prescription drug benefit that leaves a beneficiary fully
18 exposed if they don't have some coverage. What the
19 premium, the deductible, what kind of cost sharing there
20 is.
21 Then we also have -- are going to, before open
22 enrollment occurs, put up some summary rating of
23 prescription drug plan quality, which is primarily
24 looking at sort of access to appeals and -- yeah, it's
25 service quality: it's not clinical quality.

1 So, the hardest nut to crack, so to speak, has
2 really been looking at physician quality and price
3 information. There are three initiatives I want to talk
4 a bit about. Many in the room know about some of these,
5 but I don't know if everyone knows about all of them.
6 So, I'll try to give sort of an overview of the three
7 bullets there.
8 The Physician Quality Reporting Initiative or
9 PQRI is where the physician self reports on a variety of
10 different measures through codes that they basically
11 define the population to which the measures would apply
12 and then suggest whether they gave the necessary
13 interventions. There is also some intermediate outcomes
14 in that as well.
15 Currently, these are not the performance
16 measures nor whether physicians are participating in the
17 initiative is not publicly reported. However, MIPPA,
18 this summer, the new Medicare law did require CMS to,
19 beginning in 2009, report on physician participation in
20 PQRI. There is also a bonus that's paid to physicians
21 who report successfully in this program of, I believe,
22 1.5 percent.
23 The Better Quality Information for Medicare
24 Beneficiaries Project, I would describe as a research
25 project. It was really intended to look at how Medicare

1 data could be used alongside private sector data at the
2 local level, under the auspices of the QIO Program -- and
3 I say that just because it sort of was a legal
4 constraint. It allowed us to do something that we
5 couldn't otherwise do in terms of giving out individually
6 identifiable information to external organizations. So,
7 there were several local organizations that became
8 subcontractors to a QIO and they actually got Medicare
9 data.
10 There were some interesting findings from that.
11 I don't know if the report is up yet, but there's a final
12 report in progress right now and I think it would be
13 fascinating reading for anyone who's interested in the
14 data issues. But two issues I would highlight. One, it
15 became apparent that it is very difficult to actually
16 mingle together the actual claims level information; that
17 while there may be ways of putting together the
18 information at a little higher level, but actual claims
19 is hard because they are just different. They are not
20 standardized.
21 And the other thing that I think doesn't
22 necessarily have to do with Medicare data or other data,
23 specifically, is it's very difficult to identify the
24 physician. UPINs and TPINs just even technically are
25 difficult to figure out exactly which to use. A TPIN is

1 a group number; a UPIN is an individual number. Now, we
2 have the NPIs in the Medicare program. And the other
3 issue is the more qualitative issue of attribution. I
4 mean, who really is the appropriate provider to hold
5 accountable for a measure?
6 The third bullet is -- I'm going to try to
7 summarize this quickly, but I don't know -- we just may
8 need to discuss it. The GEM Project, the Generating
9 Medicare Performance Results Project, is a project that
10 grew out of BQIs. The concept from Secretary Levitt's
11 point of view was he really believes in national
12 standardization and local action. So, he really wanted
13 more organizations at the regional level to come together
14 to look at quality information and then to use that
15 information either for public reporting or working with
16 providers. So, he wanted to make it possible for
17 Medicare data to be used for this purpose.
18 So, the strategy that was devised was to --
19 because it's difficult, again, to actually release
20 individual physician-specific or individually beneficiary
21 identifiable information, was to calculate the scores.
22 So, you would have ratios for we did it at the physician
23 practice level, again, to keep it a little bit away from
24 getting down to the decisions about the individual
25 physician and, so, give ratios to the chartered value

1 exchanges, which was the name of the local organizations.
2 And the hope was that then they could calculate ratios
3 and be able to put the information together.
4 It's just begun. The information -- actually,
5 we calculated the information and it is up on our Web
6 site for -- nationally -- well, I'm not sure if it's up
7 nationally, but it's up there for all the states that
8 have chartered value exchanges for them to be able to use
9 at the taxpayer ID level. So, that's a model of using
10 Medicare information that I would be glad to talk more
11 about because there's lots of back and forth on that as
12 you can imagine.
13 I think I've said a little bit already about
14 the challenges with physician-specific information. The
15 other area that we're doing a lot of work on is trying to
16 figure out how to measure physician resource use. A few
17 years ago, MEDPAC recommended that Medicare go ahead and
18 do some physician resource use measurement and provide it
19 confidentially to physicians. MIPPA, again, this summer
20 required the agency to do that beginning -- or to put a
21 plan in place to start doing that in January 2009.
22 We do have a contractor in place to try to
23 create some of those reports. We've done a lot of
24 research on what is the best way to give those reports,
25 what's the best way to define an episode. I would not

1 suggest that we think that we've found a really great
2 method, but we are continuing to work at improving the
3 tool at the same time that we intend on using the tool
4 for confidential feedback. So, you'll see more on that
5 as time goes on.
6 So, on an ongoing basis, we continue to update
7 and expand our quality and price transparency Web sites
8 and our various initiatives. The thing I want to talk
9 about here, though, now more than what we have put out in
10 terms of information is the difficulty that the Medicare
11 program has with balancing the legal requirements to
12 protect beneficiary and individual physician information
13 with a need for more information on quality and
14 efficiency. And I guess the next bullet -- that's what I
15 want to talk about next the most -- the rest of this
16 presentation.
17 But we have also, just recently, for those that
18 are interested in prescription drug information, released
19 a regulation earlier this summer that made it possible
20 for researchers and others to actually use our Part D
21 data now, which is a huge addition to the potential for
22 looking at quality measures because now you can actually
23 use prescription drug data. It's not out there all on
24 the street yet. I think it will be, probably for
25 researchers, available December or January next year for

1 2006. But it will be available on an ongoing basis after
2 that.
3 We also were mandated by Congress to put
4 together a warehouse of information that identified
5 people and linked information for A and B for those with
6 chronic conditions. So, there's a chronic conditions
7 warehouse that researchers can also access to do research
8 on beneficiaries with chronic conditions.
9 So, when we are looking at Medicare data -- and
10 here I should probably have labeled this claims because
11 this is really -- I mean, actually, some of this applies
12 to data more generally. But I think the real issue and
13 the real rub comes when you are looking at claims.
14 There are really four laws that govern the use
15 of our data. One is the Social Security Act, and I'm
16 going to tell you a little bit more in detail about what
17 it authorizes us to do and not do. And that law
18 authorizes CMS to release data for a limited set of
19 purposes. The other is HIPAA, and I'm embarrassed,
20 there's two Ps. I've made it my pride not to have two Ps
21 in HIPAA, but now MIPPA came along, which does have two
22 Ps. So, it's very confusing for policy people in
23 Washington. So, I just hate it when there's two Ps in
24 HIPAA.
25 But, anyway, so, that protects patient

1 identifiable health information. So, we clearly have
2 that in our claims. And then the Privacy Act of 1974 is
3 something that the private sector doesn't have. I guess
4 I would say the private sector probably has something
5 called contracts which at least does some of the same
6 thing, which is it protects individually identifiable
7 information, both patients and physicians. So, it's not
8 just protecting, you know, whether you can identify the
9 patient, but it also protects the physician.
10 And then FISMA is the new and very expensive
11 kid on the block. This is a law that was passed that was
12 passed to require that anyone who uses, and CMS itself,
13 to put in place certain security requirements for use and
14 release of individually identifiable information. If you
15 want to strike terror in the heart of anyone who is
16 interested in information inside CMS, you say, if you do
17 that, it will bring in FISMA. Because we're told by our
18 Office of Information Services that it's an extremely
19 expensive, although necessary, set of rules around the
20 level of security you have to have around your systems to
21 actually be able to use individually identifiable
22 Medicare data. So, this applies both to us and anyone
23 with whom we contract.
24 So, if someone says, well, why don't you just
25 contract with us to do X, well, if that's a purpose we

1 would want a contract with you to do, we could give you
2 individually identifiable information for that purpose,
3 but you would have to meet this FISMA requirements. So,
4 that's another law that governs the use of our
5 information.
6 The next slide is the list of the statutorily
7 allowed authorized purposes. So, this is where the
8 Social Security Act comes in. We can use our data for
9 payment; we can use individually identifiable information
10 for research. So, we have a whole contractor called
11 RESDAC that handles our data for those purposes and we
12 have a privacy board that reviews any requests. We can
13 use it for demonstrations. The quality improvement
14 organizations actually have a separate section in the
15 statute that allows them to use the information.
16 We have just this year -- I'm particularly
17 proud of this because my office really made this happen
18 in part -- we figured out a way so that Medicaid programs
19 could use our data that they currently use for
20 coordination of benefits with Medicaid for a little bit
21 of a broader purpose. So, you can also look at care
22 coordination for duals populations, and we included in
23 some of that language quality improvement.
24 So, they can use the information on the duals
25 population, which is the population that's eligible for

1 both Medicare and Medicaid, for purposes beyond just
2 payment. We found that states were building these great
3 databases using their Medicaid data and trying to really
4 use it more broadly. So, this was something that we were
5 able to get done this year.
6 The other way it can be used is through patient
7 consent, which people don't like to do. It's hard, it's
8 cumbersome. But, in fact, that is probably the most
9 straightforward way of informing a beneficiary that, in
10 fact, you would like to use their identifiable
11 information.
12 This slide is really just to provide some Web
13 sites for people to go and look around if they want to.
14 And then that really concludes my presentation. I was
15 hoping that you would take from this presentation that
16 there is a wide variety of information on the Web site.
17 Some of it, for example, the hospital information, except
18 for some of the claims-based measures, is on all the
19 patients in a hospital.
20 So, I encourage any local initiatives to link
21 to that Web site because then you don't have to build
22 your own and hospitals don't have to report twice, and
23 those are measures that, in fact, have endorsed at the
24 national level. So, except for the claims based measure,
25 that's true there. Nursing homes, it's the same thing.

1 Health plans, of course, are specific to Medicare only.
2 So, we put a fair amount of information on our
3 Web site for beneficiaries that could be useful to
4 others. We are exploring different ways to try to have
5 our information used without having to actually give
6 claims databases away. And the other concept that I
7 think could bear some fruit if we got creative about it
8 are public use files. Those are files -- we just create
9 them for the purpose of the public using them. There may
10 be some ways we could strip some of the identifiers or do
11 some analyses ahead of time that would provide some
12 useful data.
13 MR. WROBLEWSKI: Thank you, Karen. I would
14 like to start off and maybe segue from Karen's last
15 point, in terms of -- the purpose of this part of the
16 discussion is really to look at those policies that would
17 overcome some of the barriers that we have talked about
18 and to get to the needs that we discussed earlier this
19 morning. I love the way Irene set it up in terms of the
20 six hurdles. We probably got up to 11 by the time we
21 ended up adding more.
22 **(Laughter.)**
23 MR. WROBLEWSKI: But, you know, what Karen was
24 just talking about in terms of CMS data -- and I know
25 Vince had mentioned it earlier, so I wanted to talk and

1 fit in with the data in terms of getting the data. We
2 can talk about policies regarding that. Then I have some
3 other questions about going through the hurdles that
4 Irene had set up initially. So, if you wanted to talk
5 about just in terms of how you want to use the CMS data,
6 and if it can't be done now, that's fine. You know,
7 that's point of making a list of what our asks would be.
8 DR. KERR: Yeah, I think, which is probably
9 obvious to you, there's great value just from the volume
10 of claims data. But to get the maximum utility out of
11 it, you would need to have an identifier. It doesn't
12 have to be personally identifiable to an individual, but
13 something that you can track claims to a unique
14 individual, and it would have to be identifiable for a
15 physician to be able to do the kind of performance
16 measurement.
17 The question would be, how do we get there?
18 And you listed some tantalizing possibilities. It isn't
19 clear that the release of data wouldn't be neutered
20 through most of those. But how do we get there? Does it
21 require a statutory change to allow you to do that? Is
22 there a safe haven, an expansion under the QIO that could
23 do that, or could Medicare receive commercial data and
24 produce the performance information that way? You've
25 chosen not to do it with the data you have at a physician

1 level, right?

2 MS. MILGATE: We haven't chosen not to, but --

3 **(Laughter.)**

4 MS. MILGATE: I have to say we have -- myself

5 and another colleague have really thought long and hard

6 and really tried to figure out how to do it. I mean, you

7 raise an interesting one that I will just expand upon.

8 Let me just give a couple of observations from trying to

9 actually put together a legislative proposal. Like what

10 would the proposal be, right?

11 You end up exempting physicians from the

12 Privacy Act for these purposes, which, you know, it is

13 possible to do, but I think you'd probably get some

14 pushback on that. But you can't really exempt anyone

15 from the HIPAA Act, right? That's kind of a pretty basic

16 protection for individually identifiable information.

17 And, so, there you either end up -- and I agree, you do

18 need individual identifiable information to link to get

19 that score. But I would suggest to you that our

20 beneficiaries don't have to link with your people because

21 they are not the same people.

22 DR. KERR: Right.

23 MS. MILGATE: So, the physician is the key. If

24 you really think -- this is the other thing that I would

25 just challenge some assumptions on this. I mean, I know

1 that some physicians see both Medicare beneficiaries and
2 under 65. But there are probably also plenty of
3 physicians that don’t overlap. And, so, I don’t even
4 know if you --
5 DR. KERR: No.
6 MS. MILGATE: No? So, all physicians see both?
7 DR. KERR: If they want to make a living.
8 Pediatricians don’t see a lot.
9 **(Laughter.)**
10 MS. MILGATE: My point in saying that -- and
11 perhaps that was a less well-informed statement -- but
12 when we’re looking at sample size in the Medicare
13 population, we have a heck of a time getting enough
14 sample size for adequate measurement just like you. I
15 know you find that surprising, but we do. And, in part,
16 it’s because there seem to be a fair number of physicians
17 -- and I don’t know, you can probably comment on this or
18 not -- that don’t see -- that see small numbers.
19 So, you will see a fairly significant number --
20 I mean, this is like one state numbers. This is not any
21 kind of statistically significant statement. But, you
22 know, we looked in a couple different states, getting
23 sample size on certain conditions, and we ended up, after
24 we excluded -- for example, we can’t do Medicare
25 Advantage. I mean, there’s a lot of exclusions you have

1 to get to actually get a good sample size. I don't know.
2 It was certainly under 50 percent of physicians had a
3 sufficient sample size, even if we used really loose
4 standards.
5 So, I don't know. I'm just not sure what it
6 gets us. I'm wondering if, in fact, we calculated some
7 scores, if you calculated some scores, and then we put
8 the scores together, we wouldn't really get to the same
9 end without having to have individually identifiable.
10 You would have to have the physicians linked, I suppose.
11 But what if you had a physician score for Medicare and a
12 physician score for private sector? Is that really the
13 worst thing?
14 DR. KERR: If you could marry up the
15 methodology so the scores would be --
16 MS. MILGATE: Right, right.
17 DR. KERR: Yes.
18 MS. MILGATE: I mean, some people in this room
19 probably know about the AHIP Foundation work. That's
20 what they're trying to do is get the health plans to
21 calculate their scores generally the same way we are, and
22 then they would have scores. But I find it interesting
23 because they're having a heck of a time trying to get
24 plans to give them the information. I think it's some of
25 the same reasons we've had a hard time because of the

1 protections on individually identifiable information.
2 MR. WROBLEWSKI: Barbara, you had a comment.
3 MS. RABSON: Sure. As a BQI pilot in a
4 chartered value exchange, I'll tell you how we see the
5 world, sort of this issue with Medicare and CMS. The BQI
6 pilots, there are six of them and they spent two years
7 and we each got over a million dollars to work on this
8 data aggregation with commercial payers and Medicare and
9 we learned a tremendous amount. I think our perception
10 was that CMS couldn't wait for this contract to end.
11 Part of it was because it was tied to the QIO eighth
12 scope of work.
13 So, I mean, there's a legitimacy -- I certainly
14 understand from CMS, it was like the eighth scope of work
15 ends, this project shuts down exactly Friday, this
16 Friday, and so it was like closure. All of us could have
17 used at least an unfunded time to actually really mine
18 the data to get the wealth of information out.
19 There were lots of delays in the project and
20 there's been a sense of frustration that there's so much
21 to learn, why turn off the lights now and is there any
22 way to sort of keep that going just to gather up the
23 information so that we can apply it towards the next
24 phase, because we know that with the chartered value
25 exchange and the GEM project and the AHIP project, under

1 the GEM project, and you've alluded to this, the data
2 that's being put on the Web site at the Tax ID level is
3 not an accurate way to group physicians and the BQI
4 projects have all proved, and it's just because they're
5 using administrative data which is available, which is
6 all you had to use.
7 MS. MILGATE: We have UPINs. We could have
8 used UPINs. It was a decision to actually use TPINs
9 because we find them much more stable in our data. You
10 would say a conclusion from the BQIs is UPINs are better
11 than TPINs?
12 MS. RABSON: No, I'm saying that you cannot
13 accurately group physicians using administrative data at
14 this time. Not reliably use it.
15 MS. MILGATE: Well, but you can't accurately
16 identify physicians using UPINs. I mean, sometimes they
17 use group UPINs, sometimes they -- I mean, we found it
18 the better of two evils.
19 MS. RABSON: Okay, I hear you. I mean, this is
20 not the place to argue about this. But I guess the point
21 is that there's some unfinished business and some
22 learning that could be used going forward and -- with the
23 GEM project, for example, MHQP cannot use that data for
24 anything because we don't know what physicians are in it
25 and we don't group physicians by Tax ID number.

1 We have an internal process where we reach out
2 to physicians and do all the groupings. So, we have
3 really reliable groups. So, there's not a meshing. So,
4 I guess the issue is, going forward, if we want to get to
5 a place where we're actually succeeding in what we're
6 trying to do with CMS and making this data available,
7 there is just more work that needs to be done, and we've
8 got a platform of research based on the BQI projects that
9 we could use. I think that's the plea, is to go back to
10 that.
11 MS. MILGATE: I mean, I can't disagree with
12 you. I was in a meeting recently where they were talking
13 about you guys having to destroy or give back the data.
14 I'm like, what does that mean, they have to take it out
15 of their databases? It was a sad moment, I have to say,
16 because we do recognize the research capacity and the
17 problem is it was in the eighth scope in the QIO program.
18 And for reasons that are beyond me, I don't know if it
19 was asked for or what the discussion was, it's not in the
20 ninth scope, and that scope does -- yeah, it ends on the
21 31st.
22 I think that maybe part of the feeling you have
23 gotten from it is I think everyone knew how like kind of
24 unique this was. I mean, you really came at a very
25 unique period of time and people really turned themselves

1 into pretzels to figure out how that data could be used.

2 MS. RABSON: I appreciate that, yeah.

3 MS. MILGATE: And that's why it was through the
4 QIO program as you probably know. I think there was some
5 fear that once it was out, people would want to continue
6 to use it. So, I'm sure that's some of the emotion you
7 heard from people, because we do recognize how useful it
8 is.

9 Having said that, I don't know -- I mean, it
10 could be turned into a research project, and I'm sure you
11 have been told that. So, that's the other way to do it,
12 is to do it through a research project. But I do
13 understand what you are saying.

14 MR. WROBLEWSKI: Peter.

15 MR. LEE: PBG is partners of one of the other
16 BQIs. So, we actually have three of the six along here
17 and so, we are also -- right now, most of my staff are at
18 home shredding right now.

19 **(Laughter.)**

20 MR. LEE: You know, little scissors, cutting up
21 all the status. But it's very compliant with FISMA. I
22 don't want to get into the --

23 MS. MILGATE: Well, let's not talk about FISMA
24 in this context then, huh?

25 **(Laughter.)**

1 MR. LEE: Just a couple of observations. One
2 is, I think, Karen's note is an incredibly important one.
3 For a lot of folks there are huge learnings that will be
4 public soon that these six pilots have submitted, and
5 they're different, because some of the sites really
6 focused on Wisconsin driving information out of medical
7 groups to populate, which is a different strategy, and
8 others, Massachusetts, focused more on group than PBGH,
9 and the California Cooperative Healthcare Reporting
10 Initiative trying to get more at the individual level, et
11 cetera.
12 But a few observations that I'd note is, first,
13 the Medicare data is incredibly important. One of the
14 things across the board is that the richness of that data
15 cannot be understated. If we compared it to the richness
16 of the data of a commercial enrollee, you know, one
17 Medicare enrollee is worth about seven or eight
18 commercial because they are older and sicker. So, they
19 have more hits. So, the value -- it's a terrible way to
20 say it. It's not really crass.
21 **(Laughter.)**
22 MR. LEE: But it really is the richness of
23 Medicare data, doing something and saying, let the
24 commercial do it without Medicare, really makes it
25 virtually impossible. So, that's one observation.

1 The second is -- I think, Karen, your point
2 about even with Medicare data, which is richer, can you
3 get to all doctors? Absolutely not. If you look at --
4 on page 432 of this report, you'll see the California
5 section, which has some charts that notes that for a
6 number of the I think 12 measures -- there might have
7 been 16 measures used, a number could only identify 50
8 percent of the Medicare physicians for particular scores,
9 but that represented, in some cases, 80 percent of the
10 Medicare enrollees for whom that score was relevant.
11 So, in some cases, it may not be talking about
12 all of the doctors, but it may be getting the 80/20 rule
13 of the majority of the doctors that are seeing patients
14 in a particular type. So, that's just an observation
15 about we want everyone, but we also want those for whom
16 patients are seeing most of them.
17 The last is -- and I think there's a lot of
18 good reasons to look at different work-arounds for the
19 information being shared. I think one of the things that
20 I think we need to look at -- now, this is not my BQI
21 hat. I'll take it off and throw it to the side. Being
22 very careful about where CMS serves as the moderator and
23 definer of here's the right way to present the
24 information as opposed to letting the market do that with
25 the pressures that come on that through things like the

1 patient charter. And I'll note as an example of that
2 concern is the hospital reports that come out of Hospital
3 Compare show -- and Nancy may be really glad her flag is
4 up now -- but it shows very, very small variation. It
5 shows that of 4,500 hospitals, for some of the scores,
6 there are 20 that are at average. If you would put the
7 same data in the market and say let's look at a 95
8 percent confidence interval, other ways to weight it, you
9 might see, God forbid, 300 hospitals that are at average.
10 And that's -- when you talk about -- we were
11 talking this morning about showing variation and
12 performance where there's real variation. Some of that
13 is scientific and some of it is actually a value
14 statement of how much uncertainty you're ready to have.
15 Does it need to be right 99 percent of the time or 95
16 percent of the time? Those issues then really mean
17 something different for consumers.
18 So, I think one of the challenges for letting
19 the Medicare data be merged with and used with is to have
20 the numerators and denominators be used that then would
21 still allow for some of that value application of where
22 do you draw the cut points. I think that's some of the
23 next discussion that we should be having as the data gets
24 out there.
25 MR. WROBLEWSKI: Thank you. We have been

1 talking all about combining payer data. One of the
2 interesting things about Wisconsin was that it was
3 provider reported. So, I wonder what people's
4 suggestions were in terms of engaging medical societies
5 to being the repository so that it would be provider
6 reported so that you wouldn't have this problem of --
7 regardless of who the payer is, what initiatives would be
8 a way to get around the whole issue of the combination,
9 which seems to be a tough nut to crack.
10 **(Laughter.)**
11 MR. WROBLEWSKI: I just wondered whether that
12 makes sense in some areas. So, Michael and Peter put
13 their tents up. And Nancy.
14 MS. Foster: No, please, physicians first.
15 **(Laughter.)**
16 DR. BARR: Wow, I don't get that treatment at
17 home, right?
18 **(Laughter.)**
19 DR. BARR: I would say from the perspective of
20 the physician, I think there is a strong interest in
21 looking at my practice data. I think that -- not from
22 different streams. I don't have that and I don't have
23 United. I have my practice data. The source of the data
24 is my practice. That's why I asked Janet earlier about
25 the health information technology and the resource. So

1 if you're able to suck the data right out of a practice
2 and reflect it back in a usable way, then all this sort
3 of aggregation is less important and it represents my
4 data.
5 Now, it needs to be standardized. You need to
6 evaluate it in the same way. I mean, all those caveats
7 agreed. But it takes away some of the mistrust factor
8 when it goes over to Vince's shop and then comes back to
9 me or to Aetna. I think there is -- but that
10 infrastructure doesn't exist. So, jumping ahead to the
11 asks later, I think investment in health information
12 technology to get us to the point where some of this
13 becomes more of a reality is a very key ask. I think
14 most of us would probably agree with that if not all of
15 us. But it has to be done in the right way, not just for
16 technology's sake. It's got to be able to deliver the
17 kinds of things that we've been talking about.
18 MR. WROBLEWSKI: Nancy?
19 MS. Foster: Sure, and I'll tie my response to
20 your question to a comment I was going to make about
21 something CMS has done well. That is, while I understand
22 the thought about having physician registry data,
23 essentially specialty-specific data, it depends on what
24 you're collecting and how you're collecting it, because
25 while I could understand that from, say, the private

1 physician office, as soon as you go to the hospital and
2 say, you have 125 different specialists and each one of
3 them has its own reporting system, now you have to report
4 to all of those and you have to report to the 125
5 organizations that are asking you, the hospital, for your
6 specific data. Sorry, it's not 125, it's actually about
7 50 in most states. You have just augmented the
8 measurement blizzard to a point where we will never dig
9 out.
10 It's just overwhelming and you have convinced
11 hospitals you really aren't serious about improvement,
12 you're only serious about data collection. Because they
13 don't have any capacity to do the improvement that would
14 go along with it, you've now sucked all of that resource
15 into the data collection. So, reasonable to think about
16 what use physician registries, reasonable also to say,
17 but you really have to do it with caution.
18 And the other point I want to make is as soon
19 as you start collecting data in a wide variety of places,
20 one might presume that there would be measures of care
21 that are similar, maybe even addressing similar patient
22 populations. When those measures change, as they
23 inevitably will, someone has to decide -- sorry, when the
24 science changes as it inevitably will, someone has to
25 decide what changes need to be made to the measures and

1 when.

2 CMS, on hospital measures, along with the Joint
3 Commission, have come together and created a single
4 measurement manual. Yes, I would like to think the fact
5 that we were screaming for that had some influence on
6 their decision to do that. But it really has been a
7 marvelous thing. They have stayed together. The
8 measurement descriptions are identical. Data collected
9 for one organization goes to the other, no problem. That
10 has been an enormous stride forward, as small as that
11 might sound to some people. But that has been an
12 enormous stride forward. I don't know how you stay on
13 that same pathway if you have data being collected on
14 basically the same kinds of patients in a wider variety
15 of locations.

16 And, then, I want to just raise an issue we can
17 come back to, which Karen alluded to the data display and
18 Peter talked about what role CMS in some of this -- I
19 think it may be time to ask the question, you know, what
20 does CMS or other parts of the Federal Government do best
21 and how can it more successfully partner with other parts
22 of the health care delivery system to take advantage of
23 what they do best?

24 MR. WROBLEWSKI: What would your suggestions be
25 in terms of what they do best?

1 MS. Foster: I would say that the
2 aggregation -- I'll speak only for hospital data. The
3 aggregation of hospital data that is done there, all
4 payer data whenever possible, has been an extraordinary
5 step forward.
6 What they don't do best, as much as I know they
7 have tried and invested hard in doing it right, is a data
8 display on hospital data. Hospital Compare is
9 overwhelming and my guess is that 1.2 million people was
10 actually me going there most of the time.
11 **(Laughter.)**.
12 MS. Foster: But we take the data and rejigger
13 it and display it and send it back to the hospitals to
14 share with their boards. A number of state organizations
15 rejigger it and make it useful to their state population
16 because we can take that overwhelming amount of data and
17 cull it down to exactly what you want to display. That
18 may be just a wholesale versus retail kind of model that
19 works extraordinarily well in other locations as well.
20 MS. MILGATE: I would say that's probably what
21 it does -- I mean, that means that the information is
22 there, and I don't know how complicated it is to take it
23 and use it, although at MEDPAC we didn't reanalyze the
24 heck out of it.
25 So, the question would be would you prefer that

1 we did that and, so, therefore, it might be more useful
2 for a consumer, but would not have all the details behind
3 it? Is it the display or is it the amount of
4 information, there's so much information you're not quite
5 sure how to use it? Because I guess the goal would be to
6 have both, right? The goal would be to have a high-level
7 summary that would be useful to someone, but I guess one
8 of the problems is that there's so much customization
9 that's necessary for each beneficiary, I'm not sure what
10 the --
11 MS. Foster: My personal suggestion would be
12 that there continue to be the ability to download the
13 data, the entire file, and use it as you see fit for your
14 patient -- for your populations, whomever you're trying
15 to reach, which there are a couple of tweaks that could
16 improve that capacity. But that's basically done fairly
17 well.
18 I don't see a way, given the constraints that
19 there are on federal Web sites, the formatting and so
20 forth of federal Web sites, I'm not sure there is a way
21 for CMS to actually display that amount of information in
22 a useful format. But others -- Consumer Reports,
23 specific business -- I'm embarrassed by the way we
24 display it when I look at how others are able to display
25 it.

1 DR. KERR: Have you seen the USA Today
2 compilation of Hospital Compare?
3 MS. Foster: Yes.
4 DR. KERR: On the interactive side, it is
5 actually quite consumer-friendly.
6 MS. Foster: They only do three of the
7 measures.
8 DR. KERR: But they only do three, right.
9 MR. WROBLEWSKI: Dr. Hoven?
10 DR. HOVEN: Yeah, I'm not a data-wonk, so
11 please accept my language here as being confusing.
12 Michael, when you said medical societies I thought you
13 had lost your mind.
14 **(Laughter.)**
15 MR. WROBLEWSKI: Specialty societies. ABMS is
16 what I'm thinking of.
17 DR. HOVEN: Okay.
18 MR. WROBLEWSKI: I'm sorry if I mis-spoke. I
19 was thinking ABMS.
20 DR. HOVEN: Having heard you say that, I'm
21 sitting here thinking. And, you know, most health care
22 is local. In fact, my data in my clinic, my state
23 collaborative, my state, in fact, is a venue that we
24 don't often talk about as being a vehicle for doing some
25 of this aggregation of information. To do data

1 collection comparative work looking at this stuff may not
2 be such a wild idea after all. Maybe there is some
3 plausibility instead of all of this being done at the
4 federal level, that more of this is taking place in
5 Wisconsin, in Massachusetts where these partnerships are
6 already taking place, and perhaps that's what we need to
7 be talking about.
8 DR. CHUMBLEY: I might just say that in the
9 collaborative, as I said when we began the day, we have
10 about 50 percent of the physicians and we have partnered
11 with the medical society, the state medical society, as a
12 vehicle to approach the other 50 percent. We're not
13 there yet, but we felt that they actually might do it.
14 So, when you said that, I said we've already had that
15 idea.
16 MR. WROBLEWSKI: What I would like to do, if
17 possible, Irene had listed six barriers and we've talked
18 about that a little bit in terms of a solution, in terms
19 of combining -- on the data barrier. But we had five
20 other ones, and I know we don't have -- time isn't
21 unlimited. So, I would like to go through some of the
22 other ones to see what the role of public policy is. I
23 will start first with awareness. That was the first one
24 Irene talked about in terms of the awareness of
25 variation.

1 So, I have one specific question for Karen
2 because this may be -- well, I'll open this up to the
3 group and then I have a specific data question if you
4 have an answer. What should be the public role to
5 educate consumers and the providers about the variation
6 and the differences in quality?
7 And to that end, I wondered how successful --
8 and I don't even know if you can make this public, in
9 terms of the ad campaign that CMS had run on Hospital
10 Compare, where they took out a number of large-scale ads
11 saying in your hospital -- in New York City, these three
12 -- you know, had the hospitals listed and had a couple of
13 their criteria. And I didn't know, was that in the 1.2
14 month or was that -- didn't know if that made a
15 difference.
16 MS. MILGATE: It did make a difference. It
17 wasn't in the 1.2 million month. But there was a
18 significant spike in the use of Hospital Compares after
19 those ads were out. As you may have read, there was also
20 -- well, I'm sure you probably don't capture newspaper
21 articles from across the country on Hospital Compare, but
22 there continued to be actually quite a bit of interest in
23 news reports across the country.
24 I think that -- I can't remember if that was
25 added when we added the mortality measures or -- do you

1 remember, Nancy?

2 MR. WROBLEWSKI: It was the patient experience

3 measures.

4 MS. MILGATE: Yeah, when we added the HCAHPS.

5 The other thing that, as some know, has captured all

6 kinds of interest is the policy on hospital acquired

7 infections -- conditions, sorry, excuse me. It’s more

8 than infection, it includes infection.

9 So, I don’t know if that’s another -- you know,

10 I wasn’t saying -- throwing that out to think, well, that

11 may have -- you know, it generated an interest in

12 variation, but I think it certainly generated an interest

13 in that concept and that there are such things that occur

14 in hospitals.

15 But that was a payment policy. That wasn’t --

16 and we didn’t say there was different -- we just said

17 some hospitals are better than others on that.

18 MR. WROBLEWSKI: Paul?

19 MR. GINSBURG: I wanted to make a comment about

20 this discussion. We usually talk about data being for

21 consumers. But, you know, I think these days, the people

22 really making use of the data are providers. I think

23 it’s very important that the data ought to be accessible

24 to providers in forms that they can use because they are

25 primed to respond to it. Whether it’s thinking down the

1 road that consumers might use it some day or just
2 strictly professionalism. That should probably be our
3 top priority now.
4 When I think about the consumers, I think the
5 government is not well-positioned to do the final -- the
6 actual consumer-friendly data. It is probably best to
7 plan on Consumers Union for-profit vendors often hired by
8 insurers to use the raw data that they get from Medicare
9 and other sources and let them compete on making it
10 usable and valuable to consumers. But let's not lose
11 sight of the fact that for the next few years, at least,
12 the biggest value for society is going to be to get
13 valuable data into providers' hands because they're
14 primed right now to respond to it.
15 MR. WROBLEWSKI: And how do we go about doing
16 that?
17 MR. GINSBURG: Well, when Nancy was talking
18 about what the American Hospital Association does with
19 Medicare Compare to transform it into a way that they
20 believe is useful to individual hospitals. So, I think
21 the key thing for the government is to make the raw data,
22 to the degree they can, available to others who will
23 massage it for different markets, different audiences.
24 Rather than trying to plan at a very high level, you
25 know, make compromising so that this data is useful both

1 to consumers and to providers of different types.

2 MR. WROBLEWSKI: Richard?

3 MR. SORIAN: It's interesting. I think Vince

4 mentioned the USA Today. There is a reason that their

5 information was more interesting and more useful. That's

6 what they do for a living is communicate to consumers and

7 they understand, just one example. But if you think back

8 to when they started, the little silly graphs and stuff,

9 now everybody's doing that because they do research and

10 they actually look into it.

11 I worry about -- it's the massaging that I

12 worry about. I don't mean to cast any aspersions. But

13 if the party that's being measured is massaging the data

14 to then communicate it to others, there's always a chance

15 that it gets massaged in a way that kind of changes the

16 message.

17 I think the media can serve in a very powerful

18 way. We've worked with U.S. News and World Report. Now,

19 for years, we've done report cards and we always stopped

20 short of ranking health plans because they would scream

21 at us. U.S. News and World Report said, we're going to

22 rank them and we need your data, and we worked out a

23 formula with them. So, they ranked them and it will be

24 out in a couple weeks for this year. But the use of that

25 has been sky high, much higher than anyone ever came to

1 the NCQA report card because it didn't make them do all
2 the work of this, well, this star plus these stars, plus
3 this and that.
4 So, it becomes more simplistic which makes a
5 lot of us nervous. But the simpler the message, the
6 easier it is to use, the more graphic it is, people are
7 much more likely to use it.
8 The problem is with hospitals -- and we talked
9 earlier, again, I think it was in Irene's presentation --
10 there are a whole lot of hospitals that are basically
11 captive of -- that have the market captured. So, you get
12 information about your hospital kind of not being the
13 best hospital in the world, but you can't go anywhere.
14 So, there has to be other uses of the data where the
15 payers start saying we're going to do something, but they
16 don't have as much power when the hospital has the whole
17 market.
18 Using the data to actually affect change is
19 often the missing piece. We collect a lot of data that
20 we don't do a lot with. In the private sector, employers
21 are much better at that. But Medicare -- and I love
22 Medicare --
23 **(Laughter.)**
24 MS. MILGATE: You will later.
25 **(Laughter.)**

1 MR. SORIAN: I'm getting closer every day.
2 They collect all the data. Every Medicare health plan --
3 almost all of them and it will be all of them in 2010 are
4 required to report a very significant amount of
5 information. But other than putting it up on the Web in
6 a form that doesn't get people upset, so it doesn't
7 inform, that's it.
8 Just one example, the State of Michigan's
9 Medicaid program -- I know it's not Medicare, but
10 Medicaid program in Michigan, they standardize all their
11 payments to the plans using an actuarial formula so that
12 there's no bidding and arguing about that. They decide
13 what plans get into the program based on their quality
14 scores. And there's a cut-off. Last year, they cut two
15 plans of the program including one that had been in the
16 Medicaid program in Michigan since almost the inception
17 of the program, but their quality had fallen below the
18 threshold. That's a very clear message that quality
19 actually matters.
20 MR. WROBLEWSKI: Thank you. Irene, you wanted
21 to add something?
22 MS. FRASER: Yes, I wanted to add something to
23 this last discussion that also harkens back to the
24 discussion about the data.
25 Two things. One is this issue of reporting at

1 the local level and getting data to the point where it's
2 useful to particular audiences. One of the things that
3 we've been working on, and it's showing really great
4 promise, is a portal through which we are going to be
5 able to take all of the software that we use to do
6 analyses of hospital data at the national level, applying
7 them to the quality indicators and other things that we
8 do on our Web site. All we can report on our Web site is
9 national data or at the state level, but we don't do any
10 reporting at the hospital level even though we have that
11 data. But that's part of our agreement with hospitals.
12 But localities, who may also have that same
13 data and want to do reporting at a local level with their
14 own data, would be able to use our software through this
15 portal that they could import and do all of the different
16 kinds of analyses that we do. So, for example, if we do
17 stat briefs on certain things at the national level with
18 breakouts by states, they can use all of the same
19 methodology and software to do that at the local level
20 and, similarly, for reporting or tracking potentially
21 preventable admissions, et cetera. So, I'm thinking that
22 might be a model for other things as well.
23 We're starting out just with our hospital data,
24 but we are, this year, expanding it and thinking that we
25 can add other kinds of data elements in. It came out as

1 part of our discussions with the chartered value
2 exchanges and providing technical assistance to them.
3 But, also, provide our local state hospital association
4 and data organizations that use the same data. So that
5 might be kind of a vehicle for that.
6 I wanted to make one comment on this question
7 of using providers as the collection points versus payers
8 as the collection points for data. That's the way it's
9 done with hospitals, but, obviously, hospitals are an
10 easier unit than individual physician practices, many of
11 which don't have the capacity. But I think in some ways,
12 the technical problems of doing it, physician group by
13 physician group, are easier or more surmountable than the
14 problems of doing it payer by a payer. I think there are
15 some strong reasons to do it, one of which is that if you
16 go payer by payer, for one thing, you don't get the
17 uninsured, which is a growing number. So, that is one
18 reason. Plus people move in and out of insurance status,
19 et cetera.
20 So, I think if we could -- I mean, there are
21 technical and financial problems with going physician by
22 physician group. But it would really be nice if we could
23 think about ways to do that. And maybe what we do is
24 just -- what it's going to require is having some kind of
25 standardization within electronic health records so that

1 as soon as something changes it can click and make it
2 easier. I mean, it's not easy, but I'm just saying I
3 think the problems are more surmountable than the
4 problems of going payer by a payer.
5 DR. KERR: I don't know who had it up first.
6 But this relates to your comments. So, you've kept mine
7 from being out of sequence.
8 **(Laughter.)**
9 DR. KERR: And that's just one caveat with
10 rolling up data at the physician level. To the extent
11 you want to view an episode of care, you will have
12 difficulty doing that. That's the view that may not be
13 supplied by --
14 MR. WROBLEWSKI: Michael?
15 DR. BARR: Can I just react to that because I
16 wanted to comment on Nancy and then you changed topics.
17 I want to amend my comment actually to say that it's
18 important to look to the patient sector and talk about
19 what information is about the patient, wherever the
20 patient goes, but reflected -- you know, I mean, you need
21 the whole practice data there. It's very distracting
22 when the physicians get information from all the
23 different places. But I think one of the most important
24 ones would be from the hospital, because if we get to any
25 sort of shared savings models or work together on the

1 transitions of care, we really need to be looking at each
2 other's data and contributing to the same pool in the
3 same way.
4 So, that was the only comment I was going to
5 make earlier.
6 MR. WROBLEWSKI: Thank you. Dr. Hoven -- oh,
7 and Elysa. Go ahead. I'll come back to you.
8 MS. FERRARA: I think that what I've heard
9 today is, you know, we've heard talk about elements of
10 what we're talking about as a public good. And you asked
11 us about CMS and CMS's role. So, what parts of this are
12 a public good?
13 We know that creating standardized measures,
14 defining those measures, putting standards around how the
15 data can and should be used and shared are all public
16 good. The investment in evidence-based medicine in
17 determining new measures that drive from the pathway
18 we've already heard discussed. Those are public goods.
19 Maybe even the methodologies for attribution are
20 something that should be standardized. I'm not sure that
21 they should, but maybe.
22 But then you get to a point where you sort of
23 come full circle to what's the purpose of this
24 discussion. It's about competition. And I think what
25 we're hearing is that the marketplace has found much more

1 creative ways to use that data where it gets to the place
2 where we want it to go because we're really not creating
3 measures and data for measures and data's sake. It's for
4 two audiences, providers so they have actionable
5 information because they want to make a change and the
6 consumers because we want to engage them with more than
7 just plan design to make a difference in the way they
8 behave.
9 So, I think what we're saying is we want the
10 UPINs, we want the TINs. We build something, I hate to
11 admit it, called a POIN and a POIN is an IPA. You know,
12 so they're not really TINs, they're 50 TINs. Right?
13 Because if you have an IPA in Rochester, you have 2,200
14 physicians under 175 TINs working together. So, I had to
15 have a way to aggregate and generate data down at that
16 IPA level. So, we invented something, and that's what we
17 use. But, you know, you have Consumer Reports, you have
18 U.S. News and World Report.
19 Whether we love it or we don't love it, we are
20 saying that if the public good could invest in the
21 standardization, if groups like NCQA can give us PHQ
22 standards that say if you're going to publish data or if
23 CMS is going to release this data file to you, these are
24 the standards you have to meet for how you use it. I
25 can't just put NCQA's seal of approval on Aetna any way I

1 want. I've got really strict standards for how I can
2 represent that. The same thing with CMS. They can
3 create the standards for how it's used and then let it
4 out in the marketplace and let us use it.
5 MR. WROBLEWSKI: Dr. Hoven?
6 DR. HOVEN: Thank you. I want to go back to
7 measurements and reporting methodologies once more. The
8 point I want to reiterate is that they have got to be
9 linked to actionable strategies. It's got to be real-
10 time and it's got to be a point of care. We can collect
11 data until hell freezes over, but unless we move this bus
12 down the road, we're not going to get to where we need to
13 be in doing what we've all been talking about today.
14 MR. WROBLEWSKI: How do we do that?
15 DR. HOVEN: I was afraid you were going to ask
16 me that.
17 **(Laughter.)**
18 DR. HOVEN: Well, let me back up. PCPI, for
19 example, is now beginning to look at composite measures
20 and continuum of care measures. And one of the issues
21 that was made a few minutes ago was that you can't do
22 that kind of thing because it's too -- probably too
23 diffuse.
24 But, in reality, I think we can do that. I
25 think we've got to make the motions, we've got to get

1 started trying to get this sort of thing done. I think
2 we're going to have to talk about this going forward. I
3 don't have the answers right now, but, clearly, it is an
4 impediment to what, I think, is happening out there right
5 now.
6 You have to have the data, as Dr. Ginsberg
7 said. Doctors are going to respond to information. We
8 love numbers. We like to see how we compare. All we
9 want is that data to be methodologically sound,
10 transparent and usable. Right now, we are having to get
11 stuff out of a lot of different pots and isn't working.
12 So, I think going forward, that's something from a policy
13 standpoint that we need to prioritize and make --
14 MR. WROBLEWSKI: When you say you're getting
15 information from different pots, you're thinking of is
16 there a -- I mean, we've been talking about ways to
17 combine the public data with private data. Are you
18 saying that we need also to think of ways to combine
19 private data -- so, you have a larger -- so you're not
20 pulling from multiple pots and so there are more -- you
21 know, you're pulling the Aetna and the United data
22 together from a methodological point of view and a data
23 point of view? Is that you're talking about?
24 DR. HOVEN: Yeah. I mean, I'm talking about
25 everything's got to be standardized. When I look at my

1 report from Aetna or my report from United, it's giving
2 me -- it's all apples. It's not apples, oranges; it's
3 peanuts, pretzels, you know, and the cut-offs are
4 different and it's uninterpretable because I'm going to
5 ditch it. That's the kind of message that I think we
6 need to listen to out there.
7 DR. WROBLEWSKI: Okay.
8 DR. NASH: Are you saying you're not getting
9 the apples to apples right now?
10 DR. HOVEN: Right.
11 MR. WROBLEWSKI: Right. Elysa, you wanted to
12 add something to that?
13 MS. FERRARA: Yes. And, actually, it's a semi-
14 related topic. I think that we are all interested in
15 multi-payer collaborators and the idea that the power of
16 the N is very important.
17 I will say that with the CVE development, when
18 I went to the first CVE, that we're a member of, and they
19 had the roll-outs in the markets and this great media
20 event and I saw the maps for the plans of CVEs, which
21 you've all seen, it was very frightening to me because
22 there are CVEs that have really done a great job and
23 there are others who spend a lot of time inventing new
24 measures and asking health plans to invest in providing
25 multi-payer data, measured a different way for each

1 county. They are not statewide collaborative. And we
2 have states with 50 CVEs they want us to engage in.
3 There are two concerns I have. One, we can't
4 afford the investment. The blizzard of measures -- the
5 blizzard of not only measures, but methods of measures
6 and methods of aggregations and different vendors that
7 they're hiring who have different approaches. In one
8 state alone, we had about 10 different hired vendors by a
9 CVE and a lot of public money to invent new ways to
10 aggregate data and new methods for attribution.
11 So, I think we've got to be really cautious
12 that we have to find the blend of local, but responsible
13 local, so that we're not investing so much in
14 measurements. Someone made the point, there's nothing
15 left to affect change with. So, I think that's been one
16 of our big concerns about the CVE movement and the need
17 to really be prudent about what we're doing in this area.
18 MR. WROBLEWSKI: You know, the one thing that
19 we haven't talked about in terms of -- really all this
20 discussion has been about provider information and we
21 haven't talked about, in terms of the solutions,
22 comparative effectiveness. Jack, I'll turn to you and to
23 Beth and Kristin if you'd like to follow up on that.
24 MR. FOWLER: Do you want to talk about
25 comparative effectiveness?

1 MR. WROBLEWSKI: In terms of what would be the
2 -- I mean, we heard there was a lack of evidence in
3 Janet's flowchart of what is it that's the public good,
4 so to speak, that creates the foundation on which
5 competition could then occur?
6 MR. FOWLER: Certainly, the plea that we need
7 to give somebody a whole bunch more money to do more
8 studies because the percentage of medical care that
9 doesn't have a good evidence base is way too high. I
10 don't think there's any doubt about that. But there are
11 some things where we do have quite a bit of evidence and
12 the problem there is packaging it.
13 Just like the inattention to the fact that
14 there's not a lot of public awareness and running to a
15 Web site where you just put things there for when they
16 want to choose a hospital or when they want to pick a
17 doctor. Most people don't spend their time thinking
18 about how to manage their health and you kind of deal
19 with health problems when an event happens or you've got
20 a problem. But I can't afford to have a liver plan at
21 the moment, I mean, for what I'm going to do about my --
22 I mean, I can't have one for all of these different
23 things that could happen to me.
24 So, you have to kind of wait until something
25 happens. Then you may not know -- have at your

1 fingertips where all the resources are and where things
2 are. So, you've got to build it into the system.
3 I agree with Richard that the provider
4 shouldn't be organizing the data. That's the wrong way
5 to have it. But having the providers or somebody who is
6 involved in the care system be the trigger to say, here's
7 where you can get the information and here it's organized
8 in a reliable, credible way makes more sense because the
9 positions, and maybe the health plans, are the people who
10 think about this stuff all the time. They have a liver
11 plan and a foot plan and a knee plant and a heart plan
12 because they think about those problems. Patients are
13 not going to be ready to do that.
14 So, I think having people that they're likely
15 to come in contact with and know at the time that they're
16 about to have to cope with this thing is really an
17 important part to getting information to patients. I
18 don't think you can rely on them.
19 We studied 10 decisions that people made, three
20 meds and three cancer screening tests and four surgeries.
21 The Internet was a tiny part of the decision-making
22 process for people. It was 20 to 30 percent max who said
23 they checked the Internet at all about these decisions,
24 because they happen fast. If somebody says, you know,
25 you want to take a med, you know, I think you should take

1 a med, they took a med. So, there's not a window,
2 there's not a period. You don't even know sometimes that
3 there's a decision to be made which people were talking
4 about.
5 So, I think somehow building it into the system
6 so that the people who are contacted have the triggers
7 and then give you reliable information has got to be the
8 case. Just sticking it up on a Web site and assuming
9 somebody will Google it and get to the right place will
10 not work.
11 MR. WROBLEWSKI: Thank you. Beth?
12 DR. NASH: Just one quick comment. There's
13 been a lot of discussion about how we need more research
14 and, of course, we do. But even if we were to start
15 today, it will be decades before we have all the answers
16 that we need.
17 So, on the data front, first of all, I think if
18 we had more physician level data, we'd also have more
19 answers. So, it wouldn't be randomized, controlled
20 trials. But, you know, you have to use what you've got
21 and you have to understand that it's registry data or
22 observational data and use it appropriately, but it's
23 better than no data.
24 And then the second thing is that, you know,
25 maybe we do need to think about other ways of collecting

1 important data. So, I do think that systematic
2 collection of patient data is also really interesting.
3 It's something that Al Mulley has worked on. It is an
4 interesting concept and one we should think about, again,
5 in the absence of the best quality data that we're all
6 looking for.
7 MS. MADISON: I really just want to reiterate
8 what Jack Fowler said and to say that I think it's
9 important and we've talked before about what consumers
10 know about what data is out there to take advantage of
11 the resources we do have, which includes both physicians
12 and health plans in publicizing the existence of reliable
13 data sources to help sort through some of the stuff that
14 is on the Internet.
15 I also think that surveys have shown that it
16 depends on what population you're talking to how willing
17 and ready they are to do things like search the Internet.
18 Certainly, my students, that is the first thing they do.
19 That is absolutely the first thing they do is go online
20 and that's partly because they're young, it's partly
21 because they're well-educated. That differentiates them
22 from a lot of other patient populations. But as we all
23 get older, I think the number of people who are willing
24 to do that will be increasing.
25 And, also, to reiterate something that was said

1 before about the importance of doing research on making
2 these sites much more usable, I think the Wisconsin site,
3 for example, is actually quite good in terms of
4 usability. So is the Massachusetts one. There are a lot
5 of other sites that aren't so good. The other thing that
6 I've had trouble with is actually finding these Web
7 sites. I've looked, at this point, probably at 100
8 different Web sites. I know they're out there, and
9 despite knowing that they're there, I have a hard time
10 finding them.
11 So, Pennsylvania, I have spent 10 minutes on
12 Google trying to find that wonderful Pennsylvania Web
13 site that gives all of these good quality measures. I
14 end up having to put Pennsylvania Health Care Cost
15 Containment Council or PHCCCC to actually pull it up,
16 which is absurd, right? You need to put in best
17 hospitals Philadelphia and be able to pull that up.
18 So, I think there are still a lot of unanswered
19 questions about design in order to make these things
20 useful for consumers.
21 MR. WROBLEWSKI: Thanks. Nancy, I'm going to
22 call on you, but I also have one quick question because
23 it's a point that you had brought up earlier. You had
24 said that in terms of quality of care we need to break
25 down the silos. Maybe I'm stealing your thunder, but how

1 do we do that?

2 MS. Foster: Thanks, Michael. I do believe

3 that. I think when I made the remark I meant in terms of

4 looking at data across the continuum, as a number of us

5 have spoken about. That really requires, I think, that

6 we have a common vision of what an episode of care -- how

7 we're going to choose to define it because that really is

8 sort of a policy decision, that there are not clear

9 boundaries on a lot of episodes. Choose it, define what

10 we're going to think of as the critical pieces to

11 measure, measure those, and share the information among

12 all of the interested parties. That would be my ideal

13 vision. That's not an easy thing to do and there are

14 lots of boundaries we've just talked about.

15 But related to that is the point I wanted to

16 make, and I'll come to that in just a moment, I promise.

17 But, Richard, I wanted to assure you when I talked about

18 the AHA sharing data, I neither think we should be the

19 organization that shares it publicly nor should be the

20 organization that, in and of itself, decides what

21 measures should be included because we would have some of

22 the very same challenges you alluded to with the health

23 plans and your data collection, which is things that we

24 might ought to be pushed to measure might fall off the

25 agenda. If we were trying to dictate this for our own

1 membership, it poses some internal challenges.
2 So, my belief is that we have another barrier
3 we have not yet talked about, and that barrier I would
4 call branding. That, in fact, a lot of organizations
5 have invested a lot of resources and dollars and so forth
6 in creating their own data display, their own data
7 collection, their own -- and we heard some of that from
8 our health plan friends. That's, in part, what they
9 share as the value to the employer groups they're trying
10 to market to. I know we have done the same thing and
11 others have done the same thing.
12 We're never going to get there. We have proven
13 that already, I think, that we're not going to get to
14 where we need to be if we continue to develop all these
15 little individual silos of data. We need to come
16 together as common stakeholders in a common purpose.
17 That will be tough for a number of us who want to say,
18 gee, it's the AHA's data collection or AHA is leading the
19 way, but we're going to have to get over that because we
20 won't get there. Quite frankly, it's also been a
21 challenge for us with some of our federal partners who
22 clearly have a reason, just like the rest of us, for
23 touting the CMS data.
24 My challenge with that around the hospital data
25 is it has made people think it is Medicare-only data when

1 it's not. I think we kind of step all over our own
2 messages when we don't do it right. So, my policy lever
3 there is that there's got to be federal legislation that
4 furthers the opportunity for the federal agencies to work
5 collaboratively as a multi-stakeholder group in achieving
6 this common goal.
7 MR. WROBLEWSKI: Thank you. We're kind of out
8 of time, but I did want to do one thing and I know this
9 is a rather -- I want to give everyone a last chance to
10 say something. What I would love it to be is kind of
11 a -- what's a real quick fix? If you have one thing that
12 you'd like to see done in the short term, what would it
13 be? One quick -- it could be a small thing. And then a
14 longer thing, a longer-term item in terms of a policy
15 recommendation to address some of the issues that we've
16 done today. I will start with anybody who wants to
17 start.
18 **(Laughter.)**
19 MR. WROBLEWSKI: Dr. Hoven, go ahead.
20 DR. HOVEN: Build the HIT infrastructure.
21 DR. BARR: That's your short or your long-term?
22 DR. HOVEN: That's my short-term.
23 DR. BARR: Well, if that's the guide, then we
24 can actually go further than that. I was going to say a
25 short-term, I think because it's relative to what Ardis

1 has suggested and it's less expensive, is the whole
2 education. I was with a group of physicians who had not
3 heard about Wennberg's data or the variability and the
4 difference between their practices, and I don't know that
5 that's terribly uncommon. So, I think -- in the short
6 term, I think we can all do a lot to educate people
7 through different venues.
8 Long-term, support primary care. I think the
9 evidence is in that if we have a good, robust, well-
10 supported primary care system with the aligned incentives
11 so there's shared information, shared incentives around
12 there with the right reimbursement system, we'll start to
13 generate the kind of patient-centered care that we're all
14 looking for. And the other would be the HIT
15 infrastructure. I think that's a -- it's not sufficient,
16 but it's necessary to get us to where we need to be.
17 MR. WROBLEWSKI: Okay. Nancy?
18 MS. Foster: Short-term, I would suggest that
19 we take the tool that has just been adopted by the
20 National Quality Forum for data collection on disparities
21 and push it out to begin to look at that. We haven't
22 really talked about disparities except for one mention
23 this morning. But we need to get a handle on where we
24 stand with care for people of different races and ethnic
25 backgrounds in this country. We won't be happy with the

1 picture it paints. That's clear.
2 Long-term, I am for building this multi-
3 dimensional stakeholder organization to really push
4 quality.
5 MR. WROBLEWSKI: Okay. Richard?
6 MR. SORIAN: Short-term, establish what I would
7 think is a two-year period of increasingly tightening the
8 current warped payment system so that in two to three
9 years, at the most, everybody is clamoring for real
10 payment reform that will actually start doing some of the
11 things we discussed today. It's the model that worked in
12 DRGs in '81, '82, and I think it's time for it to happen
13 again.
14 MR. WROBLEWSKI: Long-term?
15 MR. SORIAN: The long-term is permanent --
16 semi-permanent. Nothing's permanent. But is the
17 comprehensive payment reform that actually reflects all
18 of the values stuff that we talked about probably earlier
19 today as well.
20 MR. WROBLEWSKI: Sure. Jack?
21 MR. FOWLER: I think I've got three, but I
22 don't know whether they're long, short or medium. But as
23 we talked about -- with different areas we have evidence
24 -- I mean, we have information about hospitals, we have
25 information about individual providers or teams and we

1 have information about comparative effectiveness and the
2 pros and cons of options and things like that.
3 I think we really need three different things.
4 I think, one, the problem of the variety of not so
5 credible sources of information seems like a big problem
6 to me. I think maybe the federal government or Medicare
7 or somebody has to take that on as a certifying. I don't
8 think they should make all the data, but I think maybe
9 they should be in the business of saying this is a
10 credible source of data and it meets some set of
11 standards. It would be efficient to have one group do
12 this rather than having ten, which we already have and it
13 doesn't work.
14 Second, I think that, incrementally, Medicare
15 first and I think then others would have to follow along
16 and should start thinking about requiring that patients
17 be given this information or be exposed or have someone
18 say that you should get this information before certain
19 choices are made, whether it's choosing a hospital to
20 intervene in your heart or -- I'm not sure, we'd have to
21 make a list and the list could grow over time as the data
22 became available and as we identified the choices.
23 MR. WROBLEWSKI: And this data would be the
24 quality data?
25 MR. FOWLER: You'd have to have certified

1 quality data before you say somebody ought to see it, and
2 then you say somebody ought to see this data when they
3 are faced at certain points in the clinical pathways and
4 it should be required to pay for someone to make sure
5 that they see the data and maybe talk to them about it
6 before a choice is made. I think you need something like
7 that to structure informing people about all these
8 decisions. Each one has its own special features. But
9 that's what I'd like to see.
10 MR. WROBLEWSKI: Okay. Paul?
11 MR. GINSBURG: Well, I really like many of the
12 ideas that I've heard, so I won't repeat them. But I was
13 just thinking about the FTC with your mission about
14 promoting competition.
15 It seems that one of the summary things from
16 this discussion is that if the FTC really wants to help
17 consumers through competitive mechanisms, it has to
18 recognize that a lot of this competition will take place
19 far away from consumers. It's going to be
20 cardiovascular surgeons competing for better results on
21 bypass graft surgery and hospitals competing and insurers
22 competing. And, in many ways, the consumer, of course,
23 is going to be the ultimate beneficiary of this, but may
24 not really be involved in a lot of the competition
25 But, yet, I think that the FTC or government in

1 general can do a lot by fostering competition it
2 considers to be productive even if it doesn't really
3 involve consumers. It should focus the tools and the
4 steps on the people who could really use the data. To
5 me, consumers are very far down on that list.
6 MR. WROBLEWSKI: Thank you. To finish off this
7 side.
8 MS. FERRARA: Short-term, going in a different
9 direction we haven't talked about, I think a very short-
10 term thing we could do is CPT-2 coding. There's 132
11 codes out there ready to be introduced for measurement
12 purposes. We just need to have it reported. It's
13 reported for some sectors, it's not reported for all.
14 Adverse event reporting, it's something that's
15 captured a lot of interest. We've all talked about it
16 tangentially. There are payers, there are employers who
17 think there's a lot of money to be had out there. There
18 is a lot of hospitals who think there's not a lot of
19 money, you know. We have to put some reality around it,
20 you know, some real reality testing around it.
21 And then, of course, I have to agree, the work
22 on disparities reporting is so pivotal. We've invested a
23 lot of effort into it.
24 And, then, long-term, again, I hate to be
25 redundant, but public-private partnership. What's so

1 interesting about health care is we have to have
2 competition and cooperation at the same time. The
3 organizations that sit around this table for the most
4 part are private-sector organizations, and so, that
5 partnership is pivotal. And you can hear that when you
6 go sit in a room and have plan sponsors, payers and
7 physicians and hospitals in a room together, we really
8 all have the same goals. We really do, in fact.
9 And, then, payment reform. which is a piece of
10 that.
11 MR. WROBLEWSKI: Kristin?
12 MS. MADISON: I will reiterate the HIT point is
13 just critical to make this whole process cheaper, better
14 quality, better risk-adjustment. Making the data
15 available at the point of care. There's so many ways in
16 which I think that would help the process. I would also
17 push for more development of broader health care outcome
18 measures because I don't think we have enough and I think
19 that it is possible to develop some more.
20 MR. WROBLEWSKI: Why don't we start on this
21 end. Vince, do you want to go first?
22 DR. KERR: Oh, why not. I'm still awake right
23 now.
24 **(Laughter.)**
25 DR. KERR: I think there are two things that we

1 can do. Actually, the ideas have been fantastic. As I
2 get older, usually my conclusion is if you wait long
3 enough, you will hear the thing that you were going to
4 say anyway.
5 So, two things that I didn't hear. To support
6 payment reform, one of the things we lack is data on how
7 that should be done. So, what I would encourage short-
8 term -- and it may be CMS -- to do a structured way of
9 understanding what is most effective in terms of how you
10 structure payment and do three or four different pilots
11 and look at the behavior change in the marketplace. So,
12 we need to have that information. That's antecedent to
13 your idea, which I like.
14 And, then, the second, which is also short-term
15 -- I'm a very short-term thinker, I guess -- would be --
16 it's on us, the insurance sector, to think through, like
17 many other sectors in this country have, what are
18 industry utilities versus what are -- I think you were
19 saying this actually -- versus what are truly
20 differentiators. We haven't come to -- I mean, just
21 imagine if Wal-Mart was a leader in getting to UPC
22 coding, if everyone thought -- and it had great
23 advantages for controlling inventory and, clearly, had a
24 business advantage to doing it. But if everyone took a
25 different tact at doing that, it would have failed.

1 So, they were willing to give up some of
2 business advantage to create something that actually
3 moved the entire industry forward and from which everyone
4 -- and what I typically see happening in our sector is we
5 haven't decided where that line is. We really believe so
6 many things fit on the competitive differentiator's side
7 and they really don't.
8 MR. WROBLEWSKI: Irene, go ahead.
9 MS. FRASER: I think I'm going to say for long
10 and short-term, payment and payment. The reason I say
11 that is I think we've been trying, through a variety of
12 means, to kind of use measurements and data tail to wag
13 the dog. And competition, therefore, is part of that. I
14 think if the ultimate goal is quality, we've got to have
15 the payment piece in there because we're sort of using
16 measurement and data to try to cajole people into
17 behaving against what is presently their interest. Until
18 the payment changes, that's a real uphill battle.
19 In order for any payment change to affect
20 action, though, in a real way, it has to have a certain
21 market share. We don't know quite what that market share
22 is, but it's not small.
23 So, I think in the short-term I think what we
24 need are some demonstrations whether that be private
25 sector or Medicare. It's most likely to be private

1 sector. In fact, there's some with Prometheus going on
2 right now and other gain-sharing experiments and so
3 forth.
4 I think in the short-term we need that and we
5 need evaluations of those efforts. It's very hard for
6 CMS to jump in on some of these kinds of demonstrations
7 in a big way without having evidence on what works. So,
8 in the short-term, we also need evidence on what works
9 and that means systematic evaluations that cross payers
10 and can't be just CMS specific or private sector
11 specific. Then, so, for the long-term, we need payment
12 reform that's based on that evidence.
13 MR. WROBLEWSKI: Thank you. Dr. Chumbley?
14 DR. CHUMBLEY: I think both in the short term
15 and the long term it would be nice if government agencies
16 made it a little easier for not-for-profit systems to
17 work with independent physicians to create some
18 accountable health system, accountable care systems so
19 that we could do some of this reporting.
20 I guess in the long term just don't make it any
21 harder.
22 **(Laughter.)**
23 MR. WROBLEWSKI: Beth, go ahead.
24 DR. NASH: I'll be very brief. I really like
25 the education idea in the short term. I really do agree

1 that I don't think doctors really get it and, so, I think
2 there's a huge opportunity there. Low-hanging fruit.
3 And I think educating the public will go a long way as
4 well.
5 And in the long term, I got to believe that
6 there is a way to collect data at the physician level,
7 even independent of information systems. The cardiac
8 surgeons have been doing it for decades. So, I would
9 like to see, again, a broad-based coalition of people
10 coming together to try to figure out how to get
11 physicians to collect that data. Of course, we have to
12 deal with the episode of care issue, but I think it's
13 solvable.
14 MR. WROBLEWSKI: Okay, thank you. Paul, you
15 had one last comment.
16 MR. GINSBURG: I just have one last thought. I
17 certainly support all of the pleas for payment reform as
18 a critical thing. I also heard the word "demonstration,"
19 the word "pilots," and I just wanted to give a reaction
20 to that. The way we've done demonstrations, you know,
21 with the way CMS has done it, they take years and we
22 don't learn that much. We don't learn that much because
23 you don't expect providers to behave the same way in a
24 demonstration, particularly when it takes investments, as
25 they would when they know the policy has changed or the

1 payment system.

2 So, let's get bolder and let's -- maybe we'll

3 call them pilots, but pilot just means we're going to do

4 this and we know we're going to change it. The most

5 important changes in payments in our history have not

6 been demonstrations, were not preceded by demonstrations.

7 We just did them and we fixed them as we went on.

8 MR. WROBLEWSKI: Okay.

9 DR. KERR: Okay, regional roll-outs then.

10 **(Laughter.)**

11 MR. WROBLEWSKI: Okay. With that, it has been

12 a great day. I appreciate all of your stamina for

13 staying with us for eight hours. It is our objective to

14 produce a white paper report that summarizes what we have

15 discussed, as well as lays out the pros and cons of the

16 likely effects. Thank you very much.

17 **(Roundtable concluded.)**

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1 **C E R T I F I C A T I O N   O F   R E P O R T E R**

2

3 MATTER NUMBER: P083901

4 CASE TITLE: ROUNDTABLE ON THE COMPETITIVE SIGNIFICANCE

5 OF HEALTHCARE PROVIDER QUALITY INFORMATION

6 DATE: OCTOBER 30, 2008

7

8 I HEREBY CERTIFY that the transcript contained

9 herein is a full and accurate transcript of the notes

10 taken by me at the hearing on the above cause before the

11 FEDERAL TRADE COMMISSION to the best of my knowledge and

12 belief.

13 DATED: NOVEMBER 18, 2008

14

15 ______________________________

16 ROBIN BOGGESS

17

18 **C E R T I F I C A T I O N   O F   P R O O F R E A D E R**

19

20 I HEREBY CERTIFY that I proofread the transcript for

21 accuracy in spelling, hyphenation, punctuation and

22 format.

23

24 ______________________________

25 ELIZABETH M. FARRELL