

# **NPAF** National Patient Advocate Foundation

**The Patient's Voice | since 1996**

## **EXECUTIVE BOARD**

**Nancy Davenport-Ennis**

CEO, President  
National Patient Advocate Foundation

**Christian Downs, MHA, JD**

Board President

Executive Director

Association of Community Cancer Centers

**Leah Locke-Arnett, RN, BSN, MHCA**

Board Secretary

Associate Director

University Health Services

University of Texas at Austin

**John L. Murphy**

Board Financial Officer

Sagueneay Capital, LLC

**Edward G. Connette, Esquire**

Immediate Past President

Essex Richards, PA

**Bruce Avery, MD**

Hematology-Oncology Knoxville

**Alan J. Balch, PhD,**

Vice President

Preventive Health Partnership

**Rene S. Cabral-Daniels, JD, MPH**

Vice President of Grant Programs

Williamsburg Community Health Foundation

**Martha E. "Meg" Gaines, JD, LL.M.**

Clinical Professor of Law,

University of Wisconsin Law School

**Dennis A. Gastineau, MD**

Director, Human Cell Therapy Laboratory

Divisions of Transfusion Medicine & Hematology

Mayo Clinic

**Venus Ginés, MA**

Founder & CEO

Día de la Mujer Latina, Inc.

**Lovell A. Jones, MD, PhD**

Director, Center for Research on Minority Health

Department of Health Disparities Research

University of Texas

MD Anderson Cancer Center

**Pearl Moore, RN, MN, FAAN**

CEO (Ret.)

Oncology Nursing Society

**Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI**

President, Clinical Services & Chief Medical Officer

HCA / Hospital Corporation of America

**Roy Ramthun, MSPH**

President

HSA Consulting Services

**Reed V. Tuckson, MD, FACP**

Executive Vice President and

Chief of Medical Affairs

UnitedHealth Group

## **SCIENTIFIC BOARD**

**Robert M. Rifkin, MD, FACP**

Chair, PAF Scientific Board of Directors

Director, Cellular Therapeutics

Rocky Mountain Blood & Marrow Transplant Program

Rocky Mountain Cancer Centers

**Charles Balch, MD, FACS**

Professor of Surgery and Oncology and Dermatology

Deputy Director, Johns Hopkins Institute for Clinical

and Translational Research

Johns Hopkins

**Pamela S. Becker, MD, PhD**

Associate Professor of Medicine/Hematology

Institute for Stem Cell and Regenerative Medicine

University of Washington

**Al Benson III, MD, FACP**

GI Medical Oncology (Professor of Medicine)

Northwestern University - Feinberg School of Medicine

**David Binzel, MD**

Professor of Radiation Oncology

Associate Professor of Head and Neck Surgery

Duke University Medical Center

**Nicholas J. Petrelli, MD, FACS**

Medical Director

Helen F. Graham Cancer Center

**F. Marc Stewart, MD**

Professor of Medicine, University of Washington

Fred Hutchinson Cancer Research Center

**Lori Williams, PhD, RN, AOCN**

University of Texas

MD Anderson Cancer Center

April 9, 2010

Glenn M. Hackbarth, J.D.

Chairman

Medicare Payment Advisory Commission (MEDPAC)

201 New Jersey Avenue, NW

Suite 9000

Washington, DC 20001

## **Re: Comments on Discussion Items at April 1-2, 2010 MEDPAC Meeting**

Dear Chairman Hackbarth:

On behalf of the patients we represent, National Patient Advocate Foundation (NPAF) is pleased to submit comments to Medicare Payment Advisory Commission (MEDPAC). Our comments were developed collaboratively by National Patient Advocate Foundation regulatory and policy experts in collaboration with Patient Advocate Foundation patient service experts and senior case managers.

NPAF is a national non-profit organization which provides the patient voice on issues relating to improving access to, and reimbursement for, high-quality, affordable healthcare. The advocacy activities of NPAF are informed and influenced by the experience of patients who receive case management services from our companion organization, the Patient Advocate Foundation, which provides professional case management services to patients with chronic, debilitating or life-threatening conditions. In 2009, PAF resolved 55,384 patient cases and received more than 9 million inquiries from patients, bringing the total of closed cases since 1996 to more than 500,000. These patients find their way to PAF through many routes, including referrals from Members of Congress, the Administration, FDA and CMS. Additionally, countless millions of people reach out to PAF's website and chatline for assistance.

NPAF and PAF have reviewed the sessions presented at the April 1-2, 2010 MEDPAC meeting and are pleased to submit the following comments.

## **Enhancing Medicare's Ability to Innovate**

NPAF is committed to ensuring that patients receive the highest quality of care. Currently, while standard treatment plans have been established for cancer and end stage renal disease (ESRD) patients, there are many illnesses which lack established standard treatment plans. To that end, NPAF believes that the establishment and utilization of nationally recognized treatment guidelines is paramount in assuring CMS reimbursement for quality health care services. The creation of treatment guidelines will allow CMS to determine and monitor the quality of administered care.

In addition, NPAF believes that CMS should consult patients to assure that they are receiving accurate and reliable information from their providers. NPAF recognizes that some patients may

not feel comfortable answering these questions about providers in a doctor's office or hospital. Therefore, NPAF recommends that CMS implement either an online, mailing or call service that allows patients to complete these evaluations in a more comfortable, personalized setting. NPAF believes that a Medicare demonstration project could be used to establish an enhanced evaluation system.

### **The Medical Malpractice System**

NPAF supports implementing a medical malpractice system similar to the National Vaccine Injury Compensation Program, which is a no-fault alternative to the traditional tort system for resolving vaccine injury claims and providing compensation to people found to be injured by certain vaccines. In this new system, funded by providers and insurers, medical malpractice claims would be filed based on the severity of the injury to the patient. A pre-set schedule of payouts would be established so that patients would be assured they would secure a resolution to their claim. Patients could choose an attorney, an advocate (such as a case manager that has been following the specific claim with the patient), or any other patient representative to assist them in this process.

In addition, NPAF believes that CMS should provide an option not to use the fund if medical malpractice results in the death of a younger patient.

NPAF supports the Safe Harbor for Adhering to Evidence-based Guidelines initiative, as we believe this may work to reduce defensive medicine and dismiss claims that lack merit. NPAF also supports the Government-subsidized Malpractice Reinsurance Innovative Reform initiative. This initiative would allow providers who meet certain conditions (i.e. patient safety) to receive reinsurance subsidies or stop-loss coverage on claims that exceed a certain threshold. We agree that this initiative goes a long way in incentivizing quality care and patient safety. NPAF has included our issue brief entitled "Addressing the Needs of High Cost Individuals: A Proposal for Catastrophic Insurance: May 2009" for reference regarding this issue.

NPAF also supports the Enterprise Medical Liability initiative. The hospitals in the United States with which PAF has had the privilege of working are seeking to deliver quality care with sound oversight. We believe that this initiative will allow hospitals to have improved oversight capabilities with the doctors who are not only employed by the hospital, but also any doctors who are contracted employees of the hospital. It should be stressed that contracted physicians should be included in this initiative because while they may not technically be considered hospital employees, they should be held to the same standards of hospital-employed physicians as they are physically practicing in the hospital. NPAF believes that the quality of physicians needs to be constantly reviewed and analyzed, and this initiative seeks to achieve this goal.

NPAF also supports the health court and administrative compensation system. Specifically, we support the United States Department of Labor's Administrative Review Board, which established administrative law judges (ALJs) to preside over an administrative trial-type hearing to resolve a dispute for someone affected by a government agency. NPAF stresses that adequate funding has to be provided for such a system to be effective, and to provide staffing of ALJs. NPAF would also like to stress the need for an appeal process following an ALJs ruling. Appeals in a federal court would marginalize the ability of special interests to influence decisions.

### **Focusing Graduate Medical Education (GME) Financing on Educational Priorities**

NPAF agrees that the GME system in America is an invaluable mechanism that allows for highly qualified residents to receive expert training and utilize this training to serve America's patients. NPAF supports MEDPAC's recommendation to change Medicare funding of GME to support the workforce skills needed in delivery systems that reduce cost growth while maintaining or improving quality of care. Currently, there are billions of dollars in extra funds that are not

funding either resident, faculty and / or administration costs or empirically justified indirect costs. NPAF encourages that any extra indirect medical education costs that are not empirically justified should be allocated to residency programs that meet certain standards centered on evidence-based medicine and coordinated care.

In addition, NPAF strongly supports MEDPAC's recommendation that the Secretary of HHS should annually publish a report that shows Medicare GME payments received by each hospital and each hospital's associated costs. It is very important to know exactly how much GME funding is going into hospitals and how these funds are utilized. We also believe that resident dollars should be made available and distributed to both research and community hospitals alike. NPAF further recommends that CMS consider expanding the use of GME dollars to use a portion of these dollars to support telemedicine. This process would allow leeway for current physicians to treat patients currently in underserved areas of the country.

NPAF also agrees that the number of residents subsidized should not exceed the reformed delivery system needs. We believe primary care physicians will play an enhanced role in the diagnosis and treatment of patients, including those with chronic diseases. Because the number of patients who seek care from their primary care physicians is likely to increase, we believe that GME funding should be used to further the education of primary care physicians in areas of managing chronic care illnesses. However, it is important that GME dollars are used for both primary care residents and the specialty residents to ensure that our nation has a workforce sufficient to meet the needs of primary care services and specialty services, particularly in the areas of cancer, cardiac disease, chronic kidney failure and diabetes.

NPAF would like to recommend that for every year a resident is trained with GME funding, that resident must be required to provide the equal number of years treating Medicare patients. We also urge CMS to address the issue of international students. If GME funds are used to pay for a student's visa and subsequent training, that student should also be obligated to serve in the United States for the same allotted time. A healthy, effective GME program allows expert residents to give back to the community once their training is completed. This requirement would help alleviate the shortage of doctors accepting Medicare patients and in addition, would help maintain an ongoing database of Medicare participating physicians, in light of the expected baby boomer increase.

NPAF agrees that greater diversity in the physician workforce leads to better access to care and quality improvements for patients. According to the United States Census Bureau, in 2008 the Hispanic / Latino population was 15.4%, the African American population is 12.8% and the Asian population was 4.5%. Thus, NPAF believes that the GME program should provide incentives for minority residents to serve their communities, whether by offering direct care or by offering telemedicine services.

### **Shared Decision Making and its Implications for Medicare**

NPAF is pleased that the "Patient Protection and Affordable Care Act" mandates the Secretary of HHS to award grants to develop and update decision making aids, establish shared decision making resource centers and to help providers implement shared decision making programs. We believe that this needs to be a patient-led initiative in collaboration with CMS, where a template is developed that is written in clear language so the patient fully understands the risks and benefits of any shared medical decision. The national non-profit patient community is best qualified to assist in the development of patient-centric language.

This patient-reviewed template needs to cover the full scope of patient literature – informed consent for clinical trials, explanation of benefits, relevant patient educational material and risk/benefit explanations etc. These educational pieces, developed in collaboration with the

patient, the non-profit patient community and the medical community, is paramount to protecting both patients and providers, especially in the area of shared decision making. NPAF also supports incentives for both the patient and the provider to encourage shared decision making.

### **Improving Traditional Medicare's Benefit Design**

The Qualified Medicare Beneficiary (QMB), specified low-income Medicare beneficiary (SLMB), and qualified individual (QI) programs help low income Medicare beneficiaries pay all/some of Medicare's cost sharing amounts. In an attempt to increase patient eligibility, National Patient Advocate Foundation proposes that these programs base eligibility on income after deductions for medical expenses such as premiums, deductibles, and co-pays.

This would result in a structure similar to the Supplemental Nutritional Assistance Program (SNAP), more commonly known as the Food Stamp program. Currently seniors (age 60 or older) and disabled populations are entitled to a medical deduction that exceeds \$35.00 per month when determining their benefit amount. The medical deductions can include premiums, prescriptions costs, deductibles, durable medical equipment, prosthetics, dental work, etc.

Thank you for the opportunity to submit comments to MEDPAC. We strive to give a voice to the concerns of Medicare beneficiaries who are dealing with the burdens of a chronic, debilitating or life-threatening disease. We offer our willingness to further collaborate on the recommendations contained herein.

Sincerely,



Nancy Davenport-Ennis  
Chief Executive Officer