

**2010 PHYSICIAN COMPARE WEB SITE
TOWN HALL MEETING
October 27, 2010
1 p.m. to 5 p.m.**

TELECONFERENCE TRANSCRIPT

OPERATOR: Ladies and gentleman, hello and welcome to today's conference on the Physician Compare Web site. As a reminder, all phone lines will be on listen-only mode, and there will be Q and A sessions throughout the call. If you need assistance on the phone during the call, please press star zero to speak to an operator. And now to start off of our conference, I will turn the call over to Mr. Bill McQuiny [phonetic].

BILL MCQUINY: Hello, everyone, and welcome to your centers for Medicare and Medicaid services and today's Physician Compare Web site Town Hall listening session. I want to thank everyone who is here in person and all the people who are waiting online. I just have a few things to get out of the way before we begin.

For those of you here, this is a secure facility so we would appreciate it if you would keep your pass with you and not wander off without a CMS staff accompanying you. There are restrooms and pay phones out in the hallway here. There are additional ones across the main hallway that you came through to get in. And also I want to ask everybody to follow me and fish out their cell phones and turn them off, if you don't mind. There we go. Okay.

Today's listening session is really an opportunity for CMS to share a comprehensive description of policy and plans for quality information to be included in the CMS Physician Compare web application. It's also an opportunity for us to get additional public comment from a large number of interested partners and stakeholders. Because much of what we will do will be determined through rule-making, our speakers won't be able to go beyond their basic presentation to answer questions. But we are very interested to hear what you think about what you will hear today. So think of this meeting as a gigantic focus group, not a Q and A session.

Let me introduce today's speakers. First of all, we have Dr. Michael T. Rapp. He's the director of the quality measurement and health assessment group in the office of clinical standards and quality here at CMS. He's based here in Baltimore. This group is responsible for evaluating and supporting implementation of quality measure systems to assess healthcare quality in a broad range of settings. These include hospitals, doctors' offices, nursing homes, home health agencies, dialysis centers. The group actively works with many stakeholders to promote widespread participation in the quality measurement, development and consensus process.

Next, I would like to introduce Regina Raymond-Chell. Regina is a registered nurse, working as a health insurance specialist in the quality measurement health assessment group. She focuses on physician quality assist initiatives such as physician quality reporting system. Regina is the lead for the group practice reporting option and for implementation of the Physician Compare Web site. She's also working on implementation of affordable care organizations.

Aaron Lartey is a health insurance specialist in the Web site project management group in the office of beneficiary information services. He's the project lead overseeing the supplier directory, the participating physicians' directory and the helpful contacts' database on Medicare.gov. Mr. Lartey earned his Master of Health Sciences degree from Tulsa University and a Bachelor of Health Education from Morgan State.

And finally, Aucha Prachanronarong is a technical advisor in the quality measurement and health assessment group. She focuses on physician quality initiatives such as the physician quality reporting system and the electronic--the electronic prescribing initiative program.

So without anymore delay, Dr. Rapp?

DR. MICHAEL RAPP: Good afternoon and thank you for that. We usually don't have such formal introductions, but it's kind of nice. I learned about my staff now. So welcome on this rainy afternoon. I understand it was the lowest low-pressure system in the Midwest since the sinking of the Edmund Fitzgerald. I think there's a song about that, isn't there? So that's

what's going on in Chicago, Jennifer? Yeah.

At any rate, welcome to CMS, and I thank you for coming. This, as was indicated, is a listening opportunity for us. So we don't have too much to say. We'll have things to say later after we have an opportunity to hear from you. But I know that one of the tools that CMS has to improve quality is to put information on Web sites. So we provide leadership for the various compared Web sites including Hospital Compare, nursing home compare. We participate in that, dialysis facility and so forth. And so now there's been a lot of interest in having a physician compare Web site. And for the first time, we have really the authority and the instruction to do that in the Affordable Care Act.

We have talked about public reporting of physician information, and we realize that creates quite a few more issues that other settings may not have. We know there's a lot of both interest and opportunity but also some anxiety about it as well and how it would come out. The main purpose of it is to provide information to the public about physician services but also to drive quality improvement by physicians.

So with that dual purpose, that's really what it's about, how it would be constructed. That is up for future consideration, future determination. And I'm sure it will be informed by the thoughts that you give us here today. So I won't spend any more time talking; I'll turn it over to Regina. And I'll be able to be here for some of the meeting, unfortunately, not all of it. But I'll certainly learn all that was discussed here.

So thank you again for joining us in person, and thank those of you that have joined us on the phone. And we look forward to hearing what you suggest to us.

REGINA RAYMOND-CHELL: Thanks, Dr. Rapp. So let's go ahead. As Dr. Rapp stated, we really are here to listen to you. So with that, I would like to just start with a brief overview and background on Section 10331 of the Affordable Care Act that informs why we're here today and also just look at a time line for implementation. That sounds like it's a lot better volume.

So Section 10331 of the Patient Protection Affordable Care Act of 2010 does require CMS to establish a Web site, a physician compare Web site, as I think all of you on the phone and here are aware, because that is what sparked your interest in joining us today. The Web site will provide information on physicians enrolled in the Medicare program as well as other eligible professionals that participate in efficient quality reporting system formally known as the Physician Quality Reporting Initiative or PQRI. And also the Web site will provide information on physician performance.

The professionals eligible to participate are actually listed on the next--oh, sorry. The fact that these aren't synced and having no eyes in the back of my head, I'm going to pass this over to AUCHA. These next three slides I'm not going to really go over. I think it's information that most of you are aware of, and it's the eligible professionals that can participate in the Physician Quality Reporting Initiative.

Then if we move forward to slide nine to look at the Physician Compare Web site design, I just want to give you a little background on the rule-making. In calendar year 2011, Medicare physician fee schedule proposed rule, which was actually published on July 13, 2010, CMS did propose to use the current physician and other healthcare provider directory as a foundation for Physician Compare. We have provided you with the link to that provider directory, and you'll also have the opportunity to see a demonstration by Aaron later this afternoon on that directory.

CMS also proposed to post physician quality reporting system participation information on the site by January 1 of 2011, and also proposed to implement a plan to add physician performance information by January 1, 2013.

Then just to summarize with a time line of Section 10331, we have already mentioned that January 2011, that CMS will establish a physician compare Web site. January 1, 2012, is the earliest that reporting periods for physician performance information can begin. And then January 1, 2013, will implement a plan for public reporting on physician performance available through the Physician Compare Web site. And then January 2015, we will report to Congress

on the Physician Compare Web site and plans to use data for value-based purchasing and consumer choice. And then January 2019, a demonstration project on providing financial incentives to beneficiaries who use high-quality physicians.

So that's the overview of 10331 of the Affordable Care Act. And now I would like to pass this over to Aaron Lartey to give you an overview of the current healthcare provider directory Web site.

AARON LARTEY: Testing. Hello, I'm Aaron Lartey. Good afternoon. If we could, just switch over to the Web site. Now, this is the healthcare professional directory. And on the healthcare professional directory, we list physicians who are enrolled in the Medicare program as well as other healthcare professionals.

Just to give you an overview, we have two different types of search requirements. We have our required--well, we have two different search criteria. We have our required search criteria which allow you to select a physician or other healthcare professional. And what we mean by other healthcare professionals are physician assistants, registered nurses, physical therapists, clinical psychologists, et cetera.

And then we have also, as required, a search option. We need you to put in location, whether it's zip code, city, state, any combination will usually work. As an optional search criterion, if we can scroll down a little bit, we have provided users to determine whether if they prefer a gender, which is big nowadays in the healthcare industry. We give people the option to search for last name, and we let users determine whether they want physicians who only accept Medicare assignment as full payment as opposed to not.

So if we can scroll back a little bit further up to the required search requirements, we'll select cardiology and search for the zip code 21044 and select search providers. No Baker in the last name field, please. No, 21044. It's 21044. Can we change that zip code? 22101, that's fine.

OPERATOR: I'm sorry; it told me that wasn't a valid zip code.

AARON LARTEY: I'm sorry?

OPERATOR: It told me it wasn't a valid zip code, I'm sorry. 21044, is that correct?

AARON LARTEY: Correct. 22101. I live in 21044. Okay. So the first thing you notice when you get your results is that it gives you a brief summary of how many locations were returned with your results within a 15-mile radius of the zip code. Our searches are defaulted at a 15-mile radius, but you have the chance to modify your search results.

So if you look onto your left-hand side, you see "modify your search results." You can change your zip code, city or state. You can change the distance as well. Currently, you can only change the specialties that fall under the original specialty that you selected. You can also change your last name or put in a partial spelling for a last name to filter. You can filter by language. And if we can scroll down a little bit more, gender and, again, medical assignment.

And if we can move up further to the top--can you hear me? Okay. So when we go over to our list, you can sort at the beginning either by distance or you can sort alphabetically. Right now by default, it's sorted by distance. And if you can look over to your right-hand side, you see the pagination, one, two, three, four, five, six. So that's how you can go through the different pages of the search results.

If we look at the first physician listing, we have the physician's name, their credential. Did she click on something? That's fine. We have their name, their credential, their specialty, practice location, how far in distance it is from the zip code that you're searching. Usually people get it confused with, you know, where they are actually. We're having a little bit of technical difficulties here. Bear with me.

OPERATOR: But the good thing is we know this never happens in real life with technology so that's safer.

AARON LARTEY: So as I was saying, we have the radius. And the Radius doesn't determine, like, how far you are from the doctor's office. It's determined from the middle of the actual zip code. We have the physician's telephone number. If they have more than one practice location, we have additional office locations, a link for that. We have a map and directions feature so you can get directions to their office.

The "add to my favorites" link here is used for a tool on the Web site called mymedicare.gov. It's actually used for beneficiaries where they log in to MyMedicare. They can go up to the physician tool, add a physician of their choice to their profile in MyMedicare. And they can also remove them as well if they see fit.

If you look to the right-hand column, additional info, you see that they accept Medicare and approved amount on all claims. We'll have that up there. We also have group practice locations. A lot of these physicians are affiliated with groups. Unfortunately, a shortcoming of the tool is that we don't have a way right now to designate the specific practice location if they're affiliated with a group, so we list all of them.

So just as a higher level, we just let you know which groups they're a part of. And then once you get to the next step, you could determine which location you're comfortable with and to call to see if they practice that location. I'll get to that in a minute. If you look at the listing below the first listing, we also offer foreign language under additional info.

So if we can just click one of the names of the physicians listed on here, we can go to the physician profile page. And on the physician profile page, we basically--if we have the physician's name, the "add to favorites" feature again, which is related to MyMedicare.gov. We have the specialty and whether they accept Medicare payment in full.

The first tab you're looking at is office locations. These are the individual practice locations for the physician. So we list all of them under the first tab. As you can see, Dr. Moffi has two practice locations within that zip, within the area of the zip code that you provided your search

for. We also have locations outside of the zip code. We don't have a way to quite separate the two completely at this point in time, but we're working on it.

If you can, select the next tab where it says office locations. Group practice location, I'm sorry, up towards the top next to--there you go. Group practice locations. These are all the locations that are affiliated with their group practices. And, again, we list them in according to distance, and we also have a map directions feature for all the addresses that we list as well as their telephone number under so you can--so the user can call the office to find out if the physicians actually practice from there.

If we can, scroll back up to the top and go over to the right-hand side under additional information. Again, we list out their gender, foreign languages, hospital affiliation, their education. And then in this section is where you would find whether they successfully reported a PQRI. Unfortunately, we didn't select one that did, but that's where you would find that information.

And that is pretty much the healthcare provider directory as it currently stands. Thank you.

REGINA RAYMOND-CHELL: Okay, great. Thanks, Aaron. It's helpful, I think, to kind of see a live demo of the existing directory that we have to kind of also help you all start formulating your thoughts and ideas that you want to share with us.

Now we're at the first break in our presentation where we would like to hear from you all both in the room and on the phone lines. And at this point, we're really looking at the Physician Compare Web site and as you envision that. It was proposed in the 2011 rule to use the healthcare provider directory as that framework. So with that proposal, the final rule will be published in November of 2010, early November of 2010, this year.

So I'm going to turn the floor over to Bill now, our facilitator. And he will field your comments and recommendations and suggested to CMS. Thank you.

BILL MCQUINY: Thanks. We're going to fish for some questions in the room first. I believe that mic is on. Could you just step over to that and identify yourself? And if you know you have a question, you might want to line up. Charlie, is the floor mic on? Not on. No? Then you get me.

JENNY LILJEBERG: I'm Jenny Liljeberg with the American Society of Cataract and Refractive Surgery. And my basic question was where is this information that's already on the Web site compiled? I think one of the major issues that we already have is a lot of the information on existing Web sites isn't updated, isn't correct. So one of the major issues is making sure that the information is accurate. And how is it updated, and where does it come from, and how is it verified?

AARON LARTEY: The majority of the information that we get to put on this Web site is taken from the PECO System, the Payment Enrollment Chain Ownership System housed here at CMS. We tend to update the Web site on a monthly basis. In addition to PECO, we have a third-party contractor that provides us with a lot of supplemented data as hospital affiliation, gender information, education information and, I believe, foreign language information. So those are our two primary data sources. And we are trying to push the quality of data as far as what's being input into the PECO and how timely it gets to the Web site. So that--we are definitely aware of that concern and trying to address it to the best of our ability.

BILL MCQUINY: Okay. Another question?

PETER MCMENAMIN: Yes, hi. I'm Peter McMenamin with the American Nurses Association and, a long time back, the Chief of - - the reimbursement research at HICFA. Two minor niggling comments. I can understand not referring to participation on the Web site because the bennies might not understand it. But you might also make it consistent in that you're referring to physicians who always accept assignment as opposed to physicians who do accept assignment, 'cause there are a bunch of non-parts out there, just not too many, who do accept assignment from time to time. It's just they don't do it all the time.

BILL MCQUINY: Right.

AARON LARTEY: Well, I think, in our messaging, we do have messaging that states that just because they don't do it all the time, they do it on a case-by-case basis.

PETER MCMENAMIN: Right. But just on the right-hand side, talking about individual docs, you say "accept assignment all of the time."

AARON LARTEY: Um-hum.

PETER MCMENAMIN: On the left-hand side, you say "accept assignment."

AARON LARTEY: Okay.

PETER MCMENAMIN: And you should do it consistently so you don't confuse people.

AARON LARTEY: All right.

PETER MCMENAMIN: The other minor comment is the graduation is medical school graduation, not undergraduate medical education, not post-occ graduation. It just says "graduated."

AARON LARTEY: Medical school graduation.

PETER MCMENAMIN: Well, you might want to say that.

AARON LARTEY: We'll put that down. Thank you.

BILL MCQUINY: Okay. We want to go to our first commenter from the web. Operator, are you there? Okay. We'll take another comment from in here.

STEVE FINDLAY: All right. I'm Steve Findlay from Consumer's Union. Just a bit more on the accuracy of the existing database. Have you guys most recently and do you regularly run checks on the accuracy of the information on physicians? And what's the--if you do, what's the latest readout on the breakdown of errors, the scope of errors? What kind of errors occur, name, affiliation, scope of practice, et cetera, et cetera.

AARON LARTEY: From a web point, from the web perspective, we haven't run an analysis, but we can inquire with the PECO System owners to see if they have run analysis and see what the report comes up.

STEVE FINDLAY: And who owns that system?

AARON LARTEY: It's a component within CMS.

STEVE FINDLAY: Okay. Thanks.

BILL MCQUINY: Okay. Going back, is there anyone online on the phone who wants to comment? No. Okay. Take it away.

OPERATOR: We do, we have one question from the phone. The question is from Sarah Thomas's location. Go ahead, please.

SARAH THOMAS: Hi, this is Sarah Thomas from NCQA in Washington. And we have a number of different physician recognition programs for excellent care in diabetes and heart stroke and patients under medical home. And we would be very interested in sharing the names of people who have chief recognition with you for use on this Web site. So we would be happy to explore that possibility with you and let you know in detail what the program includes.

AARON LARTEY: Okay. Just send me an email and I'll be sure to get in contact with you. Thank you.

BILL MCQUINY: From Baltimore.

MATT MCNABB: Yes, hi. I'm Matt McNabb and I'm a geriatrician at Johns Hopkins and also with the American Geriatric Society. Regarding the first comment about the accuracy of the provider data, is it possible or could it be possible for the providers themselves to correct the data or submit information to have--get it corrected?

AARON LARTEY: Actually, we do have an Internet-based version of PECO that we link from the tool, and we actually encourage providers to go in and use the Internet-based PECO. However, there are some fields that you're restricted from updating in the Internet PECO, and we have a breakdown to let you know which fields you can update using the tool. But, you know, with participation, you have to submit it through your - - in order to get that processed. But most other fields, you can do it--you can update that information or change that information through Internet-based PECO.

BILL MCQUINY: Okay. Another question from Baltimore.

ROBERT KRUGHOFF: I guess I'm not quite sure, are we sort of commenting on something beyond--are we talking about other kinds of information that might be on the Web site or are we just confining ourselves to the accuracy of what you have right here? Either thing?

REGINA RAYMOND-CHELL: We want to hear from you what--how you envision the Physician Compare Web site.

ROBERT KRUGHOFF: Okay. All right. Well, obviously, that's a long subject. But I'm Robert Krughoff with Consumer's Checkbook Center for the Study and Services. We're a nonprofit consumer organization. At some point, I'll give you a little more background. 'Cause we've been trying to do comparisons of physicians and auto repair shops and all kinds of things for 30-plus years. In fact, the first published patient ratings of physicians in our magazine back in 1980. So we spent a lot of time trying to do this. And I think this--I'm very excited about the

potential for this Web site. I think this thing has tremendous potential, and CMS can take it and HHS can take it as far as it wants. I hope it will take it very far. I think it would be a tremendous benefit to the public to have basically all the information you could possibly want or assemble on physicians all in one place. It makes it--it becomes the go-to source, the thing that every--you know, it's the household name. It's the thing that the media referred to, et cetera. It makes it much easier.

There's much less information than we would like out there now on various sites. But even what is there, people don't find. And to have it all in one place assembled--now, it may be assembled by way of links and so on, but all of it so you can find your way around pretty much anything you need to know without a lot of effort. So when I think about that, I think your basic Web site that you're going to build this on makes sense. I don't know what the relationship--what you're thinking of as a relationship between that and the national provider registry, which is where the NPI numbers are, where the providers are required to update their addresses at least within a month of the time they have changed an address. It seems like it would make sense to make sure that you use the leverage of those two Web sites so you get accurate information. There's also a secure log-in for the National Provider Registry. So it would be possible for them to go in. You know who they are and so on.

I would say beyond that, it's very desirable to have information that is supplied by physicians where they can identify themselves with some sort of secure log-in. You know, some of those things would be just stuff like, you know, hours or whether they communicate to their patients by email or a description, I think, would be very wonderful if they described what they have in the way of electronic medical records and what patients could expect from them in terms of the kind of information this electronic medical record would provide them.

You know, I think they could also supply the health plans they participate in, the public payers, beyond Medicare that they participate in, teaching responsibilities at hospitals. There are a lot of things like that that physicians could supply. And I think we should try and set up the Web site so that all of those things can be done. And then, you know, maybe voluntary physicians can do it or not do it; although, I think it would be nice to have a little statement that says,

“physician chose not to share this on this Web site” or something so there’s some motivation for the physicians to supply that kind of information.

I was glad that NCQA called in and talked about the physician recognition programs. Why not have that right up on the Web site? Certainly, board certification information, you know, is a wonderful resource, a critical resource for people choosing doctors. Ideally, that would be on the Web site. Information from state licensing boards, these licensing boards--many of these states have very extensive information that they maintain all the time including information on disciplinary actions. I think it’s a problem to have a Web site that doesn’t alert people to the fact that there have been serious disciplinary actions about somebody who otherwise looks perfectly fine on that Web site. I just think, from your own public protection standpoint, you would want to do that kind of thing, whether you can work to get that kind of information directly from the medical boards on disciplinary actions, et cetera. I think it’s well worth exploring. And it would require building partnerships with a lot of different disciplinary boards. Although, there is some infrastructure for that now where many of these boards share their information. I think you would want to do that.

Under the Accountable Care Act, drug companies, advice makers are going to be reporting to HHS on payments to physicians, payments for various kinds, financial payments made to physicians by drug companies, biological and device makers. Also, ownership of physicians of imaging equipment that the patient might be referred to, those relate to conflicts of interest. I’m not sure you--you’re going to have, I think, a Web site for that in it of itself. But there should be some kind of linkage between those two so that people at least know there’s something to look for there. And then they can go off and look in more depth in this other Web site that you create for these--that is supposed to be, you know, sort of monitoring conflicts of interest.

You have your own Medicare fraud database. It seems that that ought to be something that is linked in. You’re going to be giving incentive payments to physicians for use of electronic medical records, presuming the physicians have to tell you what they are doing with those electronic medical records and what meaningful use they are making would be, I think, quite useful to, say on this Web site, which types of services the physician is supposed to be

supplying through electronic medical records so that a patient can say, “well, I can expect to get this.” And then, of course, if the patient doesn’t get it, it’s an opportunity for a report back to HHS that this physician qualified, got the incentive payment, but “I can't find this information. I can never get access to my personal health record,” et cetera. So I think that kind of information would be good.

Well, okay, I’ll stop at that. There are a lot of possibilities though, I guess, is all I’m saying. And I think we should seek to go very broadly with it.

BILL MCQUINY: Okay. Aaron, do you want to say something?

AARON LARTEY: I was just going to thank him for his feedback.

BILL MCQUINY: I’ll echo that. Is there anyone else waiting on the phone with a comment? Okay. We’ll take another--

OPERATOR: Yes. Our next question is from Katherine Vidello. Go ahead, please.

KATHERINE VIDELLO: No. I didn’t have a question. I’m still listening. I just joined.

OPERATOR: Oh, okay. Thank you. We did have another question in Q from Sandy Johnson. Go ahead, please. Sandy, your line is now open. Okay. It appears Sandy no longer has a question.

BILL MCQUINY: Okay. We’ll go back to Baltimore for live questions.

ANN GRUNNER: Thank you. Ann Grunner from the American Board of Internal Medicine. I want to echo Robert’s enthusiasm about this Web site and follow-up on a couple of things that he said. The certifying boards actually get information from the federation of state medical boards against sanctions against licensers. So if CMS chooses to report that, then that would be very helpful. That does exist in a database and the boards get it automatically. So there is

a way that that information is easily reported.

I also want to follow up on Sarah's comment. I think it would be a great idea to include recognition and certification programs on the site. I would suggest that CMS think about ways to describe these programs because they're not all created equally. And by that, I mean there are certifying boards that you just pay a fee and you get a certificate. And so, you know, trying to distinguish between those things, I think, in the spirit of good public information will be important. And the same is true for different recognition programs too. Thank you.

BILL MCQUINY: Thank you. Okay. Go ahead.

STEVE FINDLAY: You want to check your phone?

BILL MCQUINY: I do it every two, you're gold.

STEVE FINDLAY: All right. All right. Well, I was a little confused about where we were. I think, as Bob--you know, you had first indicated you wanted to talk about the database, but now you seem to be generally open to all comments, correct? Just--let's just clarify that.

REGINA RAYMOND-CHELL: We're open to all comments.

STEVE FINDLAY: Exactly.

REGINA RAYMOND-CHELL: But the way we have spread out the day is this section is about the Physician Compare Web site.

STEVE FINDLAY: I thought the entire day was about the Physician Compare Web site. I mean, I didn't think there was anything else on the agenda.

REGINA RAYMOND-CHELL: Yeah, but then we're going to talk a little--we're going to do a little lead-in in high-level overview before we talk about--take comments with regards to

measures.

STEVE FINDLAY: Got you. Okay.

REGINA RAYMOND-CHELL: Does that clarify? So we're going to do measures, and then we'll take some comments with regards to that. Then we're going to go into level of reporting and data collection, and then we'll take comments with regards to that. And then we'll go into data previous.

STEVE FINDLAY: Okay.

REGINA RAYMOND-CHELL: Does that help to clarify?

STEVE FINDLAY: That does. That does, I think, hopefully, for everyone here and maybe on the phone as well. Well, I have some overview comments. And I took seriously your--this Steve Findlay from Consumer's Union, by the way. I took seriously your two-minute--or at least we heard on the web that it would be two, three minutes. I think Bob always deserves more than two or three minutes so I'm glad that he took more. He deserves 20 every time so he may be back. He may be back.

I took it seriously so I'm just going to read through this high-level sort of stuff. It touches on a little bit of the stuff you're going to go into later, but it's quick. So really I'll just make--I'll cut to the chase and make nine points quickly.

One is that I think healthcare.gov sets a really terrific precedent in the insurance realm. It has been designed with the consumer in mind. It's easy to navigate. The content was developed with the average person in mind. It's really a beautiful site. I think we all know that the existing CMS, HHS compare Web sites have been evolving and improving over recent years, but they're still struggling to effectively support consumer choice. I think we have an opportunity with Physician Compare to set a new standard, and I hope there is enthusiasm for that and excitement around that with healthcare.gov as a precedent.

Point two, consumers--and you asked this in the material in prep for this meeting. Consumers want information on individual doctors. They've been told--they have told us this for years. So we support very strongly, Consumer's Union supports reporting quality information about the group and the individual physician level. There's a specific question I think we have to all resolve. And, of course, the legislation speaks about individual physicians.

Point three, we can't wait to get the methodology here perfect before presenting useful information on doctors to consumers as data is being generated and reported in varied menus now, being fairly widely used in the insurance marketplace. And we have to find ways to give it to people even as we explain very carefully and very deliberately the context, the caveats and the limitations of whatever data we have. In other words, the perfect here cannot be the enemy of the good. We all know there are important methodological challenges in presenting this kind of information, in calculating these kind of braids, numerators and denominators. These challenges will have to be met and overcome as you build this tool but not before you build it. I think there's wide recognition of that but just to state it.

Point four, quality and performance information is the priority for Physician Compare, but we strongly urge you to consider presenting other salient facts about doctors. For example, maintenance of certification is emerging as a strong, and Ann may speak to that, I saw her up here--is emerging as a strong indicator of physician's commitment to both keeping up and improving the quality of care they deliver. So maintenance of certification information, pretty important. It should be indicated as part of a physician's profile. Many consumers also care about whether their doctors do research and are experts in their field. We would urge a standardized presentation of every physician's research portfolio as well as the funding source for that research. We also believe strongly that the public has a right to know of their doctor's drug-prescribing patterns and habits may be influenced by the fact they supplement their income with money or gifts from pharmaceutical companies to make speeches or perform other functions. I won't elaborate on that now, but I'd be happy to later either in questioning or in written presentations and written testimony submission.

Point five, a core set of robust and meaningful measures of consumers' experience of their care. People's own view of their own functionality and the coordination of care they get simply must be a part of the measures posted on Physician Compare. So again, that's a core set of meaningful measures of consumers' experience of their own care.

Six, we do not support, for now, allowing consumers to post reviews of their own doctors on Physician Compare. This is a very murky area. There are some popular sites up this alley, about five or six of them that I think we all know the names of, Zargots, Angie's List, et cetera. I haven't done any systematic research on those sites. But I think we all know that's an easily manipulated area as with other reviews that you see on the web of movies or products or whatever.

Eight, yes, physicians, we believe, have rights with respect to the information about them on any government Web site, that's obvious. But we urge you not to compromise the public's right to accurate information that could affect their care because of minor quibbles over statistical details or nuances in order to get bogged down in that argument, which has been going on for several years. Doctors should be permitted to directly update certain basic directory information on Physician Compare. We do not, however, allow physicians to directly revise quality and performance information on the site. I'll skip the rest as the law requires doctor have an opportunity to review and correct the information.

And the last point is we support strongly the use of electronic health record generated data as early as that is feasible to do. So, hopefully, we won't be in a waiting period for the meaningful use stuff, et cetera, et cetera, that we will begin to experiment that--that you will begin to experiment with that as soon as possible.

Thanks. I think I went over two minutes, but I appreciate the indulgence.

BILL MCQUINY: Thanks. All right. Is there another--okay. Go ahead.

JEN BOWMAN: Hi, I'm Jen Bowman with the Podesta Group. And I have, I guess, three

comments that are somewhat related. The first is with respect to public records, as you may be aware, there are lots of companies that have made it a business to amass public records information and that, you know, from ancestry.com to all kinds of things that are used by the Department of Justice and other organizations. And I would just encourage CMS, to the extent that it's possible, not to reinvent the wheel. You know, there's a lot of that information that-- from the state licensure boards or from, you know, some of these other sources that we have talked about that is available, kind of, all in one place. And I would be happy to talk further with you about that.

Another, I think, kind of general comment is--I guess I'm working with a number of clients who have expressed concerns about just kind of sort of this issue of what information seems it would be important to have on this site. I think we have heard, you know, a lot of important aspects of how you might assess the choice of physicians. But I think it would be helpful also to take a step back to the health services research literature and really look at, you know, sort of to the extent that someone has looked at this. I can't claim to be the expert on this. But to the extent that, you know, we have information about what are the factors that are most, you know, influential with regard to being able to choose a high-quality physician or a low-cost physician or, you know, that we have sort of the top line of the information that's that first layer of detail, that which is most important in terms of the choice. And then, you know, some of the other things that might be factors that would, you know, maybe swing you at the margin, you know, but that are not sort of the things that maybe are most critical to the beneficiary's decision, to have those be kind of another layer down in the architecture. So just to try to separate the most important from the more marginal data. And I think that might have been two and three so I'll stop there.

BILL MCQUINY: Thanks. We have another commenter in Baltimore.

JENNIFER SHEVCHEK: Jennifer Shevchek AMA Staff and we will be providing more detailed comments before the November 30 deadline. But there's been a lot of discussion here of broad asks and broad comments. I think we're really--this is still a nascent field within CMS. And I mean that because one of the provisions that does not get discussed often in the

Affordable Care Act, it's 10332J, I think, and it deals with modernization of CMS's health IT system. And a report is due to Congress, I think, by next year. And I think a lot of this dovetails with all of this is in terms of understanding what is the capability of CMS at this present moment.

And AMA in particular, we have had a lot of experience of doing some caseworker positions over the past couple of years, intensely dealing with PECOS. And there have been numerous problems with PECOS in terms of enrollment, in terms of data accuracy, where their practice is located. And I'm just trying to really boil this down so we can all be speaking from the same page before we get to this high-in-the-sky vision of what we want. I think we need to look at the reality of the situation and what physicians are facing today with enrolling in Medicare and dealing with PECOS, 'cause it's really challenging.

So that's one thing, I think we need to--I really encourage CMS, as they look to develop this Web site and put forth a design of that Web site but January 1, 2011, to really look at issues of PECOS in improving just the accuracy of what we would think is pretty basic data in terms of phone number, education, practice location.

Another issue is looking at what has been done thus far. I think, look at Hospital Compare is something that you guys must do. I remember when they were--when CMS was working on developing hospital compare before it went out live, I guess, in '04, one big issue that they faced was this issue of demographic information in terms of benchmarking and whatnot. You really needed to have updated demographic information. And a lot of, I know, hospitals really poked holes in that in terms of being able to figure out the accuracy of these hospitals and their data, where they're located, you know, the size of--how many beds, et cetera. I think we need to look at--let's not reinvent the wheel here. Let's realize from those mistakes, let's try to prevent them from happening as we work to develop the Physician Compare Web site.

There was one other comment. Oh, yes. Sequencing and coordination. There have been comments here made about, you know, making sure that we link this up with now the physician quality reporting system and meaningful use. I think we all need to understand that

some of these programs are--one, I mean, PQRI or PQRS is now just in its fourth year. We're still working to make improvements to that program. And I think we have made a lot of progress, but more work remains to be done. But on the meaningful use piece and the health IT Center Program, that has not even begun yet. And I think we just need to make sure that we are sequencing and coordinating appropriately so that it doesn't end up being this mis-mash of stuff that is not helpful.

But I think the AMA looks forward to making sure this effort is accurate, valid, it's reliable. And I think we will outline this in more detail in our comments. Thank you.

BILL MCQUINY: Thank you. One more from Baltimore.

TANYA ALTERAS: Hello. My name is Tanya Alteras. I'm with the National Partnership for Women and Families and also representing the Consumer Purchaser Disclosure Project. First, I want to echo my support for many of Steve Findlay's comments. We agree that the reporting should be at the individual physician level. There should be information on maintenance of certification, and there needs to be a core set of patient experience of care measures.

My comments are as follows; our main concern is that the Web site be designed to facilitate consumer decision making. Because if it fails with that, then a huge opportunity will be missed. So all my comments relate to that, the fact that Physician Compare needs to be populated with information that's meaningful to consumers and that it's presented in a way that's simple, intuitive and easy to navigate.

We believe that in order to accomplish this, information should be presented so that it can be interpreted and used, and it will consumers make the best choice. And to do that, they have to have good decision support tools. Examples of these are framing the decision context for the consumer, using summary performance indicators while at the same time offering detail by allowing the user to drill down into the data and to sort the information based on patients' values and preferences.

We also think, you know, some others have said that you need to look at Hospital Compare. We also think that you should look at other physician reporting sites that have been up and running for many years. There are a number of examples, regional collaborative both through the allying forces for quality program and the charter value exchange program as well as others. They have a history in communicating provider performance information to consumers. And we really think that that would be a great resource for CMS to build off of.

Aligning Forces for Quality has also conducted extensive focus groups to assess consumer understanding of performance information. And we also strongly urge CMS to tap into other resources that are targeted towards communicating with consumers. Some examples are the tool kit for making written material clear and affective, Art's Talking Quality Web site and other work by Dr. Judith Hibbert and Tishana Sofair [phonetic], all these are seminal resources that have been developed over many years to really help translate technical information into something that consumers can use and understand.

We also believe that CMS should take inspiration from some of the latest web technology that is in use now for reaching and engaging consumers. And one example, which I'm sure many people are familiar with, is Amazon.com. Its built-in capability to make recommendation to consumers based on their past behavior and on behavior of people like them. And other major online retailers provide chat boxes that consumers can use to communicate directly with support staff. And we feel that if consumers are able to do this on purchases that are presumably not as important as their healthcare, they should also be able to do it with their healthcare purchases.

We think that CMS should have experts review the Web site and allow users of it to provide feedback on how it can be improved. We think that CMS should identify regional and national organizations that patients reach out to currently and encourage these organizations to advertise the availability of Physician Compare.

One of the issues with Hospital Compare is that, while everyone in this room knows about it,

many consumers don't. So this is a matter of finding the consumer where they are. The agency can also facilitate distribution by making the performance information available in a way that allows the information to be re-purposed for distribution through other venues.

We believe that the data should be current. This is sort of an obvious point, but it's important to have current data to best facilitate consumer decision making. And having something as simple as the date for when the information was last updated so users really know when the information comes from.

Where appropriate, we think that physicians should be able to directly update their information on the Web site. And this does not apply to information on their quality measures, which we understand will be a whole different section of this meeting today in talking about the auditing process. But just revising information on their context, specialty and other similar information that's important to consumers.

We think that there should be links to existing physician performance Web sites on Physician Compare. And these could be other sites that provide individual physician performance information. There are many existing Web sites right now, Consumers Checkbook is one of them. Federal and state portals for health insurance exchanges may also contain information on individual physician performance, and we believe that there should be links there.

And finally, we think that the healthcare provider directory should be expanded to meet consumers' broader information needs. So we encourage CMS to consider how it could expand the director in addition to all the Physician Compare work and provide information on other important physician attributes the consumers need to know such as the physician's hospital care system affiliations and the languages that the physician speaks. Thank you.

BILL MCQUINY: Thank you. Let me just check and see if there's anyone waiting on the phone.

OPERATOR: Yes. We have several questions. Our first one is from Donna Kenny's location.

Go ahead, please.

DONNA KENNY: I have a question. I was wondering about--since there's growing numbers of opted out providers, whether they will be listed in these lists at all.

AARON LARTEY: To answer that, we tend to--we have an indicator in PECOS that designates whether a physician or a provider has opted out, and we usually filter them out.

DONNA KENNY: Filter them out. Okay.

BILL MCQUINY: We'll take one more from the phones.

OPERATOR: Certainly. The next one is from Patrick Torkson's location. Go ahead, please.

PATRICK TORKSON: Yes, hello. This is Patrick Torkson with the Society of Hospital Medicine. Thanks to you all at CMS for the opportunity to give some input this afternoon. The Society of Hospital Medicine is the physician group that represents the 20,000 hospitals practicing in the US. And just as a background, hospitalists or hospital-based physicians whose professional focus is the general medical care of hospitalized patients. And we, under this particular structure, are being lumped under general internal medicine, which really does not reflect the scope of our practice and may not be optimal for patients. We're wondering if there is an opportunity for some further customization of the page to provide more of a definition in education around hospitalists and other similar type of physician specialties, particular with our specialty that is now approaching 30,000, which actually exceeds the number of cardiologists practicing in the US. And we also care for more hospitalized patients than any other physician group, including Medicare beneficiaries. Thanks.

BILL MCQUINY: Thank you. Back to Baltimore.

CHIP AMO: Hi, my name is Chip Amo. I'm with the American Society of Anesthesiologists. And I guess that was a pretty good segway into the comment that I have, which is we certainly

agree that the information on the Physician Compare Web site needs to be useful to patients. And which his why for physicians such as anesthesiologists, pathologists, radiologists, which physicians--which patients do not have the ability to necessarily choose when they walk through the door of a hospital. We need to make sure that there is, you know, a way to report that appropriately. You don't walk into a hospital and say, "well, I looked at the Physician Compare Web site and I want that anesthesiologist treating me today." It's based on schedules, it's based on a whole host of things. Therefore, I think certain--you know, as we're looking at that, I don't think it's appropriate to put up information that is not actionable for patients.

So to be comparing anesthesiologist to anesthesiologist is not necessarily the best way to go about doing things. Maybe looking at it from a group level and seeing what the anesthesia care in general in that hospital might be would be a more appropriate measure than, you know, doing it individual by individual.

I would also echo some comments that I think the basic demographic information and making sure that we get that up in a location. There are so many sites. If you look and find a physician on the Web site, you can't find--you can't search by area, by the type of specialty and have it be a reliable factor. I think, you know, CMS, as sort of the older of the list of all the physicians, really needs to be out there saying who the physician is, where their practice is located, what are they specialized in, do they have any additional credentials, you know, board certification or what have you? That's the best way to be preparing physicians.

But right now, and I will speak as a consumer myself, you know, when I tried to go find a primary care physician, I couldn't. You know, it was very difficult. I had to go on several different Web sites to be able to find it. So I think this is your real opportunity. And I think we talk--we get down to the level of talking about measures and we're adding on this factor and this thing, which is only making your job more complicated. Let's walk before we can run, and let's get the basic information there first. Figure out how we're going to report it for other specialties that are not primary care or not your typical office-based practices that people can go out and choose and make sure that we're really comparing apples to apples across the

board and get that basic information there first. So thank you very much.

BILL MCQUINY: Thank you. How many more people do we have waiting on the phone for comments

OPERATOR: We have three more.

BILL MCQUINY: Three more. Okay. I'll take one more from the phone and then you. Okay.

PETER MCMENAMIN: Okay. Peter MCMENAMIN, American Nurses Association. I can understand why you might not wanted to have called it the Medicare Part B Non-Institutional Provider Compare. But my recollection is there are more Part B providers who do not have MD's than there are those who do. The number of health professionals may be more comparable. Should we assume that the Web site structure is the same for all of the Part B providers who are included in PQRI or participate in any way?

REGINA RAYMOND-CHELL: So if you're talking about the Physician Compare Web site that was in the proposed rule to use the framework of the healthcare provider directory Web site, then you should not make any assumptions. What we want to hear is your input to how you would envision that Web site. Does that answer your question?

PETER MCMENAMIN: Well, I think it does. But I think that means that you may need another listening session for the non-physician providers just to--'cause there is chiropractors, advanced-practice nurses, physical therapists. The scope of practice is very different for all of them. And even within advanced-practice nursing, I mean, having looked at the PSPS database, this array of services provided by CRNA's is entire different from the certified nurse midwives.

REGINA RAYMOND-CHELL: Thank you for that. And just to provide some clarity for everyone in the room, I know I can't answer questions but I can comment on your statement with regards to other practitioners and professionals. And we do appreciate that a Physician

Compare Web site does include a variety of practitioners. So as I had those three slides that had the other eligible professionals for the physician quality reporting system so there were many professionals other than physicians on those three slides.

PETER MCMENAMIN: Would it be possible sometime later to go back to the Web site and seek a non-physician specialty and just see whether that appears is largely comparable to the physician records we saw for the cardiologist?

REGINA RAYMOND-CHELL: Oh, would it be possible today?

PETER MCMENAMIN: Um-hum.

REGINA RAYMOND-CHELL: I don't think we'll have time today just because we want to have all the time to hear what you have to say. But I think Aaron has a comment he wants to make.

AARON LARTEY: Yes. Pretty much all the profiles, everything that you saw in relating to the cardiologist's list, the other healthcare professionals are listed at the same way as well. So we pretty much have a one-for-one match as whatever data we collect for physicians, we collect some more data for the other healthcare professionals. There are some limitations here and there, but pretty much they're one-for-one.

PETER MCMENAMIN: Well, back to my earlier comment on the graduation. Again, that may be very different for the non-physician in the group. The other thing that the consumer represents, I'm almost surprised hasn't mentioned, is you do have data on the volume of services provided by the providers in that system, you know, previous year, previous quarter, some number like that, number of patients seen, number of services provided, total approved charges. And that might also be a useful indicator of, you know, does this person have an ephemeral connection with the Medicare program or are they seeing a substantial number of patients?

BILL MCQUINY: Thanks a lot. Operator, can we take our next caller?

OPERATOR: Certainly. Our next caller is Elizabeth Gallick. Go ahead, please.

ELIZABETH GALICK: Hello, this is Elizabeth Gallick. I'm from Gerenterological Advance-Practice Nurses Association. And my question is kind of similar to our previous caller in the sense that there are several groups of non-physician healthcare providers that are going to be included in this and want to be included in this. But yet the site is called Physician Compare. Is there any consideration to maybe combining physician and healthcare provider compare Web site? I don't know.

REGINA RAYMOND-CHELL: We're open to any comments or thoughts that you have that you want to send out with regards to that. This really is about hearing what our external partners have to say with regards to this Web site.

ELIZABETH GALICK: Then what I would say is, you know, to be consistent with your other directory, physician and other healthcare professional directory, I would make that recommendation that this happen with Physician Compare as well, to be more inclusive and provider neutral.

BILL MCQUINY: Okay. We have one more caller.

OPERATOR: Our next caller is Victoria Mesimodo. Go ahead, please.

VICTORIA MESIMODO: Hi. My question had to do with the PQRI reporting that you intend to show in January 2011. Is this simply a yes, no? Does the provider submit intersection to PQRI or will you be showing another level of detail on that PQRI reporting such as measures reported or, you know, information of that sort? Could you elaborate, please?

REGINA RAYMOND-CHELL: What we're required to report under MIFA is whether or not the provider satisfactorily reported PQRI. We're not talking about measure information at this point.

VICTORIA MESSAMOTO: So satisfactory report sometimes can simply mean did they report data and then you--whether the doctor has received the one and a half or two percent bonus. What will you use to determine whether they satisfactorily reported?

REGINA RAYMOND-CHELL: Whether or not they met the reporting threshold for PQRI.

VICTORIA MESSAMOTO: Okay.

REGINA RAYMOND-CHELL: So the 80 percent, and that qualifies them for the incentive payment.

VICTORIA MESIMODO: Okay. So if they don't participate because, you know, they just haven't incorporated PQRI reporting into their claims filing, they just will show as not participating; is that correct?

REGINA RAYMOND-CHELL: It will look like the example that we looked at today where there's no information at all.

VICTORIA MESIMODO: There's just no information. Okay. Thank you.

BILL MCQUINY: Okay. Here in Baltimore.

MATT MCNABB: Yeah, I'm Matt McNabb. Again, I'm a physician working with the American Geriatric Society. Two comments, one is that actually regarding that previous caller is the non-participating physician. I think we think it is important that the Web site identify them as such and not mistaken for poor quality, if somebody is seeking information and find a physician who is not participating, that it not be mistaken as someone who is not meeting quality standards.

The second larger point is regarding the measures themselves. And as geriatric healthcare providers, we take care of a disproportionate number of older Medicare beneficiaries who have

greater complexity, multi-morbidity of conditions as well as functional and cognitive impairment. And to use an example, say diabetes and hypertension which--or heart disease, which might be quality measures that are monitored and recognized on this quality site. There might be even individuals in this room who have those conditions and are participating in this symposium, maybe even also being under Medicare.

But there also are same people with those same conditions residing in the nursing home, receiving care under Hospice. And it would be important for physician providers who are taking care of a panel of patients who represent that more frail and ill population have a form of adjustment or recognition of that different population so that the quality indicators appropriately reflect that.

I think that's true for not just physicians but all healthcare providers that other people have mentioned. But overall, the American Geriatric Society fully supports the idea of quality measures that are appropriately collected and shared with the public.

BILL MCQUINY: Okay. Do we have our last commenter on the phone?

OPERATOR: Yes. Our last comment is from Ed Mendoza. Go ahead, please.

ED MENDOZA: Yes. This is Ed Mendoza from the California - - Statewide Health Planning. I have, I guess, a question and it's related to some of the other questions and comments earlier. What--

BILL MCQUINY: You're really breaking up, caller.

ED MENDOZA: Is that any better?

BILL MCQUINY: Still clipping.

ED MENDOZA: I'll try to speak louder. What has been done or what is planned to do user

testing on not only the usability of the Web site but also the usefulness of the information in terms of consumer engagement? It seems to me that some of the research, at least in the past, has indicated that more information is not necessarily better for consumers if you have so much information that you disengage people before they have really had a chance to even think about choice. So what are the plans for user testing?

BILL MCQUINY: Did you get that?

REGINA RAYMOND-CHELL: So we would, at this point, accept your thoughts and comments and suggestions for consumer testing and user testing. And you have until--after this call, we're accepting written comments 'til November 30, 5:00 p.m., Eastern Standard Time. But we are here to be informed by what your thoughts and recommendations are.

BILL MCQUINY: Okay. We have our last two commenters in Baltimore. Go ahead.

LISA GRAVER: Good afternoon. Lisa Graver with the American Hospital Association. I would like to thank my colleagues, Jennifer and Tonya, for referencing Hospital Compare as a good source to learn from, as you plan for Physician Compare. I also would like to add that in 2004, when we first started to put together the plan for Hospital Compare, that stakeholders were a very important part of the process in building it, specifically the Hospital Quality Alliance or the HQA was a very critical partner in building that. And I would encourage you to reach out with other external stakeholders as you begin to build Physician Compare. And then also on the topic of Hospital Compare, like most things in the quality world, continuous quality improvements. Hospital Compare is a great source to look at, but there are some improvements that are necessary for Hospital Compare to make it more useable for consumers. So if you take into consideration some of the factors like building in more flexibility to use the data and customize it from the perspective of the end user as you build Physician Compare, I think that would be something to also take into consideration.

BILL MCQUINY: Thanks a lot. And our last commenter in this section?

MALE VOICE: I have two things. I first have a question. You say that the earliest that reporting periods for physician performance information can begin is January 1, 2012. Does that mean that somebody who wanted to report on--let's take an extreme case. You know, suppose you wanted to report on mortality rates by physician. You're probably not going to go down that path right away, but suppose you did. Hospital Compare will look back over several years of data, previous years' data in order to produce a report this year. We do the same thing when we do death rates for hospitals in our own publications. Are you saying that you couldn't look at any data on any event that occurred before 2012 or that that would be the beginning--or that would be the point at which you started analyzing the data? A fairly important point in terms of whether this thing is years down the line or closer at hand. And, you know, that could be equally true of PQRI data or something else. Do you have an answer to that? You don't have to answer it. But I just want to raise that question.

REGINA RAYMOND-CHELL: I think that's the statutory language. The reporting period is no earlier than January 1, 2012. So that would be kind of subject to interpretation whether or not we can look back further than January 1, 2012, or is it just all data collected after January 1, 2012? That would be subject to rule-making.

MALE VOICE: For all events that happened, actually, you know, did they give the hemoglobin A_{1C} test in 2011? And can you use that in your report? So it's a fairly important thing. I just hope you'll take a hard look at it. I hate to have this held off farther than it has to be because of too conservative of an interpretation of that. And yet it's very important to sample size.

REGINA RAYMOND-CHELL: Right. And since it's subject to rule-making, that would be something that we would be interested in hearing your input on.

MALE VOICE: And my input would be there's no reason at all not to use those data from earlier time period. It's not like physicians are not doing hemoglobin A_{1C} tests because Physician Compare hasn't been launched or whatever. Okay. So I think it's quite relevant to look back into an earlier--to start doing the analysis in 2012, but to look at data that might be from a couple of years prior to that.

Okay. The other thing I just wanted to say, 'cause we're still talking, I think, about the features of the Physician Compare Web site, I think it would be very important for you to think hard about giving other entities access to the full data that you have on this Web site. I'm very optimistic and encourage you strongly to pull all kinds of data from all kinds of sources into this Web site either by link or actually by creating it or whatever.

I think there's wonderful potential for people to use this information, if they can have access to it. I mean, in a very small way, I can look even at the Hospital Compare Web site. I can download the entire database from Hospital Compare showing, for instance, the exact mortality rate for every hospital, what the upper and lower end of the expected range of mortality rates at that hospital is, et cetera, full database which, you know, could be used and re-distributed in other ways quite possibly. But you can imagine with this that there are a lot of organizations that could use the data on here that would have different ways to format the information, even if Physician Compare hasn't done it in the most successful way that the other organization entities that could do it that would have other channels for distribution of the information, that would be able to use to build sort of composite measures if--probably needs to be approved when they start doing these composite measures. At least some, you know, re-thinking of the measures themselves that they--I'm thinking of organizations like health plans and medical groups that are putting together provider directories including for the exchanges and a big burden for health plans to put together provider directories and certainly for the exchanges that will be.

And yet a very desirable part of the exchange is for you to be able to go on the exchange and see what doctors are in it. But why should they all have to do all this work? If they can just pick up the information out of this Web site, it would be much deeper and much better. And specialty boards might be able to use the information for some aspects of their maintenance and certifications. Researchers certainly could use the information. So I hope you'll think very hard about that.

The only other point that I think needs to be thought about there is how you're going to deal

with the proprietary nature of some information that I hope you will acquire. For instance, the specialty board--

REGINA RAYMOND-CHELL: Can I just interrupt you one minute? Just in the interest of sticking to our schedule and out of respect for everyone's time that's on the phone, I want to let everyone know we do have about 30 minutes built in at the end of the event today for any additional comments that we may not have gotten to on your section. So I would like to go ahead and move onto the next agenda item. And then if you have additional comment in the end, you're certainly welcome to continue that. Thank you.

So the next thing we're going to do is start our measure selection section. And I'm going to turn this over to AUCHA. Just to give you a framework for the rest of the afternoon, we'll spend about 30 minutes on the measure selection section. And then from 2:45 to 3:00, we'll take a 15-minute break and then go onto the rest of the events that are listed on your agenda. So thank you, AUCHA.

AUCHA PRACHANRONARONG: Thanks, Regina. As Regina mentioned earlier today in her introduction or overview of the Physician Compare and other requirements, Section 10331 of the Affordable Care Act requires us to implement a plan by January 1, 2013, to post performance information on physicians on the Physician Compare Web site. And the language of the statute itself sets some parameters around the selection of measures for us to post. Specifically, Section 10331 of the Affordable Care Act requires us, to the extent, scientifically sound measures consistent with the requirements of the section are available. Such information to the extent practicable shall include physician quality reporting system measures, patient health outcomes and the functional status of patients, continuity and accreditation of care and care transitions, including episodes of care and risk adjusted resource use and assessment of efficiency, patient experience and patient caregiver and family engagement, safety effectiveness and timeliness of care and other information as determined appropriate by the Secretary.

Based on the parameters that were set out in the law, some of the areas that we would

specifically like your input on today is should there be a core set of measures that apply to all physicians regardless of specialty? What about specialty-specific measures? Should we use only NQF endorsed measures or other types of standard measures? Should CMS report some measures as composites? If so, which types of measures should be reported as composites? And should trending information be displayed?

So I would like to go ahead and open up the floor for your comments now.

BILL MCQUINY: Okay. Do we have any commenters on the phone?

OPERATOR: Currently there are no comments on the phone.

BILL MCQUINY: I'm just turning on the mic here. There you go. Go right ahead.

MARY PATTON WHEATLEY: Yes. My name is Mary Patton Wheatley from the Association of American Medical Colleges. And just in regards to reporting a core set of measures, I think I would just encourage you to look at the meaningful use program for physicians. And some of the issues that I have come across, you know, they're trying to do a core set of measures. And we're finding even physicians' practices don't exactly match up or they match up on technicality but not really in the practice of scope.

So I think, as we go through the next year or two of really looking at that particular program, you'll find out how well a core set of measures will work or not.

BILL MCQUINY: Okay. Next comment?

LISA GRAVER: Lisa Graver, AHA. Prior to implementation in a federal program and public reporting on any compare Web site, measures should meet the following criteria. They must be aligned with the goals and priorities established under the National Quality Strategy that's currently being developed in the Department of Health and Human Services. And they should include meeting the triple aim that's been articulated by Dr. Berwick [phonetic], that the

measures be improved, better care for individuals, better health for populations and lower costs per capita. They should be aligned with the goals of the national quality forms, national priority partnerships, and they must be NQF endorsed.

In order to prepare for implementing the provisions in the ACA for public reporting, CMS should focus on a core measure set. Without a core measure set, there will be lack of consistency and validity in the measures. Consumers will have difficulty putting together bits and pieces of data on some physicians but not all if there's no core measure sets. You will also have problems with small sample size and the validity of the data if you don't come to a core measure set. And finally, claims data can be an appropriate source for public reporting of resource use measures. But non-clinically enhanced claims is not an appropriate source for public reporting of quality data.

BILL MCQUINY: Thank you. Next in Baltimore?

STEVE FINDLAY: Yeah, Steven Findlay, Consumer's Union. First issue is the NQF only. This has been debated widely over four or five years. NQF has gained significant momentum, included many more stakeholders in its deliberations. And we would strongly recommend that there be important deferral to using NQF endorsed measures. However, we would not support an absolute, 100 percent barring or block of measures that you developed on your own or that came from other places that were not yet NQF endorsed or had not gone through that process or just had not been submitted. There are just too many variables in this environment and, likely, it remain too many over the next four or five years to have any kind of absolutist requirement there.

We would support the other comments that made and I made actually earlier as well on a core set of measures supplied to all doctors. So our answer to that would be yes. Also, I spoke before to the issue of composites. Composites for consumers are very, very important. Seven, ten, fifteen measures on diabetes is not something most people are going to go through. And the methodology has advanced significantly over the last four or five years to do composites that are statistically valid and reliable. So that's developing in a way that, in the

next two or three years, we ought to be able to do that.

And also I would emphasize what others had said about coordination with meaningful use, but I think that's an obvious point. So that's the last time I'll make that point. You guys know you have to do that. So thank you.

BILL MCQUINY: Thank you. Do we have any callers on the line?

OPERATOR: There are currently no callers.

BILL MCQUINY: Okay. Go ahead, Baltimore.

PHILLIP MARSHALL: Thank you. I'm Phillip Marshall and I'm with Press Ganey [phonetic]. So I thought I might share with you some of our recommendations with regard to patient experience measures. And so let me share with you what we see as a reasonable time frame or some of the milestones for patient experience of care measures if, in fact, we are to meet some of the deadlines laid out in the act. And then I'll specifically address some of the questions that you asked specifically.

As we look ahead to PhysicianCompare.gov public reporting of patient experience of care by 2013, we have actually done an analysis based on our CT caps pilot experience, as well as our experience in surveying about 90,000 physicians with the patient experience of care measurement. Today as well as, of course, our HospitalCompare.gov submission of Hcavs. And so backing into--and by the way, I will be submitting this before November 30. So I'm just going to hit the highlights.

REGINA RAYMOND-CHELL: That's great.

PHILLIP MARSHALL: So don't worry about writing it all down. But if we back into that 2013 date, we have analyzed the process that is likely to be gone through. And NQF approval which, you know, we certainly support the notion of NQF approving what instrument might be

used for patient experience of care measures. So NQF of a CT caps instrument, which is our recommendation for you, because it has undergone the most testing nationwide. And by the way, if you're wondering which version of CT caps, because there are several, the four-point visit specific version is what is recommended that you go with.

NQF approval would probably need to occur by summer of 2011, with vendor training and approval by Fall of 2011, a mode study by 2011. And mode of delivery is important here, electronic surveying. We recommend that you do accept electronic surveying, even if it's to build volume of results after an initial sampling by mail. But we do recommend that that mode be acceptable. There be a dry run by Fall and November and December by 2011. And then by January of 2012, the voluntary reporting would begin. Data submission of the last results of October through December of 2012 would need to be done by April 2013. And then that would allow by mid 2013 for results to be finally available. So, again, I'll be supplying that.

I would recommend, in addition to simply visit-specific experience of care information, that some of the areas called out in the legislation can also be potentially satisfied by patient feedback. And, of course, those include continuity of care measures as well as outcomes measures. We know that sampling size and methodology is difficult when using only clinical data or even administrative claims data. And so asking patients about their outcomes of care may be a worthwhile pursuit in satisfying that portion of Physician Compare.

Specifically on your questions of should a core set of measures apply to all? We certainly believe that CT caps applies there and that that would indeed apply to all and would allow for appropriate benchmarking. Should there be only NQF endorsed measures, I think I have addressed that. Should there be composite measures? Certainly. There are roll-up measures by section that would be possible for CT caps as well as the typical global measures of likelihood to recommend in the zero to ten overall rating. And so we encourage that that would be consistent. And should trend information be displayed? Certainly. We believe that that should be true. So thank you.

BILL MCQUINY: Thank you. Another question from Baltimore?

BRIAN WHITMAN: Hi, Brian Whitman with the American College of Cardiology. Just a couple responses to the questions that are up the screen. I think it would be difficult, if not impossible, to have a core set of measures for the 800 or 900,000 physicians in this country. It's very different from the 5,000 hospitals that have a much more - - .

In addition, you kind of face the issue of how do you measure right now? The only way you could create that core set of measures would be through the claims process. And I don't think the claims measures that are out there right now are robust enough to hit all the physicians that are out there.

Overall, we think the measurement here should really be an outgrowth of the physician value-based purchasing program which allows potentially--or we believe should allow physicians to have the opportunity to review their measures, provide feedback. And then that information can go forth for a public Web site.

I think, obviously, these programs are being grown together. And I think you sort of need to focus on the value-based purchasing program. And then you can use the information from that for this public Web site. But it really needs to start at the confidential feedback level and then move up to a public Web site. Thank you.

BILL MCQUINY: Thank you. Next in Baltimore?

TANYA ALTERAS: Tanya Alteras with the National Partnership for Women and Families and the Consumer Purchaser Disclosure Project. First, I just want to say we obviously support all the Affordable Care Act mandates on what types of measures should be included in Physician Compare. And we urge CMS to take a leadership role in the development of the measures that will be needed to meet these categories, seeing that we all agree that we need measures on patient outcomes, patient experience, functional status, care coordination, resource use. But there are so many gaps in that measurement portfolio right now that really need to be filled. And we would like CMS to really make it priority to get these measures developed.

I had mentioned before and others have mentioned that we think the patient experience measures and surveys should be a strong part of this Physician Compare program. We believe that there needs to be much less focus on process measures and more on outcomes measures.

One of our big concerns is that in the development of this Web site and the decision making around which measures to use, that we don't let the perfect become the enemy of the good. We know that the Affordable Care Act calls for the use of scientifically sound measures, and we completely support that. But in defining this phrase and really operationalizing it, we think that CMS should recognize that there's no such thing as a perfect measure. And the desire for perfection really has to be balanced with the critical need to place information about physician performance in the hands of consumers. Because right now we're making decisions virtually blind. And not to say that anything is better than nothing, you know, we do obviously support scientifically sound measures. But there needs to be a balance there.

We support the use of a core measure set, as others have commented. We also support the use of composite measures. And we would advocate for the use of a composite that assesses whether patients received all appropriate care. We know there are various methodologies out there for how composites are developed. But the appropriate care model methodology receives our support.

We also support the use of trending data where available. And we think that it should be presented in a way that's not confusing or cumbersome to consumers. On the issue of NQF endorsement, we do think NQF endorsed measures, as well as non-endorsed measures if certain standards are met, should be considered for Physician Compare. And if you're considering non-endorsed measures, we think that they should be ones that meet the criteria outlined in the patient charter. And we'll be submitting written comments with more detail on that.

We think that PQRI or PQRS is a reasonable starting point for choosing which measures are

included. But we think that CMS should really be selective on which PQRI measures it includes. CMS, you should not post performance information on PQRI measures that just assess basic competencies of care or the documents that presents of an evaluation or an assessment or counseling. We don't think that that would be a meaningful addition to Physician Compare. Thank you.

BILL MCQUINY: Thank you. We have one more comment in Baltimore.

ANN GRUNNER: Ann Grunner from American Board of Internal Medicine. We agree with previous comments about NQF endorsed measure most of the time. But there's going to be times when it makes sense to include other kinds of measures.

With respect to this question of core versus specialty-specific measures, it seems like it may depend. We have collected over 200,000 patient experience surveys. And what we have found in looking at the difference between the caps surveys and condition-specific surveys is that there's much more discriminatory power with the condition-specific. And it's a much richer set of data. And the caps data, while standardized, everybody is clustered very tightly. And if one of the things we're trying to do here is provide some more discriminatory information, then the caps information may be less useful.

And the condition-specific surveys are helpful in that they give information from the patient perspective about the physician's ability to treat a particular condition with respect to, for example, diabetes. How well does my physician do in imparting information about diet and its importance to management of my condition? Or, you know, these kinds of questions that are actually very helpful from the patient's perspective.

We have also done work with respect to composites and have found that we have a whole host of - - who are very, very careful and have found that you can come up with scientifically valid and strong composite measures. So I think we would be supportive of that notion as well.

BILL MCQUINY: Thank you. Operator, is there anyone waiting on the phone?

OPERATOR: Yes. We have three questions on the phone. The first one is from Julie Cantor-Weinberg. Go ahead, please.

JULIE CANTOR-WEINBERG: Yes. This is Julie Cantor-Weinberg with the College of American Pathologists. Regarding the first question, I think it's really important to pick up on the comment made by Bryan Whitman before, that one size does not fit all. For example, pathologists often don't have physician--I mean, have patient contact and often don't prescribe at all. So that would be an important thing to note.

If there's alignment with meaningful use, many of our members, we believe, actually won't be hospital-based. But the measures do not fit our practice. And thirdly, because we're dealing mostly with laboratory measures, outcome based measures would be very challenging. So we would definitely urge you to be cautious and try to take into account important differences and specialties as you develop the measures. Thank you.

BILL MCQUINY: Thank you. Next.

OPERATOR: Our next question is from Victoria Mesimodo: Go ahead, please.

VICTORIA MESIMODO: Hi. The effort to report on patient health outcomes efficiency and so on is really exciting. But I'm just wondering, does CMS have an idea of what they will be trying to use to measure patient health outcomes other than surveys? And we have heard folks talk about cap surveys. How do you intend to get patient outcomes data that can be reported at the physician level without surveying every single patient who have enough data for physicians for it to be meaningful? And, again, efficiency, are you looking at systems such as EPSO treatment groups or are you going to develop your own methodology?

REGINA RAYMOND-CHELL: I don't think that we're in a position to be able to answer that question at this point.

BILL MCQUINY: Okay. Next. Do we have one more question or comment?

OPERATOR: The next question is--yes. Our next question is from Patrick Torkson. Go ahead, please.

PATRICK TORKSON: Yes. I'm with the Society of Hospital Medicine. I have a question that leads into a comment. And the question is does the Physician Compare Web site intend to develop its own unique set of physician-level performance measures to report? The reminder and the comment is that there already is a substantial amount of work in developing physician-level performance measures not only with the PQRI or PQRS now but with the physician hospital value based purchasing program. And we would endorse that the methodology for the measure development that has gone into these two programs has been sound with the measures being developed by the AMA's physician consortium and then endorsed by the NQF. And would very much be in favor of continuing that methodological process; although, not completely convinced that the measures are always relevant for every specialty practice, including hospital medicine, I would agree with previous callers that one size is not going to fit all and that a set of core measures is really not going to be realistic to cover all the physicians that will be reported on this Web site.

I would like to present an option for hospital-based physicians, including hospitalists, anesthesiologists, emergency medicine physicians, radiologists, et cetera, that we have the option of harmonizing our performance reporting with the hospitals for which we are associated using the performance measures that are going to be reported through the hospital value-based purchasing program or that are now being reported through the - - program. Thank you.

BILL MCQUINY: Thank you. Back to Regina.

REGINA RAYMOND-CHELL: Are there anymore questions on the line?

OPERATOR: There are no further questions.

REGINA RAYMOND-CHELL: Okay. So that brings us just within three minutes of our actual agenda time so we timed that perfectly. We're going to take the next 15 minutes and take a break. Just a reminder, as you go out the door to the right, you'll find restrooms on the left. If you go out into the lobby area, the stairs that lead down right in front of you go to a coffee bar, if you need refreshments there. And then we'll convene back here at 3:00 p.m., and we'll begin talking about--well, as you have seen, we're not doing much talking. You'll begin talking about level of reporting. Thank you.

Okay. It looks like we're gathering back in the room. So we're going to go ahead and get started on the last part of our afternoon presentation for this Physician Compare Web site, Town Hall listening session. And so next we're going to go into the level of reporting and data collection. And I'm going to turn it over to AUCHA.

AUCHA PRACHANRONARONG: Thanks, Regina. Welcome back from the break, everybody. Now we're going to dig a little bit deeper and get into the mechanics of reporting performance information. And with respect to the performance information that we're required to post on Physician Compare, section 10331 of the Affordable Care Act also specifies certain methodological issues for us to consider. More specifically, the law says that to the extent practical, we should consider measures that are specifically valid and reliable, including risk adjustment. Eligible professionals should have a reasonable opportunity to review individual results before they are made public. The data published should provide a robust and accurate portrayal of a physician's performance. The data should reflect the care provided to all patients seen by physicians under both the Medicare program and other payers to the extent such information would provide a more accurate portrayal of physician performance. We should also take into consideration attribution of care as appropriate. Timely statistical performance feedback is provided to physicians and that computer and data systems are valid, reliable and accurate.

Today we would like to focus primarily on two of these methodological issues. They would be the level of reporting, that is whether data is reported as the individual or a group practice level and the data collection or the sources of the data that we'll use to calculate performance

information.

In terms of the level of reporting, the questions that we specifically would like your input on today are at what level should the measures be reported, at the individual, professional or group practice level? How should group practices be identified? Should individuals associated with group practices be identified or should we do a combination of both individual and group practice level reporting? How should we define a practice? And are there any physician specialties that do not need to be publically reported?

In terms of the data collection, we would like to focus on which data sources should be used for measures to be reported in Physician Compare. There are, of course, the claims data that professionals regularly submit for billing purposes. This is an abundant data source. But we are limited in the scope of the measures that are available. And we would also have challenges with attributing the care to the appropriate professional.

There's also augmented claims such as the data that we collect under the physician quality reporting system where professionals submit quality data codes on their claims. There's a board scope of measures that are available under the physician quality reporting system. And when eligible professionals report the measures, they self-attribute that they're responsible for the care being measured.

There's also registry data which have the benefits of augmented claims, plus they capture outcome. There are, as we have talked a lot about today, EHR data. And then there's other data collection tools such as the group reporting option under the physician quality reporting system. And then, of course, there would be combined data sources.

So I would like to go ahead and open up the floor for comments now.

BILL MCQUINY: Okay. Thanks, AUCHA. Operator, do we have any callers waiting on-line?

OPERATOR: We do. Our first question is from Patrick Torkson. Go ahead, please.

PATRICK TORKSON: Yes. I'm with the Society of Hospital Medicine. This is to follow up on my previous question asking is the intent for the Physician Compare Web site to create a unique set of measures to be reported on the Web site? And then I have a comment to follow.

REGINA RAYMOND-CHELL: Okay. So we would be interested in hearing your comment and suggestions. We're not really in a position to speak to any intent at this point. We're just information gathering. And what performance information is reported on the Web site really will be determined through future rule-making process.

PATRICK TORKSON: Thank you for that clarification. And then just a reminder of the effort and the initiatives that are already going into developing and reporting measures through the PQRI or PQRS now and through the physician level value based purchasing program. I would also like to endorse the option for group practice reporting that's very much reflective and would be of the way physicians practice, specifically specialists like hospitalists, anesthesiologists and radiologists and refer to the same methodology being used for the PQRS to determine a group practice using a tax payer ID with no specific limit on the size of the physician group. And then, finally, whether or not some physicians should not have to publically report.

I think that having an option of tying an individual physician's level reporting with the hospital with whom they are in practice should be considered as an option. Thank you.

BILL MCQUINY: Thank you. Operator, do we have another caller?

OPERATOR: There are currently no more questions in Q.

BILL MCQUINY: Okay. Here in Baltimore, commenter?

MARY PATTON WHEATLEY: Hi. I've made this comment to other listening sessions. But when you're in the--Mary Patton Wheatley at the Association of American Medical Colleges.

When you're looking at defining a group and looking at the measures, I think it's important to consider more than tax ID number in defining groups. 'Cause we do have, like, a handful of academic medical centers where each department may have its own tax ID number. But they share some common infrastructure so they should have an opportunity to report as a group, if they think that's appropriate. So I say just to kind of keep that in mind. Thank you.

BILL MCQUINY: Thank you. Next commenter.

REGINA RAYMOND-CHELL: I just have one question. Would you have any recommendations or comments that you would elaborate on how you would define a group?

MARY PATTON WHEATLEY: And we're actually, I think, meeting with Dr. Roman next week to talk a little bit more about this. But I would have to actually talk with our members and talk with CMS and see how it would work in the systems on way to potentially be tax ID numbers, self-nominate and say we collectively can be reported as a group. That could be an option, if that would work with CMS's infrastructure.

BILL MCQUINY: Thanks. Next in Baltimore.

TANYA ALTERAS: Hi. Tanya Alteras, National Partnership and Consumer Purchaser Disclosure Project. We support the use of AHR claims registry and patient reported data. We think that AHR's will become increasingly important as a source of information, particularly in light of the meaningful use program that everyone has mentioned needs to be aligned with this, in which we agree with.

In the meantime, we do think claims data are the most readily available source of information and are particularly useful for outcomes measures, resource utilization and cost efficiency measures. And we don't want them to really--to be discounted, even as the use of AHR's grows, claims data will continue to a vital and sometimes sole source of information on cost.

We also want to express the idea that while administrative and claims data should be used to

the maximum extent possible, patients are often one of the best sources of information on functional status and experience of care. And that just echoes some comments I made earlier. The need for patient experience measures to be part of a core set. Thank you.

BILL MCQUINY: Thank you. Go ahead.

CHIP AMO: Hi. Chip Amo, American Society of Anesthesiologists. And I would just like to say that I agree with the gentleman from the phone from the hospitalists. I think anesthesiologists would probably prefer to be reported as a group. And when I say that, I'm talking specifically about anesthesiologists that work in the hospital setting. Keep in mind that there are plenty of anesthesiologists that work in the hospital-based setting, giving what we would all refer to as sort of traditional anesthesia. But that same--there may be individuals within that group that also practice pain medicine a couple of days a week on the side. So they might have their own private practice out there. And I think that there's--at some point, there's got to be a nuance way to separate those folks out and measure them for the different types of practices that they have. Because they're actually extremely different in terms of, you know, being able to look at that. So I think it's a consideration that you need to look at.

But I would agree also with his previous comment about looking at possibly, you know, tying it into the overall, you know, hospital measure. Because I think folks in the hospital compare. Because I think, really when you're going to be choosing where you're going to have surgery or where you're going to be choosing to go in to have your care, you're going to be looking at it as the total experience. And I think, you know, if I were selecting a place to have surgery, I would be looking at hospital and saying, you know, "where is the chance that I'm going to get the least chance of getting an infection, or what's the average length of stay?" And those are types of things that, you know, the anesthesiologist might have, you know, a better handle on to help out.

And I think, as you're comparing group practices, I think it's important to recognize the differences between the various hospitals as you're comparing them. For example, a group practice of anesthesiologists that works in an academic center is going to have different

outcomes and experiences than somebody working in a private smaller community hospital. And I think there needs to be some apples-to-apples comparison amongst groups when we get down to that level. So just a couple of things to note for the purpose of the hospital-based anesthesiology folks. Thanks.

BILL MCQUINY: Thank you. Operator, any callers waiting?

OPERATOR: Yes. We have one. Our question is from Judy Berlin's location. Go ahead, please.

JUDY BURLESON: Hi. This is Judy Berlin of the American College of Radiology. I just want to ask one point of clarification as far as the level of reporting for group practices. If you're referring to reporting potentially the group practice reporting option from PQRS as a level of reporting, but that option wouldn't completely assess performance of a group in cases of multi-specialty groups. Those measures are primarily primary care.

I also would like to make another comment which really goes back to the section on selection of measures. But I think it's also relevant to the level of reporting. I would like to echo the sentiments of our colleagues from pathology, anesthesiology and the hospitalists societies and also reiterate how difficult it would be to build a core set of measures that are meaningful and equally relevant across specialties. And although we do believe that it is important to align the effort with--the Physician Compare effort with meaningful use management, as an example, the core quality measures in meaningful use may be completely irrelevant to consultative specialties such as radiology, pathology and anesthesiology.

The specialties who are also eligible at the individual provider level for meaningful use measures such as childhood or influenza immunization rate, adult weight screening and tobacco use assessment are really not helpful information to the consumer to patient as well.

And also to speak to the suggestion to harmonize performance measure reporting across settings of quality reporting programs such as RHQ, DAPU or HOP, QDRP, that may not be a

complete answer either as the hospital level measures are assessing hospital performance, not specialty or department. For example, the imaging measures included in the hospital outpatient program attribute the efficiencies that the measure tried to get at appropriately to the hospital outpatient department itself, not to one department or a specialty being completely accountable for those efficiencies. And if those were reported in such a way by individual--at the individual physician or specialty level could be misleading to the consumer.

BILL MCQUINY: Thank you, caller. We have another comment in Baltimore.

PETER MCMENAMIN: Yes. Hi. I'm Peter MCMENAMIN with--put my former HICFA hat on. Let me make two suggestions, one about identifying groups. You have three million records in the NPI data, and they indicate both the entities and the individuals. And arguably, you could cross-match them and associate all of the individuals within NPI with group practices as entities that exist at NPI. Alternatively, you could do it empirically with claims data. And you would have to match up Box 24J on the CMS 1500 with Box 33. 24J is the practitioner who provided the service, and 33 either A or B is the billing entity so that, again, you could develop a list of associations for individual NPI's and the groups with which they're associated with. In a perfect world, there would be a one-to-one correspondence, and I know it's going to be messier than that.

The other issue I want to talk about is the non-Medicare data. I know this is a tobacco-free environment, but there are going to be some people out there who are wondering what were those people smoking? One I had found previously looking at Part B data is what can be described as a small, medium and large problem. There are some physician practices that have a substantial Medicare practice, and they continue to have that year after year.

What I have found, these are data from the '80s, was that about ten percent of the practices provided 50 percent of the approved charges. This is true within specialties, within individual carriers. And there were half of the practices that provided either ten percent. You have practices that basically are not in Medicare. An existing patient's dad is visiting from Schenectady, needs something and he comes to the physician and they provide the service,

but it is not really not in Medicare. And even assuming that the SGR problem went away, expecting that physicians within a femoral contact with the Medicare program would go out of their way without other incentives to provide their non-physician volume, I think it's expecting quite a lot.

So I would start--I mean, it would be nice if there were incentives to provide the additional data. But I would start with the Medicare data. And in theory, you have it under control. You could move on to Medicaid data from those same patients because, again, in theory, you have that under control. And getting the additional private market data probably would be nice. But I think you would get very strange results, because you would get complete data from some physicians and virtually nothing from others. And how would you compare them, I don't know that there's a meaningful way to do that.

But I would look to see if there is a way with existing Part B data to at least develop a threshold. You know, how many patients do you have to have before it seems like, well, you're in the program? You're staying in the program. You're seeing patients. That will be different for different specialties. Pathologists deal with a lot of specimen's, but they're all counted as different patients. Internists mainly deal with 100, but they're seeing those patients multiple times during the year. So it will be a difference in scale, even with trying to get the small, medium and large question clarified.

BILL MCQUINY: Thank you. Operator, do we have any other callers on the line?

OPERATOR: We do. Our next question is from Christine Broderick's location. Go ahead, please.

CHRISTINE BRODERICK: Hi. This is Christine Broderick. I'm representing the Campaign for Better Care as well as the National Partnership for Women and Families. The campaign is a multi-year effort to improve care especially for older adults and people with multiple chronic conditions, people that are the heaviest users with the highest cost and the poorest outcomes.

I would like to echo comments that Tanya Alteras and Steven Findlay made a little earlier and express support for reporting information at the individual clinician level as well. To make informed decisions, consumers really have to know whether a physician is providing high-quality care, whether they reflect their values and preferences, meet their communication needs and can be trusted to really help them make the best care decision.

I also want to urge that CMS insures that the standards for reporting data allow patients to clearly see variations in performance among providers. I reinforce something that Steve Findlay said earlier and urge CMS to insure that the variation is not obscured as a result of, as I think you said, minor quibbles over statistical details or confidence.

We understand that providers want to be represented accurately, but we also need to make sure that consumers have actionable information to help them make decisions. Thank you.

BILL MCQUINY: Okay. Any other callers on the line?

OPERATOR: We do. We have one other question. It comes from Alison Connor's location. Go ahead, please.

ALLISON CONNORS: Hi. I'm Allison Connors calling from Hoser Clinic. We have been participating in the PQRI since about 2007, and it's taken a huge effort in order to have our providers start participating, understand that their data that they report is, you know, the most accurate and best data based on our patients. And the PQRI--I just kind of joined the call so you might have mentioned this earlier. We're looking at historic PQRI data. My concern is that, you know, this effort was supposed to be a voluntary effort. And we were, you know, one of the first companies or healthcare organizations to start, you know, participating and reporting our data. So I'm concerned with, you know, if they were to start reporting the '08 data prior to the '09 data, I just feel like, as time goes on, data that we report and the outcomes that we report are the best for each provider. So I don't know if you're talking about historically. I think, un MIPA, you said that they were going to start reporting publically physicians - - in the PQRI. And since we have, I guess I have concerns over what year's data

is posted and making sure that the best data on each patient is reflected in, you know, the public reporting.

AUCHA PRACHANRONARONG: Are you talking about reporting of PQRI performance data?

ALLISON CONNORS: Yeah.

AUCHA PRACHANRONARONG: Okay. Thank you.

BILL MCQUINY: Thank you. Anyone else on the line with something to say to us?

OPERATOR: We have no one else in Q.

BILL MCQUINY: Okay.

REGINA RAYMOND-CHELL: Okay. Thanks. So we'll go onto our next section, which is data preview. And the Affordable Care Act does require CMS to establish processes to the extent practicable to ensure physicians and other eligible professionals receive timely statistical performance feedback and have a reasonable opportunity to review their individual data prior to publication.

So with that in mind, CMS seeks input on how should CMS provide physicians and other professionals with the opportunity to preview measures results prior to posting on the Web site? And what process should CMS develop for timely statistical provider feedback? So I'll open it up to public comment.

BILL MCQUINY: Okay. While they make their way to the mic here, is there anyone waiting to say something on the phone?

OPERATOR: There is currently no one in Q.

BILL MCQUINY: Okay. We have a commenter in Baltimore.

CHIP AMO: Chip Amo, American Society of Anesthesiologists. I don't have a specific recommendation. But more of the general recommendation is there are so many different programs out there that CMS is running between, you know, this program, the physician resource use report, PQRI, electronic health records. I think, you know, it's incumbent upon CMS to really look at all these different programs and combine them and look at some sort of way to, you know, report these in a way that's consistent and actionable by the individual physicians.

I think, you know, to have multiple--coming from one organization and having to look at a number of different ways in which you may or may not get dinged at some point, whether it be from a reputational standpoint or from an actual payment penalty standpoint, and having to jump through several different hoops and to record different measures for different things is going to be increasingly difficult. So I think that it's really incumbent upon CMS to look internally and to coordinate as best they can with the programs that they're currently operating and to make sure that they're consistent across the boards so that it reduces the administrative burden on the individual physicians. Thank you.

BILL MCQUINY: Thank you. We have another comment?

JENNIFER SHEVCHEK: Jennifer Shevchek, AMA staff. First of all, this is a really important--it's something that AMA advocacy worked on during the development of the Affordable Care Act. And it's making sure this language was included, 'cause it's absolutely essential. And we were really pleased to see, in the proposed physician fee schedule, that CMS actually acknowledge the importance of physicians having the opportunity to review their data on reporting rates and on PQRI quality measures for this new Web site. Physicians and other providers involved in the treatment of a patient must have the opportunity to prior review and comment and the right to appeal with regard to any data that is part of the public review process. Any such comment should be included with any publically reported data. This is necessary to give an accurate and complete picture of what is otherwise only a snapshot and

possibly skewed with skewed view of the patient care provided by physicians and other professionals or providers involved in that patient's care. Thank you.

BILL MCQUINY: Thank you. Anyone else waiting in the Q?

OPERATOR: There is currently no questions on the phone.

BILL MCQUINY: Okay. Go ahead, Baltimore.

STEVE FINDLAY: Steven Findlay, Consumers Union. Just to make a simple point, this is a very, very sensitive area. We support allowing physicians to have the opportunity to look at the results that apply to them beforehand. We would urge that there be a detailed rule-making proposal on this that sets out specific parameters for how that program would work, including allowing probably, you know, fixed periods of times that physicians have to look at the data, make corrections through some process, whatever makes sense. It just should be a very detailed proposal. We are very much in favor of it. But we worry, uh, that the very powerful provider organizations will come to pressure you guys for a more flexible, open-ended kind of system. And we would just urge you to resist that and pay attention to what Medicare beneficiaries need here. Thank you.

BILL MCQUINY: Thank you. Next commend in Baltimore.

PETER MCMENAMIN: This is Peter MCMENAMIN. Again, I could recall my earlier comments on volume and whether or not you could do anything timely for low-volume providers. But, again, just trying to get a common sense and actually referring to something Bob said before, in theory, claims are the timeliest of data because the providers have an incentive to get them in and they would like to get paid. If you want to get the 2009 data from CMS on Medicare volumes and Part B, it's not there yet because the carriers have to give six months to get the claims through. And then they process them. I don't know what timely means in this context, because it's certainly not going to be instantaneous. And it may not even be, you know, within several months and possibly not within several quarters. But partly

for that reason, you might want to consider developing, if you will, a report that the provider could look at that had several quarters worth of data. Because the past quarter won't be there yet, and it may be that the quarter before there won't be there yet. But the quarter before that and the quarter before that and the quarter before that might be achievable. And you could give the provider an idea of, well, how have you been measuring up? Is your trend upward or downward with quality and efficiency?

I don't think you'll be able to give a provider in a report saying, you know, "we're going to put this on the web next week or even next month." Because it will be data that's considerably old if you're only looking at a snapshot for a month or a quarter. I think you need to think in advance about developing a longer-run picture, which would allow the provider to look at, well, here's the trend. Here's how I have been doing. Here's how it's been changing. You know, does this thing--does it look like what I recall of my practice? And, hopefully, does it look like it's something that I can take advantage of and improve my practice. But it's not going to be timely.

BILL MCQUINY: Thank you. Next comment.

MALE VOICE: I think this is an area where the government again can play a very constructive role. I strongly endorse the idea of physicians having the opportunity to review data before the data are posted. Maybe I'll get a chance today to tell you a little about a survey we have done collaborating with various health plans where we surveyed patients and physicians using the group cap survey for them to evaluate their positions. And we have then sent a letter to every physician inviting the physician to come to the Web site before the data became public, gave them 60 days to review the data. This is, I think, a very positive thing for everybody concerned.

But, you know, that was one particular kind of data one time and a lot of communication back and forth with physicians on a particular Web site they have never been to before or whatever to do that. It just seems that CMS or HHS can build--it's very important that you build an overall infrastructure for this thing that is going to be increasingly needed, which is physician

review of data that are about to be published about them. And so you have a sign-up procedure where all physicians have the opportunity to sign up to be alerted to any data that ever are going to--that are in this queue for them.

And many of them can sign up to be notified by email, which tremendously reduces the burden on everybody to do. If not, there should be certain places they're told you can check every month to find out whether there is anything new. And you can at least have this log-in where you can go and find out where there's anything in queue for you. And very important in all these things to have this log-in be a secured log-in.

You know, we said, well, you can go and see your survey results, Dr. So-and-so, confidentially. Right. Well, then doctor loses the access ID that we sent to them, and we have to turn around and send another letter to them because we're not willing to send it to any other--put it out in any other way. The government has some real leverage, you know, to get physicians to say, you know, "I am who I say I am, under penalty of law" and to have very secure access systems to this kind of information. And to put that in place so it could be applied to data from registries, data from patient experience surveys, data from PQRI, all the kinds of data that eventually I hope get pulled into this system. That's a big apparatus to set up but well worth doing if you're really going to do this long-term and will really streamline things.

One of the other problems is these review processes, you know, we have some physicians who say, "well, why are those data so old?" Well, it took us two and a half months to even--you know, after we finished the survey, to even give you a chance to look at it. So making this an efficient apparatus and a rigorous and tightly secure apparatus is a really positive that the government can do and can do better than anybody else because it has the authority of the government to tell people, "don't lie."

BILL MCQUINY: Thanks for your comment. Operator, do we have any other callers standing by?

OPERATOR: We do, we have a couple. Our first one is from Joel Harder. Go ahead, please.

JOEL HARDER: Hi. This is Joel Harder from Interventional Cardiology. My recommendation is for CMS to establish a user guide that would aid the physician in performing their review of their data. One of the elements that I would CMS to include is maybe to focus the physician on what is the, let's just say, least reliable data so that the physician can say, "okay, I'm going to look at that data first before I look at all the other data in the complete data set to make sure that's the right data that CMS really, really wants to see." And if you could stratify that for the whole program, I think you would get a better outcome for having the physician review.

Also, the second point is I believe the Alliance of Specialty Medicine had a letter submitted that we had requested at least one month that CMS would allow to review their data set in order to assure that they have ample time to go back in their records, pull things, do their due diligence and make sure that CMS has the right information. Thank you.

BILL MCQUINY: Thank you. Can we have the next caller?

OPERATOR: The next call comes from Cheryl Clark location. Go ahead, please.

CHERYL CLARK: Yes, hi. It's Cheryl Clark with Health Leaders. Thank you for taking my call. I wanted to just get a clarification of what a speaker mentioned earlier, that the proposed rule making would be out in November. Can you give me a time frame? It seems as if there are so many comments that it was going to take you more than just a month to put all this together. And I'm wondering if I heard that right. So when would the proposed rule making come out for comment on this?

REGINA RAYMOND-CHELL: Okay. So let me just clarify. This is Regina. The proposed rule actually was published in the summer of 2010. So this is calendar year 2011 proposed rule. So the final rule is published November of 2010. When we're talking about future program years though, when you're talking about calendar year 2012 proposed rule, you would look to see that in the summer of 2011. Usually July of 2011 with the final rule then being published around early November 2011. So does that clarify those dates?

CHERYL CLARK: Yes. Well, so basically what we're talking about for this purpose for this Physician Compare Web site, we can expect the rule making to come out mid summer next year, right?

REGINA RAYMOND-CHELL: Well, no. We had language which we have referenced here today, and it's in your slide deck, if you're on the WebX. We did have some proposals in the calendar year 2011, Medicare physician fees schedule proposed rule with regards to the Physician Compare Web site. So there were some proposals, and the final rule will then be out November 2010.

CHERYL CLARK: Okay.

REGINA RAYMOND-CHELL: But additional years will be addressed in the additional rule--in the future rule making cycle

BILL MCQUINY: Okay. Thanks. We have a comment in Baltimore. Go ahead.

PHILLIP MARSHALL: Thank you. Phillip Marshall with Press Ganey. When it comes to the preview period and enabling a provider to preview potentially challenge the results of the measures or at least comment on the measures, when it comes to patient experience, what we found is that having a reliable sampling process up front that helps them to trust that, in fact, the results to reliably represent, other patient population is the best way certainly to mitigate this issue. And so I would encourage you to look at the sampling process, to ensure that the sampling process for at least the patient experience of care information is such that providers know that they can certainly rely upon it. And that will help to mitigate some of those demands and challenges.

BILL MCQUINY: Thank you. Another comment on the phone?

TANYA ALTERAS: Tanya Alteras, National Partnership and Disclosure Project. I just want to

reflect what some other commenters have said about there is a very strong need for having a data preview policy in place. We would just say that we really support making it a reasonable amount of time the providers are given to review their data and, where appropriate, correct the information about their performance. And we would recommend looking to the patient charter for a resource for where this is already happening and a model, perhaps, for CMS to use.

BILL MCQUINY: Thanks a lot. Operator, do we have anyone else waiting to be heard?

OPERATOR: We have one other caller. Our next caller is Judy Burleson. Go ahead, please.

JUDY BURLESON: Hi. It's Judy Burleson at the American College of Radiology. In addition to providing a data set during the data preview period, particularly for claims-based analysis of measures, it's important for individuals to also know that algorithm which the measures were calculated through, particularly in the need for challenging results.

BILL MCQUINY: Okay. Any other callers waiting?

OPERATOR: There are currently no more callers.

BILL MCQUINY: Okay. I'll turn it back to Regina.

REGINA RAYMOND-CHELL: Okay. So we're at the point in our program where we wanted to just provide an additional comment period to make sure that you felt like you were--had the opportunity to make any comments that you wanted us to hear today. So I'll open up to the phone and to the room, if there's any additional comments.

BILL MCQUINY: Okay. We have a commenter right here in Baltimore. Go ahead, sir.

STEVE FINDLAY: Yeah, I may think of some other things after other people have a chance. But just two things that occur to me quickly. It's Steve Findlay from Consumer's Union. It's we would hope that in the basic demographics/registry type data that gets developed around

physician's name, address, et cetera, et cetera, that there be a requirement for a Web site if a doctor has one and that Web site be given online on the Physician Compare site. And also if the physician is willing to be contacted to the physician's office is willing to be contacted by email and if so, what email is the appropriate contact, obvious reasons for those two things.

BILL MCQUINY: Thanks. Another comment here.

TANYA ALTERAS: Tanya Alteras again. Just a few other comments on issues that were not specifically requested. We think that this program should set standards for reported data in a way that variations in care are not obscured. In order to fulfill the Affordable Care Act requirement that publically reported data be statistically valid and reliable, we think CMS should ensure that variation of cross-measures providers is not obscured in public reporting. This has been noted in the outcomes reporting components of Hospital Compare. We also think that in order to achieve the mission of Physician Compare, it should work to really propel consumers toward physicians that provide high-quality, high-value care. So we encourage CMS to include benchmarks that identify physicians who are best in class or in the top ten percent of their specialty. Information about whether a physician meets the state or national average is really insufficient in meeting this type of goal.

We would like to see Medicare data be made available at the granular level so that these data can be combined with commercial payer data to develop a more comprehensive assessment of physician performance across public and private sectors. And we think that this will really foster the growth of all payer databases. And that can, in turn, help CMS gain availability to data that they need to populate Physician Compare with information that really comprehensively assesses how a physician cares for all their patients and not just Medicare beneficiaries.

We also encourage the more public/private collaboration on Affordable Care Act initiatives, and that refers to collaborating with a private sector, not just from Physician Compare but also across the accountable care organizations, medical homes and pilots that are done through the innovation center that will then facilitate data aggregation across purchasers. And that can

be fed back into Physician Compare. Thank you.

FEMALE VOICE: Can I ask a clarifying question? Your point about making the Medicare data available at a granular level, could you expand on that a little bit more?

TANYA ALTERAS: Just to make it--well, one of the issues that we talked about earlier was reporting composites. And so the issue of reporting--making the data also available on a granular level, being able to drill down and have it match up with all payer data from other sources so the aggregation can occur.

FEMALE VOICE: Like, in terms of drill down beyond just providing the measure rate or--

TANYA ALTERAS: No. That would be what we refer to there.

BILL MCQUINY: Thanks. Any other callers on the line, operator?

OPERATOR: We do. Our first question comes from Josh Boswell's location. Go ahead, please.

JOSH BOSWELL: Josh Boswell, Society of Hospital Medicine. Going back to the beginning of the presentation, I just have a simple suggestion about the functionality of the Web site. It just seems it would be a lot more user friendly if you could do a search based upon the user's address. I don't know how feasible that is. But it would just seem to make a lot more sense to be able to--for a user to find positions within their own radius instead of across an entire zip code. Thanks.

BILL MCQUINY: Thank you. Comment in Baltimore.

TOM GRANATIR: A quick one. This is Tom Granatir with the American Board of Medical Specialties. I would like to start by commending you for this sort of public consultation. It's really unusual, and I think it's really great that you have created this additional opportunity to

get public input on the Web site.

I wanted to reaffirm our commitment to making up-to-date certification information available to consumers through the Web site and look forward to talking to you about how that might be done. The boards maintain the most up-to-date information about certification. And I don't know whether there's been much comment yet today about creating links to outside Web sites. But we do think that having information on the CMS site and link to other sites aren't mutually exclusive opportunities. And I think we need to make sure that people have access to the most up-to-date information available.

And then finally, I give consumers a lot of credit and think that they can make sense of a lot of information. We need to make sure that we can textorilize what's there. I think it's a comment that Ann Grunner made earlier today. But we need as much transparency as we can have about the information that's available both directly from CMS and from other sources and so that people understand what it is and how much credence we give it. So thanks very much for this opportunity.

BILL MCQUINY: Thank you. We've got two more comments here.

PHILLIP MARSHALL: Phillip Marshall with Press Ganey again. Just actually just a couple of short, high-level points. So we would encourage CMS to make this both an intuitive, logical and familiar process. And using the HospitalCompare.gov process now behind us that we all have familiarity with is not a bad model to base it on. If you look at the very logical progression of a voluntary process of performance measure submission to fees being put at risk for non-participation to then value-based or results-based reimbursement being the third phase, if you will.

So following that logical progression which is very consistent with the law as well as we read it, certainly I think we'll make it more intuitive for everyone. Harmonization of certain PQRI meaningful use is something I know that you're grappling with. But patient experience is going to be an important part of this. And, again, starting with voluntary and then moving into the

other phases is a good way to start.

It is feasible and this is reasonable. You know, we do serve 90,000 physicians today with patient surveying. And so for--at least from our experience and as we look at the market, we see an eagerness, a great interest among providers. It is feasible to achieve even the aggressive timeline as it's been laid out in the legislation. So thank you.

BILL MCQUINY: Thank you. Next comment.

MALE VOICE: I would like to reinforce what many people have said with regard to patient experience surveying being a very important thing. I think it obviously is important to ordinary consumers. People relate to this. We have done a lot of testing, actually, to see which kind of information consumers most want to have. And they can much more easily understand patient experience survey results than they can understand claims-based process measures. We actually have true experiments to see which thing consumers choose when they have a choice of things, which we do on our Web site. So that's important.

I agree that it's quite feasible to get to really good patient experience survey results within quite a short time frame. You can really have patient experience comparative results on there. There are a couple of models to get to that point. I would like to take just a couple of minutes about what we have done.

In Kansas City, Denver, Memphis and New York City, my organization, Consumers Checkbook, I'm sorry, and Center for the Study of Services is our organization. We worked with health plans and got them to collaborate and provide sampling frame data. So they provide a list of all the doctors, all their members and all the claims. And we would pull that information from United Healthcare, Signa, Aetna and local Blue Cross claims, pull it all together and identify all of the patients who had seen that doctor. And based on that, we would draw a random sample of those patients and survey those patients.

So in Kansas City, for instance, we did surveys about more than 700 doctors and got an

average number of completed surveys for--58 completed surveys on average per doctor. With that number of surveys, we were able to identify statistically significant differences between those doctors and the community-wide average on a substantial number of doctors. For instance, about 25 percent of the doctors scored significantly better than the community-wide average on--one of the questions was, "how often does the doctor listen carefully to you, never, almost never" and so on up to always. And about a quarter of those doctors scored significantly better than the community-wide average on that.

That's not just a statistically interesting thing, but it's a practically interesting thing because, for instance, those doctors who scored significantly better on average, 89 percent of their patients said the doctor always listened carefully to them. In contrast, the ones who scored significantly worse on average, 58 percent of their patients said the doctor always listened carefully to me. So 89 percent versus 58 percent, that's practically significant if I'm trying to choose a doctor. What is my likelihood that that doctor will listen to me? So we find those big differences.

And so the model--that particular model was getting data from plan, pooling the data from plans and then--and the plans pay then to have access to the data at the back end to use in provider directories, to use in pay for performance programs, et cetera. That's a model that could be rolled out very easily. It's very inexpensive and could be rolled out very easily with Medicare data as well and with Medicare basically functioning as a participating plan.

So that's one model, and it would be paid for with a share of money from Aetna, a share of money from, you know, Medicare, et cetera. And I think all those plans would be likely to come in if Medicare were also part of the game. So that's one model that you need to think about, it seems to me, as you think about how to get this data up there.

The other model is to create an incentive system where the physicians provide their own claims data or some other data that could be used as a sampling frame data to identify people to survey. Then, of course, you have some auditing challenges, particularly at the individual physician level, to make sure that there's really integrity in completing this in that file that you get. But you could do that, then you have to have some way--either, again, the government

can pay for that survey if it's done that way or the government can create an incentive program as the government has done in the Hospital Compare arena, where it's in the physician's interest to--for the physician to pay to have the survey done. That's a more--that's a more complicated process. But that's a possibility too. I think you need to think about those two models as you think about how to get patient experience data up there.

Getting those data up there is going to benefit a lot of people. It will benefit consumers who can use the data, first of all, benefit physicians to help them improve. But also it may be a need of medical specialty boards, which are now requiring doctors to have these kinds of surveys done periodically. It would meet the needs of health plan provider directories and hospital provider directories, which would like to include this information. It would meet the needs, as I mentioned earlier, of all of the exchanges which would--this would be a very nice thing for every exchange to be able to have up there about every single doctor and every single participating, you know, and qualified plan so to help people choose a plan based on how responsive their doctors are.

So there are a lot of reasons to do this. I think you have two broad models that you can use which can be mixed in some way to go down that path.

BILL MCQUINY: Thank you. Operator, do we have any callers waiting?

OPERATOR: We do. Our next caller is Bill Shumaker. Go ahead, please.

BILL SHUMAKER: Thank you. And, again, thanks to CMS for offering this opportunity. I work with several health systems up and down the East Coast, and I was very pleased to hear Peter MCMENAMIN talking very articulately about the complexities of using utilization data. And can I emphasize confidence intervals? The last speaker spoke to sampling and confidence intervals, and I think it is important that when we put the data out, that we have confidence intervals around the data or when there is statistically insignificant trends or data points. And as several have said, consumers are increasing sophisticated, and they will pick up on that. And there's considerable effort and hierarchal modeling, which is certainly an issue

that we'll need to take into account if we're looking at physicians within particular groups. So confidence intervals will be very important in some aspects, particularly the utilization data. Thank you.

BILL MCQUINY: Thank you. We have another comment here in Baltimore.

CHIP AMO: Hi, Chip Amo from the American Society of Anesthesiologists again. Just a comment, I think, as we look at the--I think it will be helpful. I know a lot of us are talking about comparing, you know, physicians, anesthesiologists in our - - anesthesiologists and anesthesiologists. I think, as we're looking across the board and a number of measures apply to multiple and different provider groups. I think that it's important to not only look at Physician Compare of, you know, peer group to peer group but, you know, some going across specialties so that providers that provide the same type of service but are different, you know, their actual classification is different.

For example, you know, a primary care physician who does pulmonary work versus a pulmonologist and being able to look at, you know, can a patient easily go to their primary care physician in a neighborhood that's close to them as opposed to having to travel to go to a specialist? I think those are valuable comparisons. And I think, you know, there's an inevitable competing for, you know, the same piece of the pie. And, you know, physician groups are competing against each other, quite frankly, and we all know this.

I think it's important to recognize that, you know, for consumers to be able to look at the Physician Compare Web site and look at the types of services that they're interested in receiving and seeing which specialist or which physician or provider, for example, would be the best person to go to. Are they comparable or do they need to--you know, is it worth it for them to drive across town to get that specialist? Is it worth it for them to have the anesthesiologists to give them the sedation that they need in a particular area?

I know we're not at that level of granularity yet getting down to it. But I think, as we're starting to look at outcomes later on, I think it's going to be important to give that capability to compare

across so that we really have a good handle on who is providing the best care across all of medicine, not just within, you know, individual silos comparing, you know, provider A against provider A. I think, you know, we need to look across the whole specialty. So thank you.

BILL MCQUINY: Thank you. Next comment in Baltimore.

ERIK MUTHER: Erik Muther with the Pennsylvania Healthcare Quality Alliance. Again, I want to thank you for hosting this forum. I think this is really a great opportunity for collecting a variety of different viewpoints. While this is certainly a nascent and evolving space, work in this area is certainly not without precedence. And I would like to echo some of the comments that were put forward by previous speakers about leveraging what has already been tested or piloted, what may have already been done but is no longer continued and the lessons that could be learned from what was done and then furthermore, by looking at what already exists today.

Several folks, including Tonya and others, have referenced the regional and state collaborative that have been doing physician reporting for quite some time, using a variety of different data sources, many of the ones that we have discussed earlier today. The Robert Wood Johnson Foundation in support of the aligning forces for quality initiatives have also again had a lot of time and resources invested in learning about this, what works, what doesn't work, how to engage the provider community and to really fairly represent the care that they're providing.

And finally, I would like to also emphasize Steve Findlay and his efforts with the ambulatory quality alliance. The work groups there, again, have been working for several years on a variety of these topics. And if you haven't already, I would suggest reaching out and engaging with those folks in a consultative way to advise and make recommendations as you proceed forward. Because this is new and difficult, but there's a lot to learn from those who have done it. Thank you.

BILL MCQUINY: Thank you. Operator, any other callers?

OPERATOR: We do. Our next caller is Jennifer Untusk.

JENNIFER EAMES HUFF: Hi. My name is Jennifer Eames Huff. I'm with the Pacific Business Group on Health, and we're also a member of the Consumer Purchaser Disclosure Project. And I too would like to offer my thanks along with all the other folks to CMS for hosting this listening session. It has been a really great opportunity to talk about how to design Physician Compare and how to make it something that works for a wide variety of audiences.

I would like to emphasize that--well, this is probably obvious. CMS will be investigating a significant amount in developing Physician Compare. And it's imperative that this investment truly enables consumers to make well-informed choices about their physicians, especially in this time and this environment of limited resources. But beyond facilitating the consumer decision making, we also think it really does promote accountability had stimulates improvement, allowable goal for public reporting programs.

I would like to highlight sort of--to achieve just a few over arching comment on many of which have also been said before previously by other colleagues. But we recommend that CMS provide information that meets the needs of consumers, including performance measures that help make decisions on doctor choice and on treatment decisions. We strongly recommend that the information be made at the individual clinician level, not just at the practice group level, whenever feasible. This is important for when consumers are making a choice about their provider as well as showing the variation that can be masked when reporting is done at the group level.

We believe that there should be meaningful differences show in performance, that variations in performance should not be unduly obscured and that there's really a balance that needs to be achieved between the desire for having the perfect reporting vehicle, which we all know is very challenging to get to that level of perfection, with consumers' immediate need for information now on how to make decisions in their care.

We would also encourage you to work with a private sector to aggregate claims data and

clinical data; although, the reporting of the Medicare data on individual's physician performance should not be contingent upon the availability of all paired data.

And we would also like to strongly encourage you to adopt the standards that have been outlined in the patient charter for physician performance measurement reporting and tiering programs. The patient charter has been agreed upon by a wide range of stakeholders, including physicians, health plans, consumers and employers and really balances the fairness of reporting this information, the fairness to physicians as well as the consumer need for information that deals with many of the issues that have been talked today about. The measures that should be included, who should be included in development of the program, really making the information that is included transparent and making the methodology transparent and what measures are chosen. So we would strongly encourage you to at least use that as a starting place, since a lot of work has already been done to come to some agreement on some of these issues.

The patient charter is also being used by many health plans and regional collaborative that are already adhering to these standards. And, I think, to the point also of regional collaborative have been working in this arena for quite a while. And there's a lot that can be learned from what has already been done. Also, a lot can be learned from what CMS has already done on its other compare Web site. So using that information so Physician Compare can start from a different place, we strongly recommend.

And we also think it would be good similar to what you have done with Hospital Compare, to make the data available for others to use. Many regional programs take the information on Hospital Compare, take data from that and include it in their reporting programs as well. And it's an asset to the other regional reporting initiatives that are going on.

So, again, I would like thank you for your leadership in this area and for really taking the time to hear from everybody on this.

BILL MCQUINY: Thank you. Any other callers waiting?

OPERATOR: We do. We have two other callers. Our next caller is Alexis Cort. Go ahead, please.

ALEXIS CORT: Hi. Thank you for taking my call and also wanted to second the other callers. I think this is a great forum and a great process to be involved in. My name is Alexis Cort of Clinical Insights, and I also present the Young - - Community Medical Group, which is a clinically integrated group of about 600 physicians in Connecticut. And I just wanted to make a couple of comments. There was a discussion early on about data sources. And I would recommend that CMS develop a list of authoritative data sources and, excuse me, make that list available, whether that list includes - - and other data sources. But one question that I think remains is which is the primary data source and does that data source then have the responsibility for updating other databases?

One follow-up question is will there be a process for groups like ours to become an authoritative data source? So for example, is this list fixed or is there a process by which other groups which have been doing programs and do have good data and good processes in place to actually become a data source into this Web site.

I just wanted to share a couple of points from our experience. We have been running programs for about five years. And we have looked both at administrative and clinical data. And we found that the correlation between administrative and clinical data is often not good. So sometimes the results point in different directions.

We found that feedback to physicians is actually very important, and we do allow physicians to challenge the data. But we ask them to certify and then we reserve the right to audit. And in terms of providing out rhythms and a lot of detail, we actually provide detailed patient-level data that allows our physicians to go back directly into their charts and verify the data.

And finally, I just wanted to add that ultimately, I think, the performance picture will be somewhat complicated. Because when you - - the provider performance and patient

experience, you might find that a high-performing provider has poor patient scores. So I challenge CMS to try to the extent possible to present a comprehensive picture of performance. Thank you.

BILL MCQUINY: Thank you. Any other callers?

OPERATOR: We have one more caller. Our next caller is Nancy Whitewalk. Go ahead, please.

NANCY WHITEWALK: Yes. This is Nancy Whitewalk from the National Council on Aging, in Washington D.C. And I also want to express my appreciation for this event. And it's certainly been very educational and informative.

I am with the National Council on Aging, and we are also working with the Campaign for Better Care. And I wanted to reiterate a point that has been made but I think may get lost from time to time. And that is that the ultimate purpose of this Web site is to be useful to beneficiaries. And I strongly encourage CMS to keep looking for as many ways as possible to connect with beneficiaries, to engage them directly and not through various intermediaries around what kinds of decisions they're trying to make and how this Web site can be most useful to them.

The other point I would like to make after listening to this is how clear it is that this is going to be complicated for consumers, how do they interpret this information, how can they have discussions with informed people about using this Web site and to encourage CMS to work with the Aging Services Network and Community Organizations such as senior centers or agencies on aging, libraries, senior housing, other consumer-focused organizations to really build an educational infrastructure that will engage older adults in using this Web site and to be able to kind of have active and informed conversations around what it can mean to them. Thank you.

BILL MCQUINY: Thank you. Anyone else in the Q, operator?

OPERATOR: There is currently no one else.

BILL MCQUINY: Okay. Going, going, gone here in Baltimore. Take it away, Regina.

REGINA RAYMOND-CHELL: Okay. Well, the good news is you get the gift of about a half an hour to your day 'cause we did finish early. And I guess the down side to that is Dr. Rapp probably will not make it back for closing remarks so you're stuck with me. And I just want to thank, first of all, the panel today for the time that they put into kind of preparing as we move forward for this Physician Compare Web site and Bill for helping to facilitate the event. And most importantly, I think, to you in our audience here in Baltimore and to all the callers on the phone for taking the time out of your busy schedules to really come and inform us. I feel very positive about this afternoon, and it really is beginning to accomplish what we're looking for, and that is to be informed by our external stakeholders and to work together as we move forward with developing this Web site. So I thank you and we look forward to additional comments. And the written comment period, again, is open through November 30, 5:00 p.m. Eastern Time. And this recording, the transcript, will be posted as well as the audio will be made available. And any future decisions, as we mentioned today, will then be made through future rule-making years. So thank you very much for your time, and we look forward to continuing to hear from you.

[END]