PHYSICIAN COMPARE TOWN HALL
February 24th, 2014

MARIA DURHAM: Okay, so hello and welcome to the Center for Medicare and Medicaid Services' Physician Compare Town Hall meeting today. I really want to thank everyone that has come here in person, as well as the many people who are on the phone and have taken time out of their schedules.

My name is Maria Durham. I am the Acting Deputy Director for the Quality Measurement and Health Assessment Group in the Center for Clinical Standards and Quality in CMS, and that's a mouthful, so from now on I'm going to call us by our acronym, which is QMHAG.

So QMHAG is responsible for evaluating and supporting implementation of quality measure systems to assess health care quality in a broad range of settings. For example, hospitals, physician offices, home health agencies, dialysis centers, nursing homes, to name a few. Our group actively works with stakeholders to promote the widespread participation in the quality measurement, development, and consensus process.

Since the inception of Physician Compare in 2010, stakeholders, including healthcare professionals and the public, have shown tremendous interest in our website, and I think that's a really good thing. CMS has been very dedicated to providing opportunities for everyone to play a role in the evolution of Physician Compare, and the feedback that we've obtained in past town hall meetings, as well as our listening sessions, as well as comments that we've received in our rules, have really helped us to define the scope and the direction of the site up to this point, and of note, the posting of the first set of measures recently is really a win for us. It's really a win for all of us and for our patients, and it's something that we're really proud of, and we have a lot of transactional customers, but ultimately, the patients are our customer, so we are really excited about that.

So where do we go? As we move forward, we want to seek out the advice and suggestions of all of you, which is why we're here today. The goal of this town hall meeting is to solicit input from you on the future of Physician Compare, and we really want to make it as useful and as beneficial as possible to all of our consumers.

We're particularly interested in seeking your input regarding the types of information and the measures that should be included on Physician Compare in the future, and we're looking forward to hearing what you have to say, and we hope you find today's meeting a useful opportunity to convey your thoughts and your ideas and your suggestions to us. So please use this opportunity, and I am going to turn this over to Regina Chell who is going to give you more information.

REGINA CHELL: Okay, thanks, Maria. Good afternoon everyone, and as Maria said, my name is Regina Chell, and I am the Deputy Director of the Division of Electronic and Clinician Quality. Our work is focused on quality measure implementation in the ambulatory care setting. So many of you are familiar with the PQRS program, Physician Quality Reporting System, e-prescribing, as well as Physician Compare, and meaningful use. Our division leads all of the programs.

So it's exciting to be here today. As Maria said, we have done some incredible work, and we've just hit a really important landmark with publishing the first quality measure data on Physician Compare about group practices. So we're looking forward to kind of moving forward and expanding that website.

For Aaron and I, it's a real kind of walk back on Memory Lane for sitting in the front of many of you, because we were here three years ago, just about this time, for the first Town Hall for Physician Compare when we had the opportunity to launch the Physician Compare website using the Health Provider Directory. We had the mandate to launch this site based on ten, Section 10331 of the Affordable Care Act, and we had a very short time to stand the website up, which is why we went with the Health Care Provider Directory.

It certainly has given us the opportunity to do a lot to improve the quality data on the just demographic data on the website, as well as the functionality, so we've been working hard the past three years to kind of beef that up, and I think you'll see, a little bit later today when Aaron does his demo of what the current website looks like, that we've come a long way. And we're not finished. We have a long way to go.

So for those on the phone, if you're following along, we're on slide 4, and this slide is just to kind of look at what is the purpose of Physician Compare, and it's twofold. It's really to encourage consumers to make informed choices, as well as to incentivize physicians to maximize their performance, and we feel like a lot that we've done to clean up the just demographic data is kind of helping both of those.

So if you go to slide 5, our first step, as I said, we repurposed the Medicare Health Care Provider Directory on Physician Compare, and in doing that, the existing data there is informed by the system of record, our PECOS system, the Medicare Provider Enrollment Chain and Ownership System, and so we continue to use that as our primary source of data, but have done a lot to further inform that data and provide additional information on Physician Compare.

We've matched our data to our claims data that we have available in Medicare, and we kind of are able to look at state zip code, and we also enhanced with some external data sources so it's much more robust set up demographic data.

Some – now we're on slide 6, for those on the phone, and for the first three weeks of Physician Compare in 2010, we really, since that time, as I mentioned, have made some significant improvements to usability and functionality, and some of the more significant enhancements include a complete overhaul of the underlying database, the accuracy and the currency of the information available on the website, so that we're able to update the information much more readily, and we'll continue to work towards that update in the future as closer to, as close to live time as we're able to.

Again, as I mentioned, the foundation for the database, the primary source is PECOS, and historically we knew that we wanted it to be a lot more kind of live time or up to date, so in mid 2013 we began to use the Medicare claims, and that's when some of you may have seen some change to the demographic data on the site if you'd been following along. And then using the claims to enhance this information, we're really able to ensure that only physicians who have actually submitted Medicare claims in the last twelve months are represented on the website. So sometimes we do get e-mails, or we get inquiries, you know, "I just went to find myself on the website. How come I'm not there?" and it may be a pediatrician who hasn't billed Medicare in five years, so, in fact, they would not find them self on the website.

We also have improved the accuracy of the group practice affiliation. We only include those group practices or solo practice affiliations that professionals are actively billing to. This allows us to limit the number of addresses associated with a professional. You know, as many of you may know, in PECOS there could be multiple addresses sometimes on the – when we first went live with Physician Compare, the addresses really didn't reflect where the physician was actually practicing. So we've been able to kind of supplement that data with our Part B claims and now give more accurate information to our consumers.

Another major enhancement was the addition of the Intelligence Search functionality, and this really now allows you to search not only for a physician, you can search for a group, and you can search by a symptom, you can search by a body part, you can search by just any number of new ways, so that a consumer coming in doesn't have to be ascriptive right off the bat.

The location search was also improved. In addition to being able to search by zip code or city and state combination, you can now search by street address or landmarks.

Other enhancements include linking to hospital affiliations. So you now can link to Hospital Compare for hospital affiliation, adding group practice specialties, and then adding secondary specialties for professionals.

We improved residence, gender information, language spoken, and we also added board certification data. So we have the ABMS board certification data on the website.

Now you also can find information on groups and providers and eligible professionals who have reported on PQRS, the Physician Quality Reporting System, have e-prescribed, participated in the electronic health record program in 2012, and that, as we've stated and we're so excited about, we added the 2012 quality measure data for the group practices that reported through the group practice web interface.

And our most, the other most recent enhancement—I've mentioned the group practice reporting—but also we really need to call out that's not just the PQRS group practices, but it's the MSSP ACO, or Affordable Care Organizations, and their data. And you'll see, a little bit later today, the kind of flow of that website and what that data looks like.

And we're now on slide 7, and this just kind of takes a look at how we report for by year. So we're looking at February 2014, and what we have up is now the quality measure data that was reported for 2012 program year for the group practice reporting option for PQRS and for ACO.

(CELL PHONE RINGING?)

Excuse me. I apologize. I turned it off, but I guess I left one piece on there. (LAUGHS)

So we have rolled out over time, an increase of the information available, and that's been based on what we finalized in each of our Physician Fee Schedule Rules. And so with that, I think I would like to turn it over to Aaron, because I know he has the kind of most exciting job of showing you a demo of the live site.

AARON LARTEY: Thank you, Regina. I'm Aaron Lartey. I'm the website lead for Physician Compare, and I'm here to give you a demonstration on the Physician Compare website.

So here we are on the Physician Compare home page, and if you'll notice, we have three different ways for users to search. The first way is to find physicians and other health care professionals. Users can also find group practices, and they can explore our Search Another Way option.

The first step in the search for most of the searches is in the Location field. Users can search by zip code, city/state, landmark, or street address. And just to give you an example, we'll type in a landmark, and if you notice, in the drop down box the landmark will appear and the user can select it.

So say you have, you know, a user wants to find a physician in an area and they're not sure what the name of the city is, so they start typing in what they think the name of the city is, and they're looking for Dubuque, Iowa. In the drop down you see Dubuque, IA, so they select that.

Now under What Are You Searching For, you, like Regina mentioned, you can search for specialty, physician name, condition, or body part. In this instance we're going to do a search for Cushing's Disease, and in the drop down you can search for a general practice in the area, in Dubuque, Iowa, and here's a list of specialties—sorry—specialties to follow, and if there was a doctor Cushing, it may show up under the list of names for physicians as well. So we'll go ahead and do a search on this.

So at the top, you notice we have 111 health care professionals related to Cushing's Disease within 100 miles of Dublin, Iowa—Dubuque, Iowa, excuse me—and you have the key here for Accepts Medicare, which is, indicates par status. We also have a May Accept Assignment key as well.

So let's go to endocrinologists, just out of curiosity, and you see the result expanded, and you notice that under the results you have a physician name, specialties, physician address, telephone number, also their par status, and the distance from the center point of where you searched.

Let's go ahead and select Dr. Scott Brock. This is the Physician Profile page. On the profile page, at the top, you'll see the physician's name; their par status, whether they have had Medicare, accept Medicare in full payment; you have their specialty; and we also have this Is This You, Update Your Information link. What this link does, it takes you to Internet based PECOS where you can update your information in PECOS, or update your enrollment information as well.

Under the General Information tab, we display additional specialties for the provider, which quality programs they successfully reported to. We have their gender information, education, and residency information. We also have group affiliation information for them, hospital information, Medicare assignment again, and ABMS board certification.

Now if you want to go to their group affiliations, when you select this link, it actually goes to the Group Profile page on Physician Compare. For hospital affiliations, sometimes it will go to the Hospital Profile page on Hospital Compare as well—if applicable.

The next tab is the Locations tab, and this displays all the practice locations where the health care professional provides services. So let's go to the, back to the Physician Compare home page and conduct a group search. So I'll select Find Group Practices tab and we'll do another search in Dubuque, Iowa.

In this situation, we'll type in—excuse me—Pathology, and in the drop down you see that Pathology is populated, and then you have the name of a group as well.

In this instance we're going to search all group practices in this area and then select Search.

If you notice, we state that there are 33 group practices within five miles of Dubuque, Iowa. You'll also notice that the Results page is similar as the Physicians and Other Health Care Professionals results page as well. You see the group's name, specialties, address, telephone numbers, par status, and the distance between, the distance from the center of the search area that you're looking for.

We also want to showcase the Modify Results Panel where you can modify your results by location, group practice name, specialty, and Medicare assignment. The Modify Panel is also available in the individual search page as well. You can also go to a Map View as well, and on the left hand side there's a map of your results, and they're highlighted by these red markers here—let me scroll up, sorry—and it usually gives you high-level group information like the group name, address and telephone number, and you see their physical location as well.

Now when you switch to the Map View, you can go back to the results, and also you can also toggle back and forth between Modify Your Results and the Results List, as you see here.

So over in List View, we're going to select a couple of groups. If you notice, at the top here, you have these groups that you selected in a queue. Once you hit the Compare Now button, it will take you to the Compare page. In here you have, again, the groups' names, addresses, telephone numbers, distance from the center of the location that you're looking, that you're searching in—excuse me—specialties, their pay status. There's also a link to the affiliated health care, a list of health care providers that are affiliated with the group.

So for the purpose of this demo, we'll select Medical Associates Clinic PC. On the Group Profile page, on the General [Information tab], you see the—excuse me—you'll

see the group name and the specialties, and again, you see Is This Your Group Practice [link], so groups can go in and update their information as well.

Under the General Information tab you see the quality programs the group participated in, and whether they accept [Medicare] assignments. Under the Locations tab, you see all the locations that are affiliated with the group. Under the Affiliated Health Care Professionals tab you see a list of health care professionals affiliated with the group as well. And in the box up here in the right hand corner, you can search by health care professional's last name or specialty.

Now on the Clinical Quality of Care tab, medical – so this group here is part of 66 GPROs that successfully participated in the PQRS program for 2012. They have a Clinical Quality of Care tab as – this is what I selected – on their profile page. On this tab you'll see a selection of the Diabetes and CAD measures – excuse me, CAD GPRO measures currently published on the site. Each measure group is in its own select section, with the introductory text explaining the measure of the group. So this is the explanation here. And for more information, you can click on this link [More Information] and it will take you to a web page for the full information for these measures.

Now each measure has its own title and it's on their – and it has the – and we have these – well, so the titles are expand and collapsible, and we have these stars to signify the measures. So I have to be very careful how I explain this. (LAUGHS) That's why I'm fumbling over my words.

So each star represents 20%. So in this case, we have, this group has a percentage of 86%, so we have four stars filled up, and you notice on the fifth star, it's partially shaded to represent the 6%. So, again, I have to be very careful how I explain this.

Now these images are representation of the percentage, so this is why we have it this way. This is why it's partially shown.

Now if you expand, we have an explanation here about each measure, explaining, giving a little bit of detail on the measure itself. As per the 2012 Medicare Shared Savings Program Final Rule, Physician Compare is reporting the 2012 measures collected by way of the web interface for Accountable Care Organizations, or ACOs as well, and you can access this data from the home page. So go back to the home page, and here's our link to the ACO quality data. So select that, and it opens up in a new window.

Now we have two ways of searching here. You can search by ACO name, so I'll begin to type in the ACO name and, you know, it will start populating from the drop down. Now if the user is unfamiliar with the ACO name, they can go to the A to Z index. We'll select A, and here's a list of all ACOs that start with the letter A. We'll select Allina Health. So if you notice at the top here, we have a link to the Allina Health website for users to go to if they want more information about the ACO.

We also show the Diabetes and CAD measures for ACO, and we just show percentages for this one because the ACO measures are – the – consumers are not the primary audience for the ACO measures, so we just show the percentages instead of having the stars like we do with the GPRO measures. If you want more information or more details about the ACO measures, we have an expand and collapse [bar] here to show more details to give an explanation.

So this concludes the Physician Compare website demo, and I'll return it over to Regina Chell. Thank you.

REGINA CHELL: Okay. Thanks, Aaron. So for those on the phone, we're now on slide 9, and we'll just continue – as you look at this slide, you can see we continue to build on our plans to publicly report – sorry – as you can see on this slide, we continue to build on our plan to publicly report over the next several years, and in the 2013 PFS Rule, as I previously stated, we elaborated on our plan for publicly reporting. We established that we would report the 2013 PQRS GPRO Diabetes and CAD measures collected via the web interface. This is for both the PQRS Group Practices, as well as ACOs.

The Rule also noted that we would work towards developing and publishing composite scores at the Diabetes and CAD Disease Module level, and in alignment with the ACO programs.

Both the web interface measures and the composite score are targeted for publication in late 2014 if technically feasible.

In this same Rule we published the, that we would publish the CAHPS measures, or the Clinician and Group Consumer Assessment of Health Provider System measures, and this will be administered for group practices of a hundred or more eligible professionals for ACO and PQRS GPRO.

Then if you go to slide 10, we'll look at what was finalized in the 2014 Physician Fee Schedule Rule that was published in November of 2013. Again, we continue to expand on our plan to publicly report. In this Rule we finalized that we continue reporting the 2014 GPRO measures collected via the web interface, again, for both PQRS [GPRO] and ACO practices.

This would be, we'd also expand to quality measures that can be collected through PQRS in this Rule, and we would look at three claims-based measures, and administrative claims measures, and publicly report those for ACOs. This was finalized in the Medicare Shared Savings program. This is targeted for publication in 2015. And, again, with everything that we have finalized for public reporting, it is if technically feasible.

In addition to measures collected via the web interface, we also include publicly reporting a subset of the 2014 PQRS GPRO measures reported via registries and EHR, Electronic Health Records. Specifically, we finalized the option to publicly report the 16 GPRO Registry and 13 EHR [measures] that can be reported via the web interface. Not every measure within these subsets will be publicly reported though. Only those proved to be accurate, valid, and reliable, and of most value to consumers.

For a full list of measures available for public reporting, you can find this in the finalized 2014 Physician Fee Schedule Rule. Also in this Rule, we solidified the plan to make patient experience of care data available to consumers. We'll continue to publicly report the 2015 CAHPS measures for group practices and ACOs. We'll continue to fund this data collection for this year for group practices of 100 or more eligible professionals who participate via the GPRO web interface.

We also accept, finalized to accept CG-CAHPS measures submitted by group practices of 25 or more eligible professionals that are collecting data via certified CAHP vendors—regardless of GPRO submission method or involvement. These data are targeted, again, for publication in 2015.

And then, finally, in this Rule, we established that in 2015 we will publicly report individual eligible professionals' data collected from 2014 PQRS via claims, EHR, or Registry, and specifically, we finalized to post individual measures recorded by EPs in line with those measures reported by groups through the GPRO web interface.

The list of 20 possible measures can be found on the Physician Compare sec, in the Physician Compare section of the 2014 final Rule.

Also, for claims, EHR and Registry, we plan to publicly report performance rates on measures for the 2014 PQRS Cardiovascular Prevention measure group at the individual professional level, and this is in support of the Million Hearts Initiative. These data, again, targeted for the 2014 release – 2015, I'm sorry.

Then if you go to slide 11, you'll see a summary of our plan for publicly reporting on Physician Compare, and this just gives you a timeline.

For those of you in the room, if you want to kind of reference this, you do have this in your handouts.

In 2014, we'll update all participation information and publish the 2013 information as it becomes available. We'll also add an indicator for the eligible professionals that received a PQRS Maintenance of Certification Incentive in 2013, and we'll include the names of eligible professionals who report the PQRS Cardiovascular Prevention measure group, again, in support of the Million Hearts Initiative.

In 2015, we'll update all participation information to the most current year as it becomes available, including Maintenance of Certification in Million Hearts, the specifics of the measured data just discussed, and are noted here.

Then if you go to slide 12, as we mentioned earlier, the purpose of this meeting is really to hear from you all, so we're keeping our presentation relatively short today, and really get feedback on the type of information that you'd like to see on Physician Compare as we move forward, and well out into the future.

In the Call to Meeting and the Physician Compare Town Hall background we proposed some particular areas of interest. Specifically, we're seeking input regarding the inclusion of additional administrative information that may be of interest to consumers. For example, the addition of Board Certification, participation in other quality improvement programs, additional medical qualifications, group practice information such as office hours or website addresses.

So then if you go to slide 13, we'll kind of look at other areas of interest. We're looking to receive information, for example, on types of measures that would be most useful to consumers, and most accurately identified quality of care and/or most accurately representative areas specially represented on Physician Compare.

We're also interested in your thoughts regarding the length of measure preview period. Currently it's a 30-day preview period of the quality measure data before it goes live, and we'd like your comments and feedback on decreasing that preview period to two weeks.

Then if you go to slide 14, we'll now move on to the portion of the meeting that's been set aside for individual statements. As we outlined in the Call to Meeting, participants will be permitted to speak in the order in which they signed up. I will call your names. You'll come up to speak, to the microphone in the middle of the room.

After all the scheduled statements have been heard we'll then open the floor to, after the in-room scheduled statements, we'll open it up to the folks on the line. We have a little over 200 people who signed up who are on the line, but only a handful who signed up to speak, so you're not going to be sitting here 'til five o'clock, I assure you.

And then, after that, we will open it up to the room in case some – because we will have, anticipate having some additional time, if there's anyone in the room that would like to make some additional comments, we will allow that to happen today.

Your statements are limited to three minutes, and with that we're ready to open it up for comments from the room, and the first person that I'd like to ask to come to the mike is Lisa Satterfield. When you come up to the mic, again, if you just state your name again and your organization.

LISA SATTERFIELD: Thank you. My name is (CLEARS THROAT) – excuse me – my name is Lisa Satterfield (CLEARS THROAT AGAIN) – excuse me – and I am with the American Speech-Language-Hearing Association, which is very funny that I can't talk. So, anyway, we would like to offer three suggestions for consideration. ASHA is the professional organization for more than 166,000 audiologists and speech-language pathologists. So what we would like to be considered is our Certificate of Clinical Competence for Audiology and Speech-Language Pathology. It has been around for 55 years, and it utilizes the Educational Testing System, a national test for certification, and it is also recognized by many state licensure boards for licensure equivalency. So it's a standard that's been around for many years that we would like considered as a part of Physician Compare. And also, we have four board certifications that we would like

considered. Two that are in particular in relevant to Medicare, and one is for swallowing and swallowing disorders for speech-language pathologists, and the other one is for interoperative monitoring for audiologists. So those have been around for a while as well, and our equivalent to testing and interview and additional certification for those specialty areas in our profession.

The other things we would like considered, is participation in the National Outcomes Measurement System, ASHA's NOMS, that could be noted as a quality initiative for our members. Now NOMS tracks, helps our members track their patient progress through therapy treatment, and it has been around since the early 90's, even before a lot of things were being tracked. So we would like that to be a quality initiative.

I know that hospitals and clinics use it to compare national aggregated data to determine how their therapy services match up with the national data, so it is a quality improvement program that many facilities and individuals use.

And, finally, as Physician Compare continues to roll out, we would like consideration and conversation to be ongoing regarding the PQRS measures that are posted for audiologists and speech-language pathologists, because there are very few at this time.
We are working to develop more measures that actually represent the quality services that audiologists and speech-language pathologists perform, but at this time, we feel the PQRS measures just are not showing that, showcasing our members quality programs, so...

That's all.

REGINA CHELL: Thank you.

LISA SATTERFIELD: Thanks.

REGINA CHELL: Next, Koryn Rubin.

KORYN RUBIN: Hi. Koryn Rubin from the American Medical Association. So you presented on stuff today that requires some additional questions or clarification that I would like, but I also have some prepared statement, so I don't know how to go about addressing those comments within this three-minute timeframe.

REGINA CHELL: Sure. So, Koryn, for this timeframe, just do your prepared statement...

KORYN RUBIN: Okay.

REGINA CHELL: ...and when we're all finished with the prepared statements, if there's some clarifying questions, we'd like to take them then if that's okay with you.

KORYN RUBIN: Okay. All right. The AMA encourages the use of physician data to benefit both patients and physicians, and to improve the quality of patient care and the efficient use of resources in the delivery of health care services.

The AMA supports the use of physician data when it is used in conjunction with programs designed to improve or maintain the quality of and access to medical care for all patients, and it is used to provide accurate physician performance assessment.

The expansion of CMS' Physician Compare website is a small step in the right direction, but the quality information posted on the website is limited. Consumers must know that the information posted is only on a subset of large group practices, and the AMA cautions CMS with adding more information without rigorously testing the methodology and providing reliable data consume, to consumers and physicians.

The AMA supports efforts to make medical standards more comprehensible to patients. However, the use of star rankings or other systems that represent disparate quality scores in a simplified graphic, result in inappropriate distinctions of quality for physicians

whose performance scores are not statistically different. Such oversimplification of data can have the opposite effect from what is good intended, and lead to greater confusion among patients and false assumptions about health care professionals.

The AMA continues to hear from physicians about inaccuracies in the website search function and underlying demographics data, and these issues should be corrected before the agency adds any additional performance information.

CMS has stated it can take up to four months to correct a physician's profile information, which is disconcerting, given the website is supposed to be a tool used to assist with making decisions of medical care.

We have some, a few high level recommendations, and then I'll go into more specifics.

AMA is disappointed in CMS' rollout of Physician Compare, given that we were not provided notice with the rollout of star rankings on Friday. We would have liked more open dialogue in terms of the release of information.

With the rollout and maintenance of Hospital Compare, CMS has been actively engaged with the Hospital Quality Alliance or their group of hospitals, and there's nothing comparable for Physician Compare.

CMS meets quarterly with the hospital groups to discuss Hospital Compare issues. We request for CMS to immediately engage physician stakeholders on a routine and iterative basis. We also request clarification as to how CMS communicates on changes and feedback about the website to physician group practices, individual physicians, and the physician specialty community.

We also request for CMS to disclose and release the recommendations made by the Physician Compare technical advisory panel. We are unaware of CMS', of CMS publicly posting this information, and as to whether the Physician Compare redesign is

following the TEP's recommendations. Therefore, the AMA continues to caution CMS to be judicious in its development of Physician Compare website. The agency must continue to balance current methodological limitations associated with physician profiling and its statutory directives for developing a Physician Compare website.

Specifically, CMS must consider the current state of data collection and aggregation accuracy. As mentioned in previous AMA comments to CMS, the Physician Compare website search function and underlying demographic data must be accurate before the agency adds additional performance information.

The 2004 Health and Human Services OIG Work Plan highlights the problems with the accuracy of information posted on Physician Compare. As highlighted, the AMA supports the use of physician data when it is used in conjunction with programs designed to improve or maintain the quality of and access to medical care for all patients, and is used to provide accurate physician performance assessment. It's from this perspective we offer the following additional comments.

Website design: The AMA supports using the current CMS Health Care Provider Directory as the initial framework for developing Physician Compare. Based on the significant number of errors that occurred in the hospital demographic data when the CMS Hospital Compare website was initiated, and the continued problems with the demographic data on Physician Compare, the AMA strongly urges CMS to establish a more expedited process for correcting demographic data.

One ask again, is for CMS to develop a process by which a physician or group can review and update their demographic information directly through the website, outside of PECOS. Additionally, QRURs or PQRS feedback reports should include a display of how an individual physician and their associated group practice profile will display on Physician Compare. Including this information provides an additional opportunity for physicians to review and correct underlying demographic problems, and to see how the quality information will be posted on the website.

What physicians currently receive within PQRS is different from what's posted on the website. Also, once a physician's demographic data has been flagged as problematic, or their quality information has been flagged, the AMA recommends for CMS to stop posting a physician's or group practice quality information until the issue is resolved.

I don't know – how much longer do I have?

REGINA CHELL: I was not timing, and I don't hear the facilitator. Can somebody tell me time? I feel like, Koryn, we're over three minutes, but...

KORYN RUBIN: Okay. Well I'll...

REGINA CHELL: Do you have – so maybe if you could kind of try to summarize and wrap up, Koryn, that would be good.

KORYN RUBIN: Okay. In terms of the measure development and the selection, physicians must have a lead role in the developing and selecting their performance measures used for public reporting. This will ensure the measures are accurate and relevant to patients and physicians. Otherwise, public reporting will not achieve its goal of improving the quality experience and outcome of care for patients.

Moreover, some subspecialists currently lack measures, as well as data collection and reporting system that addresses their scope of practice. It is critical that the development of a plan for public reporting of physician performance through Physician Compare recognize these factors, and for CMS to continue to implement initiatives on a phased in basis.

Also, there, in terms of Board Certification, we urge CMS to protect physicians who have been provided lifetime maintenance of certification, grandfathered, from financial

penalties, or for information to be skewed that makes it look like they're a poor quality provider.

This approach is consistent with the AMA's recommendation that during these transition periods, physicians who face hardships such as physicians at or near retirement age, should be protected from burdensome requirements and financial penalties.

REGINA CHELL: Thank you. Okay, next, Julie Cantor-Weinberg. And while Julie's coming up to the mic, just so you can be prepared, the person that will be after Julie is Marie Castelli.

JULIE CANTOR-WEINBERG: Before I start, will we get copies of the slides? Or can we?

REGINA CHELL: Yeah.

JULIE CANTOR-WEINBERG: Hi. I'm Julie Cantor-Weinberg, with the College of American Pathologists. Thanks for having this event today.

We're a medical society serving 18,000 physician members in the global laboratory community. We're the world's largest association composed exclusively of Board Certified pathologists, but the College applauds CMS for proposing to provide physicians an opportunity to review the information about them that will be included on the CMS Physician Compare website prior to posting.

This review process is imperative. A quick poll of members of our quality working group found that 50% of the entries were inaccurate. In particular, some entries did not note participation in the PQRS when the member had participated and received an incentive, and the opposite was also true. Accurate information should be the first and highest priority before any additional information is considered for this site.

The College also believes it's important to note when a physician could not participate in a program listed. For example, the PQRS due to lack of applicable measures, or electronic prescribing because they do not meet the minimum criteria set by CMS. The absence of this information is misleading and could imply a lack of interest in quality, rather than an issue with the applicability of the program to a given provider like a pathologist.

The CAHP opens the opportunity to collaborate with CMS to develop measures relevant to our specialty and the patients we serve. These measures may need to be broader than just the individual physician, and encompass the laboratories where physicians practice. For example, in the case of a physician who practices in a laboratory, the most useful information may be, in addition to listed PQRS measures, is to the lab, should be the laboratory's accreditation status.

Pathology is a unique specialty. One approach will not all physicians, or even all subspecialists within a specialty, therefore it's critical that the Physician Compare site include notes on which quality programs are applicable to the physician.

Thank you very much.

REGINA CHELL: Thank you. So Marie Castelli? And then after Marie will be Jim Petilia...

MARIE CASTELLI: Hi, good afternoon. Marie Castelli from Press Ganey. Our mission is to ensure that we capture the voice of every patient across the continuum of care. We work with about 130,000 providers across the United States, and together we share the mission of reducing patient suffering. Suffering that comes from both disease and treatment, as well as dysfunction within our health care systems.

We applaud CMS, and we encourage you to continue to build a site that is focused on the needs of patients; not on the needs of physicians or researchers or other constituencies.

We think that Physician Compare should be user friendly, accessible, and a reliable tool that helps patients to choose their provider in moments in their life when they're going through the most difficult time.

So first, we wanted to encourage CMS to make the information easier to understand and more accessible to locate. We think that patients should be able to distinguish between providers at a glance through using a star rating type system as you suggested.

As more quality data is released onto the site, we also suggest that you update the search result page so that at a glance, a patient can tell whether a provider is participating in a certain quality program.

Second, we ask that CMS consider adding search functions that allow patients to find providers based on their individual preferences, and their desired outcomes. So, for example, a patient whose top priority would be to control their blood pressure, would be able to search for a physician that had scored highly on those measures. And as more quality and outcomes data is available, we think that search functionality would increase in utility.

A patient should also be able to find a provider who can help coordinate their care across the continuum, and for that reason, we suggest that CMS consider adding participation in private or state based quality programs as well to the site.

Physician Compare should be the number one source of trusted quality data for patients, and to that end, we believe CMS should prioritize their reporting of data at the individual provider level across all quality metrics, including patient experience metric, and we ask that CMS consider taking steps to collect CG-CAHPS data, patient experience data, at the individual provider level.

As the efforts by the American Board of Medical Specialties, in their review of maintenance of certification shows, patients have a right to be treated by a provider who

is not only clinically knowledgeable and up to date, but also a provider that is adept in communicating that information in a way that patients understand.

Finally, we would like to comment that we suggest that you keep the preview period at 30 days, rather than cutting it down to two weeks.

Thank you.

REGINA CHELL: Okay. Thank you. So next, Jim Pietila, and then after Jim, it will be Mark Zawadsky. Jim, are you in the room? (NO ANSWER) Okay. Mark, are you in the room? Okay. As Mark comes to the microphone, after Mark will be Jessie Johnson.

MARK ZAWADSKY: Hello. I'm Dr. Zawadsky, and I am an orthopedic surgeon in Washington, DC, and I'm here today to speak on behalf of the American Association of Hip and Knee Surgeons, which is commonly referred to as AAHKS.

AAHKS shares CMS' interest in exploring improvements to the Physician Compare website. We appreciate that CMS has taken the time to get the perspective of the physician community before proceeding with changes in this area. We agree that a collaborative approach offers the best opportunity to identify information that is meaningful to consumers, while portraying physicians fairly and accurately.

One of these areas CMS has asked stakeholders to address is how to accurately identify quality care. In presenting quality of care information to consumers, AAHKS believes it is critical to ensure that is appropriately adjusted for risk.

All patients are not equal. Patients with complex underlying conditions or co-morbidities do not have the same likelihood of achieving successful outcomes and avoiding adverse events while in surgery, as do healthier patients. If quality data is not appropriately adjusted, consumers may be left with an inaccurate impression of the relative skills of a physician or a physician's practice. It is therefore critical that CMS work with each

specialty to come to consensus on how best to represent the impact of risk factors on outcomes of interest among that specialty's procedures.

Consensus is also needed on how to best mitigate any unintended consequence that may derive from failure to count for risk, that go co, that the risk, that co-morbid conditions and complexity confer on outcomes. AAHKS has been proactive in its effort to engage CMS in this important activity, and it is important that such work be supported to its conclusion.

Inattention to this critical issue could ultimately be unfair to physicians who care for the sickest, most complicated patients, and importantly, leave patients with the most complex problems to face challenges in understanding how best to obtain access to care.

CMS also has asked for input on measures that would most accurately represent the various medical specialties. With regard to orthopedic surgery, AAHKS has formed a multi-stakeholder total knee replacement work group to identify and define quality measures to improve outcomes for patients undergoing a total knee replacement.

Practicing orthopedic surgeons and other clinicians created explicit valid and feasible quality measures that can be used to monitor and improve the quality of orthopedic care.

The quality care measures that AAHKS has developed, which are now operational, evaluate appropriate preoperative, intraoperative, and postoperative care for total knee replacement procedures which are critical to improving patient function and quality of life.

AAHKS' work group also intends to develop a total hip replacement measure.

While measure development is a resource intensive process that poses challenges to smaller professional societies such as AAHKS, these measures offer an important mechanism to help improve quality of care. We believe that medical specialty societies

should continue to play a formal and central role in developing and updating meaningful quality measures that will be reported on the Physician Compare website.

Finally, we urge CMS to look for ways to streamline and consolidate the various quality reporting mechanisms. Physicians currently are subject to separate but overlapping quality programs at different stages of development, and with different methodology and other considerations that must be separately navigated by physicians. This has a potential to place burdens on physician practices that may detract from time spent with patients.

Ultimately, greater consistency is needed to ensure that the results of quality measures are credible, and provide meaningful and consistent information to beneficiaries. In conclusion, AAHKS members view their roles as patient advocates who seek to preserve patient access to high quality arthroplasty services.

We urge CMS to ensure its quality measurement and reporting framework do not have the unintended consequences, consequence of reducing access to care for those who need orthopedic surgery.

Thank you.

REGINA CHELL: Thank you. Jessie Johnson.

OPERATOR: Jessie Johnson, if you would like to speak, please press pound five to unleash your line.

(SILENCE)

REGINA CHELL: Okay. Hearing nothing. Rachel Groman?

OPERATOR: Rachel, if you can hear me, please press pound five to unleash your line. Thank you.

RACHEL GROMAN: Hi. This is Rachel Groman, and I am calling in on behalf of the American Association of Neurological Surgeons and Congress of Neurological Surgeons. My comments will be brief. I just, I do want to reiterate concerns that were already raised.

Organized Neurosurgery definitely has concerns about reporting individual performance data, and does not feel that data should be posted until it's proven to be both accurate and meaningful to consumers. In particular, we warn against publicly reporting process measures, many of which are not necessarily correlated with better outcomes, and until they are, we do not feel those measures should be reported on either an individual or group practice basis.

We, Organized Neurosurgery is also opposed to reducing the length of the measure review period, and encourages CMS to keep it at least 30 days long, since that process will be very important in terms of proving the, improving the accuracy of the measures reported.

We reiterate earlier statements that medical societies should play a central role in developing the measures that are reported on Physician Compare. We strongly, strongly emphasize that Physician Compare recognize other clinical quality improvement activities that a physician may be engaging in that are outside of federal programs, such as participating in specialty society clinical data registries.

We, again, encourage more work on risk adjustments and attribution methodologies before individual performance data is reported, and I think – we also – one other thing is to reiterate earlier concerns about the risk associated with using stars and the arbitrary nature of the thresholds that they may present in terms of distinguishing performance between individual physicians.

Thank you.

REGINA CHELL: Thank you, Rachel. Is Loran Cook in the room?

LORAN COOK: Yes. Thank you. I'm Loran Cook with Billian's HealthDATA, and my comments will be brief.

I just want to first thank you for the opportunity to speak, and ask if there will be any ACO to physician affiliation data. We feel that the relational nature of physicians, be their groups and hospitals affiliations, are very useful, but would like to also see some ties to ACOs in the future.

Also, one other comment I would like to make, we've worked with Hospital Compare and Nursing Home Compare and Home Health Compare quality measures as they've evolved over time, and would just note that in Physician Compare it's very useful in your API structure to maintain a measure code because as those measures change over time, it helps to normalize how we observe measures trending and changing over time, and we just ask for that consideration.

That's all. Thank you.

REGINA CHELL: Okay, thank you. Daniel Carlat?

DANIEL CARLAT: Ah yes, hi. This is Dr. Danny Carlat. I'm a psychiatrist, and director of the Prescription Project of The Pew Charitable Trust, which is a public interest advocacy and research organization.

So PEW's had a long-standing interest as a supporter of transparency in the financial relationships between doctors and the drug and device industry, and these relationships can obviously have both positive and negative consequences for patient care. We've been a supporter of the Physician Payments Sunshine Act.

Payments and gifts physicians can, and have led to measurable changes in prescribing habits, changes that can lead to higher health care costs, and they're not necessarily beneficial to patients. Studies have shown that doctors with financial relationships are less likely to prescribe generics, and more likely to prescribe expensive brand name drugs, and in a more recent study of 330,000 physicians who prescribed medications under Medicare Part D, the Congress found that doctors receiving payments from a company are roughly twice as likely to actively prescribe that company's drug as doctors not receiving payment from that comp-any.

So because of these financial relationships, which can lead to conflicts of interest, in 2010, Congress passed the Physician Payments Sunshine Act, which requires companies to disclose all payments of $10 or more to doctors in teaching hospitals.

The Open Payments website is being designed as we speak, and already companies have collected payment data covering the last five months for 2013, and this data will be publicly reported in approximately six months, but we know that one of the key goals of Physician Compare is to provide information to consumers to allow them to make more informed health care decisions, and this is certainly a key goal of the Sunshine Act.

We would urge that CMS consider adding information from the Open Payments website under the physician profiles of Physician Compare, already enormous resources, both financial and personnel resources from both CMS and from Industry have gone into creating the Open Payments database, and we would urge CMS to leverage that investment that's already been made, in order to add some sort of a cross link to that data which will allow patients to understand whether their physicians have financial conflicts of interest that may affect the quality of their care.

Thank you.

REGINA CHELL: Thank you. Seemin Pasha?

SEEMIN PASHA: Hi. This is Seemin Pasha. Dr. Carlat submitted our statement on behalf of the PEW Charitable Trust. Thank you.

REGINA CHELL: Thank you. Moderator, I will – that's all the commenters we have registered in the room, so I will turn it over to you to facilitate the comments on the phone, please.

MODERATOR: Hi. This is the moderator. The speakers that were on the line, they already have spoken. They started at Jessie.

REGINA CHELL: Okay. Thank you. So that are the comments that we had registered for today, or commenters, so because in the interest of that we do have time available, if there is anyone who has any additional comments and you did not register, you certainly can come to the mike and introduce yourself, and share your comments. After that, I will open it up and not for, this is not, the nature of this Town Hall is not an active back and forth Q&A, but I understand there are some clarifying questions, and I certainly would open it up to try to clarify any of those.

So first, any additional commenters?

MARY WHEATLEY: So I'm Mary Wheatley. I'm with the Association of American Medical Colleges, and I'd like to thank CMS for hosting this gathering. I think this is actually a step in the right direction to engage communication around Physician Compare, which is a really important website, as is all the Compare websites.

We will submit formal comments after the Town Hall meeting, but I just wanted to reiterate a few of the points that have been made and make sure that they get carried home, and one is the importance of having accurate information, and also to make the plea that it's not only important to get the physician information right, but a way to get the group information right, and if you can have some kind of mechanism to allow the group administrators to help insure that accuracy, that would be beneficial.

I also think its worth, you know, kind of in the vein of having this, having a really detailed timeline on what to expect for communication for Physician Compare, and how we can engage in the dialogue.

You know, as Koryn mentioned earlier, how do we get the information from the technical panels out. Can we have discussions on what language is used on the websites so that we can just engage in a full description. So if we can even get just a more detailed timeline saying, this is when we'll have a draft of this out, and if you're interested, you have the opportunity to comment, that would just be very beneficial. So to go to that next layer of information and engagement so that there aren't any, isn't any confusion, or surprises, or questions like well, you know, why is there a star on one program and not on another. And so just so we can get consistency in things like that, I think that would also be beneficial.

Thank you.

REGINA CHELL: Okay. Thanks.

RODNEY PEELE: Good afternoon. I'm Rodney Peele, with the American Optometric Association, and I just wanted to follow up a little bit on what some of the other speakers have hinted at a little bit.

Mr. Lartey, in his presentation, showed us the Is This You function where if physicians have some sort of problem with their listing, a way to correct it, and it takes you into the Internet based PECOS, and I just want to say that, once again, that the Internet based PECOS is not a very friendly administrative process. In fact, it's, at the contractor level, it's the single worst administrative process that our members have to deal with.

Getting information in PECOS updated or corrected is a nightmare for a lot of physicians. It takes a lot of time. Does it have to be that way?

I know that CMS Central Office staff has worked on ways to try to improve the process, but it's still being administered poorly at the contractor level, and if you want doctors to look at their listings and see the mistakes are in there and be able to fix it, the PECOS process has to be improved.

Thank you.

REGINA CHELL: Okay. Thank you. Okay, before I open it up for clarifying questions, I would just like to make a couple of comments, and maybe some clarifications right off the bat.

So a couple of things I heard in the room this morning, one was – hang on. Let me check my notes here. So one was a reference to having ongoing conversations with CMS, and we welcome that 110%. We are always open to ongoing communication with our external stakeholders, provider groups, consumer groups across the board, so we encourage you to continue to reach out to us. We have found those conversations to be valuable over the past year, and help us as we've expanded and worked to improve the website.

The other is, I want to make sure you are all aware I did hear some comments about providing some additional timelines when is TEP information available, and we do have a website, and I'm going to kind of defer to somebody in the audience to give you the URL for that, but it's a Physician Compare Initiative website, and it's similar to the website we have for PQRS that provides a lot of educational information for providers and eligible professionals. That's the intent of this Physician Compare Initiative website.

So we will continue to provide more robust information on that website and look at how we can have things available for you. And the URL for that (SOMEONE SHOUTING THE INFORMATION OUT FROM THE AUDIENCE, BARELY AUDIBLE)), go to cms.gov (BARELY AUDIBLE) – oh, and search for (BARELY AUDIBLE) – oh, sorry.

That's why I don't have it put to memory. So go to cms.gov and put in Physician Compare Initiative in Search.

The other way is if you have saved PQRS website to your Favorites over the years, you can link to the Physician Compare Initiative from that site as well.

The couple other comments I just wanted to make is, you know, I've heard more than once and I am excited, actually, to hear this feedback, about having more live time updates to the website on demographic data, and I will say we hear you, and we have been working on where we're going to go with that in the future.

So it's still under development, so I can't really disclose when that will be available and how, but please know that CMS is actively working on how we can supplement the PECOS data, make it more user friendly for office staff and providers to come in and give us feedback on the demographic data that's on the site.

Okay, so if anyone has any additional clarifying questions – again, this isn't, Town Hall is not a Q&A session, but if there are some really specific clarifying questions, you can come to the mike and we'll see if we can help you.

WOMAN: This is very easy. Where do we get a copy of your slide deck?

(SOMEONE SHOUTING OUT THE ANSWER FROM THE AUDIENCE, BARELY AUDIBLE)

REGINA CHELL: Okay. So the answer to the question, for those of you who couldn't hear, is the slide deck will be sent to everyone who registered. The folks on the phone already have that, but you will have it when you get back to your e-mail.

KORYN RUBIN: So in regards to the ACO information posted, how is that broken down by search function? Is it just the ACO, or if you searched a provider that

participates in ACO, can you, does it show up? Or if you search a group practice that's part of an ACO, does that show up? Or can you only search by the ACO name? Because from my understanding, a patient does not know they're part of an ACO until they go into a primary care's practice that's part of an ACO, and this is part of our dialogue we've had with CMS around how an ACO can communicate that they are in an ACO.

So I think there's a level of, you know, posting information that's helpful, but there's also a need for refining how a physician can communicate to their patients that they are part of an ACO, and that would assist with the transparency around posting all the information.

REGINA CHELL: So the search on the website is by the ACO name.

KORYN RUBIN: Okay. I'm not sure how helpful that would be for a patient, just because that's not probably how they refer to seeing a physician, or when they look to find a physician practice, but something to possibly think about.

And then in terms of posting the cardiovascular measures in late 2014, when – do you have a timeline for when a physician practice, because that's going to be at the individual level, would know that that information is going to be posted, and how that information will be posted on Physician Compare? Because as I stated in my previous comments, when – what a physician knows from their PQRS report is a little bit different from what then gets posted on Physician Compare, since you break down the language and put them into kind of categorization of measures.

And then in terms of—we've made this statement before when Westat has hosted conference calls on the Physician Compare redesign—but having an opportunity for measure developers to review the language on Physician Compare to ensure that the plain language isn't altering the meaning of the quality information that's being reported on by the physician, because there could be some kind of breakdown, and interpretation can be, it can be interpreted differently by a consumer versus a physician in how they were

reporting the information and what is being collected. And then also, in terms of other – what else was there? I'm trying to make sure I get everything that I didn't address.

Oh, I also echo not reducing the length of the measurement review period from 30 days to two weeks because we, as you know, it's difficult for providers to access the information. So what, you know, the longer they have to review and possibly file informal appeal, but that also doesn't necessarily line up, the informal appeal period doesn't necessarily line up with the posting of Physician Compare information, so, but the length of time should not be reduced.

And then in terms of composites, we're supportive of composite measures, but we're also aware of existing limitations regarding risk adjustment, attribution, and aggregation methodologies that CMS uses, and in general, so we seek clarification, for example, are all the measures in the composite weighted equally is something for CMS to think about for the public to be made aware of, that also there's evidence that one measure may contribute more than another to improve quality, and would that then get a higher weight than a measure that doesn't have as much of an impact?

We also, if CMS also moves towards reporting composites, we request for CMS to outline the methodology and provide an opportunity for comment. And the AMA is supportive of physicians receiving recording credit through meaningful participation and a variety of quality measure activities, including Board Certification. We urge CMS to promote flexibility in its performance programs by allowing physicians to report through their medical boards, registries, accreditation activities.

And the AMA, we believe it would be helpful to post additional contact information such as office hours ore website addresses, but given the continued problems with the underlying demographics data, we're not sure at the capacity for CMS to manage the logistics of that, and we also request clarification as to CMS' proposed timeframe for changing out of date information, and the mechanism that providers have provided to physicians or practices to update their information, since we're still hearing from

practices today that their hospital or practice affiliation is several years out of date, when it's been updated in PECOS several years ago.

So thank you for the opportunity to comment, and we're very happy to see CMS engage in a Town Hall meeting like this like that was done several years ago, and we hope you continue the dialogue, and as we requested, to create some kind of work group with the physician community, and the AMA is happy to convene as we move towards posting more robust information so that there's a continue ongoing dialogue, much like that's done for Hospital Compare.

Thanks.

REGINA CHELL: Okay. Thank you. Okay. So just to kind of wrap up for the day, I want to review, as you see on the slide that's up currently—for those on the phone, this is slide 15—that written statements will be accepted until 5:00 PM Eastern Standard Time on Monday, March the 3rd. They're not to exceed two single spaced typed pages.

You can send comments via e-mail to physiciancompare@westat.com; by mail to the address listed here, the Division of Electronic and Clinical Quality, and I won't read through the entire address, and just have Attention: Rashaan Byers or Regina Chell.

We will work to compile the comments that we received today, as well as the comments that come in by mail. We thank you all for traveling to CMS today, for joining us on the phone, for staying engaged in the work we're doing around Physician Compare, and continuing to be vocal and give us your feedback and your input, because, as I've mentioned more than once, it is very valuable, and this work cannot get done the way it needs to unless we join together and work collectively to do that.

So thanks again for being here today.

*End of Town Hall