

CENTERS FOR MEDICARE AND MEDICAID SERVICES
**MEDICARE VALUE-BASED PURCHASING PROGRAM FOR PHYSICIAN
AND OTHER PROFESSIONAL SERVICES LISTENING SESSION**

Conference Leader: Thomas Valuck, M.D.
December 9, 2008
10:00 AM ET

Operator: Good morning. My name is (Alicia) and I will be your conference facilitator today. At this time I would like to welcome everyone to the Medicare Valued Based Purchasing program for physician and other professional services listening session.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question and answer session. If you would like to ask a question during this time simply press star then the No. 1 on your telephone keypad. If you would like to withdraw your question press the pound key.

Thank you, Mr. Kuhn, you may begin your conference.

Herb Kuhn: Good morning and thank you. I am Herb Kuhn, Deputy Administrator here at CMS. And I want to thank everybody for participating in this - today's listening session.

This listening session is going to be an essential part to kickoff our efforts to really drive the discussion, and ultimately our report to Congress on the Physician Valued-Based Purchasing report that was part of the (NPL) legislation that we are beginning to work on today.

Many of you may recall that we went through a similar exercise, and a similar process, in our efforts to develop a report on hospital valued-based purchasing, which we wrapped up November of last year and submitted to Congress at that time.

To give everybody a sense, in terms of participation and interest in this particular session, we had nearly a thousand individuals who registered to express their interest in participating in today's program.

For those that are on the phone, we have about 50 people in the audience here in our Baltimore office. And then obviously many hundreds of more on the phone out there. So we appreciate everybody's interest in this program and your participation.

We also, throughout this day really look forward to the input and the comments everybody is going to give us on the paper that was put out before Thanksgiving with all the questions and the information that - it was in that background paper. I think it is going to be very helpful for us in facilitating our work here today.

But let me just make a few opening remarks before I hand it off to the rest of the program today.

I think as everybody knows the obvious is that we are in the midst of a transition here at CMS, as well as across the country. And part of this

transition I think continues to focus on an urgent matter. And that urgent matter continues to be the financial viability of the Medicare program.

As you have heard mentioned several times over and over again, the current payment system is cynically unsustainable. Unsustainable for a number of different reasons. We continue to see health care costs growing. Our office of the Actuary International Health Expenditures report earlier this year indicated that we could see a doubling in health care expenditures over the next decade.

By 2017 we could see 20% of our GDP caught up in healthcare. And the most recent announcement I hope everybody paid attention to was that our actuary in the fall meeting of the Medicare Trustees noted that because of changes in the economy, we could see as much as three years off of the solvency of the Medicare Trust Fund, which means of course that we could be looking at solvency in 2016 instead of 2019. These are all important issues as we continue to wrestle with this issue.

Also, as we all know, the physician payment system is simply broken. Absent any action in Congress, we all know that in January of 2010, we are going to see a decrease, or an absolute cut in terms of physician payments greater than 20% because of the SGR if nothing is done as we move forward. So I think that is why this discussion is so important.

But just to give you a sense, in terms of the size of the (unintelligible) for this discussion, why it is so important for us to continue down this road of valued-based purchasing, let me share with you some numbers that have been in the news recently. But put them in context, in terms of Medicare, Medicaid, and SGF and particularly what we do in CMS.

And four different numbers that I just want to share with you that I think are illustrative of how big and how important the Medicare program is and how important the work we are about today is.

First of all, the loan guarantees for J.P. Morgan purchase of Bear Stearns. When that came out here about six weeks ago that was pegged at \$29 billion. When you look at the combined programs we have here at CMS, that's a 2.5 weeks of spending for our programs.

If you look at that loan package for AIG, that was \$85 billion to that package. That is about 6 weeks of spending for our programs here.

The big one - the rescue package for the financial industry - for the banking industry - \$700 billion. That's about 1 year, 2 weeks of spending for us here at CMS.

And just in the news this morning, the rescue package for the auto industry right now is pegged at maybe \$15 billion. That's about 1.5 weeks of spending for us here at CMS.

So what we do today as part of this discussion, what we do across the board, whether it is Medicare, Medicaid, or SGF are extraordinarily important, in terms of what those programs are all about and what we do.

But I think everybody knows that we here at CMS have been considering for a long time, and moving forward on an agenda that really tries to integrate quality and payment systems as a way to maximize that Medicare dollar that is out there.

And when you look at the evolution of the program, it simply makes sense. When you look at the beginning of Medicare in 1965, we were basically paid on customary and reasonable necessary costs, that carried us for about 2 decades. But we knew that was unsustainable.

So in the early '80s, we moved to the prospective payment systems. And that too brought in a certain level of efficiency, but that carried us for about 2 decades. Now it is time to change.

It is time to change the fee-for-service system to really get away from the consumption on quantity of care model that we have, but to really focus on quality and avoiding unnecessary costs as we go forward. And that is an important part of the discussion, as well as today.

And we have got good validation, in terms of this process, as we go forward. Good validation from the Institute of Medicine, in terms of their pathway to quality reports where they talk about linking Medicare payment to quality in outcomes and efficiency.

Wonderful reports from MedPAC - the Medicare Payment Advisory Commission, where they too have sent reports to Congress linking payment and quality as we go forward.

This administration and the budget since FY '06 have been talking about the very same thing. And Congress since the MMA have been sending signals and moving us in this direction, I think in a pretty thoughtful forthright way.

And best of all, I think the health-care community itself has already exhibited an interest in a leadership for quality improvement in so many different ways.

But as we go about our business today, one of the things to think pretty hard about and watch for, and remind us here at CMS as part of this process is that in our quality improvement road map that we put out a couple of years ago, we laid out a series of principles which we thought would be good guiding principles at that time, and I think still good guiding principles as we move into this new uncharted territory of valued based purchasing.

And I would share those with you, because I think that is going to be so important, again for holding us accountable to those and I think to help facilitate the discussions here, as well as the further development of this report.

And the first and foremost one is working through partnerships. The one thing about as we move into this new era - of payment under the Medicare system is this is something that just cannot be ordered. We just cannot tell physicians, hospitals, or other providers that this is how they are going to behave in the future.

I think we really have to have collaborations, partnerships in this area as we go forward, as evidenced by this meeting, and future efforts you're going to see as we continue to develop this report.

You're going to see another important principle for us, in terms of making sure that we measure quality and report comparative results. I think that is the key to the future. You have seen what was done so far, in terms of our compare website. This is absolutely going to be essential for us.

We have got to continue to encourage the adoption of effective health information technology wherever possible. And we need to promote

innovation and the evidence base of effective use of technology wherever possible.

So again, these are basic guiding principles that we have out there. We want to make sure that you hold us accountable to those principles through today's discussion and as we go forward.

But in conclusion, let me just wrap up here by saying that the foundation of an effective Valued-Based Purchasing program is, as I said, collaboration with the stakeholder community. Very different from what we have done in payment in the past.

And we all know that here and we need to make sure that in order to have good quality and cost measures that are evidence based, that the burden of reporting remains as low as possible for physicians and other providers. And that actual improvement is achieved through all that we do through this process. Those are important pillars that have to guide us as we go forward here.

And so we are we really are reaching out here today, and throughout this entire process, with the widest possible range of health care, providers, consumers, purchasers, the groups that represent them, and others who share our same goal of trying to drive greater value, greater quality, and more efficiency in health care.

So I think this particular listening session is a milestone. I think each effort we do are milestones, because they are the first of their kind as we try to move in this area. But I think this one is particularly important, because this is the first time we have had such a listening session in this era to think about physician payments. And the most important one I think as we go forward.

So again, thank you all for being here. We look forward to a very productive session today as we move forward.

And so it is now my pleasure to turn up program over to the Director of the Centers for Medicare Management, Dr. Jeff Rich. Jeff.

Jeff Rich: (Unintelligible) Good morning to everybody and thank you for taking time out of your schedules. And to all of you on the phone. There are a lot of people out there on the phone.

And joining me at the table is Dr. Tom Valuck, who is my copartner and co-lead on this project. It is an extraordinarily important project. I wanted to sort of talk about the opportunities here. Herb did a great job of defining the problem - the enormity of it.

I think what I have been impressed with on coming here and spending the last nine months here is just the enormity of - and the scale of the financial outlays that the government does for health care. And it is staggering sometimes to walk into work and think about billions of dollars a day and moving it around and making it effective and efficient, and really having the responsibility we do internally to spend this money wisely and to make it work. And we are trying to do that.

I will move this forward, I think. I wanted to provide you some context for the Physician Valued-Based Purchasing program. And, as you know, and I think Tom, you may talk about this. But in (NFTA) this year, Congress mandated that we come up with a plan for Physician Valued-Based Purchasing in May of 2010.

We are - that is a short time frame - believe it or not, because of the complexity of the problems and the complexity of the Physician Valued-Based Purchasing plan.

We did do a plan for Hospital Valued-Based Purchasing, and we have other plans for other sites of service. But remember that those plans really direct - are directed towards a single site of service. The Physician Valued-Based Purchasing plan is extraordinarily more complex, because physicians cross those sites of service - even an individual physician.

So we have the opportunity here to really design a system - an effective Valued-Based Purchasing system, or a plan for physicians that can really change the face of health care delivery. I think that we can have a single model, or multiple models.

But in any case we will be able to hopefully design something that will look at the gaps that exist, look at the high risk areas, look at the populations at risk, and hopefully provide incentives for physicians to improve the quality of care to those particular places and areas in the health-care delivery model, and effectively restructure our payment system.

And I think physicians have the opportunity here - and it is an enormous opportunity and an exciting one. I think this is probably my only regret in leaving soon is that I will miss a lot of the internal discussions here.

And I should say in the context of that, believe me the people here are extraordinary. There are very well intended. They are extraordinarily intelligent. They are content experts in this and they really do want to do the right thing.

And this listening session is very important, because we - I am wearing my CMS hat, really take the advice of the physician community very strongly.

We had a meeting of the Physician Payment Advisory Committee yesterday. We listened very intently. And we do and we take that advice very seriously, and turn it into what we think are effective payment models and redesigning the payments structures that do exist.

The structures that exist are very complex. And so you will have to understand that there is some rigidity built into it statutorily - the way we pay physicians and the way we pay other sites of service. So we are trying to describe and define the model here that will allow us to move forward and effectively restructure the payment system so that we can have a sustainable payment system going forward in the future.

I did want to speak - and this is just an overview of the presentation - some of the highlights my experience in the private sector before coming here and share those with you. Because I think Valued-Based Purchasing does work.

And those principles are already grounded in the private sector. There are many people - many of you out there who are doing these things. You are having programs locally and regionally. And we want to take this to a national level.

And next slide. The improvement road map, as you can see is from the Institute of Medicine. And I just want to draw your attention to the efficient - that part of the quality road map does include the efficiency.

And that means providing high-quality care at reasonable costs. And we do want all of us I think as providers need to understand that providing high-

quality care can be very expensive. We can provide high quality care. And if we do it in a patient centered, patient focused, and safe way, we can reduce costs in those care delivery models. And we need to provide incentive programs that will guide us in doing that.

I know as physicians in training, I was never taught about the cost of health care delivery. It's absent in the graduate medical education programs. It is absent in medical school. It is hopefully becoming a more important item now. But sincerely we have all done our best to deliver high-quality care. And I don't think that I in my training thought a lot about the additive tests and resources that I was consuming that may or may not have led to improved patient care or patient outcomes.

Our Road map - we do have a road map here for quality improvement. We do want to work through partnerships. And this is one of them right here. Measuring quality and reporting is extraordinarily important. And I think you - that resonates well in the physician community, at least the measuring part of it. And reporting it to ourselves internally, intellectually, and then sharing those reports with others.

Because I think patients need to know about the quality that is out there and/or the lack of it. And we certainly want to inform them through a transparent process.

Value based purchasing is just that. It is improving quality and avoiding unnecessary costs. We are encouraging the adoption of health information technology and innovation, and using evidence basis for the use of this technology.

We are driven by evidence based medicine. I know we are and I know that is how I practice. But I can tell you that internally CMS is driven by evidence based health care policy reform. I have been very impressed since I have been here that the amount of evidence - it does take a lot of evidence to change health policy.

And we use it effectively. And we do it through our demonstration programs and we do it in other ways. But what does Valued-Based Purchasing mean to us? As Herb alluded to, we have been a passive payer. We have been paying for quantity of services and not for quality of services. We are transforming Medicare and CMS as we speak, into an agency that actually wants to extract value from the health care delivery system.

We realize that the amount of money that is there to finance it is limited. And Herb discussed some of that. And I will give you some more details. And we do have tools for doing that. We have measurement tools. We have payment incented tools that have been developed, public reporting. Our conditions of participation for hospitals is important. And there are quality issues and measures placed there.

We have coverage policies in our QIO program to help support all of you during your delivery of health care in their own states.

And we have other initiatives. We have pay for reporting. As you know, I think this is an iterative process. We started with pay for reporting. We wanted physicians and other stakeholders in other sites of services to begin becoming comfortable about reporting their quality measures, and providing incentives to do so.

Then we want to move towards paying for the achievement of thresholds - or in those quality measures. And then through much of the work you will hear about today - particularly with Karen Milgate who is here in the audience about developing resource utilization tools and measurements so that physicians can actually see the resources they are consuming while delivering the care. And then eventually perhaps look at the nexus between quality and resource use consumption.

And end up in our vision of the future where we are delivering very high quality care at costs of that are - do not include duplicative tests and other unnecessary costs.

And we do have many programs that are out there to support this. And improving quality is our utmost guiding principle here, as you know. I mean, you have all seen this. You can see the variation of quality across the country. And many low quality areas of the country regionally looked at. Those are the highest cost areas. And that is the exact opposite end of the spectrum to which we want to gravitate and move towards.

We don't want to pay for quantity. And we do want pay for high quality, why avoiding unnecessary costs. And this is just a reiteration of what Herb said.

As of Dec. first, the Hospital Insurance Trust Fund, which is funded through payroll taxes - your Medicare payroll taxes that you all pay and employers pay. The expenditures are now exceeding revenues. And there's (unintelligible) Hospital Insurance Trust Fund. And the prediction was for 2019 for that to expend itself basically.

And now with the recession and all the economic crises that are going on, that has moved up. And it has moved up to perhaps an eight year time frame. And

if you think that President-elect Obama would get reelected, it will occur in his administration. So something needs to be done.

It is impossible to sit and look at this and predict that in eight years we won't have a massive financial crisis in the health-care delivery system.

And I think we are part of the solution. Because although that addresses the Hospital Insurance Trust Fund, there is another trust fund that pays for physicians. But it is not limited - it is not unlimited either. It has limited resources. And we - I think we have a very unique and exciting opportunity to help redefine the way we deliver health care here to begin to extract savings along the way, providing high quality of care, and to help restructure the payment systems in the health care delivery models that we all are engaged in.

And there is a lot of support for this. This isn't coming just from CMS. You can see it is in the President's budget. There have been a number of legislative and logs. There has been a number of legislation that have addressed this, including NMPA and that is why we're here today.

MedPAC is very much in support of this, but CIOM. And across the whole spectrum of health policy makers and think tanks, this is a very important initiative. And it is embedded here at CMS. And it will be transferred to the new administration. The new administration in our transition team discussions is clearly in favor of this. It is clearly on the same page.

This is not something that will go away. This is something that is directional for healthcare, and it is independent. It is not a partisan issue here.

We have a lot of - and to CMS' credit, they recognized this a long time ago. We had demonstrations and pilots that are looking at quality incentives,

looking at delivering higher quality care, and designing them in multiple sites of service.

As you see here in single sites of service, we have a number of demonstrations that have addressed this payment model. And in addition, have created demonstrations across sites of care, which is kind of the model that the Physician Valued-Based Purchasing initiative will be. It has to cut across sites of care. It is going to be extraordinarily complex. But I think it will help, as I said before, in really restructuring how physicians and the physician community can help move the health care delivery model in the right direction.

And we have a lot of VDP initiatives already ongoing. We started, as you know with pay for reporting on the hospital side. On the physician side the PQRI.

We are looking at physician resource use reporting. It was part of (NFTA) as well. And you will hear more about that. We are here to discuss and deliver to Congress in 2010 - In May a plan for physician value based purchasing. And we are looking at Valued-Based Purchasing in other sites of services.

And that is our goal. Basically to improve our - the health outcomes. Make sure that we're not restructuring a payment system that impedes access, or delivers lower quality care, but high-quality care with equal access in a transparent way. And make sure that beneficiaries are aware of this, and that we are aware of the financial implications of the way we deliver health care, and the way we practice medicine.

Our goals are here. These are all right out of our Issues Paper. Reducing fragmentation duplication. I see this all the time when I practice. I will see a

patient and he or she has had the same test four times in the last month, because there is no discussion. There is no care coordination. There is duplication. We are transferring patients from one hospital to another, repeating the exact same hematology, or chemistry test.

I mean, you get real granule here and you can think about all those scenarios that you see and feel all the time when you sometimes scratch their head and say, you know, why are we doing this? Or that was a test that was unnecessary. It really didn't lead to any improvements in care, and it doesn't help my care plan.

And we want to make sure that this is - when we redefine it and restructure the system, it is transparent. It is transparent to us, it is transparent to payors and to patients.

My personal experience is - had to do, and many of you might know, through the Virginia Cardiac Surgery Quality Initiative where we developed a regional collaboration of all the hospitals and cardiac surgeons, administrators, the nurse practitioners and you name it who were involved in the delivery of cardiac surgery care in the State of Virginia.

And we came together, shared data gently in a blinded way, and in an open way. We started - we develop a clinical financial tool that uses a blended database of the STS and CMS' database, so that we are actually able to look at quality improvement and its effects on costs. Sometimes it is higher. Oftentimes it is lower.

We are able to look at patient centered protocols that would reduce resource consumption while delivering the same or better quality care along the way.

And, you know, we really became sort of an accountable care organization where we had locally physicians and hospitals collaborating and then sharing those ideas and bringing it together in the State of Virginia. But we reached out to CMS to develop a demonstration program which was (unintelligible) payments, and had to do with all the cardiology and cardiac care services for patients with coronary artery disease, as well as (unintelligible) heart disease. And that was very similar in design to the AIDS demo that we know is out there right now under solicitation.

And we went into the private sector and did this with WellPoint Anthem in a fee-for-fee program. Both on the hospital side and on the physician side. And it is very parallel to what we are doing now.

We have a hospital based purchasing plan. We've developed that in the State of Virginia. And we have a physician based value based purchasing plan - or pay for performance.

But uniquely what we did is, in order to keep us collaborating and together, many of the same measures existed both at the hospital and on the physician side. And we are all - we are jointly accountable for each other's outcome.

And sometimes the hospitals would say, why would I be responsible for IMA usage by a cardiac surgeon? And my response was, well they needed to make sure that your staff is providing the highest quality care. And that includes using an internal mammary artery. And if you see that is there is a weakness there, you need to address that at the staff level.

So it worked. And the (QHIT) program has been up for about three or four years. And I guess my - the magnitude is probably close to \$75 million in

payments to hospitals. I can't tell you how many dollars have been paid to the physician side because I have been away from it for awhile.

But those two programs won an award at the (unintelligible) - at the Eisenberg patient safety award. And WellPoint is very transparent about those results. And they shared it with the community. And I presented it probably a year ago at least.

So it is important. The Physician Valued-Based Purchasing plan, as I said is extraordinarily important. It will help us we define the landscape of care delivery and cost containment in everything that we do.

I can't emphasize too much in sitting on the inside and looking at the payment systems and the payment structures that we have right now. They are somewhat dysfunctional, but they are functional, and they are statutorily mandated. It is all we have. But we have an opportunity here, I think, to help restructure those while staying within the current payment system and providing continued fee-for-service programs, and Medicare advantage programs, but integrating all these principles - the valued-based purchasing into each and every one of those programs.

So with that, I think that is the end of what I have to say. Do you want to take any questions, or just move on?

Man: Move on.

Jeff Rich: Okay.

Tom Valuck: Good morning. I am Tom Valuck. I am a medical officer and senior adviser in the Center for Medicare Management. And as Jeff mentioned, I am the career

staff co-lead for this particular project - the development of the physician and other health professional value based purchasing plan.

And Jeff is the political official co-lead. We - for those of you on the phone, we have about 80 of your colleagues here in the audience today. And many hundreds have joined us on the phone as well.

I want to begin by thanking Herb Kuhn and Dr. Jeff Rich who just presented for their strong leadership as political officials for Valued-Based Purchasing.

And as Jeff mentioned, there is every indication that as the transition progresses to a new administration, when you look at the publications of the president-elect's advisers, when you look at Senator Bacchus' White paper, laying out his plans for the Finance Committee's work, that we will be continuing forward here, and possibly accelerating even if in potentially new directions.

For those of you on the phone, we are on but slide set that is entitled Structure Process and Overarching Questions. Jeff spoke from a slide set called Defining the Opportunity. Herb did not use slides.

If you are on the phone and do not have the slides in front of you, you can go to the CMS Web site physicians center under spotlight. So if you employ your search engine for CMS Physician Center Spotlights, you will find at the top of the page, a link to a zip file that has all the presentations in it.

So if you weren't following along with the first presentation, Defining the Opportunity, I would encourage you to look back at that. Because you heard Herb and Jeff lay out very clearly the urgency, as well as the promise of the work that we are undertaking with the Valued-Based Purchasing plan.

The second slide in the overarching structure process and overarching question slide set is the overview of the particular piece that I am going to be presenting.

I will start by reiterating the legislative background and our mandate for the development of this plan and the submission of it in a report to Congress.

I will then talk about our process for developing the plan.

We found that in - when we were doing this process for the Hospital Valued-Based Purchasing Plan Development, that the stakeholders were very interested in our internal process. And that was one of the things that we received compliments on, in terms of the development of that plan.

So we want to give you as much insight into how we are going about this so that you can participate along the way, as you wish.

The - I will also cover the planning assumptions. And the general design principles. And then within the subject matter topics for today, the leads for those topics will be talking about the specific design principles for that particular part of our plan.

And then the approach to today's listening session. Now you may think that is a bit out of order, but it is placed there as the intro and how into our first substantive discussion beyond the making the case that was just done by Herb and Jeff, which is the overarching comments from the Issues Paper.

So hopefully you have all had a chance to look at the Issues Paper. Again that is under the Physician Center Spotlight Section. For those of you on the

phone, if you are busy printing slide sets and haven't done that yet, you will find that there as well.

But we will begin with the overarching questions. And then we will be proceeding through the Issues Paper to talk about the specific section - topics under each section.

So to begin with, the legislative background.

Of course the Medicare program is a public program, doesn't do anything without statutory authority from Congress. And this is our authority to do this plan.

The (NFTA) section, 131 D requires us to delegate it to CMS from the Secretary to develop a plan to transition to Valued-Based Purchasing for physician and other professional services.

So when you hear us say today Physician Valued-Based Purchasing plan, please know that we are very cognizant of the inclusion of other professional services here. And so we might use shorthand, but that doesn't undermine the importance of the broad view that we are taking of physician and other professional services.

And then the requirement is to submit a report by May 1, 2010, containing the plan with recommendations for legislative - legislation and administrative action. And we have every intention of meeting that time frame. And along the way, we will be interacting with congressional staff. And as requested, the members of Congress.

As we all know that physician payment will very likely be a hot topic during the next legislative session. So I suspect that Congress won't be waiting until May of 2010 to hear our ideas about Physician Valued-Based Purchasing. So as we work with you on the development of the plan, we will also be working with Congress as requested providing technical assistance.

This is the structure of how we are going about putting the plan together. We have a work group across CMS components, looking - with subgroups, looking at the specific four topics that you see listed here - measures, incentive structure, data strategy and infrastructure, and public reporting.

You are going to be hearing from CMS experts today in each of these topic areas. We call them the subgroup leads, because these are the four subgroups. And this would be my opportunity to just think each and every one of them.

I mean, they really have taken a very strong leadership role coming out of the blocks here in developing the Issues Paper. And I am really looking forward to working with them on a subsequent phase of designing the plan.

And they are also your contacts are for the subject matter areas. So I would encourage you to begin conversations with our workers with the sub group leads.

And this is the list of the subgroup leads. For measures, we have Dr. (Mike Graf), who is the director of our quality measure and health assessment group In the Office of Clinical Standards and Quality.

We have Karen Milgate, who is the director of our Office of Policy.

For the incentive structure, I am co-leading with Terry Kay who is a senior adviser in the Center for Medicare Management.

We have (Will Matos), from our Office of Clinical Standards and Quality Information Systems group, who is going to be addressing data strategy and infrastructure.

And for public reporting, we have Jane Thorpe from our Office of Policy, and (Jane Hammond) from the Office of Beneficiary Information Services.

So as you can see, a wide range in representation from across the organization with the experts that we look to hear. And as Jeff so kindly noted, really are nationally recognized in each of their areas.

So that is the structure. This is the process. We chartered the work group and the subgroups back in September and began the development of the Issues Paper. That is the background document for this session. And of course today, December 9th, is the conduct of those first listening sessions.

And we will use the input that we get from you all to develop a second deliverable in the form of an options paper.

And ideally, if it fits with the direction of the political leadership from the new administration, ideally we would like to have another listening session like this one to actually talk through those options with you. So we would encourage you to watch for that. Although, at this point in time we can't make any promises about what our new senior leadership will want to do, in terms of process in the development of the plan.

And then we would intend to use input on our options paper in the preparation of the final draft plan, with the intention of submitting that to Congress by the May 1, 2010 deadline.

So for that first deliverable - the Issues Paper, here is the process we used in its development. We - it was led of course of the work group and the subgroup leads, and it was posted on our website on November 24th, to give you time to review that and develop your responses to provide us input.

We will be receiving the verbal input today. But remember that we are welcoming written input and will be talking about that through the day-to-day. Because we really are looking to glean as much of your insights as possible, through this open process.

The Issues Paper itself outlines key design issues, the assumptions that I am going to be talking about in the next slide. And then the idea is that the responses to the Issues Paper would help us in preparing for our next steps down line.

These are the plan assumptions. That the primary focus will be on performance based payment. Now that may seem self-evident, since it is a Valued-Based Purchasing plan. But when our work group for started talking about what is this all about? We had lots of ideas. But we wanted to keep in mind - forefront in our minds, that the statutory requirement is to develop a plan for transition to Valued-Based Purchasing, predominately performance based payment.

The plan will accommodate different practice arrangements. Now as you all know, there is a diversity of practice arrangements. Different sizes of groups,

all the way down to individual practitioners. Individuals may practice in different settings of care.

For example, in an institutional setting versus an office practice, see different kinds of patients with many different kinds of conditions. So a lot of diversity in the physician world, and we want the plan to accommodate that to the extent possible. And that is an important caveat, given what we need to do relatively quickly. So we will need to think about the scope issue as well.

The plan will recognize the contributions of the members of the health professional team. This goes back to a comment that I made earlier, that we are talking about other health professionals, in addition to MDs and (DO)s. But also that the team approach is sometimes comprised of several different kinds of physicians as well. So this assumption was meant to recognize the team approach, and that some members of the team may not be physicians.

That will consider multiple levels of accountability, including individual teams, groups, and accountable care entities, which have already been mentioned today by Jeff.

The - this goes back to a couple of other bullets, including how we will accommodate different practice arrangements, and how we will recognize the different individuals on the team.

So a lot of food for thought there. And we're going to be delving more deeply into some of these issues in the rest of the discussion today.

The second slide lists the remaining three assumptions. One is that this plan will be at least budget neutral, looking across Medicare Parts A and B, not just within Medicare Part B, and will consider shared savings options.

A lot again in this assumption, but primary among the points to make here is that we know that Congress actually bigger than that. We know that our society is looking for how to address the costs of health care in a rational way, as opposed to just arbitrary cost cutting. And we hope that this plan will give a guide to how we do some rational approaches to looking at costs, particularly of course, focused on the Medicare program, since that's our statutory mandate. And we will be a looking at shared savings options all along the way.

The initial focus will be on a fee-for-service Medicare. And we will want to leave the door open for looking at other parts of Medicare. But again, just to define our scope - initial focus on fee-for-service Medicare.

And then that as another scope issue, how to get our arms around both the short-term opportunity that may be somewhat limited, because of what is feasible to do. And a much longer-term look at the bigger possibilities.

So we don't want to just look at the bigger possibilities and lose sight of what we would need to do to transition to those other approaches to performance based payment.

On the other hand, we don't just want to look at the short term practical implications and lose sight of what we might be able to accomplish, in terms of the bigger picture. So that is the point of that assumption.

Now let us turn to some general design principles. So you have heard the goals and objectives from Jeff. I have just covered some assumptions that are in the Issues Paper. And now we have our general design principles.

The first is the whole purpose for our discussion today, which is to engage the stakeholders in the development of the plan. And primary among those would be the physician - physicians and physician associations and other organizations.

So we have to remember as policymakers, that there are many types of stakeholders. And that includes consumers, our beneficiaries, in many respects primary in our thinking. That includes other purchasers of care, and the doors that we are open - as we are always told for the private sector plans. That includes those who advise us from the academic sector, from quality oriented organizations and so on. So lots of different stakeholders here and we want to recognize all their contribution.

We will apply experienced learned from our Medicare Valued-Based Purchasing initiatives, like our demonstration projects, which Jeff listed in Defining the Opportunity, and from the private sector.

You will note in the Issues Paper, in the appendices, we have a summary of both Medicare's efforts, as well as private sector efforts in pushing forward with Valued-Based Purchasing. And we of course want to learn from that.

We also said in our assumptions, and reiterate in our design principles that we will consider multiple approaches to accommodate multiple practice arrangements and care settings. So this goes back to the points that I was making earlier about the diversity of arrangements for physician practice.

We also believe that it is particularly important to avoid creating additional health care disparities. And through our efforts in our use of financial incentives, we would seek to address reduced existing disparities.

One of the demonizations, if you will, of Valued-Based Purchasing is that when you are using measurement data to pay and publicly report, that that could potentially lead to an adverse selection situation where vulnerable patients are avoided, or somehow left out.

We hear that and we want to avoid that an unintended consequence. So we are paying particular attention to that as we move through our planning process.

We recognize the need to develop ongoing evaluation and assessment. This was a predominant piece of what the Institute of Medicine said we should be doing in their three part series on Aligning Incentives for Medicare - the third in a three part series, that said we need to be moving forward, but with some caution. And that caution would be to monitor along the way, and to correct for unintended consequences that we see.

And then detailed design principles, as I mentioned, will be addressed in each of the relevant topics today.

So now you have had the overview from the perspective of our deputy administrator, the perspective of our director of the Center for Medicare management who is our - the political co-lead for this, and from the perspective I think from the workgroup - from the career staff standpoint.

So now let us talk about the rest of the day.

If you will turn to the agenda, you will see that we are down now to the discussion of the overarching questions. That will be followed by a presentation and a comment session. We will have a comment session on the overarching questions that will be followed by presentation on the measures section of the Issues Paper, with a comment section. Our lunch, which will run

from 12:15 Eastern until 1:00. So from those of you on the phone, be sure and set your internal clocks to Eastern time for your lunch today.

Then we will have a presentation on the incentive structure comments - data strategy and infrastructure with comments, and public reporting with comments. And we will close with an open discussion.

We found that the participants in our hospital Valued-Based Purchasing session, sometimes found it difficult to segment their comments according to these various topics. And that it was helpful to have an open discussion at the end to just sort of sweep up whatever wasn't able to be shared along the way.

So that is our agenda for the day. We are calling for verbal comments. We will take comments first from those who are here in Baltimore. You see we have the mike set up here in the aisle. You would come to the mike and state your name and organization. And limit your remarks to 2 minutes. Now that is under each topic. And we are not necessarily limited to only one set of marks from any individual.

In fact, it would be good to get some discussion going. But we are starting with a limited amount of time. We do have a timekeeper by the way. The just because we want to make sure that everyone has an opportunity. And once everyone has had an opportunity here in the room, we will go to some comments on the phone. And maybe revisit the comments from those of you in the room. And we will see how that works to get some discussion going.

In terms of breaks that will be left up to you. The only formal break that we have is to lunch. But you will note that the restrooms were on the hallway that you took coming into the auditorium. And feel free to leave the room as needed.

So with that, I would like to turn to the three overarching questions that we have in the Issues Paper. And then we are going to open up the discussion to our first round of public comments.

The first question in the Issues Paper - the first overarching question is, will the stated objectives, assumptions and principals - the general design principles that have been stated so far, support a higher quality of care for Medicare beneficiaries and better value from Medicare spending, which goes back to our goal.

And we would just be interested in your thoughts about our planning parameters, and ask what other planning parameters should be considered.

The second overarching question is, is it desirable to have several different approaches to accommodate different practice arrangements across various care settings?

Well, you may ask, why are you asking this question if one of your assumptions is you will do this? We are asking it because we want your perspectives on how to get our arms around the diversity of physician practice arrangements, styles types of conditions treated and so on. And so we wanted to project here with this question, that we are very open to your input on how to accomplish that.

And a third overarching question is, what steps can CMS take in the design and implementation of the PVBP plan to reduce health-care disparities, or at a minimum to avoid exacerbating existing disparities?

So as you note from the design principles, this is one of our very important considerations. And we want to address it right up front as an important and overarching issue.

So with that, I am going to pause in the formal presentation and open it up to comments from those of you who are here in Baltimore first.

And our first commenter is Dr. Susan Nedza, from the AMA's Physician Consortium for Performance Improvement.

Susan Nedza: Thanks, Tom. Thanks, Jeff.

The comment we specifically would like to address is, the learning from the various demonstration projects and private sector activities in pay for performance. We would like to advocate for a very rigorous, transparent, scientific, opened, and perhaps independent evaluation of the findings of those activities. Because we need to learn not only what the results were, but also the things that didn't work well.

And traditionally we share best practices, and we tend to only share those things that worked. But delve in the details. We believe it is very important that we all understand completely, and don't make the same errors that have been made in the innovation in some of those programs.

Tom Valuck: Thank you, Susan. As a and former colleague here at CMS who has participated in some of our development of Valued-Based Purchasing purchasing, your insights are particularly important to us. And that is an excellent point.

As we indicated, the Issues Paper contains an appendices - an appendix that has two appendices - one addressing CMS' demonstrations and other initiatives related to Valued-Based Purchasing.

The other selected private sector initiatives, representative from private sector health plans. Mentioned to me earlier that, you know, wouldn't it be helpful to see that more broadly? And we agreed. And we would like to work with you on developing out that particular appendix.

But that was a sign that we are paying attention to what is going on with the experience with value based purchasing, not only from CMS' perspective, but from the perspective of the private sector. So important point. Thank you Susan.

Yes, sir. Please introduce yourself and state your organization.

(Randolph Bailey): I am Dr. (Randolph Bailey), from the American College of Surgeons. I have two comments to make.

First is that shared savings across the health care delivery system provide the best incentives to increase the efficiency of the system?

And for surgery in particular, efforts of individual providers to make care more efficient are likely to be seen in reduction in hospital expenditures, rather than physician billing. And so we need to find a way to reward the surgeons and those people who are reducing the hospital costs, in order to provide them with the appropriate incentives.

And the second comment goes back to what you were talking about - avoid exacerbating the existing disparities and creating new ones.

And I think I didn't see anywhere in the paper the word - the words of risk adjustment. But clearly that has to come into play, in order to keep people from cherry picking patients and denying care to the patients who are likely to have poor results.

Tom Valuck: Thank you. Two very important points I think that go to some of the planning parameters that we have already discussed this morning.

We mentioned as one of the assumptions that we would be looking to make this particular plan at least budget neutral ideally. And that it would look at savings opportunities, not only from Part B, but would also consider savings opportunities from Part A and how those two might interact.

Now we don't have answers. That is very complicated. We have certain statutory requirements about how we make payments. So we can make no promises. But what we can say is we recognize, Dr. (Bailey), your point and will be taking that into consideration.

And the second, just highlighting the importance of our attention to disparities. And we agree that, where appropriate for measurement, we would be considering the importance of risk adjustment.

And I believe that it is addressed in the Issues Paper. And our next set of presentations and comments will be addressing that. I hope that you will address that may be in a little more detail when we have the second comment session about measures and measurement.

Next comment please.

Jeff Rich: Let me just....

Tom Valuck: Yeah, Dr. Jeff Rich.

Jeff Rich: On the shared savings models. You know, in the physician fee schedule, we went out with some very strong language about shared savings and gain sharing. And we weren't able to finalize anything, because we thought that finalizing something might be a little bit too restrictive, based on what our thought processes were and where we felt we were in the exceptions that we have already put out there.

But it is reopened for comments. And I would encourage everybody to read those and submit comments. Because we will be addressing this issue in a broader scale outside of this Physician Valued-Based Purchasing plan.

(Jason Skull): Hi. Thank you for your presentations. (Jason Skull), Infectious Diseases Society of America.

We have comments on both bundled payments and shared savings. We have serious concerns with the bundled payments issues, in that if hospitals are in charge of dispersing payments, we are concerned that inpatient specialists, such as infectious diseases physicians might have trouble getting payments through their hospitals.

As far as shared savings, I would like to echo Dr. (Bailey)'s, I believe, comments in that infectious diseases specialists who serve as infectious control practitioners could benefit greatly from a shared savings program, if it is properly structured.

And I would encourage anybody who has not read the fee schedule and the shared savings provision to review it - review the 55 different questions. And, if necessary, hire a lawyer to develop them for you.

Tom Valuck: Thank you, (Jason). I am starting to see a theme here already around shared savings as a popular option. We will see how that develops throughout the day.

Jeff Rich: And I will just address that. We did a shared Savings model in the private sector with our hospital. And it included infectious disease specialists. We did get paid from the hospitals. One of the issues with the shared Savings model is on the hospital side, who actually distributes the payments? Do they become a payor now, rather than just the deliverer of healthcare?

So those are some of the issues that are more contentious, if you would, and harder to follow. But we did have an effective model. And ID specialists were some of the bigger drivers of resource use in our hospital.

So yeah, and you will get rewarded I think. And it is important to get all of the specialists involved.

Tom Valuck: Thank you. Next question, or next comment please?

(Don Kasey): Hi. My name is (Don Kasey). I am the chief medical officer of Atlantic Health in Northern New Jersey. And by way of disclosure, I am a member of the Performance Measures Subcommittee for the American College of Physicians. And also the current president of the Northern New Jersey Heart Association. And I am speaking as an individual, not on behalf of those organizations.

First of all, congratulations to Jeff, and all of you for putting together a thoughtful document.

I have been spending the last however many days it was since you released this - I think it was Thursday before Thanksgiving, with physicians to get their input. So I want to reflect some generic ideas that I think would be helpful.

First of all, one of the themes that comes up almost regularly is the notion of demand for care. And just as an example, we recently had a 95 year old woman in our ICU who was consulted on for surgery. She had a five year history of Alzheimer's/dementia, and was on chronic maintenance hemodialysis.

So it is easy to blame physicians for that. But in fact what I hear consistently from physicians is the demand for services has to be addressed. And I know you are focused on the supply side. But I really believe that demand has to be shelled out.

The second thing is that there is an inherent skepticism that physicians have that I talk to consistently, especially in light of the hospital required conditions being a non payments. And so again, being explicit about when we are talking about payment for whatever model you use - shared savings, versus non-payment is something that should be I think address at every step, because it is on their minds.

My own opinion is the word efficiency has lost its meaning. And in fact health care seems to be inventing its own definition. I would like to see some discussion with, you know, organizations like accounting firms. I have talked to (unintelligible) about this. Efficiency seems to be a code word for many

different things. I realize we're trying to get our arms around it. But that to me is a very big term.

And lastly, we've - I - we've recently submitted comments to NQF on the safe practices. And that challenge I feel is that - again evidence based is a vague term as well. And that if you look at organizations like ACP which use the great system before ranking and evaluating evidence, ACP, which used the grade system for ranking and evaluating evidence, ACCHA, which has it's own system, The Society for Hospital Epidemiologists of America.

We think that there should be an explicit methodology applied to any of the evidence based approaches that exist, so that it is explicit and transparent.

Tom Valuck: Yeah. Well, we are starting out the session today with excellent comments from all of the commenters. And I would also like to thank them for being very concise. I am quite impressed.

In terms of your particular comments, the patient's role in value based purchasing - an interesting and important consideration when you think about, for example, the importance of patient compliance in helping the professional achieve good outcomes with that patient. So we will be taking that into consideration.

There are private side efforts to involve the patients in making value based decisions that are informing us along the way.

In terms of the healthy skepticism that you mentioned about non-payment, I guess I would just reiterate the importance of finding a rational basis for cost savings for the Medicare program.

You heard in the introduction that we need to be focused on how to take costs out of the system, and do it in a way that hopefully enhances value. And that is part of our goal.

And then the idea of what is efficiency? At least in terms of how we are defining it at CMS, the efficiency in the physicians office setting may be somewhat different, because they have a certain production function.

But at CMS, we define the efficiency as getting the highest level of quality, for our spending. That is how we can be as efficient as the largest public-sector payor. Actually the largest payor - the public sector payor for our population. So that is how we think of efficiency. So when you see it in our presentations, that is what we are referring to.

(Don Kasey): And I agree that the demand side it is important. Corollary to that, we have to develop ways of managing expectations. And that is our professional responsibilities and to help guide patients and their families into managing expectations for the patient that you just described.

And it is just in it is good to know that your record remains intact. I have been at public meetings for the last seven years and you have always provided an insightful comment at every one of them. So thank you.

Tom Valuck: So (Guy DeAndrea) of (unintelligible) Consulting.

(Guy DeAndrea): Hi, Tom. Thank you.

We do a lot of work on the private sector value based purchasing initiatives.

And my comment is in the form of a suggestion for a possible new principal to include, which would focus on avoiding overly disruptive changes in the health care system that undermine the existing provision of care.

As you contemplate new payments systems, that's likely going to require providers to restructure or re-engineering their own care processes, which of course is one of the objectives. But that needs to happen in a way that allows care to be delivered, you know, on a day-to-day basis in a way that patients continue to get the services they need.

I think the principle is implied by a number of the other principals you have, in terms of a long and short-term time frames, and looking at unintended consequences.

But I think it would be a useful exercise to really envision a transition process that providers could follow so that they can get from Point A to Point B, while still providing care along the way.

Tom Valuck: Thank you for that.

We are envisioning something of a revolution here, (Guy). And so we need to figure out how do you have this progress around new payment models and not disrupt the high quality of care that we need to provide to the beneficiary.

So keeping in mind the delivery of care to beneficiaries is primary here as we work the financing arrangements. It is a very important point.

Do we have any other comments here in Baltimore?

We have (Regan Crumb), from our sister agency.

(Regan Crumb): Good morning. (Regan Crumb) with the Health Resources and Services and Administration. Thank you for sharing all the information. I thought it was great that, in addition to avoiding additional disparities, there is an intent to work to reduce disparity.

And an answer to the - or the response to the second overarching question, is it desirable to accommodate different practice arrangements? I think maybe the answer is yes.

And two, the practice of arrangements of concern are the mental health provider settings, dealing with the mental-health parity issues. And then maybe even the HIV/AIDS practice settings deals with costs.

And the second question there is if so, how should this be accomplished? And one way is possibly working - continuing to work closely with the Substance Abuse and Mental Health Services Administration that has direct connections with those provider settings where physicians practice and provide mental health services.

And HRSA, which of course works with the HIV/AIDS provider settings and the low income providers like the rural health clinics and (unintelligible) qualified health centers that take care a lot of low-income Medicare beneficiaries.

And I think by including practice arrangements where the providers are specifically addressing those disadvantaged populations - mental health, HIV/AIDS, and low income, I think we can begin to make sure we address to reduce disparity.

Tom Valuck: Yeah. Very important points. And we hope that you will take advantage of being inside the government with us to keep a close working relationship. Not only on this disparities topic, but on the whole development of the plan.
Thank you.

(Regan Crumb): I would be very happy to do that. Thank you.

Tom Valuck: And I think that is extraordinarily important in my opening remarks I did say populations at risk. And I think that developing a model for physician PVBP that would be flexible enough to address populations at risk that cut across multiple providers would be extraordinarily important to address issue that you just brought up.

(Regan Crumb): Thank you.

Tom Valuck: We would be actually hopeful that we could understand the use of financial incentives to the level of precision where we could actually use those incentives to encourage the access for, and the higher quality provision of care to vulnerable populations.

So turning this argument that PVBP is somehow detrimental to vulnerable populations on its head through the measures that we select and the way we use our financial incentives to me would be a success

Tom Valuck: Okay. We are going to take a caller now. Operator, if you could queue up some comments from the phone. We have time for one or two before we go into our next topic.

And while they are gathering, I would just mention that we are going to have public comments throughout the day today. And so don't feel like if you

haven't gotten a chance to get yours in that you somehow lost the opportunity.
So operator.

Operator: Yes, sir. At this time if you would like to make a comment over the phone, please press star then the No. 1 on your telephone keypad.

Our first comment comes from (John Hudson). Your line is open.

(John Hudson): Hi. This is (John Hudson) from (unintelligible). Excuse me. We are in the PQRI Registry and the EHR programs.

My comment is related to maturity of standards and putting in place standards that are based on the evidence. And specifically the measures for electronic medical records and (C-Chip) in the medical home demonstration are specific to (C-Chip).

And in PQRI they are specific to functions, as well as (C-Chip), and at the - recently (Janet Corrigan) had a statement of something called a core functional EMR and the - So, the summary of the comment is to make sure that standards that are adopted are mature enough and will have the intended outcome of changing behavior in an evidence based fashion, which may be related to some of functional elements in the full (C-Chip).

And the final example of that is, when Farzad from up in New York had to testify in front of Congress, that his (C-Chip) DMR couldn't collect structured data and do performance measurements and outreach. An impact, he was spending a lot of effort with the vendor to modify the system.

Tom Valuck: Thank you for that comment. I am going to ask that when Dr. (Graf) talks about measures and measurement issues. And when (Will Matos) talks about

data strategy and infrastructure, that they keep your comments in mind. I think it is very important to set the stage for our later topics today.

Operator, do we have a second comment from the phone?

Operator: Yes, sir. The next coming comes from (Jennifer Eames). Your line is open.

(Jennifer Eames): Hi. This is (Jennifer). I am with the Consumer Purchaser Disclosure Project, which is a collaboration of over 50 leading national and local employer consumer and labor organizations.

I want to start off by saying that we wholeheartedly support CMS' intention to align Medicare's payment policies and practices to encourage ongoing improvements in the quality and efficiency of care delivered by physicians and other professionals.

Medicare is demonstrating strong leadership in reforming health care by continuing to actively pursue value based purchasing across the multiple sectors.

We recognize that a one size fits all approach to implementing and Medicare Valued-Based Purchasing program for physicians and other professional services will limit getting the maximum benefit for this initiative.

We support having multiple tracks that all strive and achieving the goal of encouraging higher quality, more efficient, professional services.

In addition to the examples listed in the Issues Paper, we also recommend CMS considered tracks and potentially preventable complications and overuse of services.

Reducing these will improve quality and have the potential of reducing waste and the savings could be used to fund financial incentives for the program.

We also want to commend CMS' attention to the issue of health care disparities in the overarching design of the program. Any program directed at improving care should ensure that it does not unintentionally create a greater gap in quality of care between those that are advantaged and those that are not.

CMS should develop an evaluation plan that includes monitoring the impact of the program on health care disparities. Thank you.

Tom Valuck: Thank you for those comments, (Jennifer) from the consumer perspective. We know that our attention to the quality and the cost of care are important to our beneficiaries and to health care consumers generally.

The idea of safety, getting at the complications, which you specifically mentioned. The idea of getting at waste and over use - very important. And of course the disparities being a very important part of the Issues Paper, but also a major theme that is evolving from the comments today.

Do we have...? We have time for one more comment from the phone.
Operator, if you would please?

Operator: Yes, sir. At this time, we have no comments in queue.

Tom Valuck: Great. So with that, I am going to exercise the moderator's prerogative to just remind folks that I know - I can see that eagerness here in the audience that a lot of you have additional comments to make. We have a lot of comment

periods that we will be having after each discussion today. And we are looking forward to those. So again, don't feel like you have somehow lost the opportunity.

And similarly, for those of you on the phone, we will try to have a mix of comments from the audience here in Baltimore and those of you who are on the phone.

With that, I am going to ask Dr. (Mike Graf) and Karen Milgate to present the measures overview.

(Mike Graf): Okay. Good morning. I am (Mike Graf). I am the director of the Quality Measurement and Health Assessment Group here at CMS. So we are involved in measurement systems for all of the different settings of care for Medicare. From physicians to hospitals, home health, nursing homes, dialysis facilities. And we are also involved in prescription drug measures.

So there's a broad area of settings that CMS is involved in with this. I have been involved in the physician quality reporting initiative significantly as well.

So I am going to present the first half of the slides with regard to the measures. And then Karen Milgate, who is the Director of the Office of Policy will take it from there.

So okay. I can't see the slides. There I can see it. Okay. Good. I pushed the wrong button. This must be the button.

Karen Milgate: That is it right there on the side.

(Mike Graf): Yeah. Forward and back. Okay. There we go. So we will start with the overview of the presentation.

We are going to talk about design principles, assumptions, data sources, technical challenges and key issues. And I will cover the first of these, which is the choice of the quality measures. And then Karen will take it from there with choice of resource use measures, unit of measurement and accountability, and combining the measures.

The design principles. First of all, we want to have breadth, in terms of all aspects of this. We heard the comment to that one size doesn't fit all. We are certainly aware of that.

It may be that we can't necessarily have all sizes the person that we are in operation. But nevertheless, there is an effort to have a broad applicability of measures.

First of all, measure key measures of quality with intentions to outcomes, cost of care, outpatient experience, care coordination, prevention and adoption of and use of health information technology. Basically reflecting that quality has many dimensions. It is not one.

Frequently, in terms of implementation, we think in terms of process of care measures. But there is a lot more to it than that.

We also have to recognize that we are somewhat early in the development of quality measures, with regard to physicians. If we think about it, only a few years ago were pretty much limited to a set of primary care and prevention measures - process measures. And the development of experience of care was being initiated.

But since then, there has been a rapid development of physician quality measures. But again, we are early in this. And we have got quite a bit of ways to go. And there will be continued evolution, and we want to incorporate the measures as that happens.

Align measures across providers and settings of care. Certainly there, as I mentioned, there are measurement systems in multiple other aspects of care. They do tend to start off with the setting, which is an issue Karen will address.

One starts with measure developments for dialysis facilities, or home health, or hospitals, and builds from there. And it is easy when one does that to not focus clearly enough on the fact that the patients are not like that. If - this is about patients and it is not about provider settings or physicians really. Yes, it is directed towards them, but the focus here really is on patients and having patient care being optimal.

And in this case, the patients do move certainly from one setting to another. And physicians are active in all of the various other settings of care that I mentioned.

Just measurement data for fairness where appropriate. We already talked about vulnerable populations. And so one always has to think in terms of the unintended consequences that might apply.

Assumptions. We want to incorporate quality and resource use measures. So this is not - quality is very - the key aspect certainly, but resource and cost is a fact of life. And we have - that is an aspect of quality too and we have to bear that in mind.

We have a current foundation, which I will explore a little bit. But we want to build on that current foundation, balance the precision - or I would say the strength of the measure with the manner in which it is used.

So when one increase measures into a Valued-Based Purchasing scoring system, one doesn't necessarily have to give all measures equal weight. So one can, depending on - one could perhaps put a measure in that may have some controversy I suppose. But still reasonably good, but weight that less if it is not as strong as other members measures.

Encourage coordination with other providers to the extent feasible. So we have that same point on both sides. So we want to make sure that we never fail to take that into account.

That this - that one of the criticisms of our health-care system, and certainly measures that an individual provider level that sort of enhance that is that it is too focused on just individuals and individual settings, and not enough on how does the overall system work? And we definitely want to encourage that.

And seek to online Medicare efforts with other payors. Medicare is certainly the biggest payor, but it is not the only payor. And therefore, to the extent that we can align - and physicians and other providers of healthcare deal with all of these different payors.

And one of the biggest criticisms about the use of quality measures, are these kind of efforts. It is when one has to report one set of information for one provider setting or another, depending on the payor. Then that becomes difficult to handle.

As far as data sources, I want to spend a little bit of time on this. This is I think pretty key. Because there are a lot of potential data sources for quality measures. And one doesn't really think about that.

You can be led to believe that everything is the same.

Claims is certainly the easiest and most readily available source of information, because claims are always being submitted. So you can take claims. And there are a number of quality measures that are - that take advantage of claims.

One (unintelligible) - and so you have abundant data, but you have a limited scope of physician practice that you can evaluate this way.

We looked in a couple of our projects and found that if one goes through all of the (unintelligible) measures - that is the basic source of claims data only measures, you can only have - find about 12 to 15 that apply to physicians, at least using Medicare data.

That is an obvious limitation. And those are primary care and prevention type measures. So claims abundant, but limited scope of physician practice. And inevitably, claims are not intended necessary for quality measurement. So one has to have inferences that drive from them. Inferences about quality, and inferences about who is responsible.

So those are challenges, but again a wide availability. They aren't what I would call a secondary use of the data. In other words, it is not primarily for that. But again it is an important area. And we could use, of course, various sources of data.

Augmented claims. That is a term that I use for our physician quality reporting initiative measures. It is basically, at least one submission vehicle is the claims mechanism. But the physician puts down additional information, like what hemoglobin A1C is. Like they prescribed a beta blocker and so forth.

In our PQRI for 2009, we have 153 measures, 18 of those can only be reported through registries, but the rest through claims. So we have a broad scope of measures available. And the physician, first of all takes responsibility, or accountability for the patient when they report that quality data code. And also take responsibility or accountability for that issue, or that clinical issue that they are reporting on. Unlike claims, where it has to be inferred.

Registries has the benefit of augmented claims, in terms of all of the information that can be submitted - the self accountability and so forth. Plus it also can capture outcomes.

Claims - augmented claims or PQRI type measures alone, they have to be directed toward what's going on at this particular point in time. For the patient, when the claim is being submitted, registries allow information that spans a great time period to be collected.

The next is EHRs. Now EHRs are clinical. They are primary source data. There is frequent reference that even for registries. Well how are you going to validate the data that is submitted?

If you think about it, when you deal with an EHR, that is the medical record. Therefore if you get the data from the medical record, of course you have to have the systems built right, and auditing, that they can't be changed and so forth.

But it is like if you asked somebody to send you in the medical record, there is nothing to validate. That is your primary source. So that has a lot of course attractive this to it. And the EHR use is growing.

There were some comments about, well how about the standards? In the PQRI program this year, we did not initiate for the qualification for the incentive payment, the submission through EHR. There were a couple of aspects to that.

One of them was that the testing of the submission hadn't been completed. But the other reason is we didn't want to get ahead of the standards process. And, CCHIT, we expect over the next year or so will get to the point that they will have standards for EHRs that reflect the type of electronic transmission that would be contemplated in PQRI so we will sink up with the standards adoption process, and CCHIT certification and so forth and not get ahead of it. So we think that in the future of this will be a very important area.

And then finally data collection tools. There are data collection tools, such as the physician group practices demonstration that combined a number of things. They use claims data, but then they also sample patients and send that out to the professionals, will then submit additional data in that tool.

I am going to jump ahead one slide and talk - and then I am going to go back and turn it over Karen, and that is on quality measures.

There are different times of quality measures. And the data sources I just mentioned lend themselves to some better than others. Clinical process measures are our most widely developed measure. But on the other hand, they have to be tied to outcomes. And sometimes in the clinical process, the measures your run up into them being topped out. That you can't - it is not

really advantageous to incentivize someone to go from 90% to 92%, possibly in certain areas. So one does run into that with the process measures. We certainly found that in the hospital arena.

And the next type quality measures are outcomes. And we look to have those. Those are what people are always looking for really - better outcomes. And if we can measure them directly, there is probably no - we are always running a mile faster. So there is probably no ultimate level that one would get to.

So you don't run into the topped out issue particularly. But - and it also ties to aspects of care that can be tied directly to cost savings, such as potentially avoidable admissions.

Structural measures are a type of measure that probably has limited use overtime. EHR use and E-Prescribing. We have an incentive program for electronic prescribing under the PQRI program for 2009, but that phases out after a few years. So I think that is probably the situation with any structured measure.

And finally, we have patients perception of care.

So that is my portion of this presentation. I am going to backtrack. Whoops, I thought I was going to backtrack. But I am going to turn it over to - now that I messed it up, I am going to turn it over to Karen, and hopefully she can get back to that other side.

It is not...There we go.

Karen Milgate: (Unintelligible) go.

(Mike Graf): Yes, the technical....

Karen Milgate: While we are talking about measures, I am going to start at resource measures. And then we will put the technical challenge slides that is still back there after that. So if you are following along, that is what I am doing here.

So (Mike) just talked about the various choices of quality measures.

In terms of resource use measures, first let's try to be as clear as we can about what we mean by resource use measures. Because clearly that is a little newer topic than quality measures.

And when we talk about it, what we are talking about basically are Medicare costs, i.e. payments as well as the beneficiary cost of services. Not, and as Tom alluded to necessarily the cost within a hospital or within a physicians' office for delivering services.

And the point of that is really to take a broader view of when we talk costs so that it goes across settings potentially, or looks more broadly than just, you know, specifically what the physician cost production function is.

Having said that, there is probably more levels of measuring resource use than we put on this slide. But the three that are talked about most are first service specific measurement. And this is really the most granular level.

Examples here would be, for example if you were looking at readmissions for hospitals. Or another one that we have discussed some internally at CMS and made some policy on is if multiple imaging is done within a close time proximity, it could be redundant services. So those are examples of service specific.

Clearly those are easy to attribute, but they don't necessarily capture care across settings of care.

A broader level of measurement is per-capita measurement, and that is where you are looking at the cost of care for the beneficiary across all the whole year, so speak. GAOs use this to identify costly beneficiaries.

The physician group practice - the demonstration that CMS is currently still working on, uses this to really calculate the actual spending of a beneficiary population to then compare that to the expected spending to see if in fact care management practices that the physician group practice has put in place has saved the program money. And then if it is at a certain level, to actually share those savings.

So there has been some discussion of shared savings today. There are different models of that obviously, but this is one model that CMS is currently looking at.

The other level that is talked about a lot is to actually look at episodes of care. This is kind of in between, so to speak, the specifics - the service specific per-capita. This is where the mechanism that is often used for this is to group clinically similar claims together so that you have an episode of care that defines a certain population that is as similar as we said you can.

So for example, you would have an episode of coronary artery disease , or an episode of hip replacement. So that would be a little bit finer level than the per-capita, but not quite at the service specific level.

Again, this captures care across settings. It creates some attribution issues, because there's often more than one provider involved. But that is another level at which you can also measure resource use.

And as you probably will see a theme throughout these presentations, these could also be used in combination. So we are looking for feedback on creative ways to do that potentially.

Now I am actually going to go back to the technical challenges slide. So somehow it doesn't do it automatically, huh?

Woman: (unintelligible).

(Mike Graf): It is probably one of those things.

Karen Milgate: It says backwards, but....

All right. Well, I will go through the technical challenges slide without it being up on the screen, but...Do you want to try?

Man: (Unintelligible).

Karen Milgate: Don't mess it up okay.

(Mike Graf): You did it. What a genius.

Karen Milgate: Oh goodness (unintelligible).

(Mike Graf): Did you just push harder, or what?

Karen Milgate: Okay, my technical adviser has now gotten us to the technical challenges slide.

So there are clearly policy challenges. There are technical challenges. You will hear some overlap in how we talk about these, but we really wanted to outline some very specific challenges that we know we have moving forward, and ask for your help in trying to address some of these challenges.

First of all is attribution. And this is clearly the need to determine which professional or provider is most able to effect either the quality measure or the resource use measure.

This is a challenge that is particularly important for the Medicare population, because there is often more than one physician or professional provider that is involved in the beneficiary care. So having to - figuring out who is actually the most responsible is a challenge for the program.

There are a variety of ways to deal with this. Sometimes the decision is to just decide who is the most able to effect it looking through claims. There may be some self attestation that these are my patients. You could assign the care to a group practice and let the practice decide.

Sometimes the decision is also to multiply attribute, so that anyone who has a significant responsibility for the patient is assigned either whatever the quality score is, or the resource use score.

There are also use issues with sample size. And I will just, you know, I think the core issue here is the higher that you set your sample size, the fewer physicians, if you are the looking at individual physicians, you are actually able to get a reasonable score for.

So, for example if you say you have to have at least 30 patients to be counted as having a score for a particular measure, it might be harder to get a large number of physicians scores than if you said you have to have a minimum of 10, and look across measures. So that is just kind of a balance between being able to have a very precise measure with trying to be able to have measurement for a broader number of physicians.

Another issue is benchmarking and what the peer group would be. There's really two kind of dimensions here we are talking about and asking for input on.

You can imagine that if you are measuring a particular physician practice, you could look at their performance on a particular quality measure, relative to a national score. That could be your benchmark. It could be relative to regional score. Either at local or state. It could be within their own health plan. There are a variety of ways you could set the benchmark.

There are also a variety of ways you can determine who they are compared to. So for example, you might want to have - compare them to any provider that saw those types of patients, recognizing their maybe some trade-offs in either quality or efficiency between specialties.

Or you may think it is only fair that they be compared to those that are within their same specialties. So there is also a balance that will need to be struck there.

Risk adjustment is absolutely key, as was mentioned from one commenter earlier. It is really important to ensure that the comparisons are fair. And more importantly, that there is no incentive in the system to avoid sicker or less

compliant patients. We, talked about that as even a goal to encourage that there is better care of those folks. So that is clearly something that is going to need to be applied, particularly when we are talking about outcomes measures for quality.

And we also recognize it is a critical issue when we are talking resource use measures. To make sure that when you are measuring populations and the costs that they incur for care, that you adjust appropriately for the fact that they may have been sicker or less sick than others in the population.

Outliers are particularly important when we are measuring resource use. And that is in the sense that, if you are looking for example at episode of care, there may be some very expensive episodes, or very cheap episodes - very low-cost episodes. And you may want to actually leave some of them out of your calculation. Although - just so you don't bias results.

On the other hand, there is some concern if you do that, you may be actually taking out some of the variation that in fact you are trying to measure.

So there is also different ways of thinking of that.

And then one key technical challenge, which isn't really - what do I want to say? A statistical or a philosophical challenge, but more of an infrastructure challenge is the fact that we really need to look at the professionals, as well as CMS resources and how we can actually implement this program.

Clearly there are hundreds of thousands of professionals. They all have different roles in the system. If they self report, the practice clearly has to know how clearly to do that reporting. And then CMS has to be able to receive those reports and process them.

If they are based more on administrative data, such as claims, it may be simpler for the practice and CMS. But still there will need to be a relationship formed between the physicians and CMS, for the practices to really understand what the reports are based on, and to use them for their own improvements over time.

So these are some key technical challenge really that apply across the program that we are looking for feedback on how to address.

All right. So let's see if I can get to my....

So we have gone over some broad assumptions and broad directions. We have looked at data sources, and what types of quality and resource use measures might be available, and have sort of a broad look at some of the technical challenges.

So this slide really is now to say, okay so we - who would you actually hold accountable for these measures?

And it is entitled Accountable Entity and Unit of Measurement. Because those two might be different. And really there are sort of interesting discussions and both of those areas.

And let me just give you an example of what is meant by that, because I don't think it is necessarily clear on the face of it.

One, if the accountable entity and the unit of measurement were the same. An example might be, you would be looking just at an individual professional's patient population, measuring adherence to certain clinical process measures,

for example, and then holding that individual accountable for whatever those quality scores were.

Another example though where you might have the entity accountable, and the unit of measurement differ could be if you were to look more broadly at the patients that were part of an accountable care entity. And I am not - I am using that word loosely. So that could be physicians with hospitals. It could be a broad group of physician practices. It could be a variety of different coming - combinations of providers.

But if you were to look at all of their population that was assigned to them. You might measure for example, readmissions at that level. Because it might be difficult to assign that to an individual physician responsibility directly.

So you would say, okay well, here is the readmission score for this accountable care entities population. And then let the accountable care entities perhaps then decide how to work within the entity to hold the individual provider responsible if you wanted to.

So the unit of measurement would be the whole population, but the accountable entity might be the individual physician within the accountable care entity. That is actually confusing to say those things. But I hope you got the message on that. You can measure at the broad level and have accountability at the narrow level.

Having said that, there are - we would like to just throw out two - three different levels of accountability and talk just a little bit about the advantages and disadvantages of each, and then we will ask for comments on these as well.

In terms of the individual professional. Obviously, it is easier to attribute if these are self reported measures, to an individual physician. It is potentially more actionable, because they clearly know more about who those patients are.

It is harder to measure from a sample size perspective, because there is just fewer patients often seeing individual professionals.

Group practices. This acknowledges that other providers might be involved, besides just the individual professional. Again, because of the sample size issue, we might be able to measure at this level a little bit more. But the broader level is this again accountable care entity, where you might actually encourage some joint accountability amongst providers.

This could either be done in a way where we create formal or informal entities. Or we would ask providers to decide what their entities would look like. Or you could even possibly - and this is moving even a little further away from actual accountability at a provider level, look at doing some measurement at a geographic region level. This is a concept we put in the paper that we are also interested in some feedback on, where it may be a geographic region that is put together from a logic perspective, because there may be some care relationships.

One example would be hospital referral regions to start with that, which people use that are based on some care system. So you can measure at that level, and possibly have some joint accountability for the measurement at that level.

And as I said before, I think one of the keys here is how we might combine some of these concepts to be able to get at multiple ways of practicing.

There are also different ways to use and combine measures. And just to state the obvious, I guess all measures are not equal. And what we mean by that is, some measures address priorities that have a higher - that are higher priorities for the program.

Some measures are more precise and stronger, as (Mike) called it, than others. Some measures are more accepted than others. And so the point here would be to just point out that the combinations of measures could be flexible.

For example, well accepted measures affecting larger numbers of beneficiaries could get more weight than others. If we are concerned about the precision of resource use measures, we might want to weight them a small amount of the score in the initial phases until those measures become more precise.

There is also a variety of ways to create composites. You could do averages across measures. There are some composites that people are creating now to look at specific conditions. So there is also some variety and flexibility in how composite measures might be created.

We have talked before in particular in the Hospital Valued-Based Purchasing plan of rewarding both attainment, as well as improvement on measures.

Clearly there are questions about how those two factors might be combined, which might you weight more heavily than others? That was a lot of the real detailed discussion that you all saw if you were a part of the discussions on the Hospital Valued-Based Purchasing plan.

There is also going to need to be some definition of the interaction between the quality and resource use measures.

One way that private-sector purchasers have done this is they have basically calculated quality measures for group practices, and calculated resource use measures for group practices. And considered those really footprints for - in both of those areas for the group practice. And then combine them in either, you know, some weighting scheme or another.

The other way to do it though would be to have more direct relationships. And say if I am going to measure resource use and quality together, it has to be on exactly the same patient population, for the same condition. So you are really looking at the direct relationship.

And clearly, all of this would be dependent upon what unit of accountability you chose as your unit of accountability. So you could use and combine measures differently, depending upon the unit of accountability.

This slide is just a slide to summarize some of the key themes that we're - that this presentation raised. And we will leave these up to stimulate thinking, if that is needed.

So the first one is to look at what measures would best achieve the stated goals. Secondly, should the plan focus - this is a more focused question, but solely on individual practices? Or is this a way, or a need to broaden the accountability? What's strategies best address the technical challenges?

Given the current and potential data sources, which measures and level of accountability would be most effective?

And then if we were to combine measures, which have - which are the higher priorities ? How do you - which ones do you think should be weighted more than others?

There are plenty of other food for thought beyond these, but this was just to remind you of some of the themes.

Tom Valuck: Thank you, (Mike) and Karen, for a great overview of the issues that we're raised in the measures section of the Issues Paper.

At this point, we will take comments from the audience in Baltimore first. And then we will be taking comments from the phone as well.

(Jason Skull): Hi. Thank you Dr. (Graf) and Ms. Milgate. This is (Jason Skull) from IDSA again. I have another comment or several comments. They pertain to both the E-Prescribing provision and the physician quality reporting initiative .

ID physicians have been and continue to be limited from participating in both the PQRI and soon-to-be E-Prescribing provisions. This is because of their unique position as primarily inpatient consultants.

While IDSA appreciates the inclusion of the four new HIV measures for the PQRI reporting in 2009, IDSA is very disappointed that the only reporting option that CMS finalized is registry based.

The E-Prescribing program offers similar challenges for our members. It requires that 10% of the physician services must be outpatient.

This rule will exclude many, if not all - if not all or most ID physicians from participating in the E-Prescribing provision. Thank you.

Man: Well I guess I - the only thing to say is I interpret that to suggest that broad applicability is an important principle for the Valued-Based Purchasing design.

Tom Valuck: Next comment from Baltimore please.

(Henry Demarais): My name is (Henry Demarais). I am with Health Policy Alternatives.

As I listened about your struggling with the measures question, I just have a suggestion. When you identify some likely measures, it seems to me you could use your Medicare claims data to try to develop an educated guess about how that is going to work in the real world.

And by that, I mean mainly the small numbers problem, especially if you are on outcomes measures that need to be risk adjusted. And you can tie back and look to see how many individual physicians, or how many practices would have a sufficient number of encounters with discrete patients with the right diagnoses, or the right procedures.

And you will either come away with a feeling that this is going to work, or only a tiny subset of the physician population could have their performance assessed. And I don't think we want to wait until the first or second year of Valued-Based Purchasing to look back and say, oh my gosh we can't assess the performance of large numbers of physicians.

And I think that is especially true, because if it is budget neutral, then we don't want a situation where large numbers of practices are disadvantaged simply because of the smaller numbers issue.

And I know you are aware of the problem. I am not sure you are planning to look at your existing data to kind of test out, gee how is this going to work?

Tom Valuck: Well, I would say we have already looked at the data for those issues in a number of projects that we have had. There is the Better Quality Information for Medicare Beneficiaries. The so-called BQI project where we had six pilots. And one of the things that they looked at was the necessary number of patients that one had to have.

But I think - so that is a critical point. That when one deals with measuring at the individual level, the small numbers issues, they are inevitably going to come up. So it is not a question about figuring out if it is going to happen. It would happen when one seeks to do it at the individual level.

Less of a problem at the group practice level. But I think - I don't - I want to kind of reemphasize this other concept. I think we all have started off, or the tendency has been with measurement, we want to measure it the individual level or some unaccountable entity. And then once you do that, you want to see if you can achieve improvement at that individual level, or at that group practice level, and so forth.

So your measurement starts at again, what I mentioned it, which is the provider or professional level and then builds from there. You, in doing that, if one has to limit it to the individual that has enough numbers, you could potentially leave out big segments of the Medicare population, or the patient population.

So this approach, which I think we would be interested in your feedback on. Because we understand about the individual. But how about at the population level? If you measure at the population level, then you are measuring the issue

that you are interested in - the process of care or the outcome at the population level. And then you have to figure out another system to do the accountability.

I would refer you, if you are interested in sort of thinking about how this could work, to our ninth scope of work. We have in that - and this is at the hospital level. But there is one of the four themes in there that is called care transitions. And it focuses specifically on readmission.

And the way that works is, the issue of readmission is again at the population level. And there's - to look at, okay in this particular area, what is the percentage of patients that's within 30 days are re-hospitalized once they come out?

The accountability is taking care of differently. And it is weighted on the basis of the percentage of care transitions that a particular professional, or provider is responsible for, with respect to those patients.

So it is a little too complex to go to in depth here. But it gives you sort of a sense of how one could approach these issues a little bit differently, focus on the population, and then figure out the accountability. So that way you don't have to worry about, did this doctor improve his or her performance by X%, or meet a particular benchmark. You focus instead on the population, and then weight the accountability and figure out a way to deal with that.

Tom Valuck: Next comment from Baltimore please.

(Randolph Bailey): (Randolph Bailey), with the American College of Surgeons. A lot of the focus of measures today looks primarily toward primary care and chronic disease management - in particular the medical home.

And we hope that, as these measures are developed that there will be measures that include the appropriateness of referrals to surgeons in a timely and appropriate fashion, regardless of incentives. That surgical responses is timely and appropriate, and that there is good coordination of care as the patients are handed back to the medical home.

The other point I would like to raise. You mentioned looking at episodes. And we are concerned that the current grouper - the episode grouper technology is proprietary and not transparent to those that are being measured or those reviewing.

So if you're going to structure measures according to episodes of care, we hope that you will commit to making the episode grouper technology used for those measures public and transparent. Thank you.

Tom Valuck: Thank you.

Woman: I would ask Dr. Rich to comment on the surgery comment.

But on the transparency of the episode groupers, I think that is a really important comment. As you may know, we have been doing a lot of research on those episode groupers.

And, you know, even at all level that we do the analysis, of course we can't get into the full logic that is inside them. And I think that is critical for everyone to understand the real inner workings and the logic of how they may be profiled. So we take that comment seriously.

Tom Valuck: And I think that episodes of care and how they relate to the continuum of care is very important and how that care gets coordinated across that continuum.

You see, as I do, patients get discharged and readmitted, and they haven't seen a physician. Or there is a lack of care coordination and communication among the professional community, with respect to that patient. And there is often people who don't want to take that responsibility. Saying well, you just had your surgery and I don't want to have to deal with this patient for 90 days. He is yours because you are covered under a 90 global.

And those are the sorts of things that we see in the payment structure system now that are dysfunctional, and lead to poor care. And we would like to sort of remind everybody that the continuum of care includes episodes of care. And we will have to figure out ways, and perhaps through Valued-Based Purchasing to provide incentives to help that care coordination be more effective.

Man: Okay.

Tom Valuck: (Mary).

(Mary Patton): Hello. I am (Mary Patton), from the Association of American Medical Colleges. And we represent medical school teaching hospitals and the faculty that practice there.

And we just want to make sure that any - that the - especially the development of measures in the benchmarks, that we consider the impact of residency training on those benchmarks. And we will provide more information and written comments later.

And also, you know, consistent with your design principle of adding flexible options for measurement. We think it is, you know, we think it is valuable to

offer group measurement in addition to just individual physician measurement. Thank you.

Tom Valuck: (Unintelligible). Thanks, Jeff.

It goes back to some of our assumptions and principles about looking at various kinds of practice arrangements. Obviously a very important consideration generally. But for AAMC specifically.

(Chip).

(Chip Armo): Hi. (Chip Armo), with the American Society of Anesthesiologists. And I would just like to echo a little bit of what (Mary) said, and also touching on what (Mike) had said.

With anesthesiologists, we often obviously - we're working in the hospital setting in a group setting. And I think, you know, our organization struggles to come down to identify the very specific areas.

And we spend a lot of time in a lot of these meetings talking about getting down to the very specific individual, physician level to be able to have each individual report.

But really, when we take a step back and get out of our bubble little bit and look at really what the value is, when you go in for surgery, you are looking at the (unintelligible), you know, as a consumer of health care - and I have consumed a lot of home care through, you know, being a weekend warrior and what not. But you look at the value that you have when you go in for surgery.

You go into a facility and you say, am I going to get - am I more likely to get an infection going to this hospital, or going to this group of physicians? Or what is the better outcome? Where do they integrate their care better? Things like that that actually impact the consumer, and I think bring value.

And so as we move forward and look at this, I think, you know, measuring things from a team based approach. Because the risk of reducing infections. That takes on a team approach. There is individual things that an anesthesiologist can do to help reduce that, but if the rest of the team fails in their effort then, you know, how - it doesn't matter what the anesthesiologist really does in the grand scheme of things. I mean, it certainly does, but if everybody else is failing around them. So there has to be some accountability at the group level and also for the public reporting of that information.

Take for example, I know you - the push is to go to a reporting website. And you already have it out there - the Hospital Compare Website, to be able to compare hospitals to hospitals.

Well, as a consumer I went on there just to take a look and to compare local hospitals in the Washington D.C. area. I look at that and say, you know, that is great that this hospital does this as a little bit better than that. But is it a better hospital? Is it a better facility? You don't know.

And to take that information and put it out to the consumer, doesn't really offer a lot of value to the consumer, unless you distill it down in a way that really makes sense for them. And that think - so it is much more important to look at things in a group setting, and then distill that down.

It also makes physicians more apt to report on these, if they know that the information is just not thrown out there willy-nilly to allow consumers to kind of guess about, you know, how they're going to be choosing their physicians.

Woman: Okay. Could I follow up on a couple of your comments?

(Chip Armo): Sure.

Woman: Because you had a lot in there.

(Chip Armo): A lot of stuff in there.

Woman: But - so two things I was interested in what you said. When you say measure at the team level, I assume you are meaning - tell me what you mean by the team. So for example, would it include...

(Chip Armo): I would say for a peri-operative - like in a peri-operative care setting, so it would be your operating room team. So that would include the, you know, physician, the surgeon, the anesthesiologist, the scrub nurse, the CRNA if there is one that's there working as well.

Woman: Okay. And would you include the hospital in the team? So if you were to measure infections, are you thinking there would be joint between the team and the hospital and the hospital? Or do you think the hospital is the team?

(Chip Armo): I think you have to break - that is when you really have to get down to the accountability level, in terms of what are the processes there?

Woman: Okay.

(Chip Armo): I think that individual team members I think could all probably point to different areas. You know, if you all set them down in a room together and said, what's the problem here? Why are we getting the...

Woman: But no need to measure at that level is kind of what you're saying? The broad (unintelligible).

(Chip Armo): I don't think that the large hospital necessarily. But perhaps the team in looking at one who is touching the patient.

Woman: And the other thing you said was how useful the information is when it is reported publicly. And I thought you were going, but I just want to double check, to say okay so on our Hospital Compare Website currently we have measures that you can compare hospitals on.

But where you suggesting there should be one composite measure. Because in some ways we have avoided that because we know there is variation across the measures. So that's the other question there.

(Chip Armo): Right. I just think, you know, you throw the information out. And there is value amongst a number of different things.

There is value for a payor at CMS. You are the ones that are paying the claim and you want to make sure that you're getting the most bang for your buck when it comes to the actual payment.

Then there is value to the physicians and being able to look at the quality data when it is organized and set up to be able to compare themselves from one group of physicians - from themselves against the broad spectrum of other physicians. So, there is value in looking at it. And it maybe at a different level.

And then there is a value to the consumer themselves, who look at it in a completely different idea.

I mean if they were in here in this room, their head would be spinning. Most consumers, in fact probably a lot of us our head spins sometimes looking at the level of detail that we get into. But really you need to take a step back and look at the value of the information that is being relayed to the consumer.

Woman: It is at different levels.

(Chip Armo): Yeah.

Woman: Different levels. Okay. Thank you.

Tom Valuck: So we are going to have some additional opportunity to focus on public reporting and the issues around public reporting this afternoon.

We are going to take one more comment here from Baltimore. And before we do that, Operator, if you would ask the callers to queue up on the measurement issue.

Operator: Yes, sir. At this time if you have any comments please press star then the No. 1 on your telephone keypad.

Tom Valuck: Thank you. And the next commenter here in Baltimore.

(Don Kasey): Hi, (Don Kasey) again, from Atlantic Health.

Specifically to the questions up here, especially the last one that (Karen) posed.

Let me say that I have been at this for a long time. I was a PRO medical director in the (unintelligible) work. So I have a lot of insights into this.

And I think that part of the challenge with this issue of combining measures and composites is - and I think there is some pretty good empiric evidence for this. That after a while, the measures - the measures are viewed by many scientifically sort of in a univariate way. And I think that is the wrong way to look at the measures.

And I think that over time they are measuring something different than a univariate list of things to do. And inappropriate settings. Again there is evidence. I can provide it to you. It begins to suggest that it is really measuring systems of care more effectively, and measuring other things besides the univariate things that it tends to do. So let me just said that.

But to the question. I think the last one, (Karen). It sort of depends on whether you take the approach that I pointed out. But if it is - if you have got a univariate mindset, then I think that those that have the highest level of evidence behind them and strength of recommendation from professional societies, with the biggest impact on cost, i.e. your previous slide, The Interaction Between Quality and Resource Use, should be prioritized in that calculation.

As an example, I think that appropriately prescribed beta blockers for heart failure patients over unfortunately a fairly long period of time can have a huge impact on reducing readmissions and things like that.

So I would again harken back to my initial comment about looking hard at an explicit approach to ranking the evidence to help you decide that.

Tom Valuck: Thank you. Operator, our first comment from the field please?

Operator: Yes, sir. Our first comment comes from (Chris Acevedo). Your line is open.

(Chris Acevedo): Can you hold one second for me? Thank you.

Hi. Yes. My question is really a comment that...

Tom Valuck: Can you identify your organization please, and restate your name?

(Chris Acevedo): Sure. Acevedo Consulting. We do a multitude of consulting services for a few hundred physicians throughout the nation. And really concerns were raised by the physician clients that we have.

Tom Valuck: Thank you.

(Chris Acevedo): There are really two comments. One, the lack of - for lack of a better term, user friendliness of the communication tools for the PQRI program. I am hoping that something a little more user-friendly would be adapted for the rollout of this program. And I understand the plan is still yet to be developed.

And two, there has been a lot of talk today - and I commend you for all of what you have done, about what incentive programs and how that will look. And I am hoping there will be a little bit of focus on what the base of the program will be as you alluded to earlier that the physician pro payment system is broken now. And that this appears to be a transition away from that.

I haven't heard any discussion on what the base of the program will be - just on what the incentive programs will be. So if there is any light you can shed on that subject that would be great. Thank you.

Tom Valuck: Could you clarify what you mean by the base of the program?

(Chris Acevedo): Sure. Well, if we have an SGR physician fee-for-service program that is believed to be flawed, and this is going to transition it sounded like away from that program, I am just wondering where the transition is? Is it that these are the options that are being looked at, that it is potentially the withholding of a percentage and payment, or - because it sounds like these are incentive programs and not a fix to a broken program.

Tom Valuck: So that is of course one of the fundamental questions that we will be addressing, based on the input that we receive during this particular listening session.

I think a number of the questions that are asked and the incentive paper again ask the question that you are asking from different perspectives.

And certainly going into the development of the options part of our process, we are going to be looking at the interaction between the performance based payment aspects of what we are trying to do, and the current physician fee schedule and all that is contained in that. So that will be an important consideration.

You also mentioned that PQRI and user friendliness of outreach in education. That is not a direct focus today. But I am sure that Dr. (Graf) and other leaders for the PQRI initiative would be happy to receive your thoughts about the user friendliness, and how to enhance that. And you can feel free to include those

in your written comments on the listening session topics for today. And we will make sure that those are shared with the appropriate leaders here at CMS.

Next phone caller please?

Operator: Yes, sir. The next person is (Bruce C. Ferguson). Your line is open.

(Bruce C. Ferguson): Good morning. I am speaking on behalf of the Society of Thoracic Surgeons. I just want to make a couple of comments.

The importance of generating, when available, information from clinical data resources, in terms of improving quality of care under any valued-based purchasing structure, I don't think could be overemphasized.

There is an enormous amount of data now that has been accumulated to document the efficacy of bringing those data and feedback form back to physicians, and fundamentally and sustainably changing physician behaviors about quality and quality improvement.

And (unintelligible) with that is the recognition that the measures that need to be evaluated have got to include more than just processes of care measures. If you don't put outcomes in there, you will never open the door to the longitudinal context of care, and the integrated care across the medical condition that is necessary to really impact on what happens to patients in their - in the context of these disease processes that we are all trying to take care of.

And the last point relates to the evolution of the data. As we look to find and combine data sources together, there really needs to be resources directed at figuring out ways to be able to utilize the data sources that are already

available and in use, rather than starting denovo from - and creating an entirely new data infrastructure system.

Or in using inadequate and inappropriate data contexts for trying to generate some of the information on which these decisions are made.

Tom Valuck: Excellent point. Thank you. We are going to be focusing on the data strategy and infrastructure this afternoon.

But as we have received the comments here on the measures section, one of obvious themes is the connection to all of the other pieces of the plan that we are putting together. To the incentives, to the public reporting, to the data strategy and infrastructure. So we appreciate the comments in helping us make those connections.

Next phone commenter please?

Operator: Yes, cervical the next comment comes from (Joyce Matola). Your line is open.

(Joyce Matola): Yes. My name is (Joyce Matola). I am with the Center for Cancer and Hematologic Disease. And also with New Jersey Society of Oncology Managers.

I actually have a question regarding the E-Prescribing criteria. The second part of the criteria that says at least 10% of eligible professional's Medicare Part B covered services must be made up of codes that appear in the denominator of the E-Prescribing measure.

Medicare Part B covered services includes drugs and lab services. And that will make it nearly impossible for hematology oncology practices to hit that 10%.

I have ran my numbers and no, that my denominators are less than 10%. There are about 8%.

(Mike Graf): Well, just to briefly answer that question. It doesn't - it pertains only to professional services. So it doesn't involve Part B drugs.

(Joyce Matola): Okay. So it should say Medicare physician fee schedule.

(Mike Graf): Right.

(Joyce Matola): Okay. All right. I just wanted to clarify that for everybody.

(Mike Graf): Professional services. But just for your information, since I - there seems to be several comments on PQRI, we will have a national provider outreach call on December 16th. I don't know what the time, but it is in the afternoon. And no doubt you have seen the list.

(Joyce Matola): Yes. I am registered for that.

(Mike Graf): We will leave that open for many questions, comments, suggestions, and possibly you would want to focus it at that time, rather than for others that may have comments with regard to PQRI we will give you plenty of opportunity, but maybe not for the Valued-Based Purchasing Plan.

(Joyce Matola): Thank you very much.

Tom Valuck: So obviously one of the initiatives that we have under way - maybe you can think of this as two initiatives - the PQRI and the E-Prescribing are very relevant to all of the folks participating in the discussion today. And certainly the relevance to our physician value based purchasing plan development can be made as well.

I would encourage the commenters to please focus, if you do want to talk about PQRI or E-Prescribing, please focus on the connection to the development of the Valued-Based Purchasing plan.

And as Dr. (Graf) mentioned, if you have other comments or questions about PQRI or you are prescribing, there are other forums to make those. But we certainly appreciate your engagement in those early steps toward the physician and other health professional value based purchasing.

Let's take one more comment from the phone. And then we need to go to our lunch break. It is not a long lunch break anyway. So I don't want to give it too short a strip.

Last comment please, Operator.

Operator: Yes, sir. The next comment comes from (Mark Segall). Your line is open.

(Mark Segall): Thank you very much for having this session. I am (Mark Segall) from GE Health Care IT.

First I would like to emphasize that we very much agree with Dr. (Graf)'s comments on the limits of claims data for performance measurement and value based purchasing.

And really underscore both the data quality and workflow implications of continued reliance on such data.

Second. Consistent with our participation in the PQRI registry program, we really urged a strong emphasis going forward on data from EHRs that are submitted directly from the EHRs or through a registry and the use of measures that are really enabled with these types of clinical data.

Overall, we support a balanced mix of measure types, including HIT structural measures in a value based payment program.

And I also think that the implementation of those measures to try to minimize as much as possible claims level reporting focusing on non intrusive measures that are really appropriate to, in a structural case, what is being measured.

Finally, we agree that the weights assigned to the different classes of measures - and this was a great discussion in the paper, that the weights assigned should reflect policy goals. With higher weights used to push the immediate goal, and to generate meaningful financial incentives for those dimensions.

Now based on the priorities that have been set out by the incoming administration, we believe strongly that consistent with the discussion paper, that health care IT measures should have a high initial weight.

This will accelerate the use of quality focused IT systems that will ultimately help physicians perform better against process and outcome and patient satisfaction measures. So thank you very much for the opportunity to comment this morning.

Tom Valuck: And thank you for those comments.

And again, for those of you who want to weigh in more on the data strategy and infrastructure issues, there will be another opportunity this afternoon after our lunch break.

So with that, we will take a 45 minute lunch break. We will reconvene promptly at 1:00 Eastern time.

For those of you who are on the phone, do not disconnect, because we will just pick right up from here when we reconvene. Thank you.

Tom Valuck: We're going to go ahead and get started. For those of you who are in person here in Baltimore if you would take your seats please, and Operator if you would open the phone lines.

Is our Operator on the line please?

Operator: Yes sir.

Tom Valuck: We're ready to get started if you would like to introduce our afternoon session and open the phone lines.

Operator: Yes sir, one moment. Are we ready to take comments?

Tom Valuck: No. I was just inquiring as to whether the phone lines were open at this point and we could proceed.

Operator: Yes sir.

Tom Valuck: Okay, great. Thank you very much.

So thank you for indulging us in a relatively short lunch period. I know that you all had messages to respond to and bodies to feed.

But we wanted to take maximal advantage of the day having you all here in Baltimore and on the phone lines in order to get as much input on our issues paper to inform our work going forward as possible.

And we have three important topics on the agenda with comment periods this afternoon. The first is the incentive considerations, the second is the data strategy and infrastructure, and the third is public reporting.

Our first presenter of the afternoon is Terry Kay, a Senior Advisor in the Center for Medicare Management. He's going to address incentives.

Terry Kay: Okay, thank you Tom. As Tom said I'm Terry Kay. I'm a Senior Advisor to Dr. (Rich).

You're probably wondering what does that mean. It basically means I do whatever Dr. (Rich) would like me to do.

(Rich): Not true.

Terry Kay: I work on...

(Rich): I think the other way around is more appropriate.

Terry Kay: I actually have been here, kind of showing my age because I've been here at CMS and the former (HIPAA) since the 1980s so I recall with fondness talk about reforms of physician payment back in the 1980s.

And actually I would like to, you know, acknowledge that there's been a lot of significant improvements in the payment system from what we have today versus the bad days of the 1980s.

But as Dr. (Rich) had indicated this morning there's, you know, much more we need to do now and it's actually a very exciting opportunity to work with you all together to make the system better.

I would just do a reminder. I'm going to cover 12 slides relatively quickly. The topic is on incentive structure.

And by that we mean payment incentive structure.

I suspect probably each one of you here in Baltimore and probably on the phone too each have an opinion about how we should we pay or how much we should pay.

And we very much want to hear your suggestions and comments on that.

I'm going to follow a slide set that as Dr. Valuck indicated is on the web site. For those of you on the phone that may have just joined its CMS web site, the physician center spotlight. And there's a tip file there of all the presentations.

This is an overview of the issues that we're going to cover specifically in this session.

And there's a separate slide for each of these.

But as an overview, we're talking about the design considerations and again sort of the principles specific to payment, funding sources, how we're going to pay for these payments, and the types of payments, distribution of them, thresholds, what should be the criteria for determining whether a practice gets a payment incentive or not, and then the basis for the incentive payment.

Then we want your thoughts about each one of these issues.

First, the design principles and sort of reinforcing the message from this morning but we're looking for alignment of incentives across providers and across settings.

And we think it's critical to get everyone, all of us working for the same performance, same direction, same outcome, so we'd like to work at ways to align the incentives across professionals, hospitals and other providers.

Second principle is that we expect we want to reward both attainment and improvement of care and performance to engage professionals at all levels.

But as you'll see later this is in a form of a question, we'd like your thoughts and certainly we'd like your confirmation that this is the appropriate direction to go.

Next is an issue about how large should the incentive payment be.

And at a minimum it's got to be sufficient to encourage participation in the program.

And then whenever possible we of course would like to make the payments as timely as possible.

Now some of the design considerations that we've been looking at, you know, whenever you try to do a program like this there's an awful lot of issues that need to be considered, issues to be balanced.

And all of these issues are important. We need to look at well what would be the impact on the Medicare Program and, you know, especially in beneficiary cost, beneficiary access to care.

We want to, you know, preserve what could we have and improve what we have.

Budget implications, this clearly is a key issue.

And sort of reading the newsletters and, you know, just talking to folks the expectation would be that under the current system we're probably not in a situation where there would be additional funding made available for VBP Programs.

But what we ideally be looking for is we do not want to increase cost from current levels and to the extent possible we actually would be interested in reducing costs.

And again reinforcing the message from this morning there's possible ways to do that, coordination of care, issues about reducing hospital admissions for example.

Another important design consideration is operational feasibility. And I'm happy to admit as a sort of federal bureaucrat the first thing I think about

operationally is can we, at CMS, actually do the program. How can we design it in a way that we can do it?

But it didn't take me long to sort of also, you know, quickly acknowledge that we need to make the program in a way that's operationally feasible for physician and professional practices.

So again we'd like to take the opportunity today to get your views on that. What kind of programs would be operationally feasible for you both, you know, for understanding the program, being able to communicate the program, submitting data, all those practical components of a program like this?

So more about funding for and possible models; again, you know, in working with professional groups, working with the Congress we'd be looking for ways to not increase cost and preferably reduce costs.

So how could we pay for this?

Well there's two broad categories to think about ways that we could fund this within the physician fee schedule range of services. That would be the first thing to come to mind.

But also we can in fact look more broadly. As (Herb King) mentioned this morning we look beyond the physician fee schedule. In developing this plan we want to look at Medicare and across the board all the Part A and Part B services and the physician role in those services.

At a minimum physicians have significant impact on quite a range of services in Medicare, right, after all physicians are the ones that order lab tests,

prescribe drugs, you know, require - ask - admit patients to hospitals and certify many different types of care in Medicare.

So we can look more broadly and not just, you know, simply at the physician fee schedule range of services.

Another very fundamental basic issue about the payment plan is what type of plan should it be?

We've listed three models as examples on this slide. Perhaps you have other suggestions. We'd love to hear them.

First of all there could be of course an add-on payment to the base payment. The concept here would be very similar to how Medicare currently does the hospital paper reporting model where there's price - a payment differential for those that successfully report quality measures and those that don't.

So there could be some kind of a base adjustment to - adjustment to the base payment.

Second major approach could be a periodic incentive payment program.

And again the concept for payment would be sort of similar to the current PQRI Program where there'd be a periodic lump sum payment. And it would be paid separately from whatever payments are made for the, you know, basic physician and other Medicare services.

And then third there could be an approach, it would be more like a bonus pool. In this concept there'd be a portion of the payment withheld and put into a bonus pool and then it could be redistributed based on performance criteria.

As I said you may have some other thoughts and other ways to do this. We would like your reaction and comments to each one of those approaches.

Now in determining payments there are the issues about distribution. How are we going to distribute these payments in a way that achieves the goals of the VBP Program that was discussed this morning?

And we also need to do this in a way that's consistent with the level of accountability that can be measured.

And again this sort of piggybacks on the discussion we had just before lunch regarding measures. There's accountability of individual physicians or professional level, group level, geographic region, service area. There could be ways to focus on primary care, surgery care, diagnostic tests; wide range of possibilities there.

And so there could also be a way to do this in sort of a combination so that looking at the different kinds of measures. There could be a financial incentive that would be a combination of the metrics used. Again some of the measures are at an individual professional level, some are developed more for groups. And so there'd be ways to combine those factors.

Now a little more about the distribution of incentive payment; who's going to get the payment?

Another fundamental question is, you know, is it going to achieve the goals of the program. Can we do that by having large payments to a small number of high performing professionals or the alternative is we could have a smaller incentive to a larger number of professionals.

And there's issues too about financial risk.

And one example would be if these two approaches on this slide, if we - one argument could be made that it's better to have smaller incentives to a larger number of physicians because perhaps that's a way to engage a larger group of physicians and professionals.

And it could reduce the potential financial risk of being involved in the quality improvement program because there'd be higher likelihood that you'd get some kind of a payment.

Again there's sort of pluses and minuses to both approaches and we look forward to your thoughts on that.

Next wanted to mention the issue of thresholds, and by this we're talking about what should the criteria be for determining who gets an incentive payment.

Again there's multiple ways that Medicare could do this. We list some of them here.

So one way is to have an absolute performance threshold, you know, in advance Medicare would announce what the criteria is. If you meet the criteria you get a payment. This is an absolute performance threshold.

And an advantage of that is that upfront everybody would know and it'd be very predictable either when you do this you get a payment, if you don't you don't get a payment, very predictable.

I would note, we sort of mentioned this - we do mention this in the paper, it can be challenging to budget a program like that because upfront we don't - we're not really going to know how many professionals are going to meet the criteria at least especially at the beginning of any new program.

So it's a factor that we would want to consider other approaches to have relative thresholds.

And again the concept here is that you just take all professionals, rank them all by their performance and those that are in a certain range of performance percentile ranking for example, like the top 10% or some top percent ranking, those would be the ones that would get the bonus payment.

That one a little less predictable for the participants because you don't know whether you're going to get a payment or not until everyone is ranked but from a budget perspective, you know, it's a little easier to do because you can upfront determine how much you want to pay out through the program and distribute that money to the top performers.

(Could be) minimum performance thresholds. So for example in order to get any bonus there could be some minimum criteria that the professional would need to meet.

And in the paper we list example or two. Accreditation is an example that I recall.

Another way to do that would be to pay based on improvement and performance. And a couple ways to do that, we could look at year-to-year improvement. If you, you know, improve a certain amount from the previous year then you could get a bonus.

Another way to do that is to have an improvement over a baseline. So if you can improve a certain amount then you'd be eligible for a bonus.

And almost all these options it's always possible to combine them too. So that's the case here. We could in fact reward attainment and improvement. As I said earlier that that's sort of what we would inclined to do. We'd sort of like to hear your thoughts on that, get some reinforcement on that.

But there does seem to be some advantages to a combination approach.

And it provides a way to be sensitive to special challenges, disparities as discussed this morning.

Another example that, you know, one of my roles here at CMS is I work on oral health issues.

And so often times oral health providers provide examples of where national programs don't necessarily fit for them from their point of view.

And potentially having a combination approach would be a way to try to address some of the issues for disparities and for oral health again just as examples.

All right, now the basis for incentive payments.

Again we sort of looked at this and identified some possibilities. One way we could pay a base - pay an incentive based on a percent of all the Medicare physician fee schedule allow charges. Sort of like the concept that we do now with PQRI Program. For 2007 it was 1.5%; for 2009 2%.

We could adopt that kind of a concept going forward.

But another possibility is we could base the payment on services where there's measures, and just from an observation I think in some ways this issue was a bigger issue when there were small number of measures. Now that we've gotten over 150 measures in PQRI and fairly high percentage of the Medicare physician fee schedule is represented by at least one measure.

But it is another option we could consider.

And then we could have other ways to subset. In order to emphasize coordination of care for example we could focus on outpatient services where, you know, many cases coordination of chronic care is especially important and takes place in outpatient settings.

There's other factors; we in the paper refer to situations where maybe we focus on the practices predominant vary of care.

So requiring that the physician practice basically report on quality measures for those services that they predominantly do, you know, almost you could see it as a little less sort of picking and choosing which measures you want to apply. It again just something we thought of and we would like your thoughts on that.

Just one more slide here and then we're going to turn to questions and comments.

The factors that influence the basis for the incentives and what kind of factors are we going to take into account when we make choices about what we do.

Again as I said earlier we were clearly interested in increasing value to the Medicare Program and to Medicare beneficiaries.

We would be looking at sort of differentiating between services that might have a larger impact on achieving the goals, try to design a program in a way, you know, that again achieves our goals.

There's operational considerations and the example there I'd give is that although we had some startup issues with the PQRI Program and a relative scale operationally it's easier to make a payment based on a percent of all the Medicare physicians fee schedule services. It's easier to do that than it is to make a payment based on savings that have resulted from coordination of care and reduced admissions.

Obviously the level of measurement skill, you know, the magnitude is significant so there's operational considerations.

And there's other equity issues some are related to what I said a few minutes ago about oral health. Lower volume professionals, lower volume clinics might have less infrastructure to participate in these kinds of programs.

Higher volume professionals may have more opportunity to receive payments merely because they provide a wider range of services.

Issues usually come up about sometimes in the context of risk adjustment but the issue about noncompliant patients and the impact of that on performance, performance measurement and performance attainment.

And then we of course need to be aware of and working to avoid unintended consequences.

And an example there that has been identified, I've seen in newsletter, you know, folks have pointed out that if we make bonus payments on a percentage of services provided that, you know, perhaps that provides inadvertent incentive to increase volume. Again it's something that we would want to take into consideration as we move forward with our plan.

So in summary, the issues that I just briefly reviewed are listed on this concluding slide.

And as Dr. (Rapp) and Karen did this morning, I'm just going to leave this slide up as a reference. We would invite your comments and suggestions on any of these, all of these. Feel free to come back and again quickly we're looking at the funding forces and the payment models that you believe would be most feasible and desirable.

How large does an incentive need to be to encourage participation?

What types of incentives are most effective?

And your comments about the distribution of payment, how to best achieve the goals of the program, and should we base payments - the incentive payments across all physician services, some subset of them, all of these issues we welcome your thoughts.

Tom Valuck: Thank you Terry. I particularly appreciated Terry's leadership in this effort not only do we get to work in the same component here at CMS but I think I was totaling it up in my head and I think his accumulated experience here at

CMS exceeds the total of the rest of us who are involved in leadership positions for this particular initiative.

So his thorough understanding of not only the current physician payment approach but also the past is particularly applicable as we're looking toward the future.

So thanks Terry.

So at this time we would open it up to comments for the participants here in Baltimore first. Looks like Dr. Susan Nedza from the AMA Physician Consortium for Performance Improvement is going to kick off our afternoon session as she did for our morning session.

Susan Nedza: Thanks Tom and thanks Terry. It's a pleasure to hear your thoughtful discussion of issues again.

We are living in an environment right now where the state I come from and where the AMA is has suspended Medicaid payments, another part of the house here to the physicians.

We also have major medical centers who have asked physicians to take 10% pay cuts because of the economy.

We also have small physician practices that basically use credit lines for their practices.

So when you're considering the payments for physicians that already may be very tenuous in their practice especially in rural communities, suburban communities, small practices with one to three to five participants it's

extraordinarily important to do it within the context of the economy within which they are practicing because the unintended consequences here are not just issues of access. They're also issues of significant consolidation in healthcare which AMA and which CMS -- I forgot who I work for today -- which other organizations have to deal with.

And on one hand you have efforts underway to keep healthcare providers from working together collaborating and consolidating.

And now you may be driving us to that particular direction.

So any type of incentive should be thought about within that particular construct.

We'd also recommend that you use the information you learn from the physician or the hospital value-based purchasing activities around incentives and how you put those in place. Certainly the methodology around hospitals was very incremental, very well thought out.

And I know that you got some very thoughtful consideration from both AHA and FHA about that particular plan.

And I hope that there'll be the opportunity to do that type of economic analysis beyond just the high level policy analysis because the stakes for communities where we already have very little access to primary care, physicians who are in their 50s, this could create some major access problems and we need to really be considerate not just of how you base these incentive payments but to the monitoring of what's going to happen. This is a very dynamic atmosphere.

And I know in our own state there are two neurologists left in downstate Illinois in rural practice. That's how tenuous access is.

So I think access should be the first thing we think of because if we don't have access all of these incentives, what good are they because there's no place for people to go based on the information.

So thanks.

Tom Valuck: Thank you for your comments Susan. And obviously we have to consider as - in this planning effort the broader implications of where our work fits into macro issues like what's happening with the economy so that's a good reminder.

I mean there are several schools of thought as to how that might play. You know, sort of the brighter side healthcare might be a focus that can help pull us out of this economic problem that we have by investing in the healthcare infrastructure because we have growing employment in the healthcare sector where many others are not. It will be interesting to see where the next Administration takes this from that perspective.

But on the other side of that coin is, you know, as there are fewer resources available generally through our tax dollars, through payroll taxes and income taxes, you know, these are the funding sources for the Medicare Program.

So we really need to be thinking about how we function, all of us in this room, and with particular focus on our beneficiaries, how we function in that environment.

And one of the things that we need to consider is the opportunity to take costs out of the system in a rationale way while we have that opportunity here through this planning.

So in thinking about shared savings models and so on, getting to higher value, preserving quality, enhancing quality in a cost saving kind of environment given the potential urgency maybe related to the economic situation, that's another thing that we have to pay attention to.

But the points that you raised about access and particularly the need to monitor the impact of what we're doing generally I think are really excellent points for us to consider in the planning.

Terry Kay: Just want to make a quick technical point. I mean as Tom said you made a lot of very important points we need to take into account; challenging economy for, you know, all sectors.

Regarding your plan about the economic analysis, I would invite more comment on that at any time in the future. I realize, for like technical, but we were thinking about this as far as how would you - how would we measure access in the environment that we're working. In other words we're trying to change the program, emphasize increasing value.

And so in the past when we measured excess, you know, for all practical purposes what that ends up being is in the past we've just simply looked at changes in services provided.

In this case the change in services provided doesn't seem like a very good metric because, you know, what we're looking for is value.

So I invite your thoughts about that, about we would in fact like to do more economic analysis. We traditionally, you know, look at things from a geographic area, from specialty.

But how to do that, what the metric would be something other than just simply looking at changes in volume.

Tom Valuck: Tanya.

Tanya Alteras: Hi. My name is Tanya Alteras. I'm representing the Consumer-Purchaser Disclosure Project.

I want to say first off that we really appreciate the chance to come in here because we're very supportive of moving from a pay for reporting system to a paying for the right care at the right time system.

We support incentives that would address my following laundry list.

First would be acknowledging the value of primary care to the patient and providing incentives that recognize that.

Incentives that encourage care coordination and support integration and delivery of services for those with chronic illness; one example would be the medical home. Of course that's not the only example.

Incentives that drive rapid reengineering of care delivery, of course looking at HIT enabled as part of that.

Those that reduce disparities and encourage care for adverse populations, and incentives that would use episode bundled care.

One way that we would suggest to look at to achieve all of those things would be to provide disproportionate share of incentives for care delivery that promotes those goals.

And finally we are concerned about over-reliance on - I'm sorry, this is for a different section.

Okay, that's about it.

Tom Valuck: Great. I'm glad to hear the consumer perspective and glad to hear that you have comments on another section as well. We'll be looking forward to that.

Chip.

Chip Amoe: Hi. Chip Amoe again from the American Society of Anesthesiologists; one of the things that I look up here and I see obviously the goal is to look at the monetary incentives.

But when you're looking at providing enough incentives to encourage voluntary participation in the program, one of the big barriers to participation is the cost on the individual provider to actually participate in the program.

And we recognize that and we've seen that in the recent PQRI issue is that the complication factor of the administrative cost and the administrative burden on physicians to participate in these programs is so huge that even though you may have, let's say you increase the payment by 2%, if it costs the, you know, provider 3% more of his time and energy and just frankly, you know, just harassment to be able to participate in this program, you're not going to get the incentive.

So to really, you know, my call to you all is to see if you can simplify the process because the less - the easier it is for them to report and participate in the program the less there - the less you're ultimately going to have to worry about paying. You can probably reduce your end result and, you know, people might shoot me up here for saying and pay less.

But if you solve the administrative problem you might end up saving in terms of what you actually have to dole out at the end of the program.

Tom Valuck: I was going to challenge you to comment on what the magnitude of the incentive should actually be.

But since you qualified it by saying it's relative to some of the other things that we're discussing today including the data strategy and infrastructure which is next and the burden of reporting, I'll let you off the hook on that particular...

((Crosstalk))

Chip Amoe: And I think that brings up the tension that exists for us is how do we reduce burden on providers? Do we use claims only and will the provider community find that acceptable because the burden is a lot lower or do we want to rely on you to do chart abstraction and submit data to us which increases the burden obviously and takes away some of the incentive payment because you're spending a lot of time doing that.

So there is that natural tension. Where should we fall on the line? Should we have a lot of (time) claims processed like we did in PQRI? Was that easy?

I'm hearing that a lot of providers found that not very easy and understandable although we're trying to refine it.

So your input on that would be appreciated.

Tom Valuck: We're hearing Dr. (Rich) discuss the policy making tensions. We certainly have a convert to health policy from the practicing physician sector.

So we'll be missing his leadership.

But I think we're going to be continuing to access it since he's become very expert in these issues.

Guy.

Guy D'Andrea: Thanks. Guy D'Andrea with Discern Consulting.

My comment goes really to the question of funding source for incentives.

And thinking about how one structures incentives that are aligned with the measures that you choose. And that gets difficult when you're trying to achieve budget neutrality if you choose a lot of quality measures which we all could get behind and agree with, there might not be a strong case for savings behind those measures and therefore you might not have the funding.

On the other hand if you focus on resource use that raises a lot of questions about unintended consequences, undesirable changes in practice behaviors.

The one set of measures and this was raised by some of the commenters earlier that I would really encourage you to consider is looking at things like

potentially avoidable hospitalization because I think of all the measures that are under consideration those are the ones that most clearly speak to both quality and resource use, right, when a chronically ill patient goes into the hospital and they didn't have to, that's a missed opportunity from a quality perspective but it's also extra dollars that are being spent in the system.

So I think as you talk about funding sources structuring incentives I think thinking about potentially avoidable complications, encouraging the right kinds of care, the, you know, primary care, investing in primary care, care coordination even spending a little more upfront you could actually build a funding model that is sustainable and that addresses those core issues of quality and resource use.

So I would encourage you to think about those measures as being essential component.

Thanks.

Tom Valuck: Thank you.

(Don Casey): Hi. (Don Casey) again. Really sort of four points.

One is in thinking about all this which is a big task it seems to me that conceptually you could break this into three parts for the most part.

One is preventive services which would include primary and secondary prevention.

And then this sort of model that (which we got) with PQRI fits that pretty well. And that's a big chunk of what you're trying to get done.

Secondly with respect to acute illness or an episode of care that has a fairly acute window. I just had my hip replaced last February and I was, you know, back at work in about two and a half weeks.

So, you know, those types of things I think would lend themselves to some variant of this.

When it gets into chronic illness though I think everything breaks apart.

And I'll talk in a minute about that.

But specifically too, at lunch I was talking with Jane Thorpe\ about an issue that I think is related to imaging which is mentioned very clearly in the Baucus Health Plan.

And I don't know how you're going to get at the imaging issues here but quite frankly what I hear constantly is that if you don't fix liability issues around what drives the use of these services at least in physicians' minds you're going to have trouble.

So I think, you know, realizing that this is out of the scope of CMS but that to fix liability reform issues around at least perception, the need to order tests and services is an important thing.

Back to the chronic illness, I've been on the New Jersey Governor's Commission for Disease Management and the Study Group looking at patients in medical homes. And have a lot of experience with heart failure readmissions.

And I'll just briefly say that, you know, there are a variety of different ways per member per month calculations, etcetera, etcetera.

The challenge with those is they don't take into account the infrastructure needed to do the chronic illness care.

And it's hard to again assign one physician responsible for it.

So I think chronic illness is going to in my opinion need a different model.

And then lastly given the fact that we work in a hospital system that is now in the midst of learning how to implement the gain sharing physician hospital, gain sharing demo, I think hospital care is just - it's a different animal as well.

And you're going to have to figure out how that fits in. It may fit into the acute episode of care model.

But if you're dealing with multiple positions in an ICU as an example I think - I don't know what the solution there is.

But I certainly think that we've got to go at that issue and that would be useful. So those are my comments.

Tom Valuck: Thank you. Any comments?

Terry Kay: No. I appreciate the very thoughtful comments.

I think in general your comments are very consistent with Dr. (Rapp)'s comments this morning about, you know, maybe one size doesn't fit all.

And that it's worth taking a look at all the physician services and trying to design an appropriate program for different portions of physician services.

The liability issue I frankly don't know what to say about that one. It clearly is an issue that's been around many years even longer than me.

And who's going to attempt to try to deal with it? We'll continue to noodle on that one and I appreciate any further talks in the future on that.

Tom Valuck: You know I agree with you (Don), we've had a lot of internal discussions about not being able to come up with a single model to do everything we want to do and needing multiple models and perhaps geared towards sort of collecting the patients in the way that you described.

And, you know, it may work and it may not but we're looking for your insights and everyone's insights about what we think would be valuable and how we can design it as either a single model or a multiple model or multiple models I should say.

So Operator we're going to take one more comment here in Baltimore.

And while we're doing that if you could queue up the commenters on the phone line please.

Operator: Yes sir. At this time if you would like to make a comment please press star then the number 1 on your telephone keypad.

Tom Valuck: Go ahead sir.

Jerry Connolly: Thank you Tom. I'm Jerry Connolly with Connolly Strategies.

And I'd like to make some comments with respect to what was mentioned this morning. I think you mentioned to Tom that this is physician value-based purchasing but it also pertains to non-physician providers and suppliers.

And I'd like to make some comments relative to the rehabilitation therapy arena.

And I represent a number of clients in the rehab profession.

Terry I appreciate your very thorough overview of this whole issue of incentive bonus payment and how it would be derived, how it would be applied.

I think the first question of what type of incentive and whether it be internal or external to the fee schedule really depends on what kind of a fundamental fee schedule we have.

And as that changes hopefully, you know, or if it does, then the answer to that question may change dependent upon whether or not we have a dependable, reliable, predictable fee schedule or a formula upon which payment is based.

With respect to the incentive payment and the one element you had on Slide Number 9 relative to improvement in performance, I think your comments really were more focused on the improvement of the performance of the professional or the clinician.

And I'd like to suggest that in some instances the rehabilitation therapy is for one, thoracic surgery for another. Where there's a number of large databases

in existence that have been formulated on valid, reliable and responsive measures that have been established with high isometric value in the literature.

And these database, these can actually - which are now very thoroughly and accurately risk adjusted, can lend themselves very well to predictability of specific types of patients.

And so rather than focus on only process measures we should think about whenever possible focusing on outcome measures.

And using this kind of information so that it is determining not only clinician improvement but also patient's improvement.

And I think this is particularly critical when we go from a pay for reporting system to a pay for performance system because the ultimate benefit of quality and value is the impact that this is going to have on the patient.

Tom Valuck: Yeah, thank you. Good point. Thank you Jerry.

Go ahead Terry.

Terry Kay: A couple quick reactions and again thank you Jerry.

The comment about fee schedule changes reminds me sort of the basic point that in developing this plan we'll need to, you know, consider timeframe. In other words short term, medium term, long term.

Clearly being flexible to what the feature will bring is something we'll all need to pay close attention to.

And then your comments about the large databases, the measures, I'd actually
- I don't pretend to be an expert in evaluating measures.

But I think it's a good connection that we need to get with Karen Milgate and
Dr. (Rapp) to take a look at, you know, what measures are you referring to.

And so I think that would be a good follow-up action.

(Jeff): I just wanted to follow-up and reinforce what Terry said. The time is now.
And we have a payment system that is structured and it's statutorily
mandated.

And what happens to SGR, we don't know what will happen. Will it be re-
based and we'll be stuck with the same payment structure that we have?

We need to think about the structure we live in now and how we can improve
it so that we can actually do some short term real wins here and then if the
system gets modified, we hope that we would be flexible enough to modify
our value-based purchasing plan to it and adopt it to whatever Congress may
come out with in the future.

But I don't want people to get going to the moon. You know let's try and get
to the space station first, you know, and sort of figure out what we're going to
do in the short term here with what we have.

Tom Valuck: So Tanya if you have a real quick follow-up.

Tanya Alteras: Very quick, yes.

Tom Valuck: And then we're going to turn to the phone line.

Tanya Alteras: This actually builds upon the previous commenter. Just want to express our concern about over reliance on measures that reflect minimum standards of practice and not using those as - not having those clog up the system. They'll divert resources that could be allocated to developing and endorsing other measures that reflect outcomes.

Tom Valuck: Thank you Tanya. That was Tanya Alteras with the Consumer-Purchaser Disclosure Project.

And so Operator will you take the first comment from the phone lines at this point?

Operator: Yes sir. The first comment comes from Mark Segal. Your line is open.

Mark Segal: Yes thank you. Just a few brief comments.

I thought that the paper and the discussion today really did a great job of focusing on the issues involved in...

Tom Valuck: Mark we've lost you. Possibly you need to speak up.

Mark Segal: Okay, can you hear me now?

Tom Valuck: Yes, we can hear you now.

Mark Segal: Okay, I'm sorry. So I thought that the paper did a great job. Again I'm from GE Healthcare IT. Did a great job of outlining the various issues associated with incentives.

I would definitely emphasize looking at this certainly initially as an incentive, as an investment rather and clearly based on the literature of the opportunities for savings as well as focusing on the opportunity for savings across Part A and Part B to fund the meaningful incentives for physicians and other professionals that will be needed to really change their behavior.

The mixed approach certainly seems to make sense both in terms of threshold and improvement as well as potentially looking at a mix of add-on and targeted bonuses has been seen in some pending legislation.

Based on what we've seen in discussing PQRI with our customers just a few observations.

One is that simplicity and clarity are really important. And that relates as well to the identified need for timely payments and with transparency on the rationale for payments so that you really get an effective feedback loop and people know why they received a bonus or didn't and what they need to change to get one.

Again for balancing you identified things well. We clearly need to have incentives that are high enough to matter and as a prior discussion indicated that are high enough to justify the kinds of investments in IT, potentially in hardware, and in change management that really are needed to secure improvement.

And finally in general I think we would favor basing the incentives on all Medicare services reflecting the role of the measures chosen, the appropriate role as sentinels for overall Medicare quality and efficiencies.

So thank you very much for the opportunity again to comment.

Tom Valuck: Thank you. Operator next comment please.

Operator: Yes sir. The next comment comes from Kevin Craig. Your line is open.

Kevin Craig: Yes hi. Kevin Craig from Specialty Care, LLC in Eastern Massachusetts. We work with surgical specialists in about ten different...

((Crosstalk))

Tom Valuck: Speak up please sir. We've lost you.

Kevin Craig: Kevin Craig, Specialty Care, LLC, Eastern Massachusetts.

First I'd just like backtrack before talking about incentives to the measures and address Dr. (Rapp) and Karen Milgate just to say that we applaud CMS for engaging the specialists in the PQRI Program with the specific process measures that they developed that we...

((Crosstalk))

Tom Valuck: We lost you again right after you said PQRI Program.

Kevin Craig: All right. The PQRI Program has specific process measures that we believe will ultimately improve the outcome and the cost of surgical care, urological care, GI, cardiac surgery, etcetera.

These are specialty measures that we don't see in Massachusetts. Most of the Massachusetts payers have performance measures that are just for primary care.

So I just want to backtrack to the...

((Crosstalk))

Tom Valuck: We lost you after Massachusetts payers.

Kevin Craig: Sorry. Most of the Massachusetts payers performance measures are just for primary care.

Tom Valuck: Sorry, you're going to have to speak directly into your phone receiver please.

Kevin Craig: All right, can you hear me now?

Tom Valuck: Yes.

Kevin Craig: Most of the Massachusetts payers performance measures are just for primary care.

And so we believe that CMS has done a good thing in PQRI.

Tom Valuck: All right. I'm sorry. Operator we're going to take the next commenter please.

Operator: Sir at this time we have no comments in queue.

Tom Valuck: Okay. To the last caller, you were saying some very complimentary things about CMS so we didn't intend to...

Man: Will you call back?

Tom Valuck: ...intentionally cut you off but unfortunately your connection wasn't good.

I however would encourage you to weigh-in during the next commentary and continue that line of thinking.

So with that, if there are no closing comments from Terry or (Jeff), okay, then we will go onto the next topic of discussion which is our data strategy and infrastructure.

And Will Matos will be presenting so give us a moment to get organized here.

Will Matos: Good afternoon everyone. I'm Will Matos from the Office of Clinical Standards and Quality. I get the opportunity to discuss this exciting task with you in the mid-afternoon after lunch.

I don't know how I always get this time slot but its okay. We'll try to make it exciting.

You see me sit back here for most of the day and I've had the opportunity to listen to my colleagues before and numerous discussions. And also listen to the different commenters.

And either directly or indirectly throughout these entire conversations I've heard the word data according to my calculations the math tells me.

And so inevitably all roads lead to data regardless of whether it was a comment or it was a discussion from one of the sessions everybody wants data.

And that's a good thing. However as I listened I kind of cringe as I heard about discussion of different models. If anybody is a data manager out there they understand what that means. It's like uh-oh, they want more data and they want it differently.

That means I have to figure out how to collect it and the other side is going to yell at me for collecting it.

So these are challenges that we go through and throughout this discussion I'll raise some of these issues.

But what I found in numerous discussions with a lot of folks is this data infrastructure validation issue also drives a lot of decision making for be it hospital or physician VP as to whether to participate in the program.

The question is is the cost to implement these types of data structure outweigh the benefits.

And I know that everybody has that challenge.

It works, great.

So I'd like to touch a little bit overall on design principles and considerations. I'm going to talk a little bit about data sources. I know that Dr. (Rapp) talked about it earlier so I just want to touch on it again.

There are a number of challenges in trying to implement something of this size.

But I just want to touch on the major ones.

Data validation, it's been a recurring theme. How do we validate data particularly in this area with data of this size and magnitude.

And I want to talk about feedback and the varying types of feedback.

Some of the design principles we want to keep in mind and I'm going to touch a little bit on Dr. (Horn) from a (doc side) discussion earlier regarding standards.

We want to minimize the burden of data exchange. And to some degree the way to do that is by implementing standard space solutions whether you're a doc building (a niche) on your own, whether it's a system, if we follow the lead that (OKIT) is doing in terms of (unintelligible) and other standard space programs particularly in the federal government that we're leading, that's kind of where I think we want to go.

It doesn't matter how you design your system as long as everybody (has) standard space.

And we'll touch a little bit more on that later in terms of the challenges and the efficiencies we gain from that.

Regardless of what we do today it has to be validated in some form, shape or manner and it's got to be an opportunity to review that data.

Feedback, feedback is absolutely critical. You have to know where you're at. You have to know where you qualify. You have to know what the next steps are. So feedback is absolutely critical to any VBP Program.

Finally we want to (draw there) the consideration use of all payer data. For data managers that presents a little bit of challenge. How do you collect it? How do you use it? How do you balance it between the government and fed and non-fed programs?

I think many of these building blocks are - don't need to be repeated. But I guess to some degree they're worth stating.

Obviously data quality and the validate of structure are critical to the VBP Program. Without them we won't have an even based program to look at in terms of having - comparing apples-to-apples.

You keep hearing me say the data has to be valid. How can we score performance if we don't have trust and integrity in the data?

So we need to have valid data.

And finally the infrastructure that we're going to use or anybody, any data strategy going to use is going to be completely dependent on what theme we use, what process do we use? Do we use claims? Do we use clinical? Do we use surveys? Do we integrate that data set.

What are the rules? What are the rules of engagement to use this data?

So any structure you use it's going to depend on what the final previous discussions.

What are the measurements?

What are the incentives?

What are the type of feedback you need?

That'll dictate to us the type of data that we need to use in this program.

To touch on Dr. (Rapp)'s presentation, let's just touch again and repeat a little bit on the data sources.

Clearly the easiest one to use is existing claims. If you're already submitting those, you're already getting paid for those, there's no extra level of effort.

And so clearly it's the easiest to use. I don't really have to build a significant infrastructure. It's already built in place so it's just a matter of us taking the data and manipulating it and spitting it back out.

But as you've heard in the previous presentation there's limitations to it.

And so another alternative is modified claims. It's submitting additional codes to help come up with additional measures.

But again as previously stated they have some limitations to that. The claim system are predominantly designed to pay claims. We're an insurance company, we pay claims.

And so it's not really designed to do measurements of the type we're looking at.

So another alternative is to supplement our data with clinical data preferably out of (VHR) or through a registry process. Here again I'll touch on the types

of data that are out there and using again standard space data, (HL-7) and existing standards which would make life a lot easier.

One thing I'm not sure it was introduced before. We'll talk a little bit about survey data. That yet is another opportunity, another source of data that we can use for measurement purposes whether we use it on its own or whether we integrate it with other data sets.

I won't go into any detail on these program initiatives. I think they've been introduced. I think you have them as appendices.

But there are a number of CMS programs, initiatives in which we've had the opportunity to experiment, try different things, analyze claims, analyze modified claims, use EHR.

So we've had an opportunity to play a little bit across the spectrum and get some lessons learned out of those areas so and there really have been some challenges as we go forward with this.

I - we have listed there on the bottom the Hospital VBP Program because that's one of the few programs at least that I've been involved in in which we've used extensively what I'm going to call the HR data. Although we know some of it does come from claims data.

But there are some models in place. I know there was a comment earlier regarding using some of the incentive space from Hospital VBP.

But yet that's another program in which we've done at least pay for reporting programs.

This is my favorite slide.

And I've highlighted these because I think everyone will recognize some of these challenges that we have with regards to collection of data.

And I don't think any of these problems are insurmountable when taking in the small context.

So if I'm doing a demonstration project for a thousand practices, that's kind of easier to manage in terms of some of these challenges.

But when I'm managing a program in terms of data infrastructure for a million practices it gets a little more difficult to troubleshoot and manage some of these issues.

So let's touch on some of these.

One of the challenges we've noticed is the association of an individual professional to a group practice system level. We have practitioners that work either individually or work in multiple locations or work from multiple organizations.

How do we track these individual clinicians or how do we - from a data perspective, how do we track them so regardless of how we decide ultimately from a measurement perspective how to attribute them to a particular area.

How do we track them?

How do we say Doctor X works for this community 40% here, 60% here and then how does that build into incentive payment?

So just building the foundation from a data perspective collecting this information gets to be a little problematic.

The next challenge is that we've had is the attribution of the patient.

Whose patient is it?

You know when you get the claims space particularly at least in some of the other programs, we use some formulas or perhaps the preponderance of a particular patient visiting a physician so many times during the year, perhaps the presence of particular ICD-9 codes.

So there's a lot of different formulas.

But it's a little tricky and it's not really absolute. So it gets a little difficult.

When you're dealing with an EHR, that's quite a better improvement, we still have a situation where actually the clinician coming to the system and (tell) this is my patient.

So it gets a little bit easier but I still have several million now come in and tell me, what do I do when half of them disagree whose patient it is?

So we have those type of issues.

You heard some of the measures. And there's clearly some measure complexity as they go and they start (trending) well they want me to collect this (data) now and they want me to collect this (data) now.

So the measures get more complex in how we calculate them.

And clearly we'd like to get as much data as we can to calculate the measures at the same time minimize to collect just what we need.

So it goes to how much data you're collecting to what degree you collect with regards to the complexity of the measure.

One of the measures to have in mind on the inpatient side, timing of antibiotics with aspirin administrated within eight hours.

So do you collect, yes or no?

Did you administer with - what if the guidelines changes to now 12 hours?
What happens to that previous - what if it goes back to six hours?

I don't have sufficient level of detail data to go back and recalculate that measure.

So when you collect the data and the level of complexity you - well what time was the patient admitted, what time was it administered?

And now although I'm talking more variables at least now I can go backward and recalculate the measure based on change guidelines.

All payer data I mentioned before.

And then it becomes a little problematic with HIPAA rules and things of that nature in terms of unique identifier for patients.

And typically we don't like to collect unique identifiers but we have to have a way of matching them up particularly if we're going to do a continuum of care and particularly if you're going to integrate data from several data sets so that becomes an issue for us.

Reporting burden, absolutely critical, we clearly want to reduce the reporting burden. And I kind of - might kind of - might also be just a collection burden but it goes hand-in-hand.

Often I've heard a lot of folks say that to collect this data, I don't have either I have EHR in place or I don't have one in place and to collect this data the incentives are just not there for me to participate in this program.

Clearly I think EHR is important. I think there's been a lot of progress made. I think we need to make more progress (in) EHRs.

And I think if we have EHRs out there based on standards I think it'll go a long way as we develop measures to use standard space measures, identify we know what the consistent (HL-7) messages are for name, for drugs, for everything. So that will certainly be a help.

Time lag, I don't think we've addressed time lag in any of the measurement areas.

Time lag certainly is an issue particularly when you look at a measurement. And if we want to measure your performance during a period then we have to have that data specific to a certain period (of present). It doesn't help you only got 30% of your data.

So some of the issues to talk about will be lock down periods. Obviously in claims I think you have a year, two years to report the claims. I can't remember the timeframe.

But if you go in EHR you need to have certain timeframes so at least we know we have a fixed timeframe at which to do your measurement performance on.

I'm not going to go in great detail on data validation simply because it's really difficult to pinpoint down on the options until we really figure out which of the approaches we're going to use whether it's claim-based, whether it's supplemental claims, whether it's EHR, whether it's either registries or the vendors submitting data.

The validation model is going to vary depending on it. In some cases we use our program (targeted) to validate claims.

But as we mentioned before those claims, that's exactly what they are, claims (debate), you know, for insurance, for care. They're not for quality measures.

So it's a big discussion going on the validation and we certainly don't have many of the answers and we're certainly looking for help from another community to help us on this one.

And again the choice really depends ultimately on the data source.

I think it goes without saying feedback is important. But not just feedback on the quality measure, I mean there's a couple things you're looking at.

You're looking at quality improvement. How am I doing in this particular area?

And you're looking at payment. How can I maximize my reimbursement?

If you're going to participate in a particular program you have to meet certain criteria.

So I think in addition to wanting to know how you're doing in a specific measure in the pay for performance is the criteria, like I think in PQRI you have to have 80% I think in the claims submitted.

You want to know, did I submit 80%?

It's a metric of some type but you need to know. Am I meeting the target? Am I getting - am I eligible?

And validation results, and we say you have to submit validate and we publish what those validation rules are. I think you need to have a feedback report as to what your validation rates and probably similar to what we do in the hospital side.

So this pretty much summarizes some key questions that we have.

In essence we want to get some feedback on the advantages and disadvantages of the different types of models that we have out there.

How can we build upon the existing ones?

We have a number out there that we try, the demonstration models, programs, and some out there actually in the private sector we would like to hear about.

At various data sources how can we reduce the reporting burden? And clearly that's really a high item for us.

How can we structure data validation? That one we can really use the help on.

And how should we provide feedback in terms of do we use portals, do we mail things, what type of feedback, the frequency.

That's kind of about it.

Tom Valuck: Thank you Will, (unintelligible) thank you Will.

I would characterize Will as the most patient member of our Leadership Team because as any IT professional could tell you you can't design an infrastructure until you know what your approach is going to be in order to make the infrastructure form follow the function that you lay out through the requirement.

So Will has been very patient in participating with us and providing this high level kind of consultation with our team so that when it does come time to do the implementation we actually have something that is implementable from the CMS perspective.

So with that if there are any comments here in Baltimore.

Yes sir.

Randolph Bailey: Randolph Bailey, the American College of Surgeons.

I just want to start with something very basic and that is that it seems to me that the only way to gather meaningful outcomes data that we can act on is going to be through some type of HIT; all the rest of this reports, process measures and those things.

But to really get down to the meat of quality I think it's going to require HIT.

In one of the earlier talks you mentioned the potential disadvantage of small practices and low volume practices.

And those are basically the people that don't have and can't afford the HIT.

And so my comment, question, plea is that we figure out some incentives and support to allow adoption of interoperable HIT.

Tom Valuck: Thank you.

Susan Nedza: Susan Nedza from the AMA again. Will one of the things we've been talking about is care coordination on the clinical side. One of the issues and I think it was a learning experience in PQRI was about data coordination across interfaces.

You know you have claims but we know that there are very complex relationships behind all these. And I'll mention one specifically and that's clearinghouses who do not have a significant - they don't have a, I believe a contractual relationship with CMS.

So when you are looking at the infrastructure for quality data and data that's going to inform VBP I think it's critical to have a very good sense of all of the various components and interfaces that this data will go between because

today we've heard about EHRs for registries. We've heard of registries.
We've heard of portals.

And this is an extraordinarily complex public, private, private practice model that really needs some thought.

And we've learned a lot in PQRI about what can happen to data not just that they can get lost but it could get changed. And, you know, then people a year later find out that what they thought they reported, you know, was stripped off a claim somewhere back in the process.

And so I think we need to be really informed about that.

The second comment I would make related to infrastructure is that this requires a significant educational program. The complexity of, if you look at the claims system and you look at the educational system that's developed either through CMS, through the carriers or through the private sector and you have entire educational systems in place to help people code correctly and to do this correctly. The more money we invest in coding correctly the first time and any infrastructure saves us the hassle, the money and the lost investments in the appeals process.

I know that in the private sector there is certain health plans that are collecting quality data that are doing a variant on VBP. And they're spending a lot of time helping physicians code correctly the first time because of the cost of the compliance, the compliance officers, all that complexity.

So I think education is one of the areas that isn't quite frequently linked to infrastructure and there's a lot of opportunity there for us to make sure that whatever dollars are invested in hospital VBP, physician VBP, any of these

programs that it's going to incent good things and it's not going to administrative burden across the whole system.

Tom Valuck: Great point Susan. Regarding the outreach in education piece of this that isn't one of the particular sub topics under the planning.

But as you point out, critical, critical to the success of what we're doing.

And I just wanted to highlight at this point to really as we're doing this process even in the planning phases to encourage those of you who represent membership organizations to engage with us in getting the message out.

For example about this listening session, about the goal, the objectives, the way that the design would be unfolding and how we're working with the stakeholders through sessions like this.

And then as we get closer to implementation how we can partner with membership-based organizations to be as effective as possible with the taxpayer dollars that we have and the membership dollars that you have in reaching out to the professionals.

Susan Nedza: Thanks.

Tom Valuck: Great point. Thank you for that.

Tanya.

Tanya Alteras: Tanya Alteras, the Consumer-Purchaser Disclosure Project.

We just want to reiterate as you already said the collection should be minimally burdensome on physicians and on you of course. Data should be derived wherever possible from available electronic data that wouldn't require additional coding.

We're very supportive of the inclusion of data that reflects episodes of care in value-based purchasing and suggest MedPAC, bridges to excellence and other models that can be used to guide those efforts.

We feel that CMS should identify strategies to reduce or possibly eliminate duplicative algorithm programming by multiple vendors in the data collection effort and to do this through the use of common codes.

And we also feel that CMS should make physician identifiable Medicare claims data available.

And at the same time to reach out to other public and private sector data collection efforts wherever possible and this could result in harmonization of data collection efforts and also could do some cross cutting technical systems in terms of addressing technical issues related to collecting data at the individual physician level.

And now this sort of crosses over into the incentive issue. But we feel that CMS should explore capturing information that identifies the referring or ordering physician and then require that lab results be included in the data as a condition for payment.

And then finally I'd like to make a pitch for making patient experience a core element of the data collection effort. We would suggest launching the

clinician group cap survey. There are several states where they're doing this already.

And California over 3,000 primary care providers and specialists are assessed on patient level, standardized surveys.

Massachusetts has demonstrated that you can obtain reliable and develop measures of patient experience on primary care providers in both the Medicaid and the commercial markets.

Thank you.

Tom Valuck: Thank you for highlighting the importance of the patient experience of care. We've mentioned surveys I think pretty generically a couple of times today.

But that's a very important consideration that is part of our planning moving forward.

(Don Casey): (Don Casey). I thank Tanya for her comments and as the past chair of the Technical Expert Panel (and then) looking at physician level patient experience I think that's clearly good. It's good to see Will. He was my project officer in the (unintelligible). I know Will from a long time ago.

And he is patient.

But let me just make a few comments. I think EHR is one concept but really I think what we're talking about is any IT application that is used in the delivery of care as being a potential data source. That's a long range. As (Jeff) would say space station opportunity.

But in fact as a health system we struggle with the Health IT industry because we don't think there is any market-based incentive for cooperation to create systems that will provide us with meaningful data.

So in essence as a healthcare provider obtaining structure data from these IT applications we are continuously told it's our cost not theirs.

And I don't know how to fix that but maybe we could pass a law. I doubt it.

But to me the industry is not going to move on this until there are truly market-based incentives and as long as there's monopoly thinking I don't think that's going to happen anytime soon.

I do think, Will you're talking predominantly about payment policy here relative to value-based purchasing. The IT in data strategy is to help you inform payment policy.

And that's fine. For example I think claims are a great way to easily measure outcomes. (Harlem Crumbholz) has shown us how to do that with a high degree of validity.

But when you get to the last bullet, how should CMS provide feedback reports to professionals and other groups, I think Susan would agree with me and my colleague from the College of Surgery that physicians care much more about improving care for their patients.

And this PQRI feedback report that is out for comment right now I think maybe helps a little bit.

But honestly if you can provide them with a mechanism to say how can I really improve care, that's fine.

This is really accountability not improvement.

So I don't know how to get at that except to say I think there are ways so just think of that in terms of how should you provide feedback because you're clearly a payer but you're also a public good trying to improve society.

So I think you have to play it both ways.

Tom Valuck: Yeah.

Man: Thank you (Don).

Tom Valuck: Action ability aspect is so important.

Brian Whitman: Hi. Brian Whitman, College of Cardiology, just to address the first question, what are the advantages and disadvantages of various data sources and addressing the issue of registries, American College of Cardiology has a very extensive suite of registries.

And we've done pretty well getting a lot of physicians involved in it.

But I think, you know, using the example of the registry integration into PQRI, we've had some difficulty. In some sense it seems that rather than pushing everyone towards what people seem to agree is the better method, a electronic transmission of actual clinical data. There's sort of this attempt to kind of retrofit this more - this better data back into the claims-based process.

So I think we would really like to have the goal and the financial incentive should reflect that to push everyone towards the electronic submission so, you know, EHRs and registries because there really is an extensive burden to participate in a registry like the (NCDR), the agency's registry.

And, you know, some physicians do it because they're able to really monitor their performance and they get great data out of it.

But we think we could do even better if we were able to tell them not that, you know, you can get a 2% bonus for reporting. You get a 10% bonus for reporting through registry and a 2% bonus for reporting through claims. Because they think there's a lot better data going through this.

Tom Valuck: Thank you for those comments. Certainly leveraging electronically reported data is something that you've heard as a theme, not only from the CMS presentations but from the audience as well, and I appreciate that reinforcement.

Are there other comments here in Baltimore? Operator, let's turn to the phone lines, please?

Operator: Yes, sir. Once again, if you would like to make a comment at this time, please press star then the number 1 on your telephone keypad. Our first comment comes from (Joseph Carey). Your line is open.

(Joseph Carey): Yes. It's (Joe Carey) from California Society of Thoracic Surgeons. It looks to me like all of the sources that have been discussed are unaudited. We've obviously had a long experience with the Society of Thoracic Surgeons National database, and we found that participation alone stimulated quality improvement, and we were able to achieve 80% participation in California.

However, the data is limited to the index hospitalization, and like all registries the STF National database is voluntary and it is unaudited. And there's limited ability to get post hospital data.

When we went to mandatory public reporting in California, we obviously got 100% participation, and we were able to audit all debts using the vital statistics file. We found that about 20% of what the STF considers operative debts occurred after the index hospitalization as a result of transfers to other hospital facilities. And the same is true of media style infection, which occurs frequently after the index hospitalization.

We also have used claims data for some of our work, and we found that this is more comprehensive because it includes all diagnoses as well as procedures in the coding. However, it misses some important clinical data, and we've used the gift charge database here in California because it's more complete and allows capture of readmissions and linkage to these other databases.

I was just thinking that since the well hanging crude hospital readmissions that it would be best to use some sort of a enhanced clinical claims data, probably collected through health information technology as a basis for a lot of the value-based purchasing rather than requiring some additional data submission as the BQRI did.

Thanks for the opportunity to talk about this.

Tom Valuck: Thank you. Excellent point about leveraging current data sources and also about how data sources can most effectively combined. Operator, next comment, please?

Operator: Yes, sir. The next comment comes from (Bruce Ferguson). Your line is open.

(Bruce Ferguson): This is Bruce Ferguson again from the Society of Thoracic Surgeons. I would just like to augment on Dr. (Carey)'s comment in just a couple of areas.

There is no perfect data source. The STS database is probably as robust a data system as it exists, and medicine in terms of clinical data encompassing over 90% of the hospitals collect that do open heart surgery in the U.S. But like all data sources, it has liability issues. It is now audited on an ongoing basis.

But since there is no perfect solution to the problem, I think energies really need to be focused on trying to figure out how to incorporate information from a variety of data sources together. And the one issue that has not been discussed today is that of HIPAA, which is that every step along the way, a tremendous obstacle to - for some valid reasons and for reasons that perhaps need to be re-examined - to the collective sharing of health information across the spectrum, where we do have patients who migrate from one health system to another, from one care provider to another, and where unless we at some point address the HIPAA issue, just as we need to address the legal liability issue, we're going to continually run up against solutions that are incomplete and in fact ineffective, and the ability to be able to really make useful information out of what we've got.

We've spent an enormous amount of time and energy and our own provider's money in improving quality of care in cardiac surgery and demonstrated that it can be done with a registry-based feedback system. It would be a shame to throw that baby out with the bathwater. Perhaps a better way is to look at how to combine information sources together. But it is ultimately going to require addressing the HIPAA issue and to a lesser degree as already discussed, the legal issue. Thanks for the opportunity to comment.

Man: Yes. Thank you for those comments. I had the opportunity a couple of years ago, just a couple of years now, to work with STS and your registry and review some of the issues associated with bringing them into our environment to do measures. I certainly understand the challenges and issues associated with it.

With regards to HIPAA, it's absolutely correct. There are issues with HIPAA that we have to address. I'm not exactly sure what the answers are. I do know for example, in the hospital side, they've done what they need to do in order for vendors to collect this information and forward it to CMS. So I'm sure there are examples out there to help more facilitate this process.

Tom Valuck: Next comment, please?

Operator: Yes, sir. The next comment comes from (Rebecca Thurman). Your line is open.

(Rebecca Thurman): Yes. Thank you for having this presentation this afternoon. It's been very enjoyable.

I am the Director of Quality Improvement....

Tom Valuck: Man, you're going to have to speak up, please. We can't hear you in the conference room.

(Rebecca Thurman): Okay. I am the Director of Quality Improvement for a rural healthcare organization, which includes long-term care, assisted living, a hospital and five clinics. We absolutely cannot afford to put anything else into health IT or anything like that that we need to.

Tom Valuck: Ma'am, speak very loudly into your phone receiver. You're breaking up, so speak very loudly, directly.

(Rebecca Thurman): We absolutely at this rural health facility cannot afford to put any more money into hiring people to do abstracting and things like this. It needs to be - as other people have said - it needs to be health IT that takes this initiative forward.

We need help in the rural health arena from CMS, the federal government, to make this a viable opportunity. If you could do that, that would greatly be appreciated.

Tom Valuck: Thank you. Thank you for your comment. Next comment, please, Operator?

Operator: At this time we have no further comments.

Tom Valuck: Well, thank you, everyone for weighing in on that important piece of data, strategy and infrastructure.

And at this point we are going to shift gears and talk about public reporting. Jane Thorpe and (Jane Hammond) are our leads for that particular topic, and they will walk us through the presentation.

Jane Thorpe: Thank you, Tom. I'm hoping this is not last but not least, as we're coming to the end of our program today. I'm happy to be here with my colleague, (Jane Hammond) from the Office of Beneficiary Services to talk to you about the force work group, Public Reporting. As you can imagine, public reporting will be a critical element in our Physician Value-Based purchasing Plan, and we're glad to have the opportunity today to walk through with you some of the

issues that we've been discussing in our work group and also hear your feedback and comments on this issue.

As I said, CMS using public reporting is a very effective vehicle to share information with Medicare beneficiaries and other stakeholders. We've embarked on this initiative in a number of settings, including hospitals, nursing homes and others. I'm sure you're all very familiar with our suite of Compare Web sites. And our goal and our thinking is that we would continue to build upon that model as we think about physician value-based purchasing and what that means for public reporting of physician information.

We feel that public reporting can be an effective non-financial incentive to make useful and actionable information available to a variety of stakeholders, including our Medicare beneficiaries as well as physicians and other providers who are delivering care to them.

I think that through our discussion today we'll be talking about the various mechanisms that we've been using to make information available to beneficiaries, and we'll also focus on how this relates to physician value-based purchasing.

Just a brief overview of our presentation, we'll walk through the goals of public reporting, we'll then walk through the design considerations, we'll talk about some of the current CMS initiatives in addition to the Compare Web sites that have certainly informed our thinking about public reporting, and then we look forward to taking your questions and comments as we will walk through a series of questions that are also outlined in the listing issues paper available today.

Public reporting has a number of goals for CMS, just as it has a number of audiences. And so what we've tried to capture here on this slide is the wide variety of goals that we have for public reporting physician, other healthcare professionals information.

As you can see here, one of the main goals is to foster greater transparency of the quality and efficiency of the care that's being delivered. We also hope that public reporting will improve quality and reduce costs, again, a non-financial incentive to make this information available for folks to act upon.

We also hope that it will support more informed decision making by a variety of stakeholders. For our beneficiaries, this probably means helping them better choose a physician and having the information they need about the quality and efficiency of care that's being delivered by the physicians in their community as they're making that very important choice.

For physicians and other healthcare professionals, we hope that this will mean actionable and useful and comparable information that they can incorporate into their systems, into their care delivery processes and help improve care where appropriate.

We also hope that public reporting will support quality and efficiency, as well as assessment and improvement. We'd like to identify best practices and encourage the use of best practices through this public reporting. We feel that by making this information available, it will help physicians and other healthcare professionals be better aware of the care that they're delivering, also opportunities for improvement. We as a Medicare program will also learn from this information. It will help us identify and reward those best practices and also develop incentives that continue to support those goals.

We also hope that public reporting will support improved care coordination. As we've talked about a lot today and you'll continue to hear us speak to, we believe that care coordination is critical to the improvement of healthcare delivery. And we hope to use public reporting to not only make useful and actionable information available at the point of care and beyond, but also to make information available that reflects how the patient actually experiences care. And by providing information about how care is delivered in various settings and making that information available to other providers, help them better coordinate care across those settings. And finally, public reporting is also a very good tool for public accountability.

As we begin thinking about what public reporting might mean as part of a Physician Value-Based Purchasing Program, there are several considerations that we were taking into account. As I mentioned previously, we've been making healthcare information in other settings of care and hope that this Physician Value-Based Purchasing Plan and the public reporting will be modeled on those, and including our existing Compare Web site.

We also are very cognizant of the fact that public reporting has multiple audiences. This goes beyond just the physicians and other healthcare professionals that are delivering care and the beneficiaries, but also other stakeholders, including families, caregivers, the Medicare programs, other payors, other providers. And clearly, as we think about what information is publicly reported - and we'll get into this in a little bit more detail with our questions - we're going to need to think very carefully about what types of information are available to all of these various audiences. And it may be that some information is more appropriate for some audiences than others. So certainly something that we'll need to take into consideration as we pursue public reporting.

Two other design considerations that we've been considering is that the public reports must be designed and tested to ensure that the audiences can use them. So it must be useful and actionable to the Medicare beneficiaries, it must be useful and actionable to the physicians and other healthcare professionals. So we will certainly spend significant time thinking about how we design the reports, how we make this information available. As with our other Compare Web sites, there will be a significant amount of consumer testing.

We welcome and appreciate all feedback and input from you all, as well as how we can make this information most useful, to ensure that it's understood. It's very important. You can make all sorts of information available, but if it's not useful, if it's not actionable, and if it's not understood, then you really haven't accomplished anything.

We'll also include other, many types of information and use performance results reports. As you can see with our Hospital Compare Web site and other types of Compare Web sites that we have, we include a variety of information, including not just demographic information but also our quality measures, reimbursement information, patient experience of care, and also volume, in particular in the hospital setting.

I'd like to say just a couple of words about current CMS initiatives beyond the current Compare Web sites that I'm assuming most of you are familiar with. We've several initiatives under way where we've been looking at how best to make information available to Medicare beneficiaries and physicians concerning physician performance information.

Specifically, we had what's been referred to as the Better Quality Information for Medicare Beneficiaries Project -- involves six pilots across the country - and we tested the feasibility of generating multi-care, physician quality

performance information, that those communities then were able to make available to the stakeholders in their community. And we found that all six of the communities actually were able to work with the information that we provided, were able to use different methods to generate physician quality information, and then have been working to post that on Web sites that each of them have designed to meet the needs of their communities.

So certainly another thing that we'll need to take into consideration is it's not just the different audiences but it may be different needs of particular communities across the country. And one thing that we've certainly learn from the (PQRI) pilots is each of their Web sites are different. They cover different information, but there is a baseline of information that has been critical, and we'll certainly want to focus on what information would be appropriate to publicly report at the national level that would be useful by all communities.

Another initiative that we've been working on, you may be familiar with the Charter Value Exchanges, These are a group of local community collaborations that have been recognized by the Secretary, and we provided them with position performance measures at the Physician Group Practice level, again quality measurement results. And we provided those to those communities with the hope that they would take this information and make it available to the stakeholders in their communities. These collaborations include physicians and other healthcare professionals, consumers, health plans and other payors in their community, and the goal was by making this information available to them that they could then publicly report it in their communities in a way that would be useful and actionable within their communities.

We're also hoping that they'll work with the private care community and perhaps merge the Medicare performance measurement results that we've provided with similar information provided by the private sector so then we would have multipayor information that would be available through these community collaboratives.

And finally, as I'm sure you're familiar, we talked about earlier the requirements of the Medicare Improvement for Patients and Providers Act of 2008. We are required to publicly report those physicians that SATS actually reports through our Physician Quality Reporting initiative, and also to publicly report those physicians who are successful (E) subscribers. And we are taking steps now to move forward with both of those requirements.

Ultimately the goal there is - you'll see as we're thinking about the Physician Value-Based Purchasing Plan and publicly reporting of information that's generated through this program - would be to include more granular information about physician performance, moving into actual quality measures, quality performance resources uses, as (Karen) described this morning - would include more comprehensive and more granular information as we move forward with developing a public reporting plan.

What you'll see here is - I just want to give you a screenshot of the current physician and other healthcare professionals directory. This is what's currently on the CMS Web site now, along with our other Compare Web sites at www.medicare.gov. You'll see here that currently Medicare beneficiaries can search for a physician on this Web site, mainly using demographic information including name, address, education, residency and other related information.

And what we're thinking at this point is that we would use this Web site as a platform on which to add the more comprehensive information that's generated through a Physician Value-Based Purchasing Plan.

And as I said, we're hoping to use the other Compare Web sites as a model as we move forward and think about how we might publicly report the physician value-based purchasing information.

I wanted to provide you a screenshot from our hospital Compare Web site. This is actually I think our most comprehensive Web site, and you'll see that it includes not only information about quality performance, but it also includes reimbursement information, it includes patient experience of care information and other related information. So ultimately the goal would be to work towards this type of more granular information but related to physicians and other healthcare professionals.

So that this point I'd like to turn to (Jane) and she's going to walk you through some of the questions that we've generated as part of our discussions with the work group. And again, once we walk through the questions we'll put up a summary slide, and we look forward to your questions and comments.

(Jane Hammond): Thanks, Jane. I'm (Jane Hammond), Special Assistant in the Office of Beneficiary Information Services. As Jane stated, I'm going to walk through the questions and the considerations that we are seeking feedback on.

Many of the questions follow the theme previously discussed today, so you'll see a lot of those continue to come up. The first question is, at what level should information be reported? Individuals, group practice, population based, or a combination?

Some thoughts for consideration are what level of care actionable for the beneficiaries, physicians, other providers, the Medicare programs, and other states' quotas, and what level best supports improved care coordination and reflects how beneficiaries receive care?

The next question. What information should be reported? Are some measures more appropriate for public reporting than others?

Publicly reported information will be driven in large part by the measures that are used. So we only can do so much with the measures that we do use.

And then, are some measures more suitable for public accountability or informed consumer choice?

The next questions are: Should resource use information be publicly reported in addition to quality information? Should research use information be provided confidentially or publicly reported? If research use information were publicly reported, should quality and research use be reported together? For example, should we use an overall or composite score, and how should resource use information be framed? And how might associations perceive and use the information?

The next question. How should the performance measurement results be scored to facilitate interpretation? Some considerations include: How should public reporting use scoring in determining incentive payments, and should those payments be publicly reported?

Another consideration is should all performance measurement results be publicly reported?

Move on to the next one. How should the performance measurement results be displayed to facilitate understanding and use? Again, should information be presented using composites? Numbers or stars, should any information be suppressed? Should we use benchmarks, and at what level? And should we use trending information to show decline or improvement?

The next slide is just a summary of our questions. And we'll leave the slide up just to remind you of the questions.

Tom Valuck: Thank you, (Jane) and Jane, for the thoughtful, probing questions for public reporting. And at this point we'll take comments from the folks who are here in Baltimore. Dr. (Nedza)? Yes.

(Dr. Nedza): Here's a note from the AMA. It's a bit ironic, if you will. We've talked about this not just being about doctors' value-based purchasing. This was in (Tom)'s comments early. And what we're calling this is physician reporting, so I think we need to look at it within the context of, this is team-based care that we do now.

The fact of the matter is, I was recently at a meeting where we discussed obesity, and it was actually recognized that it was a public health issue, and that it takes, if you will, a village to treat obesity.

So when we begin to think about what you call this, who it pertains to, there's some basic questions that go even further back than what you've asked up here on the screen today.

So the level of reporting I think also has to do with the kind of actionability of this measurement. Measurement for measurement's sake, or measurement just for public reporting, does not give individuals nor systems the ability to

improve care. What gives you the ability to improve care are measures and systems of measurement that allow you to capture variation in your clinical practice at the practice level.

So although it's not one of the questions here, we firmly believe that measuring quality just for the sake of reporting is not the goal we're seeking; it has to be linked to quality improvement.

Similarly, the idea of - I'm not sure what you mean by resource use and I'm not sure the public would understand what that means. We seem to have changed language when we talk about this from efficiency or cost, and we've had other comments about how that's changed from Dr. (Casey) earlier.

We also need to consider that most physicians don't know what happens when they make a decision upstream. So an emergency physician who would consult multiple people on a call schedule of which I had no control of, they would choose to use resources for days and days later, and I was not privy to that information.

So I think before we talk about reporting public resource use, we need to make sure that the systems understand where their care decisions and their choices makes a difference in resource use. And I know some of the private plans are considering it.

And I think the third area -before we talk about stars or bullets or all of those type of things - we need to recognize again, go back to the access issue. In certain communities we do not have primary care access. So we can give people all the stars you want, but if they don't have an ability to re-engineer their practice, if there aren't enough services in that particular community, this again becomes another way that we're spending our dollars on something

that's not actionable for the consumers, the patients, the daughters, everybody else who's out there.

So again, I don't think we can think of this without thinking about what the limitations in access are, what the limitations are in measurement, and what the limitations are, when we go right directly to public reporting. So this should not be our end goal. Our goal - and I must admit I'm somewhat disappointed that the fourth group wasn't about quality improvement and was about public reporting.

Jane Thorpe: I agree with your comments. I think that actually your first one in particular - although all of them did resonate in terms of we talked a lot about what would this be called. Currently we have a physician and other healthcare professionals directory that we even struggled I think with that name in trying to capture information that's currently available.

So I think if we - one of the primary goals and things that you see here today is care coordination, how do we encourage that care coordination. I think particularly in the realm what you consider public reporting, what you call something, how you identify it I think is clearly critical to that. So we'll certainly take that I think into serious consideration.

Also, just to comment on a couple other things that you mentioned in terms of - as I'm thinking about this, because we did come at the end, it's not the end goal. How I see this is, as we develop the other pieces, of the physician Value-Based program, that will certainly inform what if anything we do publicly report.

And one thing actually I don't think we touched on today is as we are collecting information, we're generating information and clearly we talked

about data infrastructure, we talked about incentives, there may be information that we make available on a confidential feedback purpose. Some of the things that we're considering in terms of - we talked about resource use - is making confidential feedback reports to physicians.

It may be that there's some information that's more appropriate just to report back to physicians and other healthcare professionals, and then other information that would more appropriate for public reporting once we get to that point. But we'd certainly be interested in feedback, particularly related to what types of information should be used for which purposes. Because I think both of those are very useful and functional purposes, and may overlap and may not. And that's certainly something I think we'll have to work through if we continue.

Dr. (Nedza): And we hope that there will be thoughtful consideration, including public reporting in the right place in all of this. Rushing to public reporting of data that's not actionable, we've talked about unintended consequences. And there are many consequences that we won't go through that will come in through our comments. But we need to be able to - like in the hospitals, for instance, hospitals have a chance to review their data before anything is posted. That does not currently exist in the (PQRI) program.

What will be the mechanisms for validation of the data before public reporting? It's an important question that we need to think about, too. So thank you for your thoughtful consideration.

Jane Thorpe: Thank you.

Tom Valuck: Thank you for your really important point, (Susan). And as (Jane) said, they're not points that we would disagree with, but there are some other points I think

that also need to be raised about the purpose of public reporting - and I see (Tanya) is lined up here in queue - to talk about the consumer's perspective and the importance of information and the uses of having better information.

Now, it needs to be good information. I'm fond of saying that bad information is worse than no information at all, so that point is well taken. But I think that our beneficiaries will increasingly demand accountability for the services that are being provided. They'll want better and better information over time, and there's a general understanding that better information has not only educational effects but also can be pro-competitive.

In other words, as I think those of us who are physicians are aware, there is a competitive spirit about wanting to succeed and have that be publicly demonstrated as part of professional accountability. So a lot goes into the public reporting piece, and we need to look at it together from lots of different perspectives. So thanks for raising those other perspectives.

Yes, sir?

(Brian Whitman): (Brian Whitman) from American College of Cardiology again. ACC would strongly agree with Dr. (Nedza)'s comments. We released two papers this year on public reporting of both performance measurement data and resource use data, and stated many of those same concerns. That's not in opposition to transparency, but we want to make sure any efforts that we're making really are to really benefit the patient.

And we'll send you those papers again. You may have read them already, but we'll put them in the comments, too.

But secondly an issue that we didn't address in that was the discussion about how the performance measurement results should be reported to the public if indeed they are reported. We heard some comments earlier about patients not being able to understand certain data elements. And I think our feeling is that trying to boil down complicated statistics into something very simple like a star system, really could introduce more problems than it would solve.

We don't really know what patients would know. It's a little bit insulting to say no one can understand any of this data. And the difference between a one star physician and a two star physician could be the difference between having a 10% readmission rate and a 9% readmission rate, which would be very slight.

And I think a lot of physicians would have more difficulty with that than with pure data, which once - assuming CMS put that out, I would expect there's probably private entities out there would take that data and do things with it. And they may create their own star system, may do all kinds of different analyses, but trying to boil something very complicated down to something very simple may introduce a lot more problems than it solves.

TomValuck: Yeah. An important consideration, and I know that there's a lot of research being done around that question of, I guess the tension of giving more information that then becomes information overload at a very detailed level, especially for a healthcare consumer that may not be able to digest that readily, and at the other extreme, rolling it up into too high of an aggregation so that it loses the context, the nuance that's so important to interpreting it, using it in the right context.

Literally, millions of dollars have been invested in that already, and we continue to study that.

(Tanya Alteradge): Hi. (Tanya Alteradge), Consumer Purchaser Disclosure Project. First, I'd like to say I agree with what's been said about, information for information's sake is not what we would like. There's the difference between information and consumer support tools, and obviously we support the latter. We feel that any effort at scoring and display of performance information really must be made with consumer decision making in mind.

Consumers look at the data very differently than providers do, and if we want these efforts, which takes many, many resources and much of your time to put forward, then it really leads to a consumer support tool that's usable.

Going back to something I said in the data section, again, we feel that CMS should really allow other organizations to have full access to physician and other professionals performance information. If you're going to make the goal of reporting on individual physicians and professionals across the nation a feasible goal, it's an enormous undertaking, which we understand, and there are many organizations, many of which are at the community level, that are already looking at this data and doing this in their regions. And if there is some cross-fertilization there, it might really get you closer to the goal more quickly.

But as part of that, CMS needs to provide organizations with usable data so then they can use in their performance measurement programs. And this would have the added benefit from our perspective of supporting all payor data initiatives that address the challenges of reporting at the individual physician levels.

One thing I'd like to call your attention to is the Patient Charter for Physician Performance Measurement Reporting Insuring Programs. That is a project

under the Disclosure Project. It details strict terms that sponsors of physician reporting programs must meet, and could be a reference for you.

And then finally, this is an issue which has been raised before, but consumers see their healthcare system from the lens of their provider, and so reporting at the individual provider level is critical in our perspective. They don't look at the healthcare system at the group practice level, they look at their individual provider as their gateway to the system.

And so we really advocate for not only reporting at the individual level. There are several different levels that were under your list of questions, and I was saying yes, yes, yes, yes to all of them. But individual must be there. Thank you.

Tom Valuck: Yeah. Strong statement in favor of individual level reporting. Yes, sir?

(Don Casey): Hi. (Don Casey) from Atlantic Health again. To the questions, there's a couple of issues to emphasize. One is what I might call the asymptotic effect; that is as you make as a group of caregivers, let's say nationally, tremendous improvements for example in the hospital side and AMI care so that the average performer is really on an asymptote that gives you marginal benefit by going up one more percentage point, I think you lose less discretion - and forget about how many stars or happy faces you put on it, I just think it's far less meaningful. And the public just needs to be reminded of that.

In particular, these data get used regularly by other entities, and I think they get used in different ways. So some guidelines about that. For example the state of New Jersey publishes a report care based upon composite measure for hospitals. I'm sure they're going to do the same thing for physicians through CMS's data, once that becomes available; but a very different approach, not

critically speaking against my state, but a very different approach as to how they would display it.

I think that relative to this other issue of performance measurement reporting, I don't think that beneficiaries understand the issue of evidence. I know I keep harping on that, but I think that some acknowledgment of the science behind it - not just in lay people's terms, but in fact to look at, if we've got 300 measures, which ones are the ones that have the best scientific evidence behind them. Those are the ones you should be paying attention to.

I think back to the asymptotic issue, too, is you get into composite measures. If you look at the improved data that was recently published on cardiologists performance for the delivery of heart failure care in a composite, the range was 10 to 60%.

So that's much more meaningful. That will spur providers on. That will get them interested in improving their care if there is room to move. So those are just some thoughts.

Tom Valuck: Yeah, excellent. Operator, while we prepare for the last comment on this topic here in Baltimore - actually there are two more comments - but as we prepare for the last two comments here in Baltimore, if you would queue the callers, please?

Operator: Yes, sir. At this time, if you would like to make a comment, please press star then the number 1 on your telephone keypad.

Tom Valuck: Thank you. Chip?

(Chip): Hi. (Chip), I'm over at the American Society of Anesthesiologists. I raised this issue earlier on in the first go-around, but as a consumer of healthcare, I'm all for getting down to the individual provider level when you have the opportunity to choose your individual provider.

I represent the American Society of Anesthesiologists, and for the most part when a patient comes in to a hospital to get a surgery performed, they have an opportunity to choose their surgeon in many cases, if it was an elective procedure or something like that. They do not have an opportunity to choose their anesthesiologist, their radiologist, their pathologist.

So when you go ahead and go down to the individual level, that may be fine to report to other physicians, to allow other physicians to compare themselves against one another, but you really need to look at how is that information going to be used at the consumer level? Because again, if they don't have an ability to choose, now all of a sudden you have information out there where they really don't have the opportunity. And it would create some potential problems when they go into the hospital, going in and saying, I don't want this physician or I don't want that physician or whatnot because they'd say, this is the person that was on a particular list.

Unlikely? I don't know, but we really need to pay attention to how those issues are played out in the consumer mind in terms of the quality and what's out there. Thank you.

Tom Valuck: Interesting. Well, it certainly goes to the idea that we've got a diversity of different kinds of practice arrangements to think about. It had that particular angle on public reporting that frankly never occurred to me. And it does raise questions about informed patient choice. Yes, sir?

(Randall Thele): I do want to pick my anesthesiologist, but that's another issue.

(Randall Thele), American College of Surgeons. I have two quick comments. One is that I think we must have an appeal process for providers who believe their data had been reported incorrectly or inaccurately. And the second is that if you are going - you must proceed with extreme caution if you're going to report resource use measures. And I would say it's critical, essential, whatever, that it must be reported in concert with the quality data. You can't report one without the other. Thank you.

Tom Valuck: That second point is one that we've been paying very close attention to as we work on the resource use measurement and reporting that's required under the Medicare Improvements for Patients and Providers Act.

Certainly cost information, not in the context of quality, doesn't really have meaning. You have to look at them together. You might also raise questions as to whether quality information, without looking at how it's paid for and what its value is, whether that's meaningful either, at least maximally meaningful.

So I think one of our working assumptions, at least in the Resource Use Measurement and Reporting Project, is that the two need to be reported together.

Can we take the first comments from the phone line, please?

Operator: Yes, sir. The first comment comes from (Marsha Gold). Your line is open.

(Marsha Gold): Hi. Marsha Gold from Mathematica Policy Research. I do a lot of research on beneficiaries, access, the Medicare program, Medicare Advantage.

I wanted to sort of make a comment that's a little bit in a different direction, not that it's against anything anybody has said, but it's a different way of looking at public reporting, which is the way it's discussed there is it seems like you're thinking mainly of how do you use the information to support beneficiary choice and competition.

And that may be very important, but there's also another responsibility CMS has, which is to Congress and to the public at large as voters for the Medicare program and for oversight for what we're buying for the value of it. And it seems to me that a real advantage in what you have been thinking about is that it gives the program away at the highest level to sort of say, how are we doing? What is the performance of the program? How different is it across the country? Is it getting better or is it getting worse?

And so I would think as you think through these measures, it would be important to think about what other kinds of reporting may be useful in a more aggregate way about what they say about the program overall. For example, if you were using multiple different types of payment, what are we learning over time as to whether people are moving to more aggregate units? If we look at this from the point of view of the patient or beneficiary, which is the ultimate thing, what do we know about how well the original program's doing, how it compares to Medicare Advantage, whether there's variation in practice, whether that's getting narrower.

So I would hope that some of those more macro questions get considered, because it seems that otherwise that misses potentially at a macro level a pretty big use of the effort that you have to address some of those more fundamental questions.

Tom Valuck: So, (Marsha), your comment has peaked the attention of all the policy makers in the room. There have been a lot of knowing glances exchanged here that you missed, unfortunately not being in Baltimore.

You were proactive in providing us with an overview of your comments to the issues paper prior to the listening session, which I very much appreciated.

And one of the pearls that I got out of it was the point that you just made, which is that this idea of public accountability goes beyond the individual provider or the group or some kind of accountable care entity, but in fact, if you think of Medicare fee-for-service as a sort of a health plan, what is it that the taxpayers and the beneficiaries, who frankly don't have a lot of other options, what is it that we're getting out of our investment here?

So we need some sort of national accountability for the program as well, and I really appreciate those comments. And the idea of measuring the value of fee-for-service versus Medicare Advantage is certainly something that policymakers have also been interested in.

There's a requirement, actually, that Medpac look at this particular aspect, and they are doing that. So a comment well received. Thank you.

(Marsha Gold): Thanks.

Tom Valuck: Next commenter, please?

Operator: The next comment comes from (Bruce Ferguson). Your line is open.

(Bruce Ferguson): Thank you. I have represented the Society of Thoracic Surgeons, but I'd like I guess to make this comment just as a medical provider who has, like everybody in the room, dealt with some of these issues.

I think we haven't heard a discussion in the context of reporting like we did in terms of the data context and data source context, about auditing and risk evaluation of the information which is reported. And I'm not sure it's fair to assume that those two are necessarily synchronous with the reporting process.

There's been discussion about the integration of care, and what I haven't heard is reporting from the standpoint of what is best from the patient's perspective. And if that's the case, then we cannot talk about reporting on individual providers because like the guy who builds the car in the assembly line, the consumer doesn't buy the car because a certain individual built that car on the assembly line other than knowing not to buy a car on a Monday or a Friday.

And if from the consumer's perspective, what is it that they care about the most, and is it really this consummate idea of value rather than just quality or rather than just cost. And if we're going to be reporting information which is truly beneficial to the individual, it really has to be focused on the value component and not on the individual components only. And I would just encourage the discussion to move in the thinking to move in those directions as quickly as possible and not get bogged down on whether this is a one star or two star or three star.

All the public reporting that's been done in the arena of cardiac surgery demonstrates that several things happen. Doctors change the way they take care of patients, they change their selection process for patient interaction and engagement, and that the overall change that occurs can vary by year to year

to year depending upon factors that are beyond anybody's control. And it would be a shame to repeat that experiment in this larger context. Thank you.

Tom Valuck: So Bruce, what is the best day to have cardiac surgery? Monday, Tuesday, Wednesday, Thursday or Friday? The database doesn't answer that question. There was a physician in the audience who said never. You can prevent complications if you - anyway.

On a serious note, I think the point that you're raising is very important. And as you pointed out, it's not just about public reporting. It's certainly about what we want to measure. And we've talked about getting to outcomes measures so that we can really look at the end points and the value that we're getting for those.

But just like in measurement, we don't want to abandon looking at other aspects of measurement simply because we don't have a complete library of outcomes measures at this point. Similarly I think we need to use public reporting as a tool to the extent that we have information, good information that can be publicly reported.

So we're not going to wait for it all to be the perfect answer; however, we're definitely hearing all the comments about not what I call overdriving our headlights, where we're using information in ways that lead to inappropriate or misinformed decisions. So point very well taken.

Next commenter, please, from the phone?

Operator: Yes, sir. The next comment comes from (Ingrid Lucise). Your line is open.

(Margaret Rogers): Hi. This is (Margaret Rogers) from the American Speech Language Hearing Association. We very much appreciate the opportunity to comment today.

I would like to begin by echoing the comment that was made earlier - I didn't catch her last name, (Susan) was the first name - and others have made, including Tom Valuck in his introductory comments, that the term of physician in both quality reporting initiative as well as in value-based purchasing is clearly representing the largest group of Medicare providers, but from the perspective that we hold at the American Speech Language Hearing Association, somewhat disenfranchises our providers.

And the consequences of that are as the professional society that is very much engaged in trying to move our members into voluntary reporting with a tool that by the way we've developed over 12 years ago to measure outcomes and has now been accepted by the National Quality Forum, that in our efforts to get our membership to use this, the term physician in these overarching terms has really worked against us. They don't see the relevance to them and it's really been a difficult sell, given that we have 130,000 members that we're trying to reach.

So if there was any way that we might be able to in future iterations just change that to provider quality reporting initiatives, or provider value-based purchasing, I think it would help our efforts, and we would appreciate that.

That was my first comment. I also would like to just address the general direction of these efforts in terms of trying to meet the May 2010 deadline. I think that it's very difficult to consider where we are and where we can get in six months and not consider that the product, the deliverable in six months, might be more in line with the transition plan than ultimate recommendations.

And the reason why I'm particularly focused on this concern is the unintended consequences of moving too quickly, too quickly into proposing pay for performance systems, too quickly into public reporting. Like I had mentioned, we've been developing these measures for over 12 years to look at outcomes in speech language pathology and similar efforts in audiology. And I'm sure as I'm speaking to the choir, you almost know this. It's fraught with difficulty. And I think that until we have confidence in the system, putting it out in the public arena is going to be quite dangerous.

And then the last point that I would like to make is that I don't really get a good sense of how low incidents, disorders, the very severe disabled and sick individuals, and as mentioned earlier as well in (Karen)'s comments, the less compliant patients. And I would like to see if as the approach seems to be that one size doesn't fit all, how systems could be put in place so that these individuals are not disadvantaged.

Thank you again for this opportunity to make these comments.

Tom Valuck: Thank you for your comments. What a perfect segway into a more general discussion as we move toward closing the session today.

I'm going to respond to a couple of the things that you said, but while I'm doing that, I would invite the other subgroup leads who have presented today to join us up here at the front table so that we can receive the more general comments in closing. So (Will) and (Karen) and (Terry) I see here, if you would please join us at the front table. We're hoping to facilitate a little bit of discussion here in our remaining 30 or so minutes.

In terms of what to call this thing, provider doesn't work because we have providers, as identified for Medicare in institution, from the perspective of

institutions as well. So hospitals and home health agencies and nursing homes for example, are all providers.

So we struggle with the language. Non-physician doesn't seem right. That's sort of not the connotation we want to give to the other important members of the health professional team. Other health professionals is what we have in statute. It's pretty cumbersome. Just calling everyone professionals, when you talk about a professional VBP plan, people think well, does that mean it was developed by professionals, or does that mean it's for professionals.

So we really struggle with it, and we often unfortunately end up - just from my perspective as a physician also working on these issues from the perspective of the Medicare program - we often unfortunately end up defaulting to physician. But if those of you who are commenting in your written comments, if you would give us ideas about other eloquent and concise things to call this, we would be more than open to that.

Your second point about having a transition plan versus recommendations, as policy makers we tend to be relatively pragmatic as well on this, and the idea of a very smooth transition from here to there has a whole lot of appeal. And certainly we're going to need to build in a transition plan.

But as has been discussed today from our very opening remarks, there's a lot of urgency behind what we're doing. Because the fear that drives some of us is that we may end up in an arbitrary cost-cutting situation rather than a situation where we can make good decisions about value based on measurement and use the tools that we have, like our financial incentive, like our public reporting, in order to make some rational reforms to Medicare generally, but in this case particularly to payment for physicians and other health professionals.

So we feel some urgency here, and we feel like we need to go beyond just some tentative thinking and really get to some real recommendations about reform. And we want to do that in collaboration with the stakeholders represented here today.

So with that I'm going to turn back to the commenters here in Baltimore to start our closing session with general remarks. You can say whatever you want. The things that integrate the themes would be preferred, and you've got the whole panel of CMS leadership up here, and if you'd like to start off, sir?

(Don Casey): Sure. First of all - (Don Casey). Thank you very much for this day. It's been helpful I think to everyone, and hopefully people across the country will be able to look at this and continue to be participating in this effort, because it is very important.

I have two points. One is that I think that for chronic illness care, I don't see a lot of promise for this approach, and that's because it doesn't fit into a nice Part A-Part B type scenario. And there are all sorts of issues around care coordination, structural issues in various care settings, multiple providers, end of life issues and episodes of care that are quite frankly hard to define unless you want to use death as the end point.

So I would, especially in the context of the transition, given that the (Baucus Plan) and many other plans and many state legislative initiatives are centered around the patient-centered medical home, perhaps maybe take some time to absorb those concepts into this plan and to perhaps maybe even have a separate section for chronic illness.

Secondly, I think that what we're struggling with on the training side of this is the ability to do a lot of things in teaching hospitals. And that's not to say that we're complaining or crying, that we're underappreciated - although some might - but I do think there isn't an opportunity.

I'm not sure this will be solved with a CMS payment policy and value-based purchasing, but I do believe that if we don't train the workforce to think in this regard in their day-to-day life, then we're missing the point. I think the Boards are getting that quite effectively with maintenance certification. Certainly specialty organizations like ACC and the College of Surgeons are embedding the notions of performance measurement and evaluation into daily life. But I think we have a long way to go that my colleagues from AAMC I'm sure would echo that sentiment in the undergraduate medical education standpoint.

Frankly, I just think the teachers are not equipped. And I don't think they understand, and God bless them because I'm one of them, but I just think we're not training correctly. So I'll say that, and maybe there are some simple ways maybe in Medicare to think about how we might get at that, but that seems to me to be an enormous opportunity.

Tom Valuck: We do invest a whole lot of taxpayer dollars in graduate medical education, so thinking about how to leverage that funding to support the goal and objectives that have been presented here today, definitely something to further contemplate.

In terms of chronic illness, we've tried to steer away from as a group, planning how we were going to approach the discussion today. We've tried to steer away from immediately focusing on models that are already out there for fear of locking our thinking, your thinking into those models.

And when we go back, based on the comments that we've received today and your written comments, to begin thinking through this, no doubt various models, including the idea of the medical home, which is a performance-based payment approach in and of itself, paying an amount for certain, the performance of certain in this case care coordination related activities, is something for consideration by the group. We've just as I said, purposely tried to avoid saying, let's look at these five models and figure out how they can be pieced together into some approach to a value-based purchasing plan.

So two great points. Thank you. Anyone else on the panel want to discuss points that were raised? (Susan)?

(Susan): You threw your net very broadly in looking at pay for performance programs which were basically, mainly about payments.

While we're here in this room, there's an extraordinary amount of innovation going on in communities across the country, because while we're trying to figure out what to do in 18 months, they're facing it day to day.

So I would really encourage CMS to look at what's happening in the local communities. You've got regional offices that have connections with physicians and providers. There are a lot of extraordinary collaboratives like those that are going on in the (Robert Wood Johnson Aligning Forces) area where they are already doing what CMS is talking about doing and facing these issues.

So in order to build this, and not to try to turn the whole system away from where it's going, it's really important to look at what's happening there now, and also to do it within the context of how patients present. They come in and

they're dual eligible. They're in Medicare and Medicaid. They also have mental illness. They also in some cases, will be uninsured.

We tend to segment people and believe that all disparity care happens in federally qualified clinics, or we only have rural issues or a certain group because that's what Washington traditionally hears from. But we have wonderful communication tools in place now. We have the networks, the provider and professionals such as the AMA where I'm a member and also member of the leadership team.

And I really would like to encourage CMS to look beyond the traditional static information that we tend to look at as our information sources, and go out and connect with the innovators, beyond those that traditionally come and stand at this microphone. Thank you.

Tom Valuck: Our Office of Policy was instrumental in pulling together the two appendices that look at not only what's happening within CMS in terms of value-based purchasing initiatives that might inform this discussion, but also in the private sector. I don't know, (Karen), if you'd want to comment on some of those and some of our efforts to really get at the learning that's been happening out there?

(Karen): Well, as I was sitting here, as (Susan), listening to, one of the considerations that - I don't know if we directly talked about it today, although there was one bullet that said coordination with other payors.

So not so much talking about what we've learned by talking to others, but certainly there are a variety of relationships among CMS and those various local efforts, and certainly the Secretary of HHS has been very supportive of not only learning from - but this is really the point I'd like to make - actually

using CMS in our efforts to measure and report as well as whatever incentives we might put in place in this particular effort to actually support those other efforts and to help either provide them information that they may not otherwise have so that for example, if we were to publicize certain information on physicians or practices or health systems, it in fact would be information that would be usable by those various efforts and could be used in tandem with what other information that's there.

(Tanya) spoke many times about making information, Medicare information available to communities, and that's something that we've spent a lot of time trying to figure out what is the best strategy for doing that.

So I guess I would - not to put it back on anyone else, but just to say I think another way to think about it is that the incentives that Medicare could put in place could certainly be very supportive and drive even more ready, useful change at the local level. Andn I guess personally that's my hope, that it won't just be a national program that sits out there on its own, but because of the way it's designed in fact supports those kinds of local efforts, which is where I think the real quality improvement will come from.

So little different angle on it. Yes, learning those lessons but also making sure we taken into consideration a design that really supports those efforts.

Tom Valuck: Operator, let's take a comment from the phone lines, please?

Operator: Yes, sir. At this time if you would like to make a comment, please press start then the number 1 on your telephone keypad. Your first comment comes from (John Hutton). Your line is open.

(John Hutton): Hi. I want to have a general comment about trying to focus the incentives and the innovation where we want to emphasize certain parts of healthcare, so for example, within some of the current incentive programs that are congressionally set as a percentage of fees to Medicare, those who make a lot for Medicare that are making a larger segment of the bonus.

And as you're looking at these value-based purchasing initiative, if the goal is to try and emphasize some of the resources available to primary care, to see if it's possible to work with Congress to allow for the incentives that you can fiscally offer to emphasize what's happening on the primary care side.

Tom Valuck: (John), did you mention your organization?

(John Hutton): Oh, I'm sorry. I'm with an organization called (Doc Site). We're a (PQRI) registered supplier as well as doing other healthcare IT.

Tom Valuck: Great, thank you.

(Terry Kay): Just a very quick reaction. This is (Terry Kay). Appreciate your comment. I guess the way I would look at it is in doing this, as I said earlier, trying to look at how can we best achieve the objectives and goals that were set out, and in doing that trying to use an approach that's sort of an evidence-based approach, is certainly something that we're interested in

As (Tom) indicated, we're not committed to any particular model at this point, but any sort of suggestions, evidence that you want us to consider in ways that we can best achieve the goals and outcomes, we're very interested. So thank you very much.

Tom Valuck: Next commenter, please, Operator?

Operator: The next comment comes from (Kevin Craig). Your line is open.

(Kevin Craig): Yes. I'm (Kevin Craig) from Specialty Care LLC in eastern Massachusetts. I have three comments, one on the data, one on measures and one on the incentives.

On the data, there's two objectives in looking over data. One is to see if the data that was submitted is okay. It's a basic editing function, basic feedback function to tell you whether you're sending good information.

And the second is to see if the clinical results that you achieve that are shown in the data is good, substandard or improvable. I just want to focus on whether the data submitted is valid or not and okay, whether you're doing all right in submitting your data.

One of the things we learned in the (PQRI) program is that there was no access to immediate feedback on your data. So if you were doing something wrong in terms of just getting the data over and you were not going to be eligible for the bonus because it wasn't being submitted appropriately, you had no feedback.

For (Will), if you would just keep in mind that it's important to have some immediate feedback, at least on the editing function to tell you whether you're headed in the right direction when you're submitting data, rather than waiting as we did in (PQRI) for about 18 months before you - even the data submitted was no good.

My second comment has to do with the measures for Dr. (Rapp). I was saying earlier when I had trouble with my telephone earlier when I was commenting that I think the (PQRI) program did a wonderful job of engaging special...

Man: (PQRI) did a wonderful job and?

(Kevin Craig): A wonderful job in engaging the specialists. I think (PQRI) has some specific process measures that are going to ultimately improve the outcome and costs of care for surgical patients, urological patients, GI patients. You don't see that in a lot of the pay for performance plans today.

I'm in Massachusetts. Our organization has Massachusetts payor performance plans that are just based on primary care measures pretty much. And you've succeeded in engaging the specialists, which I want to applaud you for.

But let me just switch over to the incentive structure and the actual measures and the questions that you asked us to give you feedback on on the structures of these measures and the incentive. Specialty care wants to emphasize the importance of the individual level measures and incentives which engage the individual specialist.

We've analyzed medical costs in managed care contracts here for institutional care costs like hospitals and MRIs and other institutional costs, and we found that specialists are accountable for about 50% of the care and the cost of the care for institutional care. So we think that institutional care, if it's a larger percentage of the Medicare expense like we found it in our medical budgets in our contracts here in Massachusetts, that if it's a larger percentage of Medicare's expenses than professional care is, that you would be motivated to continue directly engaging the specialists, recognizing the relative importance of their success in improvement, it's going to drive savings and costs.

And I think that both the measures and the incentive can be weighted to recognize this and to recognize if there's some value in sharing the savings, even though you might not directly be able to calculate what savings are in order to incent the positions. You could weigh some of the measures for those things that produce greater value and greater savings for Medicare on the Part A side to give it a heavier weight on the Part B side.

There is concern here, as we listen to your presentation, that the Part A versus the Part B separation of funding, which I don't totally understand, but we've gathered that it might limit the provision of very meaningful incentive instead of the greater than 10% for example, fee schedule for significant services, if you can't take savings that are reaped from Part A and provide them as incentives on the Part B side.

That's a technical issue that I'm not sure I understand totally, but I thought I heard that that might be a problem, and I just want to encourage you to make the incentive meaningful and figure out a way to take from Part A and give to Part B if appropriate.

Regarding the unit of accountability for both the measure and the incentive, we feel that it needs to get down to the individual provider level often, although we recognize that it can't always get down to the individual provider level. And there are some measures that are appropriate at a higher more group level.

But in order to engage the providers, you really need to get it down to the individual level, particularly to engage the specialists, who we all know practice in smaller numbers, but based on the data that this organization has

reviewed, influence a larger share of cost and quality at the institutional level.
And that's my comments.

(Karen Milgate): (Kevin), this is Karen Milgate. I wanted to just ask you a follow-up, see if I can say this simply.

You talked about the relationship between Part A and B and also focusing on institutional care as a high percentage of overall cost. I'm just wondering if it's exactly the same in Medicare as it might be in the private sector. So I wanted to just ask you this question.

And I'm thinking because we in Medicare pay for hospital care through DRGs, I'm just wondering if we limited it to institutional care how much variation you think there might be within the institutional care, given the Medicare program pays the DRGs?

Do you think there's still a fair amount of variation so that there actually is cost reductions to be had? I know there are some, so I'm not suggesting there aren't any, but could you comment on that?

(Kevin Craig): I'm not sure I understand your question. A large amount of variability in what aspect of cost?

(Karen Milgate): Cost around a hospitalization or within a hospitalization. You seem to be saying new should focus on that because there's a lot of ability or possibility of reducing costs. And Medicare pays with a DRG, so I just wasn't sure.

(Kevin Craig): Well, I think clearly there's several ways to save costs on institutional. There's non-hospital institutional, which is the volume and frequency of ancillaries, and then there's hospitalization. If you're paying on a DRG and reduction in

the length of stay isn't going to save you anything, then it's reduction in hospitalization, because there are different ways of doing things clinically that reduce hospitalization.

(Karen Milgate): Okay.

(Kevin Craig): And that of course applies both to primary care and to specialty care.

(Karen Milgate): Yes.

(Kevin Craig): But I can't tell you how that skews the responsibility for institutional costs between primary care physicians and specialists when you take that into account. I really can't tell you.

(Karen Milgate): Okay. That's fine. Thank you.

Tom Valuck: (Will) or (Terry)?

(Will): This is (Will). With regards to your questions regarding data validity and the edits and checks in place, I think you're absolutely right. You'd need to get feedback regarding the edits on your submissions, whether it be via the HR or claim or anything else in that matter.

And what we found along the way is that feedback occurs at varying levels. So when you submit a claim, you have a clearinghouse, you get feedback from your clearinghouse, it goes to the carrier, the carrier gives you feedback. And the feedback you weren't getting from CMS, I think there was some expectation there the feedback was occurring. In some cases we found out it wasn't occurring.

So you're actually right. When we're looking at feedback, we actually do have to look at the different levels of feedback and the different components that provide feedback.

(Terry Kay): Hi, this is (Terry Kay). I just wanted to use this as an opportunity to - I think most of you are aware of this and familiar with this, but just to make it totally clear.

The issue regarding Part A and Part B and capturing savings and using it for physician payment, the issues here are that we're in a process of developing a plan and recommendations to Congress about what should a new plan be. In many cases we may recommend changes in current law.

So under current law, when we talk about budget neutrality, current law basically restricts what we consider when we determine budget neutrality. And the current law basically charges under the Physician Fee Schedule. However, in developing this plan and recommendations to Congress, we're not limited to just looking at Physician Fee Schedule services.

So just wanted to make sure that everyone was clear about that, the major distinction between current law versus what we might recommend under this plan and recommendations to Congress so that we have the potential to look more broadly at the Medicare program and not just simply at services under the position of fee schedule.

(Kevin Craig): Great, thank, Terry.

Tom Valuck: Thank you for your persistence, (Kevin) on technical issues here. Operator, do we have another comment from the phone line?

Operator: Yes, sir, we do. It comes from (Mark Siegel). Your line is open.

(Mark Siegel): Thanks very much. Just a couple of concluding comments.

One - and I apologize if this came up, but it's been a long day. On the issue of all payor data, and in the discussion paper there was a review of the various programs like (PQRI) to combine Medicare and other payor data.

And I'd like to just encourage you to be thinking, as we look to more focus on EMRs and registries, of all patient-all payor data from those sources. Certainly when you're pulling data from an EMR, it's very feasible to pull data for beyond Medicare beneficiaries, and that gives certainly from the physician and professional standpoint a more complete view of the quality.

Secondly, just to agree with the comment that was made earlier on the need for true interoperability standards for submitting the electronic data from these sources for the in value-based payment.

Also, as Dr. (Rapp) indicated earlier, it's important that in developing the validation strategy for data sources we recognize the particular characteristics of data that's coming directly from EMR in making sure that we don't have a one-size-fits-all validation strategy.

And finally, because we are looking to the future, to as designing the program, recognize the ability of EMRs and registries to provide very timely feedback to the users on the measures that are being used in the VBP system. So with that, I thank you all for your attention today.

Tom Valuck: Thank you for your comments throughout the day and for your engagement in the (PQRI).

(Mark Siegel): You're welcome.

Tom Valuck: Next comment, please?

Operator: Sir, at this time we have no further comments.

Tom Valuck: Are there any other comments from the folks who are remaining here in Baltimore?

Okay. So a few concluding points here and next steps. First of all, wow, great input from the audience, the folks who are here in Baltimore and the folks who are on the phone.

Speaking just from my particular perspective, the level of the comments and the information that's been conveyed to us has exceeded my expectations and certainly gives me great hope that we've got the kind of start to the engagement that we would like to have with the stakeholder community for this particular project.

I need to thank some people who made the day possible today. The coordinator for our project, Dr. (Julian Howell), our provider communications group here at CMS, and (Lisa Grabert), who fortunately we didn't need her services in holding up the yellow and the red signs telling commenters that they had exceeded their time. But all of those folks contributed significantly, in addition to those who you saw as presenters, the subgroup leads who were our substance experts and listened very keenly to the comments today.

But there are other members of our work group who were not part of the presentation who need to be recognized as well. We had strong support from

our Office of Research, Development and Information. They run our demonstration projects, and their expertise has been invaluable in developing the issues paper. And we look forward to working with them, as well as our regional office Chief Medical Officers. They bring a perspective from their interactions with the physician community that are so important in keeping our work grounded here at the Central Office. So we really appreciate their participation and leadership as well.

In terms of the substance of your comments, we've been taking notes and tried to absorb all of that, but you really need to capture all of that information in written comments. We have an email box, simply Physician VBP at cms.hss.gov. That's P-H-Y-S-I-C-I-A-N-V-B-P, at cms.hss.gov for your written comments.

If you somehow misplace that, you can send your comments to me or any of the other presenters today to be shared with the rest of the folks who are working on the value-based purchasing plan.

Those comments are ideally due by Tuesday, December 16 by the end of the day. And I say ideally because if you can get your comments to us by then, we've put in some other planning steps that we need to be taking, and we would like to have your comments by the December 16 in order to include that input in these other planning steps that we're taking.

Having said that, however, we recognize that the issues paper has only been out there for a week or ten days or however long it's been, and we also recognize we're in the holiday season and so on, and we don't want to lose any other input that you would like to have.

So if you want to send those comments after December 16, please do, or if you want to embellish on the comments that you sent before December 16, it's just that we are going to be moving along, and to have the benefit of your input, it would ideally be received by close of business on Tuesday, December 16.

I also want to note that there's a recording of today's session that will be on the CMS Web site under Physician Spotlight, the same place where you got the presentation to download and the issues paper. That will be available at the end of the day on Friday, December 12. And so look for that the following week, if you want to review the interaction from today.

So now our focus will shift from the receiving comments on the issues paper to synthesizing the input that you have as we move toward the development of options. And we're planning on, given we will have leadership - they'll obviously be giving us new direction as well - but we're planning toward at least a second listing session on an options paper that would happen in mid-2009. So hopefully you all will plan to participate in that session as well. Thank you very, very much.

Operator: This does conclude today's conference call. You may now disconnect.

END