



Statement

of the

American Medical Association

to the

**Centers for Medicare and Medicaid Services
of the
Department of Health and Human Services**

**Re: Town Hall Meeting; Implementation of
Section 10331 of The Patient Protection and
Affordable Care Act, Establishment of a
Physician Compare Web Site**

November 30, 2010

Division of Legislative Counsel
25 Massachusetts Avenue NW, Suite 600
Washington, DC 20001
(202) 789-7426

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Re: Town Hall Meeting; Implementation of Section 10331 of The Patient Protection and Affordable Care Act, Establishment of a Physician Compare Web Site

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The American Medical Association (AMA) appreciates the opportunity to present our views to the Centers for Medicare and Medicaid Services (CMS) concerning implementation of section 10331 of the Patient Protection and Affordable Care Act (the ACA) relating to the “Establishment of a Physician Compare Web Site.”

The AMA cautions CMS to be judicious in its development of a Physician Compare Web Site. The agency must balance current methodological limitations associated with physician profiling, with its statutory directives for developing a Physician Compare Web Site. Specifically, CMS must consider the current state of data collection and aggregation accuracy, availability and use of clinically relevant and electronically specified quality measures, as well as tested and widely used risk-adjustment and attribution methodologies. In developing a plan for public reporting of physician performance through Physician Compare, these significant barriers in public reporting processes must be addressed. To minimize unintended consequences, the initial phases of public reporting should be limited to group or organizational level reporting. The Physician Compare Web Site must be designed so that accurate, valid, and timely information is available to Medicare beneficiaries in a format that will enable them to make educated decisions about their health care needs.

The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data when it is used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care for all patients, and is used to provide accurate physician performance assessments. It is from this perspective that we offer the below comments.

Web Site Design

The AMA supports using the current CMS Healthcare Provider Directory as the initial framework for developing a Physician Compare Web Site. Based on the significant number of errors that occurred in the hospital demographic data when the CMS Hospital Compare Web Site was initiated, the AMA

recommends CMS establish a process by which a physician or group can review and update their demographic information directly through the Web Site. Along these lines, the AMA encourages CMS to evaluate lessons learned from developing and implementing the Hospital Compare Web Site.

The AMA believes that information from the CMS Healthcare Provider Directory could be updated annually, with some data, like board certification, requiring more frequent updates to remain current. This information should be verifiable by the physician, accompanied with a process for correcting data inaccuracies.

Measure Development and Selection

Physicians must have a lead role in developing and selecting the performance measures used for public reporting. This will ensure that the measures are accurate and relevant to patients and physicians. Without this tenet, public reporting will not achieve its goal of improving the quality, experience and outcome of care for patients.

In 2000, the AMA convened the Physician Consortium for Performance Improvement (PCPI) to develop performance measures that are patient-focused and that can be implemented to improve patient outcomes. The PCPI is comprised of over 170 member organizations, including national medical specialty and state medical societies; other health care professional organizations; the Council of Medical Specialty Societies; American Board of Medical Specialties and its member-boards; experts in methodology and data collection; the Agency for Healthcare Research and Quality; and CMS.

The PCPI measure selection and development process actively engages all stakeholders including payers, patient advocates, quality experts and other organizations that are committed to high quality care. The PCPI operates through a transparent, consensus-based process for developing quality measures. Since its inception, the PCPI has developed more than 270 performance measures and specifications covering 42 clinical topics and conditions. These measures are currently in use within many CMS quality improvement demonstrations and programs, including the Physician Quality Reporting System (PQRS) and Medicare and Medicaid Electronic Health Record Incentive program. **In addition, the PCPI ensures that measures: (i) are evidence based and technically sound; (ii) developed with cross-specialty and interdisciplinary representation; (iii) address known gaps or unexplained variation in care; and (iv) that the measures are updated on a regular basis. Publicly reporting systems must use measures that meet these criteria.**

While the PCPI will continue to identify and develop measures based on clinical conditions, it recognizes that many future measures will need to apply across disciplines and settings, account for multiple chronic conditions, and provide information on the outcome of care. In addition to individual measures, the PCPI recognizes the value of composite measures (combined metrics that incorporate multiple individual measures to create a single score) to patients, payers and providers. To support this goal, the PCPI has devised a composite measurement framework, and will begin to explore the construction and use of composite measures where appropriate. The availability of composite measures, along with other independent measures, can create a more comprehensive picture of where improvement, resources, and incentive payments should be focused.

While we are supportive of composite measures, we are also acutely aware of existing limitations regarding risk adjustment, attribution, and aggregation methodologies. At this time, there are no widely accepted models that accurately attribute care provided through multidisciplinary teams, or when a

patient's care is provided by multiple physicians or across two or more care settings. The agency's plan for developing Physician Compare should clearly address and resolve any attribution issues prior to publicly reporting this information.

Moreover, some subspecialties currently lack measures, and a data collection and reporting system that addresses their scope of practice. It is critical that the development of a plan for public reporting of physician performance through Physician Compare recognize these factors, and implement initiatives on a phased-in basis to ensure reporting requirements are undertaken only when physicians have the opportunity and resources to participate on a widespread basis.

The AMA recognizes the value of trend data, collecting three or more consistently derived data points over time to monitor improvement. However, public display of trend data must meet the same validity, reliability, and physician review standards as mentioned above for performance information.

We continue to believe that publicly reported measures should be endorsed by the National Quality Forum (NQF). This requirement is important to ensure that CMS uses a common set of measures that have been properly vetted by multiple health care stakeholders for the purpose of public reporting. Further, we support the use of alternative measures only when there are no NQF endorsed measures meeting the subject matter. These measures should be used only on a provisional basis and should be endorsed by NQF within a specified timeframe e.g., 12-18 months. Finally, we urge CMS to devote attention and support to the measure development pipeline. Today, the vast majority of NQF endorsed measures are process measures related to a specific clinical topic. The information needed to transform the health care system into a high quality, value-driven environment will require outcome measures applicable at the individual, group, system, and population level. Measures of appropriate use and efficiency are needed. In addition, measures that reflect the personal values of patients are of high priority. Without adequate resources available to measure developers, significant measurement gaps will remain.

Patient Experience Information

Until the relationship between patient satisfaction and other outcomes is better understood, data collected on patient satisfaction is best used by physicians to improve how they respond to patient needs. Because of the difficulty in determining whether responses to patient satisfaction surveys are a result of physician performance, health insurer demands or restrictions, or other factors outside a physician's control, the use of patient satisfaction data is not appropriate for public reporting or financial incentive programs. Moreover, until collection methods associated with patient experience information are uniform and valid, such information should not be made public through Physician Compare.

Level of Reporting and Data Collection

To date, there are only a few examples of public reporting at the physician level. Those that do exist, have had limited auditing and evaluation to determine the accuracy and value of this information to patients, payers, and providers. Scientific knowledge on the type of information patients are seeking, as well as the best display format to facilitate understanding and suitable decision making is scarce. Therefore, public reporting at the individual physician level should be extensively piloted before wide scale public reporting occurs. Furthermore, it is well-known that statistically valid minimum thresholds are often difficult to achieve at even the organizational level. This issue will be amplified at the individual physician level. **Until more information is available regarding the informational needs of**

patients, understandable format for display of the data, and impact of publicly reporting individual physician level data, individual physician performance data should not be posted on Physician Compare.

Key lessons from the Physician Quality Reporting System, formally “PQRI,” are that quality measurement and reporting must allow physicians and CMS adequate lead time to implement changes. CMS must aggressively educate and implement outreach activities for physicians and eligible professionals on how to successfully participate and share accurate performance data for purposes other than internal quality improvement. Development and implementation of a Physician Compare Web Site must require detailed confidential, actionable interim and final feedback reports that inform physicians of reporting errors and how to correct them. These reports must also be issued on a timely basis. PQRS reports are issued far too late for physicians to address reporting problems, which caused inaccurate reporting practices to continue far too late to be helpful even in the subsequent reporting year. Timely, detailed reports will assist in increasing the number of eligible professionals with accurate and valid performance data posted on Physician Compare.

The AMA supports the use of registries and EHRs as reporting mechanisms. Use of registries and EHRs will allow data capture and submission to move beyond the use of administrative claims data alone to facilitate real time quality improvements. Procedural protections are needed, however, under the Medicare program, to ensure the accountability of the registry or EHR product vendor for successful submission of data to CMS from physicians and eligible professionals. The data submission process under a quality program (whether data is submitted directly to a quality program or through an intermediary) must be transparent, tested and reliable. **CMS should specify procedures and requirements that registries (and EHR product vendors) must meet to minimize errors in the registry or EHR reporting process, including interim and final feedback reports, as well as procedures to be followed to correct errors that may occur when the registry or vendor submits the data to CMS.**

Finally, an interoperable health information technology (Health IT) system is critical for the success for a performance data infrastructure and reporting system. When implemented properly in a connected environment, widespread Health IT adoption will transform the practice of medicine and provide physicians with a powerful tool that puts real-time medical information in physicians’ hands at the point of care. To achieve this reality, a comprehensive Health IT environment will need to be highly connected, secure, and affordable. To truly ensure success, Health IT must integrate into the typical workflow of medical practices across the care setting, including large hospitals, community health centers, long term care facilities, home health and small or solo physician practices.

Data Preview

The AMA urges CMS to establish a meaningful process for physicians to review and correct errors in their performance and measurement data and to appeal any such errors before publication. The AMA has serious reservations regarding the agency’s ability to provide timely statistical performance feedback to physicians to ensure appropriate review of their data prior to publication. As evidenced in the FY2011 Medicare Physician Fee Schedule Final Rule, CMS decided to not finalize its proposal to provide eligible professionals who report PQRS measure groups using the claims-based reporting mechanism with interim feedback reports for 2011. Further, the Final Rule claims that it already provides “timely” feedback through its current processes of providing an annual feedback report at or about the time of issuing incentive payments. The AMA strongly disagrees. CMS must undertake a more serious

evaluation of options for improving the ability of timely and meaningful feedback for PQRS, development of a Physician Compare Web Site, and other quality improvement provisions mandated by the ACA.

Section 10339 of the ACA requires the Secretary of HHS to develop and post on a Web Site a plan, including needed resources, to modernize CMS computer and data systems to support improvements in care delivery. The AMA looks forward to reviewing this report and working with CMS to ensure improvements are made to the agency's computer systems to promote more timely and meaningful feedback to physicians participating in various Medicare quality improvement and measurement programs.

We thank you for the opportunity to provide our comments and look forward to working with CMS to resolve issues related to public reporting that could present barriers to a health care system in which physicians and other providers work together to deliver high quality, cost-effective care to our patients.