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Regina Chell
Centers for Medicare & Medicaid Services
Division of Electronic and Clinician Quality
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Mailstop S3-02-01
Baltimore, Maryland 21244-1850

Re: Physician Compare Town Hall, February 24, 2014

Dear Ms. Chell:

The American Medical Association (AMA) appreciates the opportunity to present our views to the Centers for Medicare & Medicaid Services (CMS) concerning the future of the Physician Compare website. The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports the use of physician data when it is used in conjunction with 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 assessment.

The expansion of CMS' Physician Compare website is a small step in the right direction, but consumers need to be informed of the greater context of the information since only a subset of large group practices are eligible to participate in the Physician Quality Reporting System (PQRS) program's Group Practice Reporting Option (GPRO). **Therefore, we caution CMS to avoid adding additional information until after data accuracy is improved and the methodology for calculations is verified and tested.**

The agency must continue to balance current methodological limitations associated with physician profiling and its statutory directives for developing a Physician Compare website. Specifically, CMS must consider the current state of data collection and aggregation accuracy. **The AMA urges CMS to continue being judicious in its development of the Physician Compare website, and to enhance the transparency of the process by providing opportunities for public input on particular changes, and engaging frequently with interested stakeholders.** It is from this perspective we offer the following comments:

Website Design

The AMA supports using the current CMS Healthcare Provider Directory as the initial framework for developing Physician Compare. Based on the significant number of errors that occurred in the hospital demographic data when the CMS Hospital Compare Website was initiated and the continued problems with the demographics data on Physician Compare, the **AMA strongly urges CMS to establish a more expedited process for correcting demographic data.** CMS stated in its September 18, 2013 letter to the AMA on the Physician Compare redesign that it can take up to four months for changes that have been made in the Provider Enrollment, Chain and Ownership System (PECOS) to show up on Physician Compare. We have also heard from physicians that their information on Physician Compare has been inaccurate for several years, even when their information in PECOS is correct. In addition, we continue to hear from physicians who have queried their zip-code and specialty in major metropolitan areas and the website indicates, incorrectly, that there are no specialists within that geographic area. In fact, the 2014 Department of Health and Human Services (HHS) Office of Inspector General (OIG) Work Plan highlights particular problems with the inaccuracy of information posted on Physician Compare. We find this unacceptable. Furthermore, it undermines physicians' trust in CMS' ability to expand and correctly post their quality scores on Physician Compare.

The AMA is also profoundly disappointed in CMS' recent roll-out of major changes to Physician Compare. Last Friday, CMS went live with posting star ratings for GPRO practices and accountable care organizations. The AMA, medical specialty societies, and state medical societies received no advance notice regarding the posting of this information. Consequently, we were unable to notify the physician community that this new rating system was coming. Nor were we provided an opportunity to review the information in advance of its posting. This is in vast contrast with the roll-out and maintenance of Hospital Compare, whereby CMS has been actively engaged with the Hospital Quality Alliance, and meets quarterly with the hospital groups to discuss Hospital Compare issues. Apart from CMS' request last fall for public input on the redesign of Physician Compare, there is no comparable, ongoing engagement with interested stakeholders. **We therefore implore CMS to immediately engage physician stakeholders on a routine and iterative basis. We also request clarification as to how CMS plans to communicate with the physician community regarding changes and feedback about the website. In addition, we urge CMS to disclose and release the recommendations made by the Physician Compare Technical Advisory Panel (TAP).** We are unaware of CMS publicly posting this information and any analysis as to whether the Physician Compare redesign is following the TAP's recommendations.

One simple request is for Quality and Resource Use Reports (QRURs) and PQRS Feedback Reports to include a display of how the profile of an individual physician and the associated group practice (with quality scores if available) will be displayed on Physician Compare. Including this information would provide an additional opportunity for physicians to review their quality scores and correct underlying demographic problems from the onset. **Once a physician's demographics data or quality information has been flagged as problematic, the AMA recommends that CMS remove a physician's or group practice's quality information until the issues are resolved.**

Intelligent Search Functionality

We are also concerned with the new intelligent search function as it may steer patients to providers who are not adequately qualified to treat certain diseases. With the new feature, a patient can search for a

physician by a specific disease. The site then lists various specialties that might be able to treat that disease. However, we are unaware of CMS performing any internal vetting to validate specialty organizations' representations that they treat a particular condition. Without a process for confirming appropriate disease classification, CMS may be directing patients to providers who are not trained in diagnosis, treatment, or managing a particular condition.

Display of Quality Information

The AMA supports efforts to make medical standards more comprehensible to patients. However, the use of star rankings or similar systems that display disparate quality scores in a simplified graphic result in distorted, inappropriate distinctions of quality for physicians whose performance scores are not statistically different. Such oversimplification of data can have the opposite effect from what is intended, confuse patients, and create false assumptions about health care professionals. When CMS recently proposed to use a star rating system for Hospital Compare, critics were quick to point out the challenges. Private groups have come to differing judgments on the same hospitals (e.g., Leapfrog vs. Consumer Reports) due to differences in their analyses. Even Medicare's evaluations can lead to inconsistent overall conclusions (e.g., one facility may be above average in keeping heart attack patients from dying, but below average in readmissions). It was also pointed out that Medicare's statistical methodologies have resulted in the agency drawing the conclusion that most hospitals are indistinguishable from one another on major performance measures such as death rates. On Hospital Compare, 9 out of 10 hospitals' mortality rates are described as "average." This narrow range simply doesn't lend itself to a star system.

Given the overwhelming majority of physicians who would fall within a small range of average quality, the AMA believes that the only information that accurately identifies what is truly valuable to a patient, considering the evolving state of quality measurement, is whether a physician is an outlier. Therefore, **the only information that CMS needs to report publicly at this point in time is whether a health professional is one standard deviation below the mean. The recommended display of information should be highlighted on a measure-by-measure basis, but only for those measures that are both clinically relevant to the health professional and his/her patient population and adequately risk-adjusted.**

Measure Development and Selection

Physicians must have a lead role in developing and selecting the performance measures used for public reporting. This will ensure the measures are accurate and relevant to patients and physicians. Otherwise, public reporting will not achieve its goal of improving the quality, experience, and outcome of care for patients. Moreover, **several subspecialties currently lack sufficient measures, as well as the necessary data collection and reporting system, to accurately capture quality measures and improvement activities relevant to their practice area. It is critical that the development of a plan for public reporting of physician performance through Physician Compare recognize these factors, and for CMS to continue to implement initiatives on a phased-in basis.**

What measures would most accurately/completely represent the various medical specialties?

The AMA recommends that CMS work with the various medical specialty organizations to identify the appropriate measures that are relevant to each specialty. The AMA is happy to act as a convener on behalf of CMS to assist with facilitating this process. CMS must also recognize that many sub-specialties

still do not have meaningful measures to report in PQRS. This information should be clearly documented and displayed on Physician Compare.

What non-CMS measures should potentially be considered for Physician Compare and what are the logistical means of obtaining these measure data?

Experience needs to be gained with measures prior to implementation in public reporting. Measures also need to be tested to ensure they have no association with adverse consequences. This requirement is also important to ensure that CMS uses measures that have been properly vetted by multiple health care stakeholders for the purpose of public reporting. **Finally, we urge CMS to devote sufficient attention, support, and resources to the measure development pipeline.** Transforming the health care system into a high quality, value-driven environment will require outcomes measures applicable at the individual, group, and population levels. The public is also calling for measures of appropriate use and efficiency. But without adequate resources available to measure developers, significant measure gaps will remain.

Third-Party Entities

There are several significant benefits for allowing third-party entities to report quality data to CMS on behalf of physicians and other eligible professionals (EPs). Such an approach reduces measurement burden and represents an efficient and effective method for CMS to engage a large percentage of EPs in a region/state. Initially, some shortcomings may arise around the ability of third-party entities to accurately and meaningfully report quality measure data and/or results to CMS on behalf of physicians. For example, any data and/or results reported to CMS for the PQRS program have to be as accurate as possible because the performance information will be posted on Physician Compare. We are in a period of transition where more physicians are using electronic health records (EHRs) and starting to share data through other activities such as registries. However, until we have robust and well tested data exchanges, it is important to have a supplemental process that allows practices to review and correct information extracted from the EHR or third party data activity before CMS calculates scores and posts these on Physician Compare. To help address some of these potential shortcomings, CMS first needs to ensure that third-party entities that engage in data collection, validation and reporting employ safeguards in their processes to protect the accuracy of the underlying data.

Before these data are publicly reported by CMS or any other entity (including the collecting entity)**, the quality data activity should have an established infrastructure with requisite experience and expertise in the realm of secure collection/storage of patient-level data, performance measurement, and public reporting.** There must be safeguards to ensure that the data is valid, comprehensible, and subject to effective methodologies for risk-adjustment and attribution of care. Physicians should have an opportunity for review and appeal of the data prior to public reporting. **In addition, protections should be implemented to ensure that any performance report ─ or data used as the basis for the report ─ will not be subject to discovery or admission as evidence in judicial or administrative proceedings without the consent of the physician(s).**

Composites

While we are supportive of composite measures, we are also acutely aware of existing limitations in the evolving methodologies for risk adjustment, attribution, and aggregation. For example, are all the measures in the composite equally weighted? If not, is there evidence that one measure contributes more

than another to improved quality and hence, gets a higher weight? If the result of one or more measures in the composite is not a percentage (e.g., mortality is often relative to an expected result, or X/100,000) how is the composite calculated? If CMS moves forward with composites, we request that CMS first outline their methodology and provide an opportunity for public comment.

Plain Language

We are concerned with CMS' process for posting measures in plain language and the general lack of transparency around how CMS arrives at this information. CMS has yet to consult with measure developers/owners to ensure the intent and meaning of each measure is still intact, and that interpretations by interested parties are correct. We urge CMS to do so.

Is it appropriate to reduce the length of the measure preview period from 30 days to 2 weeks?

It is unclear to the AMA exactly what CMS means by reducing the measure preview period from 30 days to 2 weeks. If CMS means a physician's or other EPs ability to review their quality rating score, then we are not supportive of reducing the length of time. Physicians need advance notice on the posting of information and the ability to review and file any necessary appeals. It often takes practices several weeks and sometimes months to register and obtain their PQRS and QRUR reports. We are also not aware of the mechanism CMS is utilizing to alert practices on their public ratings, but we anticipate problems and backlogs as the program expands and more practices are profiled.

<u>Additional Information</u>

Is there additional board certification information we should consider including on Physician Compare?

With regard to medical board certification activities, we urge CMS to "grandfather" physicians who have been provided lifetime Maintenance of Certification, exempt them from financial penalties associated with Medicare programs (e.g., PQRS, Meaningful Use), and post this information on their profile. This approach is consistent with the AMA's recommendation that, during these transition periods, physicians who face hardships, such as those who are at or near retirement age, should be protected from burdensome requirements and financial penalties.

What other types of quality improvement programs or quality initiatives should we potentially consider publishing participation for?

The AMA is supportive of physicians receiving reporting credit through meaningful participation in a variety of quality measure data activities, including board certification (e.g., satisfying Part IV Maintenance of Certification). The AMA urges CMS to promote flexibility in its performance programs by allowing physicians to report through their medical boards, registries, accreditation activities (e.g., The Joint Commission), clinical quality measure reporting in EHRs for demonstrating meaningful use, or other state, local, or regional quality improvement activities.

Is there additional healthcare professional or group practice information we should include on Physician Compare, such as office hours or website addresses, etc.?

The AMA believes it would be helpful to post additional contact information such as office hours and/or website addresses on Physician Compare, but given the continued problems with the underlying demographics data, we are not sure how CMS would realistically manage the logistics. We request clarification as to CMS' time frame for changing outdated information and the mechanism that will be provided to physicians and practices to update their information outside of logging into PECOS. The AMA regularly hears from physicians that Physician Compare lists hospital and/or practice affiliations that are several years out of date.

We also strongly discourage Physician Compare from incorporating Sunshine Open Payment Program data. The current process outlined by CMS for validating information concerning industry interactions with individual physicians does not adequately establish a reasonable means for corrections to the reports. Of particular concern, CMS' aggregation of such information into individual reports has not been sufficiently tested to minimize errors and the process outlined by CMS to dispute errors does not ensure timely corrections are made. **Moreover, combining the quality data on Physician Compare with the unrelated Open Payments disclosures could lead consumers to incorrectly assume a linkage between two completely separate issues.** In light of these concerns and ongoing implementation delays, the AMA strongly opposes further complicating Open Payments implementation by establishing a misleading linkage to Physician Compare.

Furthermore, we understand that CMS is currently considering ways to publish aggregate physician Medicare claims information. The AMA cautions against release of this information without appropriate safeguards and engagement with the physician community. We also urge CMS to consider alternatives to adding this data to Physician Compare given the existing concerns outlined above.

We thank you for the opportunity to provide our comments. We look forward to working with CMS to resolve the issues related to public reporting, and to remove barriers that prevent physicians and other providers from working together to deliver high quality, cost-effective care to our patients.

Sincerely,

James L. Madara, MD