STATEMENT

of the

American Medical Association

to the

Practicing Physicians Advisory Council

Re: Doctor's Office Quality (DOQ) Project: A Physician Level Measurement and Improvement Initiative

December 16, 2002

The AMA urges the Practicing Physicians Advisory Council to make the following recommendations to CMS —

MEDICARE PAYMENT UPDATE

- **That CMS support immediate enactment of legislation, when Congress returns in January, that will stop Medicare payment cuts and keep the Medicare program strong for America's seniors.**

DOCTOR'S OFFICE QUALITY PROJECT

In response to a request by CMS, the AMA has agreed—on behalf of the AMA-convened Physician Consortium for Performance Improvement (The Consortium)—to provide to CMS evidence-based performance measures and reporting tools developed by the Consortium for use in the Doctor's Office Quality (DOQ) Project. The performance measures are intended for use in demonstration projects/pilot tests in Quality Improvement Organizations (QIOs) in California, New York, and Iowa.

The AMA urges the Practicing Physicians Advisory Council (PPAC) to recommend that CMS, as it proceeds with the DOQ Project:

- **Use the Consortium's evidence-based performance measures and any resulting data for quality improvement purposes only, the purpose for which the measures are designed and intended;**

- **Continue to work with the AMA and The Consortium to ensure the appropriate development and implementation of evidence-based clinical performance measures that enhance the quality of patient care and advance the science of clinical performance measurement and improvement;**

- **Use information gleaned from implementing the measures in the pilot tests of the DOQ Project to further refine the measures, if necessary, in collaboration with The Consortium, and The Consortium should be involved in future implementation efforts;**

- **Recognize the "state-of-the-art" of physician performance measurement, which supports the use of measurement to promote continuous quality improvement; existing methodologies do not warrant the use of measures for purposes of individual accountability, comparison, or choice;**

- **Acknowledge the serious limitations in using performance measurement to assess physician competence and to work with the AMA and The Consortium to ensure that data from the DOQ Project are used to improve the overall quality of patient care and not to assess individual physician performance;**

- **Consider the burden of data collection; consider the use of electronic medical systems to collect and process data; and agree to collect data for the DOQ Project prospectively only;**

- **Involve the national medical specialty societies and boards in addressing what constitutes the appropriate specialty-specific variance in clinical practice; and**

- **Indicate physician participation only as the sole criterion for public recognition by the DOQ Project.**

The American Medical Association (AMA) appreciates the opportunity to submit this statement to the Practicing Physicians Advisory Council (the Council) concerning quality of care for our nation's patients. Providing high quality of care is the highest priority for the physician community. There are important two aspects to quality of care that we address below: (i) the Medicare payment crisis in access to medical care for Medicare beneficiaries, and (ii) the development of performance measures for use in the Doctor's Office Quality (DOQ) Project: A Physician Level Measurement and Improvement Initiative (the DOQ Project or Project).

The AMA is substantially involved in the development of performance measures for use in the DOQ Project, and we are pleased to have the opportunity to provide physician performance measures developed by physicians for physicians to enhance the quality of patient care. As discussed below, we have some serious concerns, however, about potential implementation of physician performance measures and how collected data could be misused.

MEDICARE PAYMENT UPDATE

Ongoing cuts in Medicare payments for services furnished by physicians and numerous other health care professionals are causing Medicare's foundation to crumble. Medicare payments for all services provided by physicians and numerous other health care professionals were cut by 5.4 percent in 2002, and additional cuts of 12 percent are expected over the next three years, totaling $11 billion. (The attached chart shows the astronomical losses that will occur on a state-by-state basis.) If these cuts are implemented, Medicare payments in 2005 will be back below the 1991 payment levels, while at the same time, physicians' practice expenses will have risen by 40 percent.

If Congress and the Administration do not act to avert this crisis, physicians will be forced to make the difficult decision about whether to stop taking new Medicare or near-Medicare aged patients into their practices, or even withdrawing from the program altogether. Indeed, many physicians have already been forced to make this difficult choice.

As we have previously discussed with the Council, numerous news reports across the country have documented the growing access problem resulting from Medicare cuts. Recent data from multiple studies indicate that Medicare payment cuts reduce beneficiaries' access to service. Rural communities are particularly at risk.

According to a survey conducted by the AMA shortly after the 5.4 percent Medicare cut was implemented on January 1, 2002, some 24 percent of physicians either had placed limits on the number of Medicare patients they treat or planned to institute limits this year. The survey also found that, if there is an additional large Medicare cut in 2003, 42 percent of responding physicians would not sign or renew a Medicare participation agreement. In a similar vein, a survey by the American Academy of Family Physicians found that nearly 22 percent of family physicians are no longer taking new Medicare patients, a significant increase from the same survey conducted a year earlier.

Surveys from two nonpartisan policy organizations also suggest that physicians' ability to treat Medicare patients is declining. One by the Center for Studying Health Systems Change concluded that the number of physicians accepting all new Medicare patients declined from 74.6 percent in 1997 to 71.1 percent in 2001 — a year before the cuts even took effect. The other, done for the Medicare Payment Advisory Commission, found, based on preliminary data, a more precipitous slip — specifically that between 1999 and 2002, the percentage of physicians accepting all new Medicare patients dropped from 76 percent to 69 percent.

This crisis does not impact only Medicare patients. The families of active duty military and military retirees are also at risk because Medicare rates are tied to TRICARE rates. The Retired Officers Association (TROA) has called on Congress to fix the error and stop the cuts.

Although key leaders and most Members of Congress strongly support fixing the Medicare payment update problem, Congress was not able to pass and enact legislation to remedy the problem before it adjourned in 2002. CMS has announced its intention to publish shortly the final Medicare physician fee schedule rule, which is expected to contain an additional round of Medicare cuts of 4.4 percent for 2003. This rule has not yet been published, however, and thus when Congress returns in January, it will have a narrow window of opportunity to address the looming Medicare crisis.

We urge the Council to recommend that CMS support immediate enactment of legislation, when Congress returns in January, that will stop Medicare payment cuts and keep the Medicare program strong for America's seniors.

DOCTOR'S OFFICE QUALITY PROJECT

BACKGROUND ON AMA CLINICAL QUALITY IMPROVEMENT ACTIVITES AS THEY RELATE TO THE DOQ PROJECT

The AMA has a long and strong history of leadership and involvement in many aspects of clinical quality improvement and enhancement, including clinical practice guidelines and performance measures. Specific to the DOQ Project, over the past three years, the AMA has been heavily invested in the development of physician performance measures derived from evidence-based guidelines focused on improvement and enhancement of the overall quality of patient care and outcomes.

Toward these ends, the AMA convenes the Physician Consortium for Performance Improvement (The Consortium), which is dedicated to building the tools and resources necessary to assist physicians in collecting and using clinical data to improve and enhance patient care. In addition to the AMA, The Consortium is comprised of more than fifty national medical specialty societies, the Agency for Healthcare Research and Quality (AHRQ), and Centers for Medicare and Medicaid Services (CMS). The

Consortium has taken the lead in developing evidence-based clinical performance measures and reporting tools and is making this information available to physicians by distributing physician performance measurement tools in a variety of formats, including hard copy, within an information kit entitled *Taking the Lead Together*, as well as electronically.

Based on The Consortium's experience and expertise, CMS has requested The Consortium's performance measures for use in the DOQ Project. CMS has developed similar performance measures for hospitals. Although CMS had planned to extend this initiative to physician-level data, CMS determined that the Consortium measures are better suited for this purpose. We believe the AMA's involvement through its convening of The Consortium to develop performance measures for the DOQ Project pilot will assist physicians in improving the quality of care in their practice of medicine. We have not and will not advocate for implementation of any performance measures that interfere with the practice of medicine or add to the regulatory and administrative burdens already imposed on physicians by the federal government.

More importantly, we support the use of performance measurements for quality improvement only; we do not support the use of the measures for accountability or punitive purposes.

The AMA urges the Council to recommend to CMS that it use The Consortium's evidence-based performance measures and any resulting data for quality improvement purposes only, the purpose for which the measures are designed and intended.

DEVELOPMENT OF PERFORMANCE MEASUREMENTS

The Consortium has agreed to develop clinical performance measures for six areas of medical practice with respect to patients ages 65 - 79 years: adult diabetes, coronary artery disease, major depressive disorder, osteoarthritis, hypertension, and congestive heart failure.

Specific performance measures for these areas of medical practice will be provided to CMS by the end of February 2003. CMS will use these Consortium measures in pilot studies that will be implemented shortly thereafter. These pilots will be conducted in physicians' offices in three states: California, New York, and Iowa; QIOs will be responsible for implementation of the pilots. The Consortium intends to continue its involvement with the DOQ Project throughout all stages of the pilots and to monitor the project for purposes of reviewing and, if necessary, revising the performance measures.

The AMA urges the Council to recommend that CMS continue to work with the AMA and The Consortium to ensure the appropriate development and implementation of evidence-based clinical performance measures that enhance the quality of patient care and advance the science of clinical performance measurement and improvement.

The AMA urges the Council to recommend that the use of information gleaned from implementing the measures in the pilot tests of the DOQ Project be used to further refine the measures, if necessary, in collaboration with The Consortium and that The Consortium be involved in future implementation efforts.

LIMITS IN USE OF CLINICAL PERFORMANCE MEASUREMENT DATA

The AMA and The Consortium value the opportunity to lead the way in developing physician performance measures, and we view our participation in the DOQ Project as an additional opportunity to improve quality of care for America's patients. Without the involvement of the medical community, the chances that performance measures will enhance the quality of care would be significantly diminished; indeed, poorly designed measures could, instead, interfere with or burden a physician's practice and lead to a reduction in the quality of care provided.

The AMA believes that data collected from use of the performance measures during the DOQ Project pilots can enhance patient care if CMS uses the data for quality improvement purposes only. CMS must also keep in mind that there are significant methodological limits in the use of clinical performance measurement data. Again, the AMA does not support the use of these data for any purpose other than quality improvement, and particularly not for accountability or punitive purposes.

It should be noted that the DOQ Project will help identify issues surrounding the collection of specific data in a uniform manner across different practices. Both individual physicians and physicians working in group practices will participate.

Limits of clinical data are discussed at length in a 2002 Institute for Health Policy report on physician clinical performance assessment, which was commissioned jointly by the AMA, the Accreditation Council on Graduate Medical Education (ACGME), the American Board of Medical Specialties (ABMS), and the Council of Medical Specialty Societies (CMSS) and supported by the UnitedHealth Foundation. The report was developed by the Institute of Health Policy at Massachusetts General Hospital/Partner HealthCare System and is a review of the state-of-the-art of physician clinical performance assessment. The Executive Summary of this report is attached for your reference.

This report specifies a number of significant barriers in assessing physician clinical performance. First, there is a lack of readily available performance measures that are based on sound evidence, as well as a lack of agreed-upon, evidence-based criteria for excellent, acceptable, and unacceptable performance. In addition, risk adjustment methods to insure that individual patient factors are considered and addressed are critical, but not widely available. Moreover, there are methodological concerns related to the number of patients necessary for providing meaningful quality improvement feedback to physicians that is a reliable estimate of the physician's clinical performance.

A substantial amount of work is needed to determine how differences among the medical specialties with regard to diagnoses, treatments, and procedures affect the practice of medicine and how the evidence-base is applied within various medical specialties. Further, the cost and feasibility issues associated with identifying and collecting data are formidable. Patient attitudes toward adherence to medical recommendations may also influence the outcomes of an individual physician's performance, which needs to be recognized as an important source of variation among clinical practices.

These serious limits in using clinical data to assess individual physician performance are also discussed in the attached editorial by Donald M. Berwick, MD, MPP, entitled: *Public Performance Reports and the Will for Change*, *JAMA, Sep. 25, 2002* .

The AMA urges the Council to recommend that CMS recognize the "state-of-the-art" of physician performance measurement, which supports the use of measurement to promote continuous quality improvement; existing methodologies do not warrant the use of measures for purposes of individual accountability, comparison, or choice.

The AMA urges the Council to recommend that CMS acknowledge the serious limitations in using performance measurement to assess physician competence and to work with the AMA and The Consortium to ensure that data from the DOQ Project are used to improve the overall quality of patient care and not to assess individual physician performance.

The AMA urges the Council to recommend that CMS consider the burden of data collection; consider the use of electronic medical systems to collect and process data; and agree to collect data for the DOQ Project prospectively only.

The AMA urges the Council to recommend to CMS the involvement of the national medical specialty societies and boards to address what constitutes the appropriate specialty-specific variance in clinical practice.

CMS QUESTIONS FOR COUNCIL DISCUSSION OF THE DOQ PROJECT

CMS is requesting that certain questions be discussed in connection with the Council's discussion of the DOQ Project. Specifically, CMS has asked the following questions:

1. What will motivate physicians to measure their success in providing care that is known to be of high quality and to improve that performance?

2. Specifically, what is the role of public recognition as an incentive?

3. How might such public recognition be made?

The foregoing questions focus on the concept of using public recognition to motivate physicians. The AMA supports using public recognition of participation in the CMS

DOQ Project. Participation in the Project requires substantial time and money on the part of the physician and the physician's office, and thus a physician who agrees to participate in the Project should be given public recognition. We have concerns, however, that public recognition could be misused against certain physicians. Therefore, the simple fact that a physician participated in the DOQ Project should be the sole recognition offered. There are myriad reasons for this recommendation. For instance, if CMS were to develop an "index scoring" type of system for physicians who participate in the Project to reward or recognize those who achieve a high score, this could, in effect, penalize physicians who do not achieve a high score. Further, categorizing physicians into a high- versus low-score, or somewhere on a scoring continuum, would be tantamount to judging the level of care provided by a physician. Further, as discussed above, there are serious methodological concerns surrounding the use of clinical performance measures to measure a physician's clinical competence. Use of an index-scoring system to provide public recognition, in essence, would ignore the existence of these limitations.

The AMA urges the Council to recommend to CMS that the sole criterion for public recognition provided by the DOQ Project indicate that a physician participates only.

We appreciate the opportunity to provide our views to the Council on these critical matters, and are happy to work with the Council and CMS to achieve all of the foregoing recommendations.