609.896.1766
609.896.1347 (FAX)
WWW.MSNJ.ORG
INFO@MSNJ.ORG
2 PRINCESS ROAD
LAWRENCEVILLE, NJ 08648

November 30, 2010

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland
21244-1850
Via e-mail to: physiciancompare@cms.hhs.gov

Attn: Physician Compare Town Hall Meeting Comments

The Medical Society of New Jersey (MSNJ) appreciates the opportunity to present our views to the Centers for Medicare & Medicaid Services (CMS) concerning implementation of section 10331 of the Patient Protection & Affordable Care Act relating to the Establishment of a Physician Compare Website. MSNJ represents 9,000 member physicians in the state of New Jersey.

In New Jersey, our members have found that the healthcare insurers often do not change the status or demographic information on practices on their websites in a timely manner. This, alone, creates inefficiencies in terms of staff time spent with patients to correct misinformation and patient dissatisfaction. For this reason, we strongly recommend that CMS establish a process by which physicians can review and update their demographic information directly through the Physician Compare Website. In addition, CMS should establish a schedule whereby this information is updated, at least annually, and CMS initiates the updating process with physicians.

Physicians must have a lead role in developing and selecting the performance measures used for public reporting. MSNJ strongly believes that quality assessments must be based on nationally recognized quality standards, such as those established by the National Quality Forum (NQF), using evidence-based medicine.

Because of concerns with the data analysis and accuracy of physician profiling programs MSNJ has a policy with respect to such programs. The policy sets forth the following minimum standards for these programs.

- **DATA: Assessments must be based on accurate, current, and adequate data that can be validated. The data must be risk, severity, and outcomes adjusted.** Clinical data, including chart review, must be used to verify and support administrative claims data, which should never be the sole source of information. **Sample size must be sufficient to produce statistically significant results.**

- **METHODOLOGY: Quality assessments must be based on nationally recognized quality standards, such as those established by the National Quality Forum (NQF), using evidence-based medicine.** The methodology for determining cost-efficiency must be clearly disclosed. **To the extent that cost-efficiency is based on costs outside the control of the particular physician (including pharmaceuticals, DME, referrals, facility costs) it should be identified and disclosed to patients.** Methodologies should be uniform and standard throughout the industry.

- **TRANSPARENCY: The physician ranking program should be transparent to physicians and all stake-holders in terms of the data and methodologies used.** Quality and cost-efficiency should be determined separately, but to the extent that they are combined, there must be full disclosure of the allocation to quality and to cost-effectiveness. The burden is on the entity ranking physicians to ensure that all stake-holders have full disclosure and that there is a meaningful "plain-language" explanation of the ranking system. **The physician ranking must make clear to patients/consumers that no negative inference should be drawn about a physician who is not ranked.**

- **APPEAL AND OVERSIGHT: The physician ranking program must allow adequate time for review and correction of incorrect data. There must also be adequate time to review and dispute rankings,** which should include independent review. Physicians should have the option of opting-out of an assessment, either before or after the assessment takes place. All physician ranking programs should be reviewed by an independent body that includes physicians and other stake-holders, to assure that the program incorporates minimum standards. All physician ranking systems should be reviewed continually to ensure that the implementation is in accordance with minimum standards. An independent body should report compliance to all stake-holders on a periodic basis. If there is non-compliance, either in program structure or implementation, the independent body should have the authority to require remedial action in a timely manner. Remedial action might include correcting ranking status with an explanation to all stake-holders. [MSNJ Policy adopted March 16, 2008 (emphasis added)].

MSNJ has serious concerns about the current limitations on risk adjustment, attribution, and aggregation methodologies. Since there are no widely accepted models that accurately attribute care provided by multidisciplinary teams or by multiple physicians we urge CMS to address and resolve any attribution issues prior to publicly reporting this information. MSNJ is also concerned about whether there are statistically

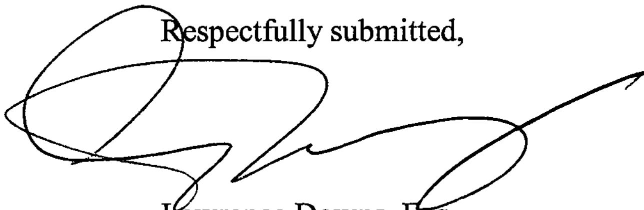
valid minimum thresholds to evaluate group performance, much less the performance of individual physicians. Therefore, we urge CMS to first report only at the group level, not individual physician level. Reporting at the individual physician level should be extensively piloted before wide-scale public reporting occurs.

MSNJ urges CMS to consider the lessons learned from the Physician Quality Reporting Initiative (PQRI). Our members found that the agency's reports were issued too late for them to address reporting problems which caused inaccurate reporting practices to continue. The reports were simply too late to be helpful. CMS should undertake education and implement outreach activities on how to successfully participate and share accurate performance data. Development and implementation of the Physician Compare Website should include detailed confidential interim and final reports that meaningfully inform physicians of reporting errors and allow adequate time for them to correct the errors.

CMS should establish a meaningful process for physicians to review and correct errors in their performance and measurement date and to appeal any errors before publication.

Finally, the use of patient satisfaction data is not appropriate for public reporting. This information is best used by physicians to improve how they respond to patient needs. There are already a number of websites that report on patient satisfaction and it is unclear whether the information is useful in assessing quality. MSNJ urges CMS not to report on patient satisfaction until the data can be analyzed and assess factors that are outside of the physician's control.

Respectfully submitted,



Lawrence Downs, Esq.
General Counsel
Medical Society of New Jersey