



Statement of

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Cleveland, Ohio

CMS Listening Session

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RE: Confidential Feedback Reports and Implementation of a Value-Based Payment Modifier for Physicians

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Ms. Roman, Ms. Cheetham, and other Medicare officials, I am Dr. Steven Schmitt, a clinician member of the Infectious Diseases Society of America (IDSA). I live in Cleveland, Ohio and practice infectious diseases (ID) medicine at the Cleveland Clinic. IDSA represents more than 9,000 physicians and scientists and is widely recognized as the pre-eminent authority on infectious diseases in the United States. Thank you for the opportunity to speak about the Resource Use Reporting and Value-Based Payment provisions of the Patient Protection and Affordable Care Act (ACA) of 2010.

In the 2011 Physician Fee Schedule Proposed Rule, the Centers for Medicare and Medicaid Services (CMS) proposes to build on its work during Phase I of the Physician Resource Use and Reporting Program to implement several changes that are statutorily required by the ACA during future phases. These changes include 1) moving beyond reporting of resource use measures at the individual physician level to include quality and cost information that will be confidentially reported to both individual physicians and group practices and 2) establishing a value-based payment modifier that will reimburse physicians differentially based on their quality and cost of care.

In previously submitted comments to CMS officials, IDSA described several possible unintended consequences of linking a portion of physicians' payments to their quality and cost of care. Quantitative resource use could be attributed to the wrong physician—this is likely to occur using the Phase I attribution process (i.e., straight attribution of claims to per episode costs). Also, the referral patterns of both specialists and internists may be inappropriately influenced by the cost of care without regards to the quality of care—this will likely happen if information from the confidential feedback reports is made public in the future. Internists may be disinclined to consult with subspecialists for fear of higher costs appearing in their reports—this will almost certainly happen under the “plurality minimum” attribution methodology in which the entire cost of care is attributed

to the physician who performed the plurality of Evaluation and Management (E&M) services. In order to minimize the impact of these unintended consequences, **feedback reports must tie costs to risk-adjusted patient outcomes and a process must be developed to further analyze the data if a physician is shown to be a high cost outlier. These capabilities will be critical as CMS moves forward with plans to publically report physician-level performance data.**

The value based payment modifier will be implemented beginning in 2015 concurrent with the establishment of payment penalties against physicians who fail to report on applicable accountability metrics under the Physician Quality Reporting Initiative (PQRI). **CMS should explain how these two programs will interact. Specifically, will success in one program preclude failure in the other, will failure in both programs result in two negative payment adjustments, and so on?**

The resource use and value-based payment provisions are intertwined with the ACA's requirement that Medicare make physicians' performance information publically available by 2013. Presumably, information that is released to the public through the Physician Compare Website would include much of the same cost and quality data that Medicare currently proposes to report confidentially to physicians and group practices. IDSA has serious concerns that much of this confidential data may not be appropriate for public dissemination or even actionable from a patient choice perspective. As such, **CMS should specifically clarify what information it plans to make available to the public and carefully consider how to present such information in a manner that is easily understandable by individuals who have no healthcare or statistical background.**

A case in point, "patients who are hospitalized have little control over care associated with their stay—for example, the professional services of physicians"¹ or the inpatient physicians who treat them for that matter. This is because ID consultants and other predominantly inpatient physicians, many of whom work in small community-based hospitals where only a few physicians from a particular specialty have privileges and even fewer are on the consult service at any given time, typically see all patients who are referred to them. Moreover, it is highly unlikely that ID inpatients, who are routinely among the sickest and most complex in the Medicare population, would have the means to access and the ability to compare meaningful performance information from their hospital bed prior to the initiation of consultative care. **Making such data publicly available would serve no purpose other than to provide retrospective and misleading performance information to hospitalized patients and their family members.**

Moreover, CMS's ability to measure ID specialists and other hospital-based physicians' performance is virtually non-existent given that the Agency has not included more measures related to inpatient care in the PQRI. While this is partly due to the lack of

¹Report to the Congress. Aligning Incentives in Medicare. MedPAC, p. 60. June 2010.

interest shown by the Physician Consortium for Performance Improvement and the National Quality Forum for inpatient and specialty metrics, these groups largely take direction and receive funding from CMS. Accountability measures must recognize the role of ID specialists and other hospital-based physicians in the treatment of highly complex hospitalized patients or in implementing system-wide practices that retard the development of antimicrobial resistance, reduce the prevalence of hospital-acquired infections and prevent new disease outbreaks. **These measure gaps must be addressed before CMS can confidentially report cost and quality data to hospital-based physicians and publicly release their performance results. ID physicians in particular have impacts on the healthcare system that goes beyond traditional patient care.**

Finally, IDSA generally supports the ACA provision that authorizes Medicare to develop episode treatment grouper (ETG) software. Medicare-developed ETG software that is available in the public domain may remedy many of the problems inherent with the commercial software utilized by CMS to build episodes of care during Phase I. However, in order to minimize problems related to risk adjustment and attribution, **CMS should solicit stakeholder input prior to and during the development of any open source ETG software product. IDSA would support the establishment of an advisory body, composed of practicing physicians with expertise in software development and health information technology, that could provide guidance to the Agency on this subject.**

I appreciate the opportunity to testify before you today on confidential feedback reports and implementation of a value-based payment modifier for physicians. Please feel free to use IDSA staff (jscull@idsociety.org) and me (schmits@ccf.org) as resources as these provisions are implemented in the coming years. Thank you.